TO BE COMPLETED BY PHYSICIAN

Past History

Heart_________ Rupture________ Fainting spells__________

Tuberculosis_________ Kidneys_______________

Habits: Alcohol __________ Drugs_________________

Other Unusual Medical History ___________________________

Physical Findings

Height ________ Weight _______

Hernia ________ Vision _______

Hearing _______ Throat ________

Nose _________ Neck _________

Lungs ________ Abdomen ______

Heart _________ Blood pressure ______/______

Extremities____

Recommendations ____
____

Hepatitis B Vaccination Record if applicable:
Dose Vaccination Date:
#1 ________
#2 ________
#3 ________

IS THERE ANY REASON WHY YOU FEEL THIS APPLICANT WOULD NOT BE ABLE TO TO SERVE AS A FULL ACTIVE MEMBER OF THE CLOSTER VOLUNTEER AMBULANCE AND RESCUE CORPS . ____
____

Signed _____________________________
(Physician)
Address ____________________________
____

Date _______________