PHYSICIAN'S STATEMENT

Date:_____

To: The City of South Bend Civil Service Commission

From:_____
Physician's Name

_____
Street Address

_____
City, State, Zip

I have reviewed the events of the Physical Ability Examination, which will be administered to

my patient _____.

He/she has no health problem that precludes his/her participation in this examination.

_____
Physician's Signature

NOTE TO APPLICANT: THIS STATEMENT IS REQUIRED TO PROTECT YOU AND THE COUNTY. IT MUST BE GIVEN TO THE EXAMINER OF THE PHYSICAL ABILITY EXAMINATION AT THE TIME OF THE EXAMINATION. NO PHYSICAL ABILITY EXAMINATION WILL BE ADMINISTERED WITHOUT A SIGNED PHYSICIAN'S STATEMENT.