Wisconsin Department of Safety and Professional Services

6. Referee Medical Examination Report:

Your physician should complete this form in its entirety. This completed form must be submitted with the application.

Applicant's Full Name	Date of Birth (mm/dd/yyyy)
	☐☐/☐☐/☐☐☐☐

For all referees (Please answer all of the following)

1. Any illness or injuries since last examination or within the last 5 years? ☐Yes ☐No
2. Has this patient ever had severe headaches, fainting spells, or dizziness? ☐Yes ☐No
3. List any physical condition or past illness which might affect this patient's ability to perform the job. (Attach separate sheet)

Vitals	Result	Description
Pulse		
Temp		
Weight		
Height		
Blood Pressure		

Eyes (ALL REQUIRED)	Left	Right	Description
*Distant Vision	20/	20/	
*Light Reflex	☐Normal ☐Abnormal	☐Normal ☐Abnormal	
*Accommodation Reflex	☐Normal ☐Abnormal	☐Normal ☐Abnormal	
*Fundi	☐Normal ☐Abnormal	☐Normal ☐Abnormal	
*Cataracts	☐Normal ☐Abnormal	☐Normal ☐Abnormal	

Tendon Reflexes	Left	Right	Description
Knee Jerk	☐Normal ☐Abnormal	☐Normal ☐Abnormal	
Babinski	☐Normal ☐Abnormal	☐Normal ☐Abnormal	
Romberg	☐Normal ☐Abnormal		
Finger to Nose	☐Normal ☐Abnormal		

Upper Extremities		Description
Hands	☐Normal ☐Abnormal	
Wrist	☐Normal ☐Abnormal	
Elbows	☐Normal ☐Abnormal	
Shoulder Girdle	☐Normal ☐Abnormal	

Misc		Description
Lower Extremities	☐Normal ☐Abnormal	
Mouth and Pharynx	☐Normal ☐Abnormal	
Adenopathy	☐Normal ☐Abnormal	
Lungs	☐Normal ☐Abnormal	
Heart	☐Normal ☐Abnormal	
Abdominal Palpation	☐Normal ☐Abnormal	
Testis	☐Normal ☐Abnormal	
Hernias	☐Normal ☐Abnormal	
Boils, Herpes, Impetigo	☐Yes ☐No	

Physician/Examiner Name	Title (M.D., D.O., P.A.)	Physician/Examiner License Number
Address		**Phone Number (with area code)**
Signature (If unable to provide a digital signature print and sign form.)		**Date**
		☐☐/☐☐/☐☐☐☐