



# PHYSICAL EXAMINATION FORM

*This form must be completed within 90 days prior to submission  
Must be Stamped by the Medical Examiner*

## 1 Applicant Information

First Name	Last Name
Date of Birth	*Social Security #
Home Address	Phone Number
City	State
	Zip
License Type:	
License Number (if, licensed)	

## 2 Health History TO BE FILLED IN BY EXAMINING PHYSICIAN (Please print)

Yes	No		Yes	No		Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Muscular Disease	<input type="checkbox"/>	<input type="checkbox"/>	Head or spinal injuries
<input type="checkbox"/>	<input type="checkbox"/>	Kidney	<input type="checkbox"/>	<input type="checkbox"/>	Psychiatric Disorder	<input type="checkbox"/>	<input type="checkbox"/>	Seizures, fits, convulsions or fainting
<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	Cardiovascular Disease	<input type="checkbox"/>	<input type="checkbox"/>	Extensive confinement by illness or injury
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Gastrointestinal Ulcer	<input type="checkbox"/>	<input type="checkbox"/>	Any other nervous disorder
<input type="checkbox"/>	<input type="checkbox"/>	Nervous Stomach	<input type="checkbox"/>	<input type="checkbox"/>	Ethanol use	<input type="checkbox"/>	<input type="checkbox"/>	Suffering from any other disorder
<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>	Rx drug use	<input type="checkbox"/>	<input type="checkbox"/>	Permanent defect from illness, disease or injury
<input type="checkbox"/>	<input type="checkbox"/>	Over the counter drug use						

IF ANSWER TO ANY OF THE ABOVE IS YES, **EXPLAIN:**

\_\_\_\_\_

\_\_\_\_\_

General Fitness and Health:  Good  Fair  Poor

**Vision:** For Distance:  Right/20  Both/20  Without Corrective Lenses  
 With Corrective Lenses

Evidence of disease or injury Right \_\_\_\_\_ Left \_\_\_\_\_

Color Test \_\_\_\_\_

Horizontal Field of Vision: Right \_\_\_\_\_ Left \_\_\_\_\_

**Hearing:** Right \_\_\_\_\_ Left \_\_\_\_\_

Evidence of disease or injury Right \_\_\_\_\_ Left \_\_\_\_\_

**Audiometric Test:** Decibel loss at  500HZ  1,000 HZ  2,000 HZ  3,000 HZ  4,000 HZ

**Throat:** \_\_\_\_\_

**Thorax:** Heart: \_\_\_\_\_

If organic disease is present, is it fully compensated? \_\_\_\_\_

Blood Pressure: Systolic \_\_\_\_\_ Diastolic \_\_\_\_\_

Pulse: Before Exercise \_\_\_\_\_ Immediately after \_\_\_\_\_

Lungs: \_\_\_\_\_

**Abdomen:** Scars \_\_\_\_\_ Abdominal Masses \_\_\_\_\_ Tenderness \_\_\_\_\_

# PHYSICAL EXAMINATION FORM (CONT'D)

<b>2</b>	<b>Health History (cont'd)</b>	<b>TO BE FILLED IN BY EXAMINING PHYSICIAN (Please print)</b>
<b>Hernia:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No    If so, where? _____    Is truss worn? _____		
<b>Gastrointestinal:</b> Ulceration or other disease?    Yes _____    No _____		
<b>Genito-Urinary:</b> Scars: _____    Urinal Discharge: _____		
<b>Reflexes:</b> Romberg: _____		
Pupillary: _____    Light: R _____ L _____		
Accommodation: _____    R _____ L _____		
<b>Knee Jerks:</b> Right    Normal _____    Increased _____    Absent _____		
Left    Normal _____    Increased _____    Absent _____		
<b>Remarks:</b> _____		
<b>Extremities:</b> Upper _____    Lower _____    Spine _____		
<b>Laboratory &amp; Other Special Findings:</b> Urine Spec. Gr. _____    Alb. _____    Sugar _____		
Other Laboratory Data (Serology, etc.) _____		
Radiological Data _____    Electrocardiograph _____		
<b>General Comments:</b> _____		
_____		
_____		
_____		
<b>3</b>	<b>Physician</b>	<b>TO BE FILLED IN BY EXAMINING PHYSICIAN (Please print)</b>
Name of Physician _____		
Address of Physician _____		
City _____ State _____ Zip _____		
Physician's Signature _____ Date _____		
<b>4</b>	<b>Physician's Clearance (To be Completed Only If Applicant Is Found Qualified)</b>	
<b>TO BE FILLED IN BY EXAMINING PHYSICIAN (Please print)</b>		
I certify that I have examined:		
with the knowledge of his/her duties, I find him/ her qualified under the regulations. (see addendum)		
<input type="checkbox"/> Qualified only when wearing corrective lenses.		
<input type="checkbox"/> Qualified only when wearing a hearing aid.		
<input type="checkbox"/> Qualified - - see Accommodation Statement attached.		
A complete examination form for this person is on file in my office:		
Address of Examination _____		
Date of Examination _____ Name of Physician _____		
Signature of Physician _____		
Name of Applicant _____		
Signature of Applicant _____		



# PHYSICAL EXAMINATION FORM

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## Addendum: License Regulations

### License Type

### Relevant Regulations

Hoist Machine Operator

This license authorizes a NYC licensee to take charge of or operate power operated hoisting machines (depending on the class of license) used for hoisting purposes or cableways under the jurisdiction of the Department. Including but not limited to Cranes.

Rigger

NYC Administrative Code Section 28-405; Title 1 of the Rules of the City of New York Section 104-09

This license authorizes a NYC licensee to hoist or lower an article outside of any building in the city. This may include the use of suspended scaffolds. Tower or climber crane rigger licensees may supervise the erection and dismantling of tower or climber cranes.

NYC Administrative Code Section 28-404; Title 1 of the Rules of the City of New York Section 104-10