



**Carlsbad Unified School District**

6225 El Camino Real • Carlsbad, CA 92009  
(760) 331-5000 • (760) 431-6707

*...a world class district*

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# MEMO

To: Retired Teachers

From: Rick Grove  
Assistant Superintendent, Personnel Services

Re: Form I-30 CERTIFICATION OF FREEDOM FROM CONTAGIOUS OR INFECTIOUS DISEASE

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Attached is Form I-30 – Certification of Freedom from Contagious or Infectious Disease. Education Code Section 23919 requires that retired teachers have Form I-30 completed and signed by their physician if they plan to continue working as a substitute teacher and/or in any other school-related positions.

Please return the completed form to the Certificated Personnel Services Office. A copy will be placed in your personnel file and the original will be sent to the STRS Retirement Office, San Diego County Office of Education. THE COMPLETED FORM MUST BE RETURNED TO THE PERSONNEL OFFICE AS SOON AS POSSIBLE.

Please do not delay in taking care of this very important matter. Failure to do so will result in a hold of your pay warrant.

5/5/14

Employee Name \_\_\_\_\_

(Type or Print)

Social Security No. \_\_\_\_\_

School District \_\_\_\_\_

**CERTIFICATION OF FREEDOM FROM CONTAGIOUS OR INFECTIOUS DISEASE**

*(For use in the Employment of Retired Teachers-Education Code section 44839.5 & 87408.5)*

I hereby certify that:

(1) I am licensed to practices as a physician and surgeon in California.

(2) On the date shown herein below I examined \_\_\_\_\_  
(Name)

Who gave \_\_\_\_\_ as his (her) address. On that date I found him (her) to be free from any contagious or infectious disease including freedom from active tuberculosis.

Date \_\_\_\_\_ [Signature of Physician] \_\_\_\_\_

Name of physician (type or print) \_\_\_\_\_ State License No. \_\_\_\_\_

The following authorization signed by the person examined shall be set forth below the certificate:

**AUTHORIZATION**

Dr. \_\_\_\_\_:

You are hereby authorized to give to the State Board of Education, any county superintendent of schools, the governing board of a school district to which the undersigned has applied for employment, and representatives of any of them, any and all information you may have regarding my physical or mental condition, including but not being limited to the history, findings, diagnosis, treatment given, present condition, and prognosis.

Date \_\_\_\_\_ [Signature of Person Examined] \_\_\_\_\_

Address \_\_\_\_\_

Notice: This form may be reproduced by school districts and offices of county superintendents of schools.