PHYSICIAN'S CERTIFICATE FOR MINOR WORK PERMIT

3331.02 ORC 4109.02 ORC

APPLICANT INFOR	RMATION							
Name of Student / Applicant in full:						Sex:		
						Male	Female	
Date of Birth:	Height: Weigh	t·	Color of Hair:			lor of Eyes:	_	
Date of Birth.					٦ ا			
	ft. in.		lbs.					
Distinguishing Characteristics, in	t any:							
School District:			Building:					
Parent or Guardian:				Parent or	Guard	ian Telephon	e Number:	
_								
PHYSICIAN'S APP	ROVAL							
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;			NOTE: IF WORK SHOULD BE LIMITED TO A CERTAIN TYPE OF EMPLOYMENT, THE PHYSICIAN MUST MARK THIS FORM ACCORDINGLY IN THE AREA BELOW.					
☐ IS	☐ IS NOT		Limited Certificate:	YES		☐ NO		
IN THEIR OPINION PHYSICALLY FIT TO PERFORM THE WORK OF ANY EMPLOYMENT NOT FORBIDDEN BY LAW TO A PERSON OF THIS AGE AND SEX.			If Marked YES; Employment should be Limited to Work Specified Below:					
X] [
Physician's Signature								
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Date Signed								

LAWS COM 0000 (Replaces OHIO FORM V)