

## DOCTORS CERTIFICATION

I hereby certify that \_\_\_\_\_ is physically able to safely  
APPLICANT'S NAME  
participate in a pre-employment physical evaluation, age and gender adjusted, in  
accordance with the criteria of the Cooper Institute.

YES \_\_\_\_\_ NO \_\_\_\_\_

\_\_\_\_\_  
(PHYSICIAN'S PRINTED NAME)

\_\_\_\_\_  
PHYSICIAN'S SIGNATURE