**The Philadelphia Parking Authority Taxicab & Limousine Division**

# 2415 S. Swanson Street Philadelphia, PA 19148

Phone: 215-683-9895

**Driver Medical History Form**

# Applicant’s First Name: Last Name:

Address: City: State: Zip:

Phone Number: Date of Birth:

This Section Must Be Filled Out By a Licensed Medical Provider

## Date of Physical

**Height**

**Weight**

**Pulse**

**BP** /

**Vision** R 20/ L 20/ **Medications**

|  |  |  |
| --- | --- | --- |
| **MEDICAL** | **NORMAL** | **ABNORMAL FINDINGS** |
| EYES (must specify if glasses are needed) |  |  |
| HEARING |  |  |
| MENTAL/EMOTIONAL |  |  |
| REFLEXES |  |  |
| APPEARANCE (must specify if prosthesis needed) |  |  |
| DRUG/ALCOHOL |  |  |
| OTHER: | | |

From your examination and review of applicant’s HEALTH HISTORY does this person have any other condition that would prevent control of a motor vehicle? **Answer Below**.

# .

I hereby certify that I have performed a comprehensive initial physical evaluation of the herein applicant, and, on the basis of such evaluation and the applicant’s HEALTH HISTORY, certify that, except as specified above, the applicant is physically fit to perform the duties necessary to work as a taxicab or limousine driver.

# AME’s Name (print/type) License #

Address:

Street City State Zip

# Phone:

Signature: circle MD, DO, PAC, CRNP, or SNP