



STATE OF DELAWARE
 DEPARTMENT OF SAFETY AND HOMELAND SECURITY
 DIVISION OF STATE POLICE
 P.O. Box 430
 DOVER, DELAWARE 19903

PHYSICIAN AUTHORIZATION FORM

FIRST NAME	MIDDLE NAME	LAST NAME	SUFFIX
SOCIAL SECURITY NUMBER	DATE OF BIRTH	PLACE OF BIRTH	
CURRENT ADDRESS (NUMBER, STREET, APT NO., CITY OR TOWN, STATE, AND ZIP CODE)			

NOTE – The Physician Authorization Form must be completed by a Doctor (MD), Physician Assistant (PA) or a Nurse Practitioner (NP) and dated within one (1) year of the date that you will be participating in the Physical Testing Assessment. Applicants failing to provide a valid and completed Physical Authorization Form will not be permitted to take the Physical Fitness Assessment and may be disqualified from the process.

Physical Fitness Assessment Requirements

- 1.5 Mile Run
- Sit-Ups
- Push-Ups

PHYSICIAN'S NAME (PRINT)	
PHYSICIAN'S DEGREE	PHYSICIAN'S SPECIALTY
PRACTICE ADDRESS (NUMBER, STREET, CITY OR TOWN, STATE, AND ZIP CODE)	
PHONE NUMBER	

I have reviewed the above mentioned applicant's medical information, and conducted a physical examination and I am rendering the following professional opinion:

"I find the above applicant to be in proper physical condition to engage in all of the physical exercises of the Delaware State Police Physical Fitness Assessment."

 Physician's Signature

 Date