UAHS WORK PERMIT INSTRUCTIONS

Your application is divided into THREE sections. Complete all sections before returning to the main office.

Page 1
Section 1 – “Student/Applicant Information”
Complete the top half of the form. Parent’s or Guardian’s signature is required.

Section 2 – “Pledge of Employer”
Your Employer is required to complete the second half of the form.

Page 2
Section 1 – “Applicant Information for Physician”
Complete the Applicant Information section. You are required to have a physical within one year, so please take the form to your physician’s office. If you are an athlete and the trainer has a copy of your current physical form, please attach a copy.

You are required by the State to have a physical within the last year of your applying for this work permit. Please have your Physician complete the form.

**Bring the completed forms (two pages) back to the main office of the Upper Arlington High School. The information provided will be entered on the State’s website, then the “work permit” will be generated to give to your employer.**

If you are not an Upper Arlington High School student, please bring a copy of your birth certificate or passport.
APPLICATION FOR MINOR WORK PERMIT

STUDENT / APPLICANT INFORMATION

Name of Student / Applicant in full: ______________________________

Sex:  [ ] Male  [ ] Female  Grade Level: ________________

Proof of Age (Type of document): ____________________________

Age:  ____________________ Date of Birth: ________________

Physician’s certificate:  [ ] Submitted with this application  [ ] Valid physician’s certificate on file

Address of Student/Applicant: ________________________________

School District: __________________________ Building: ____________

Parent or Guardian: __________________________ Parent or Guardian Telephone Number: ________________________________

Address of Parent or Guardian: ________________________________

I HEREBY CERTIFY THAT TO THE BEST OF MY KNOWLEDGE AND BELIEF THE ABOVE STATEMENTS ARE TRUE AND THAT THE MINOR NAMED ABOVE WILL WORK WITH MY APPROVAL.

Signature of Parent or Guardian: __________________________ Date Signed: ________________

PLEDGE OF EMPLOYER

Name of Firm: __________________________ Telephone Number at Minor’s Work Location: ________________

Address of Student/Applicant’s Place of Employment, Job Site, or Work Location: ________________________________

Specific Nature of Employment: ________________________________

Employer’s Tax ID Number (9 digits). THIS FIELD IS MANDATORY: ________________

No. of Days Per Week: __________ Hours Per Day: __________ Starting Time: __________ Quitting Time: __________

IF MINOR WORKS A VARIED OR IRREGULAR SCHEDULE, ENTER “REPRESENTATIVE” TIMES IN ITEMS 1 THRU 4. ARE HOURS TO BE WORKED WITHIN THE LIMITS OF THE LAW?

[ ] YES  [ ] NO

THE UNDERSIGNED HEREBY AGREES TO EMPLOY THE ABOVE NAMED CHILD IN ACCORDANCE WITH LAWS REGULATING THE EMPLOYMENT OF MINORS. THE EMPLOYER FURTHER AGREES TO GIVE MINOR A COPY OF THE WAGE AGREEMENT IN ACCORDANCE WITH SEC. 4109.42 ORC. THE EMPLOYMENT WILL BECOME EFFECTIVE AS SOON AS THE NECESSARY AGE AND SCHOOLING CERTIFICATE IS VERIFIED BY THE EMPLOYER. THE EMPLOYER AGREES TO PERMIT THE CHILD TO ATTEND PART TIME SCHOOL WHEN SUCH IS AVAILABLE AND TO NOTIFY THE SCHOOL WITHIN FIVE DAYS AFTER THE EMPLOYMENT OF THE CHILD TERMINATES.

Signature of person authorized to sign for employer: __________________________ Date signed: ________________ Telephone number: ________________

Address of employer if different from minor’s place of employment: ________________________________

E-Mail address (Optional- if employer wants notification in case of revocation):

LAWs.COM 0000 (Replaces Ohio Form II & III)
PHYSICIAN’S CERTIFICATE FOR MINOR WORK PERMIT

APPLICANT INFORMATION

Name of Student / Applicant in full: ________________________________

Sex: □ Male □ Female

Date of Birth: ____________________________

Height: ______ ft. ______ in.

Weight: ______ lbs.

Color of Hair: ____________________________

Color of Eyes: ____________________________

Distinguishing Characteristics, if any:

______________________________

School District: ____________________________

Building: ____________________________

Parent or Guardian: ____________________________

Parent or Guardian Telephone Number: ____________________________

PHYSICIAN’S APPROVAL

THE UNDERSIGNED HEREBY CERTIFIES THAT THEY HAVE
THOROUGHLY EXAMINED THE ABOVE NAMED APPLICANT WHO
WAS BORN ON THE DATE STATED ABOVE, AND WHO MEETS THE
DESCRIPTION GIVEN HEREON, AND THAT SAID PERSON;  

□ IS □ IS NOT

IN THEIR OPINION PHYSICALLY FIT TO PERFORM THE WORK OF
ANY EMPLOYMENT NOT FORBIDDEN BY LAW TO A PERSON OF
THIS AGE AND SEX.

X

Physician’s Signature

Date Signed

NOTE: IF WORK SHOULD BE LIMITED TO A CERTAIN TYPE OF
EMPLOYMENT, THE PHYSICIAN MUST MARK THIS FORM
ACCORDINGLY IN THE AREA BELOW.

Limited Certificate: □ YES □ NO

If Marked YES;
Employment should be Limited to Work Specified Below:

______________________________