

**Religiously Exempt Child Day Centers  
Model Form**

**STAFF HEALTH REPORT**

**Physician's Statement**

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INSTRUCTIONS: Please provide a copy of this form to each employee to be given to his/her examining physician. The top portion of the form should be completed by the employee; the bottom portion must be completed and signed by the physician, physician's assistant, or licensed nurse practitioner. The signature of an R.N. or L.P.N. is NOT acceptable. Staff must have this form completed and submit it on an ANNUAL basis.

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Name of Religious Institution

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Name of Staff Member

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This statement is signed in compliance with the Code of Virginia, Section 22.1-289.031.

I certify that \_\_\_\_\_ is free from any  
(Patient)  
disability which would prevent him/her from caring for children under his/her supervision.

Physician/Nurse Practitioner's Signature: \_\_\_\_\_

Physician/Nurse Practitioner's Printed Name: \_\_\_\_\_

Date \_\_\_\_\_  
(Month/Day/Year)

Address: \_\_\_\_\_

Telephone  
Number \_\_\_\_\_