Tallahassee Fire Department
Physician Statement

- This physician statement is valid for 6 months from the date signed by the physician
- This physician statement must be signed by a licensed physician
- Keep a copy of this document for your records
- Provide emergency contact information at the bottom of the form

I have reviewed the Tallahassee Fire Department's Physical Ability Test description of events.

I examined _____ Last 4 digits of Social Security # _____
(Patient's Name) (Patient's)

on _____, and found nothing to indicate it would be medically inadvisable for him
(Date)

or her to participate in the department's Physical Ability Test.

Physician's Signature: _____

Date: _____

Type of Print the following:

Physician Name: _____

Address: _____

_____

Telephone Number: _____

Firefighter Applicant – Please list 2 emergency contacts below:

#1: Name _____ #2: Name _____

Relationship _____ Relationship _____

Phone _____ Phone _____