

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

☐ Nonbinary

INSTRUCTIONS TO HEALTHCARE PROVIDER:

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 **they are physically qualified for lawful employment.**

(Date of Physical)

(Signature of Healthcare Provider)

(Address of Healthcare Provider)

B. 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 ---

(Date)

(Signature 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.