

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

**PHYSICAL FITNESS CERTIFICATION**

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(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.**