

## MEDICAL CERTIFICATION FORM

Candidate's Name: \_\_\_\_\_

Candidate's Address: \_\_\_\_\_

\_\_\_\_\_  
Candidate's Date of Birth: \_\_\_\_\_

Candidate's Social Security #: \_\_\_\_\_

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 agility test.

### PHYSICAL ABILITY TEST

### CUT-OFF SCORE

- |                  |                       |
|------------------|-----------------------|
| 1. Vertical Jump | 12.5 inches           |
| 2. Sit-up        | 22 in 60 seconds      |
| 3. 300 Meter Run | 84 seconds or less    |
| 4. Push-up       | 19 in 60 seconds      |
| 5. 1.5 Mile Run  | 19:00 minutes or less |

The candidate is required to perform their maximum amount of exercise 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