Organized in 1914

Marion Fire Department, Inc.

P.O. Box 1 3786 Mill Street
Marion, New York 14505
"Home of The Flying Dutchmen"

FIRE FIGHTER MEDICAL CERTIFICATION

Date: _______________

Subject: Medical Certification

To: Marion Fire Department, Inc.

Ref: __________________________________
(Name of individual requesting Medical Certification)

After reviewing this individual's medical history and status, it is my recommendation that he / she:

A ______ IS medically capable of wearing a Self Contained Breathing Apparatus and CAN perform the duties of an Interior Structural Firefighter with No Workload Restriction

B ______ IS medically capable of wearing a Self Contained Breathing Apparatus and CAN perform the duties of an Exterior Firefighter with Light to Moderate Workload Restriction

C ______ IS NOT medically capable of wearing a Self Contained Breathing Apparatus and CAN perform the duties of a Support Firefighter with Light Workload Restriction

D ______ IS NOT medically capable of wearing a Self Contained Breathing Apparatus and CANNOT perform the duties of a Support Firefighter

I recommend that this individual undergo another physical evaluation within __________ years from the date of this letter.

Respectfully,

Dr.____
(Name of physician completing Medical Certification)

____
(Address)