

Paducah Police Department

Applicant's Endorsement

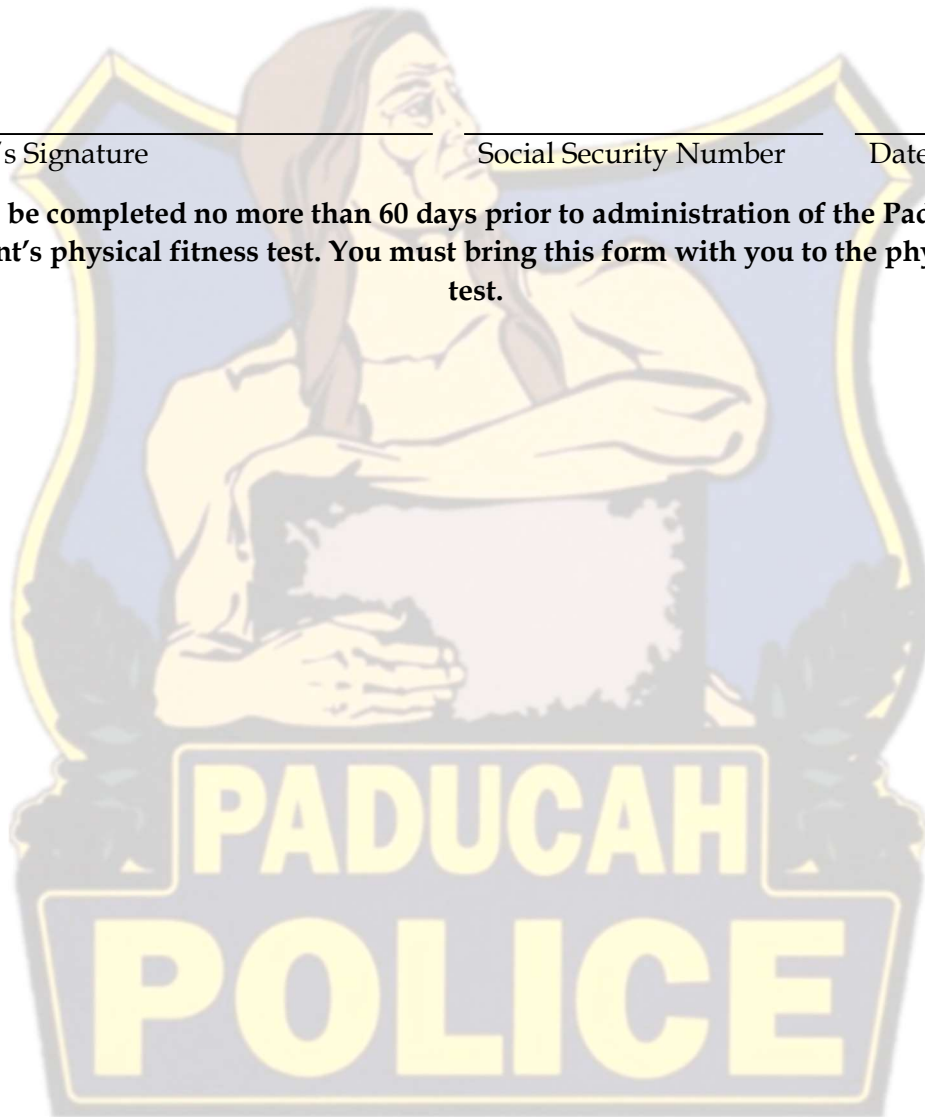
I understand the nature and extent of the physical activities required as part of the testing procedures conducted by the Paducah Police Department. I hereby assume any and all risks for injuries that may occur due to participating in the physical activities required as part of the testing procedures.

Applicant's Signature

Social Security Number

Date

This must be completed no more than 60 days prior to administration of the Paducah Police Department's physical fitness test. You must bring this form with you to the physical agility test.



Form T-1**Kentucky Law Enforcement Council***MEDICAL RELEASE*

Mail: Kentucky Law Enforcement Council
 Funderburk Building
 4449 Kit Carson Drive
 Richmond, KY 40475

Phone: 859-622-6218 **Fax:** 859-622-5943
Web: <https://klecs.ky.gov> **Email:** klecs@ky.gov

INSTRUCTIONS: This form must be completed by the applicant prior to participating in the physical agility. Please have applicant bring form to the test site at the time of testing along with picture identification.

Name of Applicant _____

Date of Birth _____ **SSN** _____

	YES	NO	
1.			Has a doctor ever said you have heart trouble?
2.			Do you frequently suffer from chest pains?
3.			Do you often feel faint or have severe spells of dizziness?
4.			Are you over age fifty (50) and not accustomed to vigorous exercise?
5.			Has a doctor ever said you have an abnormal electrocardiogram (ECG)?
6.			Do you have diabetes?
7.			Has a doctor ever said you have high cholesterol or blood fats?
8.			Has a doctor ever said you have high blood pressure?
9.			If you are 35 or older: Do you smoke?
10.			Has a doctor ever told you that you have a muscle, skeletal, or joint problem which would stop you from doing any type of exercise?
11.			Optional: What is your reading for the following: Blood Pressure: SBP _____ DBP _____
12.			Optional: Blood lipids: Total Cholesterol _____ Total to HDL Ratio _____

If any one item between numbers 1-10 is checked "YES," the Physician's Medical Release Form (T-1a) must be completed. These forms must be received in the KLEC office on or before the scheduled date for Phase I Testing.

I hereby verify that the above information is true and accurate.

Signed this _____ day of _____, 20_____.

Signature of Applicant

Printed Name of Applicant



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INSTRUCTIONS: This form must be completed by a physician, physician assistant or Nurse Practitioner, prior to the applicant participating in the physical ability, **IF** the applicant checks "yes" on any question between numbers 1-10 on the Form T-1. **If this form is required and not completed, the applicant will be sent home.**

NAME: _____

Date of Birth _____ **SS#** _____

Peace officers in the Commonwealth of Kentucky are required to perform a variety of essential physically demanding tasks including the following:

- Walking for extended periods
- Short sprints
- Long pursuit running lasting over 2 minutes
- Jumping over and around obstacles
- Lifting and carrying objects sometimes up and down stairs
- Using hands and feet in use of force situations
- Using force in short and long term (greater than 2 minutes) efforts
- Bending and reaching
- Dragging people and objects as in extracting victims from vehicles

To measure an individual's capacity to perform these critical tasks all applicants must undergo a physical ability test consisting of the following items:

- 1.5 mile run to measure aerobic power
- 300 meter sprint to measure anaerobic power
- Sit ups to measure abdominal muscular endurance
- Push ups to measure upper body muscular endurance
- Free weight bench press to measure upper body absolute strength

Your professional opinion is requested as to whether the individual can safely participate in physical ability testing.

PLEASE CHECK ONE:

- _____ There are no contraindications to the individual either 1) being capable of performing the essential physical tasks or 2) being capable of undergoing the physical ability test items.
- _____ There are contraindications and it is recommended that the individual **not** participate in the physical ability test items.

I hereby verify that the above information is true and accurate.

Signed this _____ day of _____, 20_____.

Signature of Physician, Physician Assistant or Nurse Practitioner

Printed Name of Physician, Physician Assistant or Nurse Practitioner