Craven County - Field Experience

1. Complete and submit the following documents:

    a. Health Examination Certificate- Page 2.

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

HEALTH EXAMINATION CERTIFICATE

North Carolina Public Schools

Certificate may be faxed to Human Resource Services, Craven County Schools at (252) 514-6352

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. NCGS 115C-323)

Name:_______________________________________ **Social Security Number:** _________________________

ADDRESS: ____
(Street/P.O. Box) (City) (State) (Zip Code)

The above-named individual is to be recommended for employment by Craven County Schools in a position of _______________________________________. 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 above. Further, I certify that this person is free of any physical or mental disability that would impair job performance.

Please enter TB Skin Test Result: ____________________

If unable to certify the above, please comment:____

II. Other Health Areas

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

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

Date: ______________________ ____
Physician, Physician's Assistant, or Nurse Practitioner (Type or Print)

____ __________________________________
Physician's Business Address **Physician's Business Phone Number**

SIGNATURE OF PHYSICIAN: ____**M.D.**
Signature Please (NO STAMP)

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. 03/2015