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**INSTRUCTIONS**

To be completed by applicant for admissions to the Rhode Island Municipal Police Training Academy prior to the physical examination and presented to the examining physician at the time of examination. All questions must be answered completely and accurately. The original or a copy must be retained in personnel filed by the appointing agency.

**SECTION 1: CANDIDATE IDENTIFICATION**

DATE

NAME (Last, First, Middle)			BIRTHDATE (MM/DD/YYYY)	
ADDRESS		CITY		STATE ZIP
PHONE NUMBERS WHERE YOU CAN BE REACHED			SOCIAL SECURITY NUMBER	
DAY ( ) - EXT	EVENING ( ) - EXT			

**SECTION 2: CURRENT MEDICATIONS**

PRESCRIPTION MEDICATIONS: (INCLUDE PAIN RELIEVERS, BIRTH CONTROL PILLS, ETC.)

OVER THE COUNTER MEDICATIONS: (INCLUDE ALL COLD ALLERGY, HEADACHE, VITAMINS, ETC.)

**SECTION 3: ALLERGIES**

DRUG ALLERGIES: (INCLUDE YOUR REACTION TO THE MEDICATION)

ALL OTHER ALLERGIES: FOOD, INSECTS, SEASONS, ANIMALS, MATERIALS, ETC (INCLUDE REACTION)

**SECTION 4: FAMILY HISTORY**

Have any of your parents, brothers, or sisters suffered from: (check all that apply)

Y	N	?	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	1. Diabetes?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	2. Heart problems?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	3. High blood pressure?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	4. Arthritis?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	5. Neurological or psychological problems? (seizures, depression, schizophrenia, etc.)



**SECTION 5: PAST MEDICAL HISTORY**

LIST ALL HOSPITALIZATIONS AND OPERATIONS SINCE CHILDHOOD: (INCLUDE TYPE OF SURGERY, DATE OF SURGERY, ANY COMPLICATIONS OR OTHER SIGNIFICANT INFORMATION)

Have you EVER, in your life, had any of the following types of medical problems? (check all that apply to you)

- | Y                        | N                        | ?                        |  |
|--------------------------|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 1. CANCER: any type of cancer including skin cancer, breast cancer, and leukemia?  |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 2. MAJOR INFECTIONS DISEASE: such as tuberculosis, hepatitis, HIV/AIDS, Rheumatic fever and others?  |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 3. NEUROLOGICAL PROBLEMS: such as seizure disorder, stroke, concussion, severe headache, skull fracture, recurrent vertigo, balance problems, encephalitis, meningitis, tremors, multiple sclerosis, Huntington's chorea, peripheral neuropathy and others?                    |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 4. PSYCHOLOGICAL PROBLEMS: such as depression, manic episodes, psychotic episodes, post traumatic stress disorder and others?  |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 5. EYE PROBLEMS: such as eye injury, color blindness, poor night vision (night blindness), glaucoma, blindness in one or both eyes, very poor vision when not corrected and others?  |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 6. EAR PROBLEMS: such as ear injury, chronic ringing (tinnitus), chronic or long lasting ear infection, Meniere's disease, moderate to severe hearing loss in one or both ears and others?   |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 7. NOSE PROBLEMS: such as nose injury, allergies, nasal bleeding, loss of sense of smell, chronic or long lasting infections and others?   |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 8. MOUTH OR THROAT PROBLEMS: such as injury, major dental work, any kind of speech defect, chronic or long lasting infections, abnormality of nose, mouth or throat that would interfere with wearing a respirator and others?   |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 9. LUNG PROBLEMS: such as asthma, emphysema, chronic or recurrent bronchitis, pneumonia, tuberculosis or lung abscess and others?  |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 10. HEART AND CIRCULATION PROBLEMS: such as heart murmur, heart disease, heart attack, irregular rhythm, valve abnormalities, varicose veins, phlebitis, peripheral vascular disease, Raynaud's disease and others?  |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 11. DIGESTIVE SYSTEM PROBLEMS: such as any kind of ulcer disease, hepatitis or liver disorder, any kind of colitis, Crohn's disease, ulcerative colitis, irritable bowel syndrome, esophageal disorders, pancreatitis, gall stones, stomach or intestinal bleeding and others? |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 12. HORMONE OR ENDOCRINE PROBLEMS: such as diabetes, thyroid disease, parathyroid or adrenal problems or others?   |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 13. URINARY TRACT PROBLEMS: such as kidney stones, pyelonephritis (kidney infection), nephrosil, single functioning kidney, polycystic kidney disease, repeated bladder infections and others?   |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 14. HERNIA: such as inguinal, umbilical, ventral, femoral, hiatal or incisional hernias?   |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 15. MUSCLE, BONE AND JOINT PROBLEMS: such as chronic back or neck pain, fibromyalgia, back or neck disk disease, osteomyelitis (bone infection), muscular dystrophy, arthritis, spinal curvature, loss of a finger or toe or others?   |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 16. BLOOD SYSTEM PROBLEMS: such as anemia, hemophilia or bleeding disorder, white blood cell abnormality and others?   |

**MALES ONLY:**

- | Y                        | N                        | ?                        |   |
|--------------------------|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 17. Prostate problems such as enlargement or prostatitis?       |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 18. Genital problems such as epididymitis or testicular injury? |

**FEMALES ONLY:**

- | Y                        | N                        | ?                        |   |
|--------------------------|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 19. Currently pregnant?   |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 20. History of endometriosis, pelvic inflammatory disease, abnormal Pap smear, PMS or other problems with your menstrual cycle? |

**SECTION 6: IMMUNIZATIONS**

- | Y                        | N                        | ?                        |  |
|--------------------------|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 21. Have you ever had a positive TB test?                          |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 22. Have you received Hepatitis B vaccinations?                    |
|                          |                          |                          | 23. When did you receive your last tetanus (lockjaw) immunization? |



**SECTION 7: OCCUPATIONAL HISTORY**

Have you ever been exposed to any of the following, whether at home, work or military or any other setting?

- |                          |                          |                          |  |
|--------------------------|--------------------------|--------------------------|--|
| Y                        | N                        | ?                        |  |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 24. Repetitive Loud Noises (including guns, jet engines, loud machinery)?                            |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 25. Chemical exposure to skin or lungs?  |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 26. Dusty conditions (sandblasting, grinding, mining or drilling or rock, coal, silica or asbestos)? |

Check all that apply

- |                          |                          |                          |   |
|--------------------------|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 27. Have you ever sustained an injury while at work that necessitated extended care by a health care provider?                          |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 28. Have you ever had a motor vehicle accident causing back or neck pain?   |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 29. Are you limited or unable to perform any physical activity because of muscle or joint discomfort?                                   |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 30. Do you have any missing limbs or non-functional joints?   |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 31. Have you ever been advised by a physician to avoid lifting above a certain weight limit?  |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 32. Have you ever been advised by a physician to avoid sitting or standing over a certain time?   |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 33. Have you ever worked in law enforcement?  |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 33a. If yes, have you ever missed more than three consecutive days or service for any medical or psychological problem?                 |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 34. Have you ever served in any of the armed forces?  |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 34a. If yes, have you ever missed more than three consecutive days or service for any medical or psychological problem?                 |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 35. Do you have any difficulty in properly holding, aiming or firing a handgun, rifle or shotgun?                                       |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 36. Do you have any difficulty driving at high speeds in a motorized vehicle?   |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 37. Have you ever had an automobile accident while driving over sixty (60) miles per hour?  |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 38. Have you ever had any automobile accidents as a result of losing control of your vehicle?   |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 38. Do you have any difficulty driving for three (3) consecutive hours without stopping?  |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 40. Do you have any difficulty running for five (5) consecutive minutes without stopping?   |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 41. Have you ever passed out, temporarily lost control of any part of your body, or had blackout spells (episodes you do not remember)? |

**EXPLANATION OF ANY YES ANSWERS: (IDENTIFY BY NUMBER)**

May use additional sheets of paper, write name, SS#, sign and date.



SECTION 8: PENALTY

Any falsification, withholding or failure to answer all questions completely and accurately may disqualify you from receiving or retaining employment or certification as a criminal justice officer.

SECTION 9: CERTIFICATION

I hereby certify that there are no willful misrepresentations, omission or falsification in the foregoing statements and answers to questions and that all statements and answers are true and correct to the best of my knowledge and belief.

SIGNATURE OF APPLICANT (INK)

DATE SIGNED

PHYSICIAN REVIEW:

SIGNATURE OF PHYSICIAN (INK)

DATE REVIEWED

PRINTED NAME AND ADDRESS OF PHYSICIAN COMPLETING REVIEW: