

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This declaration is not public information and is valid unless withdrawn or invalidated, and is valid only if signed by a licensed physician.