FDNY BUREAU OF HEALTH SERVICES

CANDIDATE EVALUATION BY BHS PHYSICIAN
BHS FORM 6

CANDIDATE INFORMATION

Name (Last, First):	Last Four Digits of Social Security:	Date of Birth (MM/DD/YYYY):	Civil Service Title:

EVALUATION BY BHS PHYSICIAN
(Candidates Shall Not Write Below This Line - To Be Completed by FDNY – Bureau of Health Services Personnel Only)

ITEM	QUALIFIED	NOT QUALIFIED	RESERVED
HEART RATE: SPO2			
HEIGHT: BMI:			
WEIGHT: OVERWEIGHT? Y N			Target Weight:
BLOOD PRESSURE: SYSTOLIC: DIASTOLIC:			
VISION RIGHT: LEFT:			
HEARING			
BACK / SPINE			
LEG / FEET			
CARDIOVASCULAR SYSTEM			
RESPIRATORY SYSTEM ARMS / HANDS ASTHMA			
ALLERGIES			
GASTRO-INTESTINAL			
GENITO-URINARY SYSTEM			
NEUROLOGICAL			
PSYCHIATRIC			
HERNIA			
TUMORS			
OTHER CONDITION (Specify):			
LABORATORY & TEST RESULTS			
URINE/BLOOD (For Medical Conditions)			
URINE (For Unauthorized Substances)			
EKG			
CHEST X-RAY/TB TEST			
OTHER LABS AND TESTING			
PFT			
STAIRS			
PHYSICIAN COMMENTS:			

RECOMMENDATION: ☐ **QUALIFIED** ☐ **NOT QUALIFIED** ☐ **RESERVED**

Physician Signature **Printed Name** **Date**