Child Care and Development Fund Provider

PHYSICIAN'S MEDICAL EXAMINATION VERIFICATION FORM

I have conducted a medical examination upon _____

Name of Applicant

And it is in my opinion that (S)he does not have a physical or mental impairment that either (**doctor's initials** required by the statement that applies):

____ Prevents him/her from being able to safely and effectively perform all essential job-related functions once reasonable accommodations are provided by the employer, or

____ Poses a significant risk or substantial harm to the health or safety of the employee or other people in the work place that cannot be eliminated or reduced by reasonable accommodations.

Doctor's initial required: (Initial only one)

_____ The applicant is free of Tuberculosis.

_____ Latent TB / not active. Does not pose a health risk to others and is cleared for work.

Additional Comments:

_____ _____. _____

Name of Physician (Print) **Signature** **Date**

Address	**City**	**State**	**Zip Code**
Required Hospital Seal or Stamp here			