Raymond School District
School Administrative Unit #33

43 Harriman Hill Road
RAYMOND, NH 03077
(603 895-4299)

MEDICAL EXAMINATION OF SCHOOL DISTRICT EMPLOYEES

NAME:(Miss, Ms., Mr.)_____
First (Middle Initial) (Last)

ADDRESS:_____

TELEPHONE:_____ DATE OF BIRTH:_____

POSITION FOR WHICH EMPLOYED:_____ SEX (F/M)____

CERTIFICATION OF MEDICAL EXAMINATION

This is to certify that I have examined_____

(Patient)

and find her/him free of communicable disease and from any physical or mental disabilities that might interfere with the performance of her/his assigned duties, with the following exception(s):

_____

_____

Special requirements, such as glasses:_____

Date of Medical Examination:_____

_____
Signature of Physician

_____
Physician's Name (please print)

_____
Physician's Address
