## **MEDICAL CERTIFICATION AFTER EXAMINATION**

Patient:	<del></del>	
On the below date, I, a duly licensed physician*, examined the officer position with the New York State Police.	ne above patient, who is a candidate for	r a police
I am aware that the New York State Police selection process request. Before completing this certification, I reviewed the descrithe New York State Police website – <u>joinstatepolice.ny.gov</u> .		•
Based upon my interview and examination, which is <b>documents</b> can safely engage in the physical ability test.	ed in the attached, it is my opinion that the	ne patient
Date Examined:	rior to the date of processing)	
Examining Physician's Signature	 Date	
Examining Physician's Name (print)	License Number	
Examining Physician's Address (print)		

## **TO BE COMPLETED BY A DULY LICENSED PHYSICIAN\***

\*Registered Nurse Practitioner or Registered Physician's Assistant acceptable

## **PHYSICAL EXAMINATION FORM**

Last Name	First Name		ı	MI	Date of	ate of Birth		
			l					
Examination					1			
Height	\	Weight			Gender			
BP	Pulse			Vision		Corrected		
					0/ D/		Yes No	
Medical		Normal				rmal Fi		
Appearance					<u> </u>		- 0-	
-Marfan stigmata								
Eyes/ears/nose/throat								
-Pupils equal / Hearing Lymph nodes								
Heart								
-murmurs -location of point of maximal impulse (P	PMI)							
Pulses								
-Simultaneous femoral and radial pulses Lungs	S							
Abdomen								
Genitourinary (males only)								
Skin								
-HSV, lesions suggestive of MRSA, tinea	corporis							
Neurologic								
Musculoskeletal	ſ	Normal			Abno	ormal Fir	ndings	
Neck								
Back (including scoliosis screeni	ng)							
Shoulder/arm								
Elbow/forearm								
Wrist/hand/fingers								
Hip/thigh								
Knee								
Leg/ankle								
Foot/toes								
Assessment								
Name of medical provider (print/type)				Date			License/NPI number	
Address				Phon	е			
Signature of medical provider						STAMP HERE		
1				,MD	/DO/NP/PA			