# Volunteer Medical Clearance

*(Please refer to “Physicians’ Guidance Regarding Medical Clearance as a Fire Rescue Volunteer”)*

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**To be completed by physician’s office:**

Date of Examination:

Date of Payment: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Amount of Payment: $

I have reviewed the “Physicians’ Guidance Regarding Medical Clearance as a Fire Rescue Volunteer.” I have examined the above individual, reviewed his/her medical history, and make the following recommendations for his/her participation as a volunteer with \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

[ ]  Full Participation

[ ]  No Participation

[ ]  Limited Participation

[ ]  Additional Evaluation Required

If not full participation, please provide limitations:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physician’s Signature Date

Physician Name:

Address:

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_State: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ZIP Code:

Telephone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ]  Please send additional information on NFPA 1582

**To be completed by volunteer applicant:**

I am requesting reimbursement for the examination noted above. I understand reimbursement will be paid for the amount of my insurance co-pay or out-of-pocket expense up to a maximum of $\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Signature of Individual\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**NOTE: THIS FORM IS AN EXAMPLE. THE ACTUAL CRITERIA YOU USE**

**SHOULD BE DEVELOPED BY YOUR DEPARTMENT/COMPANY MEDICAL DIRECTOR.**