

CERTIFICATION STATEMENT – ASTHMA/RESPIRATORY AILMENTS

I, _____ **HEREBY CERTIFY THAT THE**
(Printed name of selectee – First, Middle, Last)
INDIVIDUALS LISTED BELOW DO NOT HAVE ASTHMA OR OTHER RESPIRATORY AILMENTS.

NAME

RELATIONSHIP

(List names and relationship below. Include yourself and/or family members as applicable.)

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

(Signature)

(Date)