

MEDICAL CERTIFICATION FORM

Candidate's Name: _____

Candidate's Address: _____

Candidate's Date of Birth: _____

Candidate's Social Security Number: _____

The above named candidate will participate in a physical agility test as outlined below. Kindly examine the candidate to determine his/her fitness for participation in this physical agility test.

1. VERTICAL JUMP (Cut-off Score 15 inches)
2. SIT-UPS (Cut-off Score 28 in 60 seconds)
3. 300 METER RUN (Cut-off Score 71.1 seconds)
4. PUSH-UPS (Cut-off Score 24 in 60 seconds)
5. 1.5 MILE RUN (Cut-off Score 15:55 minutes)

The candidate is required to perform their maximum amount of exercises in the given time permitted.

Based upon the medical examination, the above named candidate is determined to be:

(Check one)

_____ Medically fit to participate in the physical agility test.

_____ Not medically fit to participate in the physical agility test.

Physician's Name: _____

Physician's Address: _____

Physician's Signature and License Number

Date