

GOVERNMENT OF THE DISTRICT OF COLUMBIA  
DEPARTMENT OF HEALTH  
HEALTH REGULATION AND LICENSING ADMINISTRATION



**Health Certificate for Staff**

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**NAME:** \_\_\_\_\_ **SEX (Please circle one):**    MALE        FEMALE

**DATE OF BIRTH:** \_\_\_\_\_ **TELEPHONE No:** \_\_\_\_\_

**ADDRESS:** \_\_\_\_\_  
                             **Street**                                      **City**                                      **State**                                      **Zip Code**

**TYPE OF PROFESSIONAL LICENSE:** \_\_\_\_\_

I have examined the above-named person and certify that he/she is:

1. Free from disease in communicable form. **{Please Circle One:}**    YES    NO
2. In addition to a general physical health examination, the following test have been done:

Tuberculin Test (**check one**)                                      [ ] Tine    [ ] PPD

Date: \_\_\_\_\_                                      Result: \_\_\_\_\_

Chest X-Ray, Date: \_\_\_\_\_                                      Result: \_\_\_\_\_

**Remarks:**

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\_\_\_\_\_  
**Signature of Health Care Practitioner**

\_\_\_\_\_  
**Date of Examination**

\_\_\_\_\_  
**Address of Health Care Practitioner**

\_\_\_\_\_  
**Telephone No.**