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

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(Date of Birth)

**INSTRUCTIONS TO HEALTHCARE PROVIDER:**

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

1. I hereby certify that I have examined the above-named applicant and find **they are**

**physically qualified for lawful employment.**

(Date of Physical) (Signature of Healthcare Provider)

(Address of Healthcare Provider)

1. I hereby certify that I have examined the above-named applicant and find **they have a disability that requires limited employment.**
	1. Disability ---
	2. Occupation ---
	3. Employer ---

(Date) (Signature of Healthcare Provider)

(Address of Healthcare Provider)

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