**State of Louisiana**

**Department of Public Safety and Corrections**

**Division of Probation and Parole**

**PHYSICAL FITNESS ASSESSMENT - HEALTHCARE PROVIDER RELEASE**

**NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**ADDRESS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

The applicant listed above has applied for a job with the Louisiana Department of Corrections - Division of Probation and Parole. The applicant must complete a Physical Standards Assessment which will require him/her to complete very strenuous physical and high impact aerobic activities. Please answer fully and completely, all applicable parts. All answers must be based upon your knowledge of the patient’s current physical and mental condition. The Division of Probation and Parole must be able to determine from the answers provided if the applicant possesses the physical and mental abilities required to participate in such activities. As a result of your examination, you should be able to determine if the applicant has any medical conditions that would prevent them from safely performing the below activities. Can the applicant safely perform:

1.5 mile run Yes No Handcuffing exercises Yes No

Sit-ups Yes No Take down/handcuffing Yes No

Push-ups Yes No Joint locks Yes No

Firearms training Yes No Punch block exercises Yes No

Aerobic exercises Yes No Weapon retention techniques Yes No

Kicking exercises Yes No Ground fighting techniques Yes No

Escape exercises Yes No Other strenuous activities Yes No

Follow verbal instructions Yes No Comprehend written instructions Yes No

Participate in group activities Yes No Work with others in close physical Yes No

proximity

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PHYSICIAN: PRINT NAME, ADDRESS, AND PHONE NUMBER

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PHYSICIAN’S SIGNATURE

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PHYSICIAN’S COMMENTS

DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_