

HIRING DEPARTMENT

ADDRESS	CITY	STATE	ZIP

Suitability Declaration - to be maintained in the background investigation file

Instructions to the Physician:

- This form is to be completed and submitted to the hiring department.
- The hiring department will maintain this Medical Suitability Declaration page in the individual's background investigation file. **Do not include medical information on this page.**

Medical Suitability Declaration

CANDIDATE'S NAME	BIRTH DATE	LAST 4 DIGITS OF SSN

On _____, I completed a pre-employment medical screening evaluation
[DATE OF EVALUATION]
on the above-named peace officer candidate, in accordance with POST Commission [Regulation 1954](#). The evaluation was conducted using the medical screening procedures and evaluation criteria outlined in subsection 1954(c) and the required sources of information identified in subsection 1954(d), including:

1. Job information provided by the hiring department,
2. Medical history statement completed by the candidate, and
3. Relevant medical records provided by the candidate and/or medical health professional, if warranted and obtainable.

Based on the results and findings of that evaluation:

- I certify** that the candidate is free from any physical condition that might adversely affect their ability to exercise the powers of a peace officer and is medically suitable to perform the peace officer duties and responsibilities as defined and provided by the hiring department either without any accommodations, or provided that the specified work restrictions, limitations, or reasonable accommodations can be implemented. *(Describe any work restrictions, limitations, or reasonable accommodation requirements on a supplemental medical information page. The supplemental page is to be maintained as a confidential medical record, separate from the background investigation file.)*
- I cannot certify** that the candidate is medically suitable to perform the peace officer duties and responsibilities as defined and provided by the hiring department.

Physician's Signature ► _____

PHYSICIAN'S PRINTED NAME	MEDICAL LICENSE NUMBER		
EMAIL ADDRESS	PHONE NUMBER		
ADDRESS	CITY	STATE	ZIP