AT-16

THE UNIVERSITY OF THE STATE OF NEW YORK

THE STATE EDUCATION DEPARTMENT

Albany, New York 12234

# PHYSICAL FITNESS CERTIFICATION

(Name of Applicant) (Address)

☐ Male ☐ Female ☐ Other

(Date of Birth)

**INSTRUCTIONS TO HEALTHCARE PROVIDER:**

**Complete Part A unless certificate is limited --in which case complete Part B**

bove-named applicant and find they are

A. I hereby certify that I have examined the a

physically qualified for lawful employment

(Signature of Healthcare Provider) (Date of Physical)

(Address of Healthcare Provider)

they have a

B. I hereby certify that I have examined the above-named applicant and find

ment.

disability that requires limited employ

(1) Disability

(2) Occupation

(3) Employer

ignature of Healthcare Provider) (Date) (S

vider) (Address of Healthcare Pro

ited certificate is indicated, the disability, occupation, and employer must be indicated to make this If a li

cate valid. certifi