203 N Washington Street
Joy, IL 61260
Phone: 309-582-2238
Fax: 844-975-1215

PHYSICIAN'S CERTIFICATE

Employee Name _____

I hereby certify that I have given the above named school employee a complete physical examination and find the same to be physically fit to perform the duties assigned and to be free from communicable disease.

Date of examination _____

Address _____

Physician's Signature _____

TUBERCULOSIS TEST

*** No longer required due to the changes in Public Act 098-0716 which no longer requires employers to have employees complete a TB Test prior to employment unless otherwise required by the Local Health Department**