

**OHIO DEPARTMENT OF JOB AND FAMILY SERVICES
EMPLOYEE MEDICAL STATEMENT**

(0DJFS 5101:2-12 -25)

Name of Employee

Date of Birth

Street Address

Date of Employment

City, State, and Zip Code

THIS IS TO CERTIFY THAT I HAVE EXAMINED THE ABOVE-NAMED PERSON WHO IS FOUND TO BE:

- 1. FREE OF COMMUNICABLE TUBERCULOSIS.**
- 2. PHYSICALLY AND MENTALLY FIT FOR EMPLOYMENT IN A FACILITY CARING FOR CHILDREN.**
- 3. IMMUNIZED AS REQUIRED BY THE OHIO DEPARTMENT OF HEALTH .**

Is the employee in the process of receiving the series of shots to meet the Occupational Safety and Health Enforcement Administration requirements? Yes _____ No _____

**NAME OF PHYSICIAN or CERTIFIED NURSE PRACTITIONER
(PLEASE PRINT OR TYPE)**

STREET ADDRESS

CITY, STATE, AND ZIP CODE

TELEPHONE

PHYSICIAN or CERTIFIED NURSE PRACTITIONER'S SIGNATURE

DATE OF EXAMINATION

- **THE EMPLOYEE MAY BE EXEMPT FROM THE IMMUNIZATION REQUIREMENTS FOR MEDICAL REASONS UPON FILING A WRITTEN REQUEST FROM THE PHYSICIAN OR CERTIFIED NURSE PRACTITIONER.**
- **THE EMPLOYEE MAY BE EXEMPT FROM THE IMMUNIZATION REQUIREMENT FOR RELIGIOUS REASONS UPON FILING A WRITTEN REQUEST WITH THE CENTER**
- **EMPLOYEE MEDICAL EXAMINATIONS PER RULE MUST BE UPDATED EVERY THREE YEARS**