





**PHYSICAL FITNESS CERTIFICATION**

(Name of Applicant) (Address)

(Date of Birth)

Male  Female  Other

**INSTRUCTIONS TO HEALTHCARE PROVIDER:**

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

I hereby certify that I have examined the above-named applicant and find they are physically qualified for law enforcement employment.

(Signature of Healthcare Provider)

(Date of Physical)

(Address of Healthcare Provider)

I hereby certify that I have examined the above-named applicant and find they have a disability that requires limited employment.

(1) Disability ---

(2) Occupation ---

(3) Employer ---

(Signature of Healthcare Provider)

(Date)

(Address of Healthcare Provider)

(Address of Healthcare Provider)

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

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