PHYSICIAN'S CERTIFICATE FOR MINOR WORK PERMIT

3331.02 ORC
4109.02 ORC

APPLICANT INFORMATION

Name of Student / Applicant in full:

Sex: ☐ Male ☐ Female

Date of Birth:

Height: ft. in.

Weight: lbs.

Color of Hair:

Color of Eyes:

Distinguishing Characteristics, if any:

School District:

Building:

Parent or Guardian:

Parent or Guardian Telephone Number:

PHYSICIAN'S APPROVAL

THE UNDERSIGNED HEREBY CERTIFIES THAT THEY HAVE THOROUGHLY EXAMINED THE ABOVE NAMED APPLICANT WHO WAS BORN ON THE DATE STATED ABOVE, AND WHO MEETS THE DESCRIPTION GIVEN HEREON, AND THAT SAID PERSON;

☐ IS ☐ IS NOT

IN THEIR OPINION PHYSICALLY FIT TO PERFORM THE WORK OF ANY EMPLOYMENT NOT FORBIDDEN BY LAW TO A PERSON OF THIS AGE AND SEX.

X

Physician's Signature

Date Signed

NOTE: IF WORK SHOULD BE LIMITED TO A CERTAIN TYPE OF EMPLOYMENT, THE PHYSICIAN MUST MARK THIS FORM ACCORDINGLY IN THE AREA BELOW.

Limited Certificate: ☐ YES ☐ NO

If Marked YES;
Employment should be Limited to Work Specified Below: