OHIO DEPARTMENT OF JOB AND FAMILY SERVICES
EMPLOYEE MEDICAL STATEMENT
( 0DJFS 5101:2-1-25 )

Name of Employee

Date of Birth

Street Address

Date of Employment

City, State, and Zip Code

THIS IS TO CERTIFY THAT I HAVE EXAMINED THE ABOVE-NAMED PERSON WHO IS FOUND TO BE:

1. FREE OF COMMUNICABLE TUBERCULOSIS.

2. PHYSICALLY AND MENTALLY FIT FOR EMPLOYMENT IN A FACILITY CARING FOR CHILDREN.

3. IMMUNIZED AS REQUIRED BY THE OHIO DEPARTMENT OF HEALTH.

Is the employee in the process of receiving the series of shots to meet the Occupational Safety and Health Enforcement Administration requirements? Yes _________ No _________

NAME OF PHYSICIAN or CERTIFIED NURSE PRACTITIONER
( PLEASE PRINT OR TYPE)

STREET ADDRESS

CITY, STATE, AND ZIP CODE

TELEPHONE

PHYSICIAN or CERTIFIED NURSE PRACTITIONER’S SIGNATURE

DATE OF EXAMINATION

• THE EMPLOYEE MAY BE EXEMPT FROM THE IMMUNIZATION REQUIREMENTS FOR MEDICAL REASONS UPON FILING A WRITTEN REQUEST FROM THE PHYSICIAN OR CERTIFIED NURSE PRACTITIONER.

• THE EMPLOYEE MAY BE EXEMPT FROM THE IMMUNIZATION REQUIREMENT FOR RELIGIOUS REASONS UPON FILING A WRITTEN REQUEST WITH THE CENTER

• EMPLOYEE MEDICAL EXAMINATIONS PER RULE MUST BE UPDATED EVERY THREE YEARS

JFS 01296 (Rev. 4/2003)