Physician's Clearance to Test Form

Agency Name: Sarasota County Sheriff's Office

Name of Applicant: ____

Dear Physician:

The purpose of this communication is to inform you of the above-named individual's intentions with regards to participation in the pre-employment physical abilities test for the above-named agency. We are aware of the fact that strenuous physical activity may be inadvisable for some individuals. As such, we request that you indicate whether the above-named applicant has any medical condition or disorder that would preclude participation. It must be emphasized that we are not asking you to assume responsibility for the applicant while participating in this test. Rather, we merely want to have as much information as possible when making decisions concerning applicability of testing.

The testing program will consist of a series of physical abilities tests. The battery of job-related field tests is intended to be completed in the fastest possible time and will require maximum effort by the applicant. Tests are designed to measure balance, muscular endurance and strength, flexibility, anaerobic power and capacity, fine motor skill and aerobic power. Tests will include two 220 yard runs, dragging a 150 pound object 100 feet, jumping over obstacles (12-24 inches high), climbing over a wall (40 inches high), two 50 foot sprints and movement around a series of pylons.

Ultimately, the primary goal of this testing is to determine whether the applicant is capable of performing minimum standards appropriate to this agency.

I have examined this applicant and his/her medical history, and based upon my evaluation I recommend that:

__________ Participation is not advisable at the present time. (If you advise against participation, please do not disclose the applicant's medical condition on this form.)

__________ Within a reasonable degree of probability, no medical condition or disorder exists which precludes this applicant from participation in the physical abilities tests as described.

Signature of Physician ______________________________ **Date** __________

Physician Name (print) ______________________________

Address ______________________________

Office Telephone ______________ **State License Number** ______________

Thank you for your cooperation.

Agency Representative ______________________ **Telephone Number 941-861-5800**

This form is only valid for 45 days from the date of the physician's signature.

J-150b