WALTON COUNTY FIRE RESCUE
WALTON COUNTY SHERIFF'S OFFICE
MEDICAL/PHYSICIAN'S CLEARANCE TO TEST FORM

AGENCY NAME: Walton County Sheriff's Office

NAME OF PARTICIPANT: _____

Dear Physician:

The purpose of this communication is to inform you of the above named individual's intention with regards to participating in the Walton County Sheriff's Office pre-employment Physical Abilities Test. 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 participant has any medical condition or disorder that would preclude participation. It must be emphasized that we are not asking you to assume responsibility of the participant while participating in this test, we merely want to have as much information as possible when making decisions concerning applicability of testing.

The Physical Abilities Testing program will consist of a series tests conducted at our training site. The battery of job-related field tests are intended to be completed in the fastest possible time and will require maximum effort by the participant. Tests are designed to measure balance, muscular endurance and strength, flexibility, anaerobic power and capacity, fine motor skill and aerobic power. Tests will include dragging a 150 pound object 50 feet, climbing 5 flights of stairs and 1 24' ladder, and advancing a charged hose line.

Ultimately, the primary goal of this testing is to determine whether the participant is capable of performing minimum standards appropriate to Firefighting and Emergency Medical Operations.

I have examined this participant 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 participant's medical condition on this form.

☐ Within a reasonable degree of probability, no medical condition or disorder exists which precludes this participant from participating in the Physical Abilities Testing as described.

_____ _____

Signature of Physician Date

THANK YOU FOR YOUR COOPERATION

NAME OF AGENCY REPRESENTATIVE: SHERIFF MICHAEL A. ADKINSON, Jr.

AGENCY ADDRESS: 752 Triple G Road Defuniak Springs, FL 32433