

**PRLEA Medical Provider Physical Form**

Dear Medical Provider,

The individual named below is enrolling in a **law enforcement training academy** that would qualify them for employment as a law enforcement officer for an environmental agency (National Park Service, Washington State Parks and Recreation Commission, etc.) or as a Reserve Police Officer in the State of Washington. The training dates set for the program are EITHER Jan 02 – Apr 27, 2024; August 19 – December 14, 2024; or Jan 06 – May 03, 2025 and include training in, but not limited to, the following areas:

- EVOC (Tactical/emergency vehicle operation) - Patrol Procedures

- Defensive Tactics, including ground fighting - Radio Techniques

- Chemical Agents and full-face pepper spray exposure - First Aid/CPR

- Taser Training - Use of Force

- Firearms - Academics

- Physical conditioning, including 1.5 mile run - Verbal Communication

- Field Exercises (scenario-based training)

- Skills demanding dexterity, attention and coordination

Please examine this applicant to verify that s/he is in **above-average physical condition** to undertake the rigorous Parks Law Enforcement Academy at Skagit Valley College. This Academy consists of approximately 720 hours of training in the above subjects, which requires mandatory physical and mental training and preparation in order to become certified.

Respectfully,

Rick Mossman, Academy Director

Parks Law Enforcement Academy

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

This is to verify that I have examined \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ and did not find any physical impairment that would interfere with his/her functioning while undertaking the Parks Law Enforcement Academy at Skagit Valley College in Mount Vernon, WA.

Please print or type the Medical Provider’s name, business address, and contact number below:

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

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

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

(\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Date Medical Provider’s Signature and Title