AT-16

THE UNIVERSITY OF THE STATE OF NEW YORK
THE STATE EDUCATION DEPARTMENT
Albany, New York 12234

PHYSICAL FITNESS CERTIFICATION

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(Name of Applicant) (Address)

______________________________ ❑ Male ❑ Female

(Date of Birth)

INSTRUCTIONS TO PHYSICIAN: **In addition, please stamp your name in box below**
Complete Part A unless certificate is limited --in which case complete Part B

A. I hereby certify that I have examined the above-named applicant and find **he/she is physically qualified for lawful employment.**

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(Date of Physical) (Signature of Physician)

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(Address of Physician)

B. I hereby certify that I have examined the above-named applicant and find **he/she has a disability that requires limited employment.**

(1) Disability ---

(2) Occupation ---

(3) Employer ---

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(Date) (Signature of Physician)

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(Address of Physician)

If a limited certificate is indicated, the disability, occupation, and employer must be indicated to make this certificate valid.