

**Ontario Fire Administration Inc.**  
**Firefighter Candidate Testing**  
**Medical Clearance Form**



Candidate Name: \_\_\_\_\_  
Date of birth: \_\_\_\_\_  
Address: \_\_\_\_\_  
\_\_\_\_\_  
Telephone: \_\_\_\_\_

**CONSENT**

I, \_\_\_\_\_, hereby consent to undergo a medical assessment and any appropriate examinations and/or diagnostic tests for the purposes of determining my fitness to participate in Firefighter Candidate Testing by Ontario Fire Administration Inc. I further confirm that I have provided the assessing physician with:

- A copy of my completed Firefighter Candidate Testing “Medical Questionnaire”
- Firefighter Candidate Testing - Physician Information Booklet

Candidate Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**MEDICAL FITNESS CERTIFICATION**

By applying the physician’s stamp or signature below, I certify that I have personally assessed the person named above and am of the opinion that he/she is medically fit to undertake firefighter candidate testing by Ontario Fire Administration Inc.

Date : \_\_\_\_\_

PHYSICIAN SIGNATURE / STAMP

A large rectangular dashed box intended for the physician's signature or stamp.

Ontario Fire Administration Inc.  
520 Westney Road South, Unit 22  
Ajax, Ontario L1S 6W6  
905-426-6756 FAX: 905-426-3032

***You are required to present two copies of this form at every assessment. This “Medical Clearance Form” expires six (6) months from certification date.***