THE
EASTON VOLUNTEER EMERGENCY MEDICAL SERVICE, INC.
P.O. BOX 62 ● EASTON, CONNECTICUT 06612 ● 203.452.9595 ● www.eastonems.com

MEDICAL CERTIFICATION

Date of Physical: ____________________

Patient Name: ________________________________

D.O.B. ________________________________

Address: ________________________________

City, State ZIP: ________________________________

Height: ________________ Blood Pressure: ______________

Weight: ________________ Pulse: ______________

Allergies: ____

Medications: ____

Date of Last Tetanus: ________________ *(Provide a copy of your most recent immunization records)*

Hepatitis B Vaccine: 1st ________ 2nd ________ 3rd ________
DATE DATE DATE

I certify that the above individual is physically able to work at Easton Volunteer Emergency Medical Service, Inc.

____ ________________________
Physician Signature Date

____ ________________________
Address Phone