

12080 US Hwy 85, Jay Em, Wy 82219 • 308-224-4694 • 308-224-4697

Applicant Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

The above applicant has applied for the Mustang for Veterans or 1st Responder program. Applicant must be able to stand, walk, jog, bend, push, pull, kneel and possibly lift light to moderate weight. Applicant may also need to move quickly at times.

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| Examination |
| Height Weight BP / Pulse Vision: R 20/ L 20/ Corrected? Yes / No |
| Medical | Normal | Abnormal Findings |
| Appearance  |  |  |
| Eyes/ears/nose/throat |  |  |
| Lymph nodes |  |  |
| Heart |  |  |
| Lungs |  |  |
| Abdomen |  |  |
| Musculoskeletal |  |  |
| Neurologic Skin |  |  |
| Psychological |
| Is patient being treated for PTSD, anxiety, depression or other mental health disorder? Yes / No |

꙱ Cleared for participation **without** restriction

꙱ Cleared for participation **with** restriction or special accommodations: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

꙱ Not cleared

**I have examined the above-named applicant and completed the preparticipation physical evaluation. The applicant does not present apparent clinical contraindications to practice and participate in the activities outlined above.**

**Name of physician (print)** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ MD, DO, PA, NP

Date \_\_\_\_\_\_\_\_\_\_\_\_ Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of physician \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_