

# Cabarrus County - Field Experience

1. Complete and submit the following documents:
  - a. Cabarrus County Health Form- Page 2. Must be completed and signed by a licensed medical professional.
  - b. [Cabarrus County Background Check](#). You will receive a time-sensitive link from their background investigation bureau and must complete and submit it within 3 days of receipt.
  - c. Pass a drug test (in-processing paperwork).
  - d. Attend the Orientation session at the Cabarrus County Ed Center.
2. Submit all completed documents through the Microsoft Form link available on the Field Experience website.
3. Placement confirmations will be provided by the Office of Educator Engagement and Student Success and reflected in the Brave Educator Dashboard. Be sure to check the dashboard regularly for updates.

Questions? Please contact the Director of Educator Engagement and Student Success, Dr. Kamina Fitzgerald, [kamina.fitzgerald@uncp.edu](mailto:kamina.fitzgerald@uncp.edu)

**HEALTH EXAMINATION CERTIFICATE      North Carolina Public Schools**

Required of all persons upon initial employment, separation from employment more than one school year, absence of more than 40 successive days because of a communicable disease, or when deemed necessary by a local school board or superintendent. (Ref.NCGS115C-323)

Name: \_\_\_\_\_ Social Security Number: \_\_\_\_\_  
Address: \_\_\_\_\_

The above named individual is to be recommended for employment by Cabarrus County Schools in a position of **student teacher/intern**. In this position, the condition of certain physical capacities will be of importance. Please examine the areas listed below and report any limitations, deficiencies or related restrictions.

**I. Communicable Disease**

By my signature I certify that the above **named person does not have any communicable disease, including tuberculosis**, that poses a significant risk of transmission in our schools or would impair this person’s ability to perform the duties of the job, except as may be noted below. Further, I certify that this person is free of any physical or mental disability that would impair job performance.

If unable to certify the above, please comment:

\_\_\_\_\_  
\_\_\_\_\_

**II. Other Health Areas**

AREAS	LIMITATIONS		NATURE OF LIMITATIONS (continue on back as needed)
	YES	NO	
Vision			
Hearing			
Heart			
Lungs			
Lifting/Carrying			

Appropriate Immunizations	Current?		Any Immunization Recommendations
	YES	NO	
Td(tetanus), Hep B, MMR, etc.			

**\*\*\*\*REQUIRED\*\*\*\***

Date of TB Test: \_\_\_\_\_ Circle Results: Positive/Negative

\_\_\_\_\_  
SIGNATURE of Physician, PA, or Nurse Practitioner (Type or Print)      Date: \_\_\_\_\_

License/Registration #: \_\_\_\_\_ State\* Granting License/Registration: \_\_\_\_\_

\*For initial employment of an out-of-state applicant the certificate may be completed by a health care provider with an out-of-state unrestricted current license or registration.