Physical Fitness for Employment Certification
CITY OF NEW YORK • DEPARTMENT OF HEALTH & MENTAL HYGIENE

9415 (Rev. 8/02)

☐ FIRST EXAM
☐ REN. REG.
☐ REN. LIM.
☐ OTHER

LAST NAME OF CHILD	FIRST NAME	ADDRESS	BORO	ZIP	TELEPHONE

ISSUING CLINIC/SCHOOL	NAME OR NUMBER OF SCHOOL ATTENDED	BORO	ZIP	GRADE

BIRTHDATE	SEX	DATE OF EXAM	HEIGHT	WEIGHT	VISION	Right	Left	Both
Month / Date / Year	☐ Male ☐ Female	Month / Date / Year	Feet / Inches	lbs.	With Glasses			
					Without Glasses			

MEDICAL HISTORY (Check ✓ and describe in Remarks)

☐ RHEUMATIC FEVER
☐ HEART TROUBLE
☐ KIDNEY TROUBLE OR URINARY PROBLEM
☐ ORTHOPEDIC PROBLEM
☐ ALLERGY (INCL. ASTHMA)
☐ BRONCHITIS OR CHRONIC COUGH
☐ DIABETES
☐ CONVULSIVE DISORDER
☐ GASTROINTESTINAL DISORDERS
☐ SERIOUS INJURIES
☐ TREATMENT/MEDICATION
☐ EXCUSED FROM GYM MORE THAN 3 MONTHS

☐ OTHER DISEASES, List here _____

HOSPITAL CARE, WITH CAUSE _____

FATHER LIVING ☐ DEAD ☐ MOTHER LIVING ☐ DEAD ☐

SOCIAL SECURITY NUMBER ___ - ___ - _____ MEDICAID NUMBER _____

PHYSICAL EXAMINATION
(If defect, Check ✓ and describe in Remarks)

BLOOD PRESSURE

☐ 1. EYES ☐ 2. EARS ☐ 3. HEARING
☐ 4. MOUTH/THROAT ☐ 5. SKIN ☐ 6. TEETH
☐ 7 NECK/GLANDS ☐ 8 HEART ☐ 9. LUNGS
☐ 10. ABDOMEN ☐ 11. HERNIA/GENITALIA ☐ 12. ORTHOPEDIC
☐ 10. NEUROMUSCULAR *(Strength, Coord., Speech)* ☐ 12.OTHER

REMARKS

MEDICAL REFERRAL

☐ REGULAR CERTIFICATE ☐ DECISION PENDING ☐ PERMANENT REJECTION
☐ LIMITED CERTIFICATE, for ☐ ONE MONTH ☐ SIX MONTHS

Type of Job ☐ CO-OP ☐ FULL-TIME ☐ PART-TIME

Signature *Date*

M.D.

CERTIFICATE OF PHYSICAL FITNESS FOR EMPLOYMENT * CITY OF NEW YORK * DEPT. OF HEALTH & MENTAL HYGIENE

CLINIC / SCHOOL STAMP

I hereby certify that I have examined _____ and found that he/she is physically qualified for lawful employment, being in sound health and of normal development or that he/she is in such condition as justifies the limited employment indicated.

☐ REGULAR CERTIFICATE ☐ LIMITED CERTIFICATE, AUTHORIZING EMPLOYMENT FOR ☐ 1 MONTH ☐ 6 MONTHS

IN THE FOLLOWING OCCUPATIONS ONLY: _____

☛ **THIS IS NOT AN EMPLOYMENT CERTIFICATE** *Signature of Examining Physician* _____ **M.D.** *Date* _____