

THE UNIVERSITY OF THE STATE OF NEW YORK  
THE STATE EDUCATION DEPARTMENT  
Albany, New York 12234

**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.**