

Firefighter Candidate Physical Examination Form

CANDIDATE INFORMATION

Full Name

Date of Birth

Gender

Address

Phone Number

Email

MEDICAL HISTORY

Condition	Yes/No	Comments
Asthma		
Heart Disease		
High Blood Pressure		
Diabetes		
Seizure Disorder		
Other		

PHYSICAL EXAMINATION

Height

Weight

Blood Pressure

Pulse

System	Result	Comments
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Vision	<input type="text"/>	<input type="text"/>
Hearing	<input type="text"/>	<input type="text"/>
Respiratory	<input type="text"/>	<input type="text"/>
Cardiovascular	<input type="text"/>	<input type="text"/>
Musculoskeletal	<input type="text"/>	<input type="text"/>
Other	<input type="text"/>	<input type="text"/>

PHYSICIAN'S COMMENTS/RECOMMENDATIONS

CERTIFICATION

Medically Fit for Firefighting Duties

Physician Name

Physician Signature

Date