BOZRAH VOLUNTEER FIRE CO. INC.
239 Fitchville Road • P.O. Box 2 • Bozrah, CT. 06334
Phone: 860-887-9474 • Fax: 860-887-8819
www.bozrahfire.org

FIREFIGHTER MEDICAL CLEARANCE FORM

This form must be filled out and signed by your primary physician and returned with your application for Membership.

Name of Applicant: _____

Date of Birth: _____

Firefighter Statement (Filled out by Applicant)

I intended to perform the following duties: (Check all that apply)

Respirator/SCBA use	❑ Yes	❑ No
Interior Firefighting	❑ Yes	❑ No
Fire Ground Support	❑ Yes	❑ No
Fire Police	❑ Yes	❑ No
Fire Apparatus Operator	❑ Yes	❑ No
EMT/MRT	❑ Yes	❑ No

Physician/Examiner Statement

I have examined the above firefighter applicant on _____ and I am familiar with OSHA Standard 29CFR 1910.134. Based on the results of that exam, it is my opinion the above firefighter applicant is cleared for the following:

Respirator/SCBA use	❑ Yes	❑ No
Specific Limitations: _____		
Follow-Up Evaluation: _____		
Interior Firefighting	❑ Yes	❑ No
Fire Ground Support	❑ Yes	❑ No
Fire Police	❑ Yes	❑ No
Fire Apparatus Operator	❑ Yes	❑ No
EMT/MRT	❑ Yes	❑ No

Physician Name: _____ Date: _____

Physician Signature: _____

Name of Practice: _____ Phone #: _____

Medical Examiner's Lic. or Cert. #: _____ Issuing ST: _____ Exp. Date: _____