TOWN OF WEST SENECA
"PROUD PAST – UNLIMITED FUTURE"

TOWN OF WEST SENECA PROOF OF PHYSICAL FORM

This form is to be completed by the (prospective) employee's physician and returned to Human Resources within one week of the employee's hire date.

The Town will accept record of a physical that has been performed within one month prior to the employee's date of hire.

Employee's Information

Full Name _____
(Last) (First) (Middle Initial)

Address _____
(Number and Street) (Town, State)

Date of Birth _____
(MM/DD/YYYY)

Department _____ Job Title _____

Employee Acknowledgement:

My employment is also contingent upon providing the Town with required proof of a recent medical physical. The Town Board of the Town of West Seneca may refuse to hire a candidate whose proof of physical form indicates they are physically unable to perform the work for which they were hired.

_____ _____
Signature of Employee Date

Job Information (Recreation)

Employees in these departments may be required to perform tasks that involve motions or actions such as:

- Lifting, Pulling or Pushing up to 35 pounds
- Climbing (such as onto playground equipment)
- Driving
- Bending, Twisting, Stooping (during the course of games and activities)
- Standing for at least four (4) hours continuously without a break
- Walking for at least four (4) hours continuously without a break
- Ability to communicate (listening & speaking)

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Physician's Statement

Employee Name: _____

Is the employee able to perform the following work duties:

1. Lifting, Pulling or Pushing up to 35 pounds?.....☐ Yes ☐ No
2. Climbing (such as onto playground equipment).....☐ Yes ☐ No
3. Bending, Twisting, Stooping .....☐ Yes ☐ No
4. Standing for at least four (4) hours continuously without a break .....☐ Yes ☐ No
5. Walking for at least four (4) hours continuously without a break .....☐ Yes ☐ No
6. Ability to communicate (listening and speaking) .....☐ Yes ☐ No
7. Is the employee able to perform the essential job functions of the job for which he/she is applying with or without reasonable accommodation? .....☐ Yes ☐ No

If the response to any of the above questions was "No", please explain (i.e. lifting restrictions, etc.):

_____

_____

_____

_____

If the response to any of the above questions was "No", please indicate the anticipated duration of the condition:

_____

_____

Provider Name and Name of Practice: _____

Provider Address: _____

Provider Signature: _____

Date: _____