



Applicant Name:

Application ID:

Credential Type:

## HEALTH CERTIFICATE

**The Health Certificate section must be completed by a United States licensed physician, physician's assistant or nurse practitioner.**

I certify that I am a: (circle one)

- Physician (DO, DR, MD or OS);
- Osteopathic or Medical Training Resident (OT or MT);
- Physician's Assistant (PA or PAC); or
- Certified Registered Nurse Practitioner (CRNP or SP)

licensed/certified as such in a state of the United States or its capital; that I have examined the applicant and find that the applicant is not disqualified by reason of a mental or physical disability or a communicable disease from the successful performance of the essential functions of a teacher with or without a reasonable accommodation.

\_\_\_\_\_  
Signature of Examining Physician

\_\_\_\_\_  
Date

\_\_\_\_\_  
State in which licensed

\_\_\_\_\_  
State License No.

\_\_\_\_\_  
Daytime Phone Number