



Certificate of Medical Clearance

NAME: _____

COMPANY NAME: _____

- 1) Does this individual currently have any physical or mental restrictions or limitations, which might affect his or her ability to perform the job?
- ☐ YES ☒ NO
- 2) Does this individual currently have any health conditions, which in any manner pose a direct threat to the health or safety of himself/herself or others, which cannot be eliminated with reasonable accommodation?
- ☐ YES ☒ NO
- 3) Do you believe this individual is currently able to perform the essential functions of the job, with or without reasonable accommodations?
- ☒ YES ☐ NO

Additional Comments:

Apr 23, 2013
Date of Report

4/23/13
Physician

Partnering with Employers to Promote Employee Health & Wellness...