FIREFIGHTER MEDICAL EXAMINATION CERTIFICATE

Last Name: ________________________ **First** ______________________ **Middle** ______________

Date of Birth: ________________________ **Social Security #:** __________________________

Address: ____

____

City **State** **Zip**

I certify that I have completed my examination of the examinee and I have concluded that on this date, the examinee has:

CHECK THE APPROPRIATE BOX(ES)

☐ **PHYSICAL EXAM**

To be physically sound and free from any defect which may adversely affect the performance of duty appropriate to the type of license sought.

Passed ___________ **Failed** ___________

Physician: ____

Name **State License Number**

Mailing Address: ____

Street **City** **State** **Zip**

Phone No.: ( ) ________________________________

______________________________ ______________________________

Date **Signature of Physician**

This declaration is not public information and is valid unless withdrawn or invalidated, and is valid only if signed by a licensed physician.