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	
☐	☐	Asthma	☐	☐	Muscular Disease	☐	☐	Head or spinal injuries
☐	☐	Kidney	☐	☐	Psychiatric Disorder	☐	☐	Seizures, fits, convulsions or fainting
☐	☐	Tuberculosis	☐	☐	Cardiovascular Disease	☐	☐	Extensive confinement by illness or injury
☐	☐	Diabetes	☐	☐	Gastrointestinal Ulcer	☐	☐	Any other nervous disorder
☐	☐	Nervous Stomach	☐	☐	Ethanol use	☐	☐	Suffering from any other disorder
☐	☐	Rheumatic Fever	☐	☐	Rx drug use	☐	☐	Permanent defect from illness, disease or injury
☐	☐	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)

2 Health History (cont'd)

TO BE FILLED IN BY EXAMINING PHYSICIAN (Please print)

Hernia: ☐ Yes ☐ No If so, where? ____________ Is truss worn? ____________

Gastrointestinal: Ulceration or other disease? Yes ____________ No ____________

Genito-Urinary: Scars: ____________ Urinal Discharge: ____________

Reflexes: Rhomberg: ____________

Pupillary: ____________ Light: R ____________ L ____________

Accommodation: ____________ R ____________ L ____________

Knee Jerks:

	Normal	Increased	Absent
Right	______	______	______
Left	______	______	______

Remarks: ____________

Extremities: Upper ____________ Lower ____________ Spine ____________

Laboratory & Other Special Findings:

Urine Spec. Gr. ____________ Alb. ____________ Sugar ____________

Other Laboratory Data (Serology, etc.) ____________

Radiological Data ____________ Electrocardiograph ____________

General Comments: ____________

____

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____

3 Physician

TO BE FILLED IN BY EXAMINING PHYSICIAN (Please print)

Name of Physician

Address of Physician

City State Zip

Physician's Signature ____________ Date ____________

4 Physician's Clearance (To be Completed Only If Applicant Is Found Qualified)

Physician's Clearance **TO BE FILLED IN BY EXAMINING PHYSICIAN** (Please print)

I certify that I have examined:

with the knowledge of his/her duties, I find him/ her qualified under the regulations. (see addendum)

☐ Qualified only when wearing corrective lenses.

☐ Qualified only when wearing a hearing aid.

☐ 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

*In accordance with Federal and State Laws, the New York City Department of Buildings requires that all applicants for licenses/license holders provide their Social Security Number (SSN). DOB will use the SSN to conduct background investigations and maintain accurate license and related records. This information may be shared with other government agencies, consistent with applicable laws and Departmental policy or with the SSN holder's written permission, but will otherwise be kept confidential. The specific statutory authority for requiring SSN's is in the following: Federal Law-Privacy Act of 1974 (Section 7 of P.L., 93-579); Welfare Reform Act of 1996 (42 USCA 666(a)), and Section 5 of the NYS Tax Law.

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