MEDICAL FITNESS CERTIFICATION

Date: [Insert Date]

To: [Employer Name/Organization Name]
Department: [Insert Department, e.g., Aquatics Division]
Address: [Insert Address]

RE: Medical Clearance for Lifeguard Duties

Candidate Name: [Insert Candidate Full Name]
Date of Birth: [Insert Date of Birth]

To Whom It May Concern,

I have conducted a physical examination of the above-named individual to determine their medical fitness for employment as a Lifeguard. My assessment included an evaluation of their vision, hearing, cardiovascular health, and musculoskeletal function.

Based on this examination, I certify that the candidate:

- Possesses the physical strength and agility to perform water rescues.
- Has vision correctable to at least 20/40 in both eyes.
- Has hearing sufficient to perceive emergency signals and verbal communication in a noisy environment.
- Shows no medical conditions that would result in a sudden loss of consciousness or impaired mobility.

Fitness Determination (Check One):

[ ] FIT for lifeguard duties without restrictions.
[ ] FIT for lifeguard duties with the following restrictions: [Insert Restrictions]
[ ] NOT FIT for lifeguard duties at this time.

Sincerely,

Signature: _____
Physician Name: [Insert Printed Name]
Medical License Number: [Insert Number]
Clinic/Hospital Name: [Insert Name]
Phone Number: [Insert Phone Number]

[Clinic Stamp/Seal Here]