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

(Date of Birth)

INSTRUCTIONS TO PHYSICIAN:
Complete Part A unless certificate is limited --in which case complete Part B

A. I hereby certify that I have examined the above-named applicant and find **he/she is physically qualified for lawful employment.**

(Date of Physical) (Signature of Physician)

(Address of Physician)

B. I hereby certify that I have examined the above-named applicant and find **he/she has a disability that requires limited employment.**

(1) Disability ---

(2) Occupation ---

(3) Employer ---

(Date) (Signature of Physician)

(Address of Physician)

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