# Southampton Fire Department

P.O. Box 1435
Southampton, New York 11969

## Physician's Statement of Fitness

On _____, I examined _____, Age _____
Date Name

**My findings are as follows:**

**1. General Health:**

**A.** Please indicate whether he/she is afflicted with or receiving treatment for:
_____ Epliepsy _____ Diabetes _____ Heart Disease
_____ Stroke _____ Loss of eqilibrium or consciousness
If yes, explain: _____

_____

**B.** Is he/she subject to or receiving treatment for any nervous, organic, or functional disorder? _____ If yes, explain: _____

_____

**2. Physical Condition:**

**A**. Has he/she lost any of the following members : _____ fingers
_____ hand _____ arm _____ foot _____ leg
If yes, explain: _____

_____

**B.** Is there any partial loss of use of any of the above members? _____
If yes, describe: _____

_____

**C.** Blood Pressure: _____

**3. Hearing:**

A. Can he/she hear ordinary conversation without a hearing aid? ___Yes ___ No

**4. Vision:**

**A**. Does he/she wear glasses? ___ Yes ___ No

**B.** Has he/she lost the use of either eye? _____ If yes, what is the degree of visual field ? _____

**C.** Is there any opacity of the crystalline lens of either or both eyes?

_____
If yes, indicate : ____ Left ____ Right ____ or Both

**D.** Can he/she distinguish colors? _____

_____

**5. The exam findings are as follows:**

| | Normal | Abnormal |
|---|---|---|
| EKG | | |
| Pulmonary Function Test (Spirometry) | | |
| Laboratory Work | | |

Blood Type: _____ **(REQUIRED)**

Passed the physical: _____ Yes _____No

**6. Please state your opinion of this person's ability to perform the duties of a volunteer fireperson:**

**Qualified as (REQUIRED)**

**Interior firefighter** _____ **Exterior Firefighter** _____ **Administrative Duty Only** _____
**Driver Only** _____

If administrative duty only, please explain: _____

**7. Name & Address of Examining Physician:** _____

**Signature of Examining Physician:**

**8. We welcome any further comments you may wish wish to make:**