

**DAVID MORGAN**  
ESCAMBIA COUNTY SHERIFF



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## ESCAMBIA COUNTY SHERIFF'S OFFICE

### Physician's Clearance to Test

Applicant Name: \_\_\_\_\_

Dear Physician:

The purpose of this communication is to inform you of the above-named individual's intention to participate in the pre-employment physical abilities test for employment with the Escambia County Sheriff's Office. 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 he or she is 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 conducted at our training site. 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 the George Stone Physical Fitness Pre-test, please see attached. On a later date, the applicant will have to perform 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 above-named applicant is capable of performing the minimum physical standards appropriate to this agency.

Physician's Statement:

I have examined the above-named applicant and his or 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 test as described.

\_\_\_\_\_  
Signature of Physician

\_\_\_\_\_  
Date

\_\_\_\_\_  
Type or Stamp Physician's Name

\_\_\_\_\_  
License Number