Triad Community Unit School District No. 2

Employee Physical Examination Form

Name: _____ SSN#: _____

Address: _____ Position: _____

Phone Number: _____

As a condition for employment with Triad Community Unit School District No. 2, you must successfully pass an examination to determine that you are in good health and free from communicable disease.

I hereby give consent for the physician who examined me to release further information that is requested by Triad Community Unit School District No. 2.

TO BE COMPLETED BY PHYSICIAN:

Date of Physical Examination: _____

Summary of Findings: _____

_____

_____

_____

I hereby certify that I have examined the above applicant and the above is a complete and accurate

record of my examination and the applicant is free from communicable diseases and physically fit to perform the essential functions of the position for which the applicant is applying.

Medical License Number: _____

Print Name: _____, MD Signature: _____

Address: _____ Telephone: _____

Revised 10-27-14
(removed TB requirement as per Board Policy 5:30-revised 10-27-14)