Medical Clearance Form for Employment

Employee Details

Employee Name: _____

Position: _____

Department: _____

Date of Employment: _____

Health Information

Do you have any health conditions that we should be aware of? [ ] Yes [ ] No

If yes, please describe: _____

Workplace Requirements

Does the job require physical labor? [ ] Yes [ ] No

If yes, specify the nature of the labor: _____

Clearance Certification

I hereby declare that the individual named herein is physically and mentally fit for the specified employment role, based on the medical evaluation conducted.

Physician's Name: _____

Signature: _____

Date: _____