ANDERSON SCHOOL DISTRICT ONE

Medical Report

This is to certify that on _____ I, a licensed medical doctor, examined _____ and found him/her free from any condition which would in my opinion impair or prevent the performance of duties, functions, or responsibilities as a school district employee.

_____
Signature of Doctor (facsimile stamp not acceptable)

Doctor's Address: _____
(Street)

_____
(City) (State) (Zip Code)

Please return to: Anderson School District One
P. O. Box 99
Williamston, SC 29697

Employee – Please fill in information below and please print legibly:

Name:_____

School Location:_____School Year_____

Home Address:_____

_____