Name of Student / Applicant in full:	Sex: Grade Level:
·	Male Female
Proof of Age (Type of document); Age: Date of Birth:	Physician's certificate:
	Submitted with Valid physician
Address of Student /Applicant:	this application certificate on f
School District: Building:	
arent or Guardian:	Parent or Cyardian Talantana Maria
	Parent or Guardian Telephone Number:
ddress of Parent or Guardian;	
HEREBY CERTIFY THAT TO THE BEST OF MY KNOWLEDGE AND LIEF THE ABOVE STATEMENTS ARE TRUE AND THAT THE MINOR ABOVE NO	CERTIFY THAT I HAVE EXAMINED AND APPROVED TH
AMED ABOVE WILL WORK WITH MY APPROVAL.	TED DOCUMENTARY PROOF OF AGE.
X	
Signature of Parent or Guardian Superintende	ent / Chief Adminstrative Officer / Designated Issuing Office
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(Optional- if employer wants notification in case of revocation)

PHYSICIAN'S CERTIFICATE FOR MINOR WORK PERMIT

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Name of Student / Applicant i	n tuli:					
Date of Birth:	Height:	Weight:	Color of Hai	f:	Color of Eyes:	
	ft. in.		lbs.			
Distinguishing Characteristics	, if any:					
School District:			Building:			
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Parent or Guardian: Parent or Guardian Telephone I					Guardian Telephone Number:	
PHYSICIAN'S AP	PROVAL					
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