

**PHYSICAL FITNESS CERTIFICATION**

(Name of Applicant)

(Address)

(Date of Birth)

Male

Female

**INSTRUCTIONS TO PHYSICIAN:**

**Complete Part A unless certificate is limited --in which case complete Part B**

**A.** I hereby certify that I have examined the above-named applicant and find **he/she is physically qualified for lawful employment.**

(Date of Physical)

(Signature of Physician)

(Address of Physician)

**B.** I hereby certify that I have examined the above-named applicant and find **he/she has a disability that requires limited employment.**

(1) Disability ---

(2) Occupation ---

(3) Employer ---

(Date)

(Signature of Physician)

(Address of Physician)

**If a limited certificate is indicated, the disability, occupation, and employer must be indicated to make this certificate valid.**