



THE ACADEMY

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MEDICAL EXAMINATION REPORT

(To be completed by a Licensed Physician)

Part 1:

Name (Last, First, Middle): _____

Birthdate: _____ Sex: ☐ M ☐ F Social Security Number: _____

COURSE:

REQUALIFICATION ☐

OTHER ☐ (specify) _____

Dear Physician:

An examination of an individual's physical and mental fitness is required by the California Commission on Peace Officers Standards and Training (POST) prior to employment as a peace officer in a participating law enforcement agency.

The individual you are examining has been requested to obtain a Medical Clearance to participate in a Basic Training Program at the South Bay Regional Public Safety Training Consortium. The training program consists of several areas requiring demonstration of physical strength and fitness. Areas include, but are not limited to, Arrest Control Techniques, Firearms, Physical Fitness, and Scenario Training.

During the Arrest Control Techniques portion of the course, the individual will be required to apply and receive control type holds, perform repeated baton techniques, ground fighting techniques, and various other physical maneuvers. The control holds include various joint-locks designed to obtain "pain compliance" as well as take down techniques designed to obtain control and compliance. This class also includes demonstrated proficiency and use of the 'carotid restraint'.

During this course, the individual will also be required to handle and shoot firearms (handgun and shotgun). If, during the course of your examination, you determine (or reasonably suspect) there is some mental deficiency which could be detrimental to the health and well-being of this individual or others, you are requested to comment.

Your examination should include current and pre-existing medical conditions if applicable. Thank you for your attention and cooperation.

PART 2:

Having reviewed the individual's Medical History and having personally examined the individual, it is my opinion that:

PLEASE CHECK AND INITIAL (ONE):

☐ It is highly unlikely that participation in this program will pose significant medical risk.

☐ The above named person should NOT participate in this program.

South Bay Regional Public Safety Training Consortium is NOT responsible for any financial costs incurred with this required medical exam and will NOT make payments to any health care provider, insurance company, student or others. All exam-related expenses are the responsibility of the prospective student.

Physicians Signature: _____ Date: _____

Physicians Address: _____

Physicians Phone Number: _____

Comments: _____

TO BE COMPLETED BY THE STUDENT:

I acknowledge that I have read and understand that this course contains several physical requirements. I have no current or pre-existing physical limitations or conditions that would preclude me from participating in the course.

Student Signature: _____ **Date:** _____

Academy Use Only:

Received By: _____ **Date:** _____