Medical Clearance Form

Candidate Name: _____ Date:_____

Health Care Provider's Name: _____

Physician Contact Phone: _____

Clinic Address: _____

The following information is required to state the medical clearance of this person to perform the duties of a firefighter.

Medical Clearance Statement

Mr. / Mrs. _____ has been examined and cleared of any physical and mental restrictions that would prevent them from performing the duties of a full time firefighter.

_____ _____

Name **Signature**