Medical Clearance Form PDF

Applicant Details

Full Name: _____

Date: _____

Contact Number: _____

Email: _____

Medical Assessment Required For

[ ] Employment

[ ] Insurance

[ ] Other: Specify _____

Health Evaluation

List any relevant recent medical diagnoses:

_____

_____

Certification by Medical Practitioner

I, the undersigned, certify that the individual named above has been examined by me and is medically fit to engage in the activities specified above.

Name of Practitioner: _____

License Number: _____

Signature: _____

Date: _____