PHYSICIAN FORM

Applicant _____ Date _____

(TO PHYSICIAN: PLEASE PROVIDE A VERY BRIEF DESCIPTION OF THE FOLLOWING)

- Heart _____
- Eyes, Ears, Nose _____
- Throat _____
- Reflexes _____
- Mentality _____
- Nervous System _____
- Mental Health _____
- Emotional Health _____
- Respiratory _____
- Teeth _____
- Dietary Issues _____
- Allergies _____
- Capability of Strenuous Work _____
- Capability to Engage in Normal Class Day _____
- Capability of Sports Participation _____
- Additional Comments _____

_____

Name of Practice _____Address _____

City _____ State _____ Zip _____ Phone _____

Signature of M.D. _____ Date _____