Annual Medical Evaluation -Medical Clearance Form **Effective Date: 1-1-2020**
Administrative Order-40A **Revised Date:**

FIREFIGHTER MEDICAL CLEARANCE

(Please see accompanying "Physicians' Guidance Regarding Medical Clearance as a Firefighter)

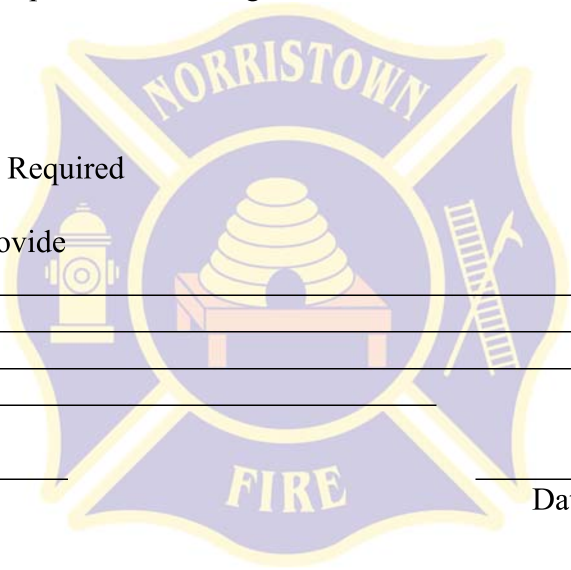
Name: ____

To be completed by Physician's office:

Date of Examination: ____

I have reviewed the accompanying "Physicians' Guidance Regarding Medical Clearance as a Firefighter." I have examined the above individual, reviewed his/her medical history, and make the following recommendations for his/her participation as a Firefighter with the Norristown Fire Department:

- ☐ Full Participation
- ☐ No Participation
- ☐ Limited Participation
- ☐ Additional Evaluation Required



If not full participation, please provide limitations:____
____
____
____

______________________________ ____________________
Physician Signature Date

Physician Name: ____
Address: ____
City: ____________________________ State: ___________ Zip Code: __________

Telephone: ______________________