Division of Labor Standards
1220 Washington Ave.
Albany, NY 12226

NEW YORK STATE | Department of Labor
WORKING FOR YOU

Physical Fitness Certification for Child Performers

(Include with initial application or renewal)

Permit # (if available): _____

Child's name:(Last) _____ (First) _____ (M.I.) _____

Professional name (if different): _____

Name of parent/guardian:(Last) _____ (First) _____ (M.I.) _____

Instructions to Physician:

- **Complete Part A unless the certificate is limited. If it's not limited complete Part B.**
- **For Part B you are not required to give any information about the condition or disability that may limit employment, but only to describe the limitation that you place on the applicant's employment.**
- **Include the following factors in your examination.**

1. The child's overall health and fitness, keeping in mind the artistic services in which this child will typically engage.
2. The child's physical stamina to perform in a long-term performance or strenuous role without endangering his/her health.
3. Whether the child appears to exhibit symptoms of ongoing physical or mental health related issues such as eating disorders, substance abuse, or emotional problems that may interfere with the child's ability to undertake employment without endangering his/her health.
4. All other issues, which you believe are relevant to the child's ability to undertake employment without endangering his/her health.

Eating disorder screening information is available via the following link:
http://www.labor.ny.gov/workerprotection/laborstandards/secure/Child_Performer_Advisory_Board.shtm

A. I hereby certify that I have examined the above-named applicant and find he/she is physically qualified for employment as a child performer with no limitations.

Signature of physician: _____ Date of examination: ____ / ____ / _____

Printed name of physician: _____ Phone number: (_____) _____ - _____

Address of physician: _____

B. I hereby certify that I have examined the above-named applicant and find he/she is physically qualified for employment subject to the following limitations:

Signature of physician: _____ Date of examination: ____ / ____ / _____

Printed name of physician: _____ Phone number: (_____) _____ - _____

Address of physician: _____