NO OTHER MEDICAL INFORMATION SHOULD BE INCLUDED ON THIS FORM

LINCOLN COUNTY
EMERGENCY MEDICAL SERVICES

HEALTHCARE PROVIDER'S STATEMENT OF ABILITY TO PARTICIPATE IN THE PHYSICAL AGILITY ASSESSMENT

PLEASE PRINT NEATLY: Healthcare Provider Who Performed Evaluation:

_____
Name of Health Care Provider

_____
Address

_____
City State Zip Code

_____
Daytime Phone Fax

I, _____, have reviewed the attached description of the EMS
(HEALTHCARE PROVIDER'S PRINTED NAME)

employee candidate physical agility assessment and certify that:

_____:
(APPLICANT'S PRINTED NAME)

Check One:

_____**CAN** safely perform this assessment _____**CANNOT** safely perform this assessment

_____ _____
Healthcare Provider's Signature Date

_____ _____
Applicant's Signature Date

NO OTHER MEDICAL INFORMATION SHOULD BE INCLUDED ON THIS FORM