

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**This declaration is not public information and is valid unless withdrawn or invalidated, and is valid only if signed by a licensed physician.**