GOVERNMENT OF THE DISTRICT OF COLUMBIA
DEPARTMENT OF YOUTH REHABILITATION SERVICES
OFFICE OF LICENSING

ADULT HEALTH CERTIFICATE

Name: _____ Sex: ☐ Male ☐ Female

Date of Birth: _____ Telephone Number _____

Address: _____
Number Street Apt # [if applicable] City State Zip Code

I have examined the above-named person and certify that he/she is:

1. ☐ Free from disease in communicable form.

2. ☐ In satisfactory physical condition, which will permit, close association with children without danger to them.

In addition to a general physical examination, the following tests have been done:

Tuberculin test (Check One): ☐ Tine ☐ PPD

Date: _____ Result: _____ _____

Chest X-Ray: Date: _____ Result: _____

Other: _____

_____

_____

_____

_____

_____ M.D. Date of Examination: _____
Signature of Examining Physician

_____ Telephone No: _____
Address Area Code