

INSTRUCTIONS

A Completed Academy Packet consists of the following:

All of These Items Need to Be Completed and In the Packet Before it is Returned to the Academy.

USE THIS CHECK-OFF SHEET TO ENSURE ALL FORMS ARE ENCLOSED BEFORE MAILING.

- ONE (1) Completed** Application For Admission Basic Police Training School.

- One (1) **Preprinted ORI/WVWSP0000** Federal Applicant Cards. Record on the **front of each card where applicable. Sticker WVSP39** (Release of Information) **ALSO NEEDS FILLED OUT**. These cards are mailed to you in the packet. Do not use these cards for your background investigation. They are for entry into a Basic Class ONLY.

- Completed** Medical History Statement/Medical Examination Report. Take the **Medical Standards (ENCLOSED)** with you to the physician. The physician needs to read this before he/she can sign the last page of the **Medical Examination Report**.

- ALL OF THE FOLLOWING LAB TEST RESULTS**
 - Complete Blood Count (CBC)
 - Blood Chemistry (Chem 20 or equivalent)
 - Urinalysis (with dipstick)
 - Tuberculosis (Mantoux)
 - Electrocardiogram (ECG)(Resting)
 - Drug Screen (DOH-5 or 8-10 panel)

ALL OF THE ABOVE PAPERWORK MUST BE IN THE RETURNED PACKET TO BE CONSIDERED COMPLETED. DO NOT RETURN A PACKET WITHOUT ALL THE ABOVE PAPERWORK. IF YOU NEED ASSISTANCE WITH THE PAPERWORK, CALL MICHELLE WATSON AT THE BELOW PHONE NUMBER AND I WILL HELP YOU.

**Mrs. Michelle Watson
West Virginia State Police Academy
135 Academy Drive
Dunbar WV 25064
Phone: 766-5800**

linda.m.watson@wvsp.gov

APPLICATION FOR ADMISSION BASIC POLICE TRAINING SCHOOL

SPONSORED BY THE WEST VIRGINIA STATE POLICE

FULL NAME: _____			Social Security Number: _____		
Last	First	MI			
Male <input type="checkbox"/>	Female <input type="checkbox"/>	Date of Birth: _____	Email: _____		
Name of Agency: _____			Date of Employment: _____		
Agency Address: _____					
(Street)		(City)		(State) (Zip Code)	
Agency Phone: _____			Agency Fax: _____		
Agency Contact: _____					
(Name)			(Email)		
TOTAL COMPLEMENT OF DEPARTMENT _____			NUMBER OF PERSONNEL REQUIRING _____		
(SWORN PERSONNEL)			TRAINING UNDER PRESENT LAW		
<u>LIST THE CALIBER OF WEAPON THIS STUDENT WILL BE USING FOR TRAINING AT THE ACADEMY</u> _____					

I, _____ of _____
(Chief/Sheriff) (Department)

give my permission for _____ to attend the Basic Police
(Applicant)

Training Course. This officer has been employed for a period of less than 90 calendar days and this Department agrees to pay his/her salary for a forty-hour work week while s/he attends this school. I have read the State Police Academy "Admission Policy for Applicants with Prior Criminal Record" and this applicant DOES ___ DOES NOT ___ need prior review by the Law Enforcement Training Subcommittee of the Governor's Committee of Crime, Delinquency and Correction. I fully understand the Subcommittee has the right to allow the applicant to either continue in the academy admission process or deny admission to a basic entry level training program based on prior arrest(s). Such denial requires the applicant to be terminated as a law enforcement officer.

ONE FEDERAL APPLICANT FINGERPRINT CARDS ATTACHED: YES _____ NO _____

DATE RECEIVED AT THE ACADEMY ____/____/____ (LEAVE BLANK)

(SIGNATURE OF CHIEF OR SHERIFF)

(SIGNATURE OF APPLICANT)

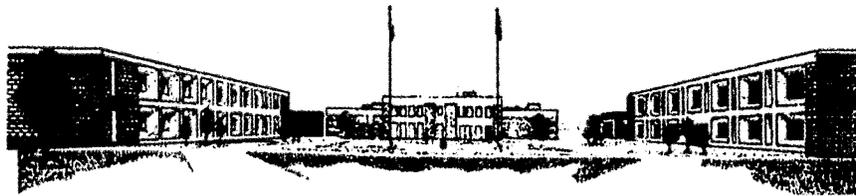
Please return application & medical to:

*West Virginia State Police Academy
 Attn: Michelle Watson
 135 Academy Drive
 Dunbar, WV 25064*

Phone: (304) 766-5800 Fax: (304) 766-5860
 linda.m.watson@wvsp.gov

For office use only-do not write in this space

P.A.T. Date	Pass	Fail	Excused
_____	{ }	{ }	{ }
Comment: _____			
_____	{ }	{ }	{ }
Comment: _____			



*West Virginia State Police Training Academy
135 Academy Drive
Dunbar, West Virginia 25064*

*Jim Justice
Governor*

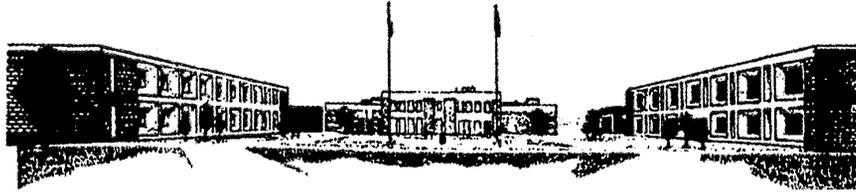
*J. L. Cahill
Superintendent*

Admission Policy for Applicants With Prior Criminal Record

In compliance with Legislative Rule 149-2-16 (attached) it shall be the policy of the West Virginia State Police Academy to refuse admission into a Basic Police Officer Training Program of any person who has been convicted or arrested by any state or by the federal government of any crime the punishment for which could have been imprisonment in a federal or state prison or institution or who has been convicted of or pleaded guilty to or entered a plea of nolo contendere to any felony charge or to any violation of any federal or state laws or city ordinances, or to a sufficient number of misdemeanors to establish a pattern of disregard for the law, unless such person shall first petition for and receive from the Law Enforcement Training Subcommittee of the Governors Committee on Crime, Delinquency and Correction a declaration that such conviction or plea will not result in a Subcommittee recommendation to deny certification should the person be admitted to and successfully complete the Basic Police Officer Training program.

In furtherance of this policy all applications for admission to a Basic Police Officer Training Program must include one Federal Bureau of Investigations APPLICANT fingerprint card, properly completed and bearing the applicants fingerprints. Such card will be submitted, by the Academy Commandant, to the Criminal Identification Bureau and the Federal Bureau of Investigation and any prior criminal record revealed as a result of such submission will become a part of the application file for use in enforcement of this policy.

The failure on the part of any student to disclose, prior to admission, any conviction or plea entered as hereto before specified or to report any such conviction or plea after being admitted, will be considered misconduct and upon discovery of such concealment, the student will be immediately dismissed from the Academy.



*West Virginia State Police Training Academy
135 Academy Drive
Dunbar, West Virginia 25064*

*Jim Justice
Governor*

*J. L. Cahill
Superintendent*

Legislative Rule

§149-2-16. Certification Denial, Suspension or Revocation

16.1. The Governor's Committee on Crime, Delinquency and Correction, upon the recommendation of the Law Enforcement Training Subcommittee, may suspend, revoke, or deny the certification of a law enforcement officer or, if applicable, deny admission to a basic entry-level training program for conduct or a pattern of conduct unbecoming to an officer or activities that would tend to disrupt, diminish, or otherwise jeopardize public trust and fidelity in law enforcement. Such conduct, pattern of conduct, or activities may include, but not be limited to the following:

16.1.a. Willful falsification of any information submitted or relied upon to obtain certified status;

16.1.b. Having a physical or mental condition affecting the officer's ability to perform his or her duties as described in subsection 8.3 of this rule;

16.1.c. Addiction to or unlawful sale, possession, or use of narcotics, drugs, or drug paraphernalia;

16.1.d. Having admitted the commission of or been convicted of a felony or any crime involving dishonesty, unlawful sexual conduct, physical violence, or driving under the influence of alcohol or drugs;

16.1.e. Failure to participate in the required in-service training;

16.1.f. Legal prohibitions that prevent an officer from performing some or all of his or her required law enforcement duties. It is the responsibility of the officer to report any such legal prohibitions to the Committee within ten (10) days;

16.1.g. Failure to report legal probations as required by 16.1.f. of this rule;

16.1.h. Whose certification as a law enforcement officer has been suspended, denied or revoked by another state's Peace Officers Standards and Training Commission.

16.2. Employment by another agency or reinstatement of a law enforcement officer by his parent agency after termination, whether termination was voluntary or involuntary, does not preclude suspension, revocation or denial of law enforcement certification, if the law enforcement officer was terminated for any of the reasons contained in this section.

16.3. Termination of a law enforcement officer, whether voluntary or involuntary, does not preclude suspension, revocation or denial of law enforcement certification, if the law enforcement officer was terminated for any of the reasons contained in this section.

16.4. The Subcommittee may not suspend, revoke, or deny law enforcement certification when an officer is terminated for infractions of his or her agency's policies, general orders, or similar guidelines of operation that do not amount to any of the causes outlined in this rule.

16.5. An employing agency shall not seek de-certification of a law enforcement officer prior to or in lieu of terminations.

16.6. Law enforcement officers whose certification has been suspended, revoked or if applicable an applicant who has been denied admission to a basic entry-level training academy, may not remain employed as a law enforcement officer and may not exercise any authority as a law enforcement officer during the period for which their certification is suspended, revoked or denied.

TO WHOM IT MAY CONCERN:

ATTACHED IS A **MEDICAL HISTORY STATEMENT** AND A **MEDICAL EXAMINATION REPORT** WHICH IS DESIGNED FOR ENTRY LEVEL POLICE OFFICERS

THE **MEDICAL STANDARDS**, SET UP BY THE LEGISLATIVE RULE, LAW ENFORCEMENT TRAINING SHOULD ALSO ACCOMPANY THESE MEDICAL REPORTS. **THIS WILL ASSIST YOU.**

THE FOLLOWING **LIST OF LAB TESTS ARE REQUIRED BY THE L.E.T. AND NEED TO BE PERFORMED** ALONG WITH THE PHYSICAL. **THE PATIENT WILL NEED A COPY OF EACH OF THE LAB TEST RESULTS** TO SUBMIT TO THE STATE POLICE ACADEMY FOR ENTRY INTO A BASIC TRAINING CLASS:

1. BLOOD CHEMISTRY (CHEM 20 OR EQUIVALENT)
2. COMPLETE BLOOD COUNT (CBC)
3. ROUTINE URINALYSIS
4. TUBERCULOSIS (MANTOUX)
5. ELECTROCARDIOGRAM (ECG)(RESTING)
6. DRUG SCREENING (DOT-5 OR 8-10 PANEL)
7. HEARING IN DECIBELS (AUDIOGRAM)

IF YOU HAVE ANY QUESTIONS, PLEASE CALL MICHELLE WATSON AT 766-5800 or EMAIL linda.m.watson@wvsp.gov

THANK YOU

APPLICATION FOR BASIC ENTRY LEVEL TRAINING

MEDICAL HISTORY STATEMENT

Law enforcement officer applicants must be examined by a licensed physicians to ensure that the applicant is free of any physical defect or medical condition which might adversely affect job performance or the applicant's ability to successfully complete a prescribed basic law enforcement training course. A declaration of the applicant's medical history must be made available to the examining physician and the medical history will become part of the applicant's academy application packet.

The information you provide in this statement is extremely important. It will be used by the examining physician to evaluate your qualifications for entry into a basic level training program. Therefore, please fill out the questionnaire completely and accurately. Please keep in mind that: (a) all statements are subject to verification, and (b) deliberate inaccuracies or incomplete statements may bar or remove you from a basic entry level training program.

This statement was designed to explore those areas which bear directly upon the physical demands of the position for which you are applying. A thorough and accurate evaluation of this information will contribute to sound decisions benefiting both you and your employer.

This statement is confidential. The information you provide will be part of your medical record.

When answering "Yes/No" questions, place an "X" in the appropriate box. If you are unable to answer a question for any reason, place an "?" in the "Yes" box.

Name			Date of Birth			Social Security Number		
_____			_____			_____		
<i>Last</i>	<i>First</i>	<i>Middle</i>	<i>Month</i>	<i>Day</i>	<i>Year</i>	<i>In accordance with the Federal Privacy Act of 1974, disclosure is voluntary. The SSN will be used for identification purposes to ensure that proper records are maintained.</i>		
_____	_____	_____	_____	_____	_____			
Address						Work Phone _____		
_____						Home Phone _____		
<i>Street or P. O. Box</i>						Cell Phone _____		
_____		_____		_____				
<i>City</i>		<i>State</i>		<i>Zip</i>				
I, the undersigned, do hereby consent to undergo a medical examination, including blood specimens, X-rays, skin tests, immunizations, and other examinations which the examiners may consider necessary to complete the medical evaluation.								
<i>Signature in Full:</i> _____						<i>Date Completed:</i> _____		

MEDICAL HISTORY STATEMENT

1. Have you been medically examined for entry into basic level training program? <input type="checkbox"/> Yes <input type="checkbox"/> No			
If "Yes", your name at the time?	Date?		
2. Please list all medications you regularly use, including vitamins, birth control pills, laxatives, aspirins, antihistamines, tranquilizers, and weight reducing aids.			
3. Please list any medications you have taken in the last two months. (Prescription & Non-Prescription)			
4. Name any drugs to which you may have ever had an allergic reaction.			
5. Please list any other substances to which you are allergic, including food, insect stings, etc.			
6. Please list your last three hospitalizations, beginning with most recent (excluding routine childbirth).			
Reason	Hospital/City	Month	Year
Reason	Hospital/City	Month	Year
Reason	Hospital/City	Month	Year
7. Please list any operations you may have had which are not listed above.			
8. If a parent, grandparent, brother or sister has had any of the following diseases, please check the correct spaces.			
	Mother Father Other		Mother Father Other
DISEASE		DISEASE	
Diabetes	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Tuberculosis	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Cancer/Tumor	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Heart Disease	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Hereditary or Familial Disease	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Have you ever been exposed to any of the following, whether at home, work, or in any other setting?			
	Yes No		
9.	<input type="checkbox"/> <input type="checkbox"/>	Prolonged loud noises?	
10.	<input type="checkbox"/> <input type="checkbox"/>	Substances which irritated your skin or eyes?	
11.	<input type="checkbox"/> <input type="checkbox"/>	Sprays or powders for insects or plants?	
12.	<input type="checkbox"/> <input type="checkbox"/>	Prolonged X-rays or other radiation?	
13.	<input type="checkbox"/> <input type="checkbox"/>	Dusty conditions such as sandblasting, grinding or drilling rock, coal, silica, asbestos, or asbestos products?	
Have a bad reaction to:			
14.	<input type="checkbox"/> <input type="checkbox"/>	High environmental temperatures?	
15.	<input type="checkbox"/> <input type="checkbox"/>	Low environmental temperatures?	

MEDICAL HISTORY STATEMENT

	Yes	No	
16.	<input type="checkbox"/>	<input type="checkbox"/>	Have you been rejected by the military for health reasons?
17.	<input type="checkbox"/>	<input type="checkbox"/>	Were you ever in the Armed Services? If "Yes", please enter the following:
18.	<input type="checkbox"/>	<input type="checkbox"/>	Did you receive a medical discharge?
Have you ever had a claim for the following:			
19.	<input type="checkbox"/>	<input type="checkbox"/>	An occupational disease?
20.	<input type="checkbox"/>	<input type="checkbox"/>	An industrial accident?
21.	<input type="checkbox"/>	<input type="checkbox"/>	Have you any claim now pending for the above?

If you have ever had or now have any of the following, please check the appropriate space.

	Yes	No			Yes	No	
22.	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	40.	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease
23.	<input type="checkbox"/>	<input type="checkbox"/>	Pneumonia	41.	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatism, Arthritis
24.	<input type="checkbox"/>	<input type="checkbox"/>	Bronchitis	42.	<input type="checkbox"/>	<input type="checkbox"/>	Varicose Veins
25.	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema	43.	<input type="checkbox"/>	<input type="checkbox"/>	Phlebitis
26.	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	44.	<input type="checkbox"/>	<input type="checkbox"/>	Hay Fever
27.	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	45.	<input type="checkbox"/>	<input type="checkbox"/>	Typhoid Fever
28.	<input type="checkbox"/>	<input type="checkbox"/>	Heart Murmur, Heart Disease	46.	<input type="checkbox"/>	<input type="checkbox"/>	Scarlet Fever
29.	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic Fever	47.	<input type="checkbox"/>	<input type="checkbox"/>	Valley Fever (<i>Coccidioidomycosis</i>)
30.	<input type="checkbox"/>	<input type="checkbox"/>	Encephalitis, Meningitis	48.	<input type="checkbox"/>	<input type="checkbox"/>	Histoplasmosis
31.	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy, Convulsions	49.	<input type="checkbox"/>	<input type="checkbox"/>	Venereal Disease <i>(V.D., Syphilis, Gonorrhea)</i>
32.	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma	50.	<input type="checkbox"/>	<input type="checkbox"/>	Cancer
33.	<input type="checkbox"/>	<input type="checkbox"/>	Duodenal or Stomach Ulcer	51.	<input type="checkbox"/>	<input type="checkbox"/>	Hyperthyroidism
34.	<input type="checkbox"/>	<input type="checkbox"/>	Gall Bladder Trouble	52.	<input type="checkbox"/>	<input type="checkbox"/>	Hypothyroidism
35.	<input type="checkbox"/>	<input type="checkbox"/>	Liver Trouble or Hepatitis	53.	<input type="checkbox"/>	<input type="checkbox"/>	Allergic Rhinitis
36.	<input type="checkbox"/>	<input type="checkbox"/>	Hiatal or Diaphragmatic Hernia	54.	<input type="checkbox"/>	<input type="checkbox"/>	Other (<i>Explain Below</i>)
37.	<input type="checkbox"/>	<input type="checkbox"/>	Sickle Cell Disease				
38.	<input type="checkbox"/>	<input type="checkbox"/>	Anemia				
39.	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes (<i>Sugar Disease</i>)				

	Yes	No	
55.	<input type="checkbox"/>	<input type="checkbox"/>	Have you gained or lost more than 10 pounds in the past two years without trying to do so?
56.	<input type="checkbox"/>	<input type="checkbox"/>	Have you had any changes in your appetite in the past six months?
57.	<input type="checkbox"/>	<input type="checkbox"/>	Have you noticed unusual fatigue or weakness recently?
58.	<input type="checkbox"/>	<input type="checkbox"/>	Have you been told by a doctor that you had trouble with your thyroid gland?
59.	<input type="checkbox"/>	<input type="checkbox"/>	Have you noticed changes in your hair or skin color or texture?
60.	<input type="checkbox"/>	<input type="checkbox"/>	Have you had a change in the size or color of a mole (dark growth) or wart in past year?
61.	<input type="checkbox"/>	<input type="checkbox"/>	Do you have a skin rash, burning, itching or other skin sensitivity?
62.	<input type="checkbox"/>	<input type="checkbox"/>	Have you had any skin cancers removed?

63.	<input type="checkbox"/>	<input type="checkbox"/>	Have you had bleeding gums in the past year?
64.	<input type="checkbox"/>	<input type="checkbox"/>	Do you have frequent nosebleeds for no apparent reason?
65.	<input type="checkbox"/>	<input type="checkbox"/>	Do you frequently have sinus trouble?
66.	<input type="checkbox"/>	<input type="checkbox"/>	Do you have colds more than twice a month?
67.	<input type="checkbox"/>	<input type="checkbox"/>	Have you ever coughed up blood?

MEDICAL HISTORY STATEMENT

	Yes	No	
68.	<input type="checkbox"/>	<input type="checkbox"/>	Have you had a chest X-ray in the past two years?
69.	<input type="checkbox"/>	<input type="checkbox"/>	Do you often cough up a large amount of mucus?
70.	<input type="checkbox"/>	<input type="checkbox"/>	Have you ever had a positive TB (Tuberculosis) skin test?
71.	<input type="checkbox"/>	<input type="checkbox"/>	Do you have unusual shortness of breath?
72.	<input type="checkbox"/>	<input type="checkbox"/>	Do you ankles or feet often swell?
73.	<input type="checkbox"/>	<input type="checkbox"/>	Have you had a feeling of pressure or tightness in your chest in the past year?
74.	<input type="checkbox"/>	<input type="checkbox"/>	Have you had a pain in your chest in the past year?
75.	<input type="checkbox"/>	<input type="checkbox"/>	Do you sometimes wake up at night short of breath?
76.	<input type="checkbox"/>	<input type="checkbox"/>	Do you get pains or cramps in the back of your legs while walking?
77.	<input type="checkbox"/>	<input type="checkbox"/>	Do you get pains or cramps in your legs at night?
78.	<input type="checkbox"/>	<input type="checkbox"/>	Do you smoke cigarettes? How many per day? _____
79.	<input type="checkbox"/>	<input type="checkbox"/>	Do you use other forms of tobacco?
80.	<input type="checkbox"/>	<input type="checkbox"/>	Do you sometimes have severe soaking sweats at night?
81.	<input type="checkbox"/>	<input type="checkbox"/>	Have you had an electrocardiogram (ECG, EKG) in the past two years?
82.	<input type="checkbox"/>	<input type="checkbox"/>	Do you suffer from indigestion or heartburn?
83.	<input type="checkbox"/>	<input type="checkbox"/>	Is swallowing painful or difficult for you?
84.	<input type="checkbox"/>	<input type="checkbox"/>	Do you frequently have pain in your stomach or abdomen?
85.	<input type="checkbox"/>	<input type="checkbox"/>	Do you frequently take antacid medications, such as Tums or Alka Seltzer?
86.	<input type="checkbox"/>	<input type="checkbox"/>	Have you vomited blood or coffee ground-like material?
87.	<input type="checkbox"/>	<input type="checkbox"/>	Have you ever had jaundice?
88.	<input type="checkbox"/>	<input type="checkbox"/>	Are your bowel movements ever black or bloody?
89.	<input type="checkbox"/>	<input type="checkbox"/>	Are your bowel movements ever painful?
90.	<input type="checkbox"/>	<input type="checkbox"/>	Have you ever had hemorrhoids?
91.	<input type="checkbox"/>	<input type="checkbox"/>	Do you frequently get up at night to urinate (pass water)?
92.	<input type="checkbox"/>	<input type="checkbox"/>	Do you ever have difficulty stopping or starting urination?
93.	<input type="checkbox"/>	<input type="checkbox"/>	Have you had pain or burning with urination?
94.	<input type="checkbox"/>	<input type="checkbox"/>	Has your urine ever been red, black, brown, or bloody?
95.	<input type="checkbox"/>	<input type="checkbox"/>	Have you ever been told by a doctor that you had sugar or pus in your urine?
96.	<input type="checkbox"/>	<input type="checkbox"/>	Have you ever had a bladder or kidney infection?
97.	<input type="checkbox"/>	<input type="checkbox"/>	Have you ever passed kidney stones or gravel?
98.	<input type="checkbox"/>	<input type="checkbox"/>	Have you ever had a hernia (rupture)? <i>If "Yes", was it surgically repaired?</i>
99.	<input type="checkbox"/>	<input type="checkbox"/>	Have you ever had a minor back sprain? <i>If "Yes", please answer the following:</i> How many times have you had an attack of this condition? _____ How many days were you unable to work because of this condition: _____
100.	<input type="checkbox"/>	<input type="checkbox"/>	Have you ever had a severe back injury or episode of severe back pain? <i>If "Yes", please answer the following:</i> How many times have you had an attack of this condition? _____ How many days were you unable to work because of this condition: _____
101.	<input type="checkbox"/>	<input type="checkbox"/>	Have you ever had problems with low back pain?
102.	<input type="checkbox"/>	<input type="checkbox"/>	Have you ever had a problem with any bones or joints, including fractures, dislocation, limitation of movement, stiffness, or pain? <i>If "Yes", please describe the problems:</i>
103.	<input type="checkbox"/>	<input type="checkbox"/>	Have you had any fainting spells or seizures?
104.	<input type="checkbox"/>	<input type="checkbox"/>	Have you had a skull fracture or a head injury which made you unconscious?
105.	<input type="checkbox"/>	<input type="checkbox"/>	Do you suffer from migraine headaches or other bad headaches?
106.	<input type="checkbox"/>	<input type="checkbox"/>	When you have a headache is it relieved by aspirin?

MEDICAL EXAMINATION REPORT

EXAMINING PHYSICIAN: Please review applicable Medical Selection Guidelines before examining the candidate. For each condition listed, check box if it represents a **Potentially Excludable Condition**.

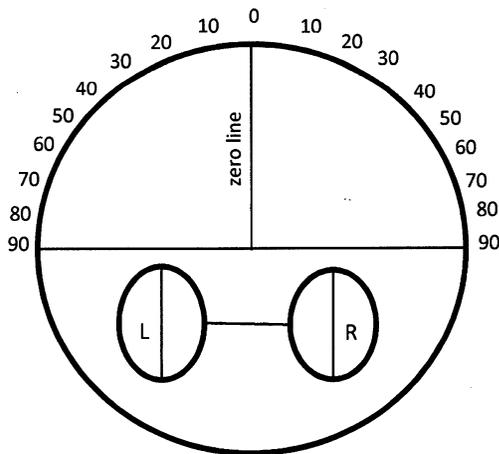
1. Applicant Name (Last, First, Middle)			2. Birth Date (Month/Day/Year)		
3. Height (without shoes)	4. Weight (without shoes & coat)	5. Chest Girth (Expiration)	6. Abdominal Girth		
7. Department					

SECTION ONE Eyes & Vision

Minimum Vision Standards for Police Officers

Applicant must possess normal color discrimination, normal binocular coordination, an normal peripheral vision. See Medical Selection Guidelines for specific measurements. Applicant must possess uncorrected or corrected visual acuity of 20/30 in both eyes combined.

CONTACT LENSES WORN	Yes	No	Potentially Excludable Condition	
1.1 Distant Vision (if applicant wears glasses, test and record acuity both with and without glasses)				
Without Glasses	R 20/ _____	L 20/ _____	B 20/ _____	□
With Glasses	R 20/ _____	L 20/ _____	B 20/ _____	□
1.2 Near Vision (if applicant wears glasses, test and record acuity both with and without glasses)				
Without Glasses	R 20/ _____	L 20/ _____	B 20/ _____	□
With Glasses	R 20/ _____	L 20/ _____	B 20/ _____	□
1.3 Color Vision	_____		□	
1.4 Depth Perception	_____		□	
1.5 Peripheral Vision				
Form Fields of Vision (Temporal): Right Eye _____ Left Eye _____				
Each Eye on Zero Line _____				
<i>(Record degrees of temporal fields obtained by instrumentation or confrontation in spacs above and diagram below)</i>				
Evidence of Suppression _____				
<i>(Note any Abnormality)</i>				
1.6 Glaucoma			□	
1.7 Strabismus			□	
1.8 Cataracts, Current			□	
1.9 Proliferative Retinopathy			□	
1.10 Nystagmus or Other Extra-Ocular Movement			□	
1.11 Monocular Vision			□	
1.12 Blindness, Including Night Blindness			□	
1.13 Retinal Detachemnt			□	
1.14 Chronic Keratitis			□	
1.15 Optic Neuritis			□	



MEDICAL EXAMINATION REPORT

Applicant Name <i>(Last, First, Middle)</i>	Birth Date <i>(Month/Day/Year)</i>
---	------------------------------------

SECTION FOUR <u>Peripheral Vascular System</u>		
Yes No		
4.1 <input type="checkbox"/> <input type="checkbox"/>	Hypertension	
4.2 <input type="checkbox"/> <input type="checkbox"/>	Varicose Veins	
4.3 <input type="checkbox"/> <input type="checkbox"/>	Venous Insufficiency	
4.4 <input type="checkbox"/> <input type="checkbox"/>	Peripheral Vascular Disease	
4.5 <input type="checkbox"/> <input type="checkbox"/>	Thrombophlebitis	

SECTION FIVE <u>Heart & Cardiovascular System</u>						
		Blood Pressure	Pulse Rate	Sounds	Rhythm	
Type of Action						
At Rest						
Pulses		Right	Left	Note Any Abnormality	Right	Left
	Femoral					
	Popliteal					
	Dorsal Pedis					

Yes No		
5.1 <input type="checkbox"/> <input type="checkbox"/>	Congenital Heart Disease	
5.2 <input type="checkbox"/> <input type="checkbox"/>	Valvular Heart Disease	
5.3 <input type="checkbox"/> <input type="checkbox"/>	Coronary Artery Disease	
5.4 <input type="checkbox"/> <input type="checkbox"/>	ECG Abnormalities <i>(if associated with organic heart disease)</i> - See Medical Selection Guidelines For Specific Abnormalities	
5.5 <input type="checkbox"/> <input type="checkbox"/>	Angina	
5.6 <input type="checkbox"/> <input type="checkbox"/>	Congestive Heart Failure	
5.7 <input type="checkbox"/> <input type="checkbox"/>	Cardiomyopathy	
5.8 <input type="checkbox"/> <input type="checkbox"/>	Active Pericarditis, Endocarditis, Myocarditis	

SECTION SIX <u>Respiratory System</u>		
Yes No		
6.1 <input type="checkbox"/> <input type="checkbox"/>	Active Pulmonary Tuberculosis	
6.2 <input type="checkbox"/> <input type="checkbox"/>	Chronic Bronchitis	
6.3 <input type="checkbox"/> <input type="checkbox"/>	Active Asthma	
6.4 <input type="checkbox"/> <input type="checkbox"/>	Chronic Obstructive Pulmonary Disease	
6.5 <input type="checkbox"/> <input type="checkbox"/>	Bronchiectasis & Pneumothorax	
6.6 <input type="checkbox"/> <input type="checkbox"/>	Pneumonectomy	
6.7 <input type="checkbox"/> <input type="checkbox"/>	Acute/Chronic Mycotic Diseases	

SECTION SEVEN <u>Gastrointestinal System</u>		
Yes No		
7.1 <input type="checkbox"/> <input type="checkbox"/>	Colitis	
7.2 <input type="checkbox"/> <input type="checkbox"/>	Esophageal Disorders	
7.3 <input type="checkbox"/> <input type="checkbox"/>	Hemorrhoids	
7.4 <input type="checkbox"/> <input type="checkbox"/>	Pancreatitis	
7.5 <input type="checkbox"/> <input type="checkbox"/>	Gall Bladder Disorders	
7.6 <input type="checkbox"/> <input type="checkbox"/>	Active Peptic Ulcer Disease	
7.7 <input type="checkbox"/> <input type="checkbox"/>	Symptomatic Injunal, Umbilical, Ventral, Femoral or Incisional Hernia(s)	
7.8 <input type="checkbox"/> <input type="checkbox"/>	Malignant Disease of Liver, Gall Bladder, Pancreas, Esophagus, Stomach, Small or Large Bowl, Rectum or Anus	
7.9 <input type="checkbox"/> <input type="checkbox"/>	Gastrointestinal Bleeding	
7.10 <input type="checkbox"/> <input type="checkbox"/>	Active or Chronic Hepatitis	
7.11 <input type="checkbox"/> <input type="checkbox"/>	Cirrhosis of the Liver	

MEDICAL EXAMINATION REPORT

Applicant Name <i>(Last, First, Middle)</i>	Birth Date <i>(Month/Day/Year)</i>
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People with communicable diseases must be evaluated relevant to their ability to train and perform essential tasks without posing a direct threat to the health and safety of themselves and others.

SECTION EIGHT Genitourinary System

	Yes	No	
8.1	<input type="checkbox"/>	<input type="checkbox"/>	Pregnancy
8.2	<input type="checkbox"/>	<input type="checkbox"/>	Nephrectomy
8.3	<input type="checkbox"/>	<input type="checkbox"/>	Acute Nephritis
8.4	<input type="checkbox"/>	<input type="checkbox"/>	Nephrotic Syndrome
8.5	<input type="checkbox"/>	<input type="checkbox"/>	Acute Renal/urinary Calculi
8.6	<input type="checkbox"/>	<input type="checkbox"/>	Renal Transplant
8.7	<input type="checkbox"/>	<input type="checkbox"/>	Renal Failure
8.8	<input type="checkbox"/>	<input type="checkbox"/>	Hydrocele and/or Varicocele <i>(symptomatic)</i>
8.9	<input type="checkbox"/>	<input type="checkbox"/>	Malignant Disease of Bladder, Kidney, Ureter, Cervix, Ovaries, Breasts, Prostate, etc.
	<input type="checkbox"/>	<input type="checkbox"/>	<i>List Specific Disease(s)</i> _____
8.10	<input type="checkbox"/>	<input type="checkbox"/>	Active Venereal Disease
8.11	<input type="checkbox"/>	<input type="checkbox"/>	Urinary Tract Infection
8.12	<input type="checkbox"/>	<input type="checkbox"/>	Polycystic Kidney Disease
8.13	<input type="checkbox"/>	<input type="checkbox"/>	Pelvic Inflammatory Disease
8.14	<input type="checkbox"/>	<input type="checkbox"/>	Cervicitis
8.15	<input type="checkbox"/>	<input type="checkbox"/>	Endometriosis
8.16	<input type="checkbox"/>	<input type="checkbox"/>	Bartholin Gland Abscess
8.17	<input type="checkbox"/>	<input type="checkbox"/>	Vaginitis
8.18	<input type="checkbox"/>	<input type="checkbox"/>	Inflammatory Disorders
8.19	<input type="checkbox"/>	<input type="checkbox"/>	Presence of Illicit Drugs

SECTION NINE Endocrine & Metabolic Systems

	Yes	No	
9.1	<input type="checkbox"/>	<input type="checkbox"/>	Untreated Thyroid Disease
9.2	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes Mellitus
9.3	<input type="checkbox"/>	<input type="checkbox"/>	Adrenal Dysfunctions
9.4	<input type="checkbox"/>	<input type="checkbox"/>	Hypoglycemia
9.5	<input type="checkbox"/>	<input type="checkbox"/>	Pituitary Dysfunction
9.6	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Tumor

SECTION TEN Skin & Collagen Diseases

	Yes	No	
10.1	<input type="checkbox"/>	<input type="checkbox"/>	Serious Dermatological Disorders
10.2	<input type="checkbox"/>	<input type="checkbox"/>	Lupus Erythematosus
10.3	<input type="checkbox"/>	<input type="checkbox"/>	Contact Allergies <i>(of a serious or relevant nature)</i>

SECTION ELEVEN Musculoskeletal System

11.1	<input type="checkbox"/>	<input type="checkbox"/>	Disorders that Limit Motor Performance
11.2	<input type="checkbox"/>	<input type="checkbox"/>	Cervical Spine or Lumbosacral Fusion
11.3	<input type="checkbox"/>	<input type="checkbox"/>	Degenerative Cervical or Lumbar Disc Disease <i>(if symptomatic)</i>
11.4	<input type="checkbox"/>	<input type="checkbox"/>	Extremity Amputation
11.5	<input type="checkbox"/>	<input type="checkbox"/>	Osteomyelitis
11.6	<input type="checkbox"/>	<input type="checkbox"/>	Muscular Dystrophy
11.7	<input type="checkbox"/>	<input type="checkbox"/>	Loss in Motor Ability from Tendon or Nerve Injury/Surgery

MEDICAL EXAMINATION REPORT

Applicant Name (<i>Last, First, Middle</i>)	Birth Date (<i>Month/Day/Year</i>)
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SECTION ELEVEN (CONTINUED)	<u>Musculoskeletal System</u>																												
<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 10%;"></td> <td style="width: 10%; text-align: center;">Yes</td> <td style="width: 10%; text-align: center;">No</td> <td></td> </tr> <tr> <td>11.8</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td>Arthritis</td> </tr> <tr> <td>11.9</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td>Joint Conditions</td> </tr> <tr> <td>11.10</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td>Uncoordinated Balance</td> </tr> <tr> <td>11.11</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td>Herniated Disc (<i>symptomatic</i>)</td> </tr> <tr> <td>11.12</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td>Spinal Deviations</td> </tr> <tr> <td>11.13</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td>Fracture Deformities (<i>symptomatic</i>)</td> </tr> </table>		Yes	No		11.8	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	11.9	<input type="checkbox"/>	<input type="checkbox"/>	Joint Conditions	11.10	<input type="checkbox"/>	<input type="checkbox"/>	Uncoordinated Balance	11.11	<input type="checkbox"/>	<input type="checkbox"/>	Herniated Disc (<i>symptomatic</i>)	11.12	<input type="checkbox"/>	<input type="checkbox"/>	Spinal Deviations	11.13	<input type="checkbox"/>	<input type="checkbox"/>	Fracture Deformities (<i>symptomatic</i>)	
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Spine	Toe Touch (<i>distance from floor</i>)	Symmetry	Posture	X-Ray Recommended <input type="checkbox"/> Yes <input type="checkbox"/> No
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Upper Extremities	Limited Function	Missing Parts
Lower Extremities	Limited Function	Missing Parts

Skin (*scars, varicosities, disease, abnormalities - nature and severity*)

SECTION TWELVE	<u>Hematopoietic & Lymphatic Systems</u>																												
<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 10%;"></td> <td style="width: 10%; text-align: center;">Yes</td> <td style="width: 10%; text-align: center;">No</td> <td></td> </tr> <tr> <td>12.1</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td>Anemia (<i>all</i>)</td> </tr> <tr> <td>12.2</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td>Polycythemia</td> </tr> <tr> <td>12.3</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td>Sickle Cell Trait</td> </tr> <tr> <td>12.4</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td>Sickle Cell Disease</td> </tr> <tr> <td>12.5</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td>Hematopoietic Disorders (<i>including malignancies</i>)</td> </tr> <tr> <td>12.6</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td>Hemophilia</td> </tr> </table>		Yes	No		12.1	<input type="checkbox"/>	<input type="checkbox"/>	Anemia (<i>all</i>)	12.2	<input type="checkbox"/>	<input type="checkbox"/>	Polycythemia	12.3	<input type="checkbox"/>	<input type="checkbox"/>	Sickle Cell Trait	12.4	<input type="checkbox"/>	<input type="checkbox"/>	Sickle Cell Disease	12.5	<input type="checkbox"/>	<input type="checkbox"/>	Hematopoietic Disorders (<i>including malignancies</i>)	12.6	<input type="checkbox"/>	<input type="checkbox"/>	Hemophilia	
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SECTION THIRTEEN	<u>Nervous System</u>																																												
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Nervous System (*describe any pathology or abnormal reflexes*)

MEDICAL EXAMINATION REPORT

Applicant Name <i>(Last, First, Middle)</i>	Birth Date <i>(Month/Day/Year)</i>
---	------------------------------------

STATEMENT OF CONDITION

- I have reviewed the Governor's Committee on Crime Delinquency and Correction, Law Enforcement Training Medical Selection Guidelines or the National Fire Protection Association 1582 Medical Selection Guidelines (if applicable) and find the applicant ***is able*** to perform all Law Enforcement functions.
- I have reviewed the Governor's Committee on Crime Delinquency and Correction, Law Enforcement Training Medical Selection Guidelines or the National Fire Protection Association 1582 Medical Selection Guidelines (if applicable) and find the applicant ***is able*** to perform all Law Enforcement functions with some accommodations.
- I have reviewed the Governor's Committee on Crime Delinquency and Correction, Law Enforcement Training Medical Selection Guidelines or the National Fire Protection Association 1582 Medical Selection Guidelines (if applicable) and find the applicant ***is not able*** to perform all Law Enforcement functions.
(Please explain below.)

Section Item #	Explanation <i>(attach additional sheets if necessary)</i>

Physician's Signature _____ Date _____

Name & Address of Physician (Printed or Typed)

GIVE THIS TO THE PHYSICIAN

This is the Governors Committee on Crime, Delinquency & Correction, Law Enforcement Training, Medical Selection Guidelines

8.5. Medical Standards. -- All applicants for entry into a basic entry-level training program shall submit to a medical examination by a licensed physician chosen by and at the expense of the employing agency. The applicants shall complete a comprehensive medical history questionnaire, as well as submit to a medical examination which shall include the following minimum requirements: A medical history; a physician's examination; laboratory tests; blood chemistry (Chem 20 or equivalent); Complete Blood Count (CBC); urinalysis (with dipstick); Tuberculosis (Mantoux); Electrocardiogram (ECG) (resting); drug screening (DOH-5 or 8-10 panel).

8.5.a. The medical examination shall consist of selection criteria aimed at identifying conditions that may potentially exclude an applicant from entry into a basic entry-level training program.

8.5.b. Applicants employed by a law enforcement agency that are required to meet medical requirements for firefighters (© National Fire Protection Standards 1582) as a condition of employment will use that medical standard for entry into a basic entry-level training program (W.Va. Code §8-22-16).

8.5.c. The Medical History Statement and Medical Examination Report are valid for a one-year period, to be measured from the date of the examining physician's signature on the State of Condition page of the Medical Examination Report.

8.5.d. The examining physician shall note if the applicant has any of the following conditions. These conditions may be cause to exclude an applicant from consideration for acceptance except where specifically noted.

8.5.d.1. Eyes and Vision. -- With regard to eyes and vision, the examining physician shall note any of the following conditions:

8.5.d.1.A. Visual Acuity -- An applicant's uncorrected vision may be equal to but not worse than 20/100 in the weaker eye, and shall be correctable to better than, or equal to, 20/30 (Snellen) in each eye. Means of correction must be worn on the job and the means of correction shall not interfere with proper fitting of a facial mask, e.g., gas mask, riot helmet or air or blood borne pathogen masks, etc.

8.5.d.1.B. Far visual acuity shall be at least 20/30 binocular with contact lenses or eyeglasses. Far visual acuity uncorrected shall be at least 20/100 binocular for wearers of hard contacts or eyeglasses. Successful long-term soft contact lens wearers (six months without a problem) are not subject to the uncorrected standard.

8.5.d.1.C. Ophthalmological procedures such as radial keratotomy, repair of retinal detachment. Sufficient time (minimum, six months) shall have passed to allow stabilization of visual acuity and to ensure that there are no post surgical complications.

8.5.d.1.D. Visual Acuity -- Color Vision: The applicant shall pass a "controlled color discrimination test", such as, United States Department of Transportation Color Vision Examination.

8.5.d.1.E. Visual Acuity -- Depth Perception: An applicant's depth perception should be sufficient to demonstrate normal stereo depth perception with or without correction to the standard: 80 ARC seconds.

8.5.d.1.F. The examining physician shall note any other conditions which may interfere

with the applicant's ability to perform the essential tasks listed in the job description of entry-level law enforcement officer.

8.5.d.2. Ears and Hearing. -- With regard to ears and hearing, the examining physician shall note any of the following conditions:

8.5.d.2.A. Hearing Acuity -- Using an audiometer, the applicant should have less than average loss of 25 or more decibels at the 500, 1000, 2000, and 3000 Hertz (Hz) levels in either ear with no single frequency loss in excess of 40.

8.5.d.2.B. Acute Otitis Media, Otitis Externa, and Mastoiditis -- If the applicant meets hearing acuity guidelines, then these conditions are non-disqualifying.

8.5.d.2.C. Any Inner /Middle/Outer Ear Disorder Affecting Equilibrium, e.g., Meniere's Disease - If the applicant has historically had episodes of vertigo, the applicant may require further evaluation.

8.5.d.3. Nose, Throat, and Mouth. -- With regard to the nose, throat and mouth, the examining physician shall note any of the following conditions:

8.5.d.3.A. Loss of sense of smell;

8.5.d.3.B. Aphonia, speech loss or speech defects; and

8.5.d.3.C. Abnormalities of the nose, throat, or mouth, except as described in subparagraphs 8.5.d.3.A. and 8.5.d.3.B. - If the abnormality does not interfere with the applicant's breathing, or the proper fitting of a gas mask, the condition is non-excludable.

8.5.d.4. Peripheral Vascular System. -- With regard to the peripheral vascular system, the examining physician shall note any of the following conditions:

8.5.d.4.A. Hypertension - An applicant's resting blood pressure should be less than, or equal to, 140 mmHg systolic and 90 mmHg diastolic on three successive readings. If the applicant has controlled hypertension not exceeding this standard and is on medication with side effect profiles which do not interfere with the performance of his or her duty as an entry-level law enforcement officer, the condition may not cause the applicant to be excluded. The applicant shall have a functional and therapeutic cardiac classification no greater than 1A, i.e., Functional Capacity I: Applicants with cardiac disease and no limitation of physical activity. Ordinary physical activity does not cause discomfort. Applicants in this class do not have symptoms of cardiac insufficiency, nor do they experience angina pain. Therapeutic Classification A: Applicants with cardiac disease whose physical activity need not be restricted.

8.5.d.4.B. Peripheral Vascular Abnormality - Any condition that is severe and/or symptomatic may cause the applicant to be excluded, e.g., arterial insufficiency, deep or superficial vein thrombophlebitis, or Raynaud's Disease.

8.5.d.5. Heart and Cardiovascular System. -- With regard to the heart and cardiovascular system, the examining physician shall note any condition that may interfere with the applicant's ability to perform the duties attendant to the position of a basic entry-level officer as well as any of the following conditions. The following conditions may or may not exclude an applicant from consideration depending on their effect in performance of the job duties as set forth in this section.

8.5.d.5.A. Congenital Heart Disease - If the applicant's functional work capacity is unimpaired, then the condition may not cause the applicant to be excluded.

8.5.d.5.B. Valvular Heart Disease - Includes significant valvular insufficiency, significant septal defects (any valve), and prolapsing mitral valve (symptomatic).

8.5.d.5.C. Coronary Artery Disease.

8.5.d.5.D. ECG Abnormalities (if associated with organic heart disease) - Including but not limited to: WPW Syndrome, ST Depression, Partial or Complete Left Bundle Branch Blocks, 3 Degree A-V Block, Mobitz Type II A-V Blocks, Sinoatrial Block or Sick Sinus Syndrome, Ventricular Extrasystole (frequent - 20/minute with exercise, 10 minutes without exercise), Ventricular Tachycardia, Atrial Fibrillation or Flutter, Episodic Supraventricular Tachycardia or Consistent Supraventricular Tachycardia at Rest or Persistent After Exercise even if Asymptomatic.

8.5.d.5.E. Angina;

8.5.d.5.F. Congestive Heart Failure;

8.5.d.5.G. Cardiomyopathy; and

8.5.d.5.H. Pericarditis, Endocarditis, and Myocarditis.

8.5.d.6. Respiratory System. -- With regard to the respiratory system, the examining physician shall note any of the following conditions:

8.5.d.6.A. Any chronically disabling conditions that would interfere with the applicant's ability to perform essential job tasks;

8.5.d.6.B. Infectious or potentially infectious Pulmonary Tuberculosis;

8.5.d.6.C. Chronic Bronchitis;

8.5.d.6.D. Chronic Obstructive Pulmonary Disease;

8.5.d.6.E. Emphysema;

8.5.d.6.F. Restrictive Lung Diseases;

8.5.d.6.G. Bronchiectasis and Pneumothorax (current or repeated history);

8.5.d.6.H. Pneumonectomy;

8.5.d.6.I. Acute Mycotic diseases - Including but not limited to coccidiomycosis and histoplasmosis;

8.5.d.6.J. Acute Pleurisy;

8.5.d.6.K. Malignant Disease - Any condition that may interfere with the applicant's ability to perform the duties attendant to the position of a basic entry-level officer shall be noted.

8.5.d.7. Gastrointestinal System. -- With regard to the gastrointestinal system, the examining physician shall note any of the following conditions. If any of the following or other G-I condition is controlled, then they may not cause the applicant to be excluded.

8.5.d.7.A. Colitis - Including but not limited to Crohn's Disease, Ulcerative Colitis, Irritable Bowel Syndrome (symptomatic or needing medication), Bacterial Colitis;

8.5.d.7.B. Diverticulitis;

8.5.d.7.C. Esophageal disorders - Including, but not limited to, Esophageal Stricture, Lower Esophageal Ring and Esophageal Spasm.

8.5.d.7.D. Pancreatitis;

8.5.d.7.E. Gall Bladder disorders;

8.5.d.7.F. Active Peptic Ulcers;

8.5.d.7.G. Symptomatic Inguinal, Umbilical, Ventral, Femoral, or Incisional Hernias;

8.5.d.7.H. Malignant Disease of the Liver, Gall Bladder, Pancreas, Esophagus, Stomach, Small or Large Bowel, Rectum, or Anus;

8.5.d.7.I. Gastrointestinal Bleeding;

8.5.d.7.J. Active or Chronic Hepatitis;

8.5.d.7.K. Cirrhosis of the Liver; and

8.5.d.7.L. Motility Disorders, e.g., Scleroderma.

8.5.d.8. Genitourinary System. - With regard to the genitourinary system, the examining physician shall note any conditions that may interfere with the applicant's ability to perform essential job tasks listed in this section as well as any of the following conditions;

8.5.d.8.A. Pregnancy;

8.5.d.8.B. Nephrectomy - If an applicant possesses this condition with normal natural renal function, then the condition is non-disqualifying;

8.5.d.8.C. Acute Nephritis;

8.5.d.8.D. Nephrotic Syndrome;

8.5.d.8.E. Acute Renal/Urinary Calculi;

8.5.d.8.F. Renal Transplant;

8.5.d.8.G. Renal Failure;

8.5.d.8.H. Hydrocele and Varicocele (Symptomatic);

8.5.d.8.I. Malignant Diseases of Bladder, Kidney, Ureter, Cervix, Ovaries, Breasts, Prostate, etc.;

8.5.d.8.J. Active Venereal Diseases;

8.5.d.8.K. Urinary Tract Infection;

8.5.d.8.L. Polycystic Kidney Disease;

8.5.d.8.M. Pelvic Inflammatory Disorders;

8.5.d.8.N. Endometriosis;

8.5.d.8.O. Inflammatory Disorders, e.g., prostatitis, orchitis, epididymitis; and

8.5.d.8.P. Scleroderma.

8.5.d.9. Endocrine and Metabolic Systems. -- With regard to the endocrine and metabolic systems, the examining physician shall note any of the following conditions:

8.5.d.9.A. Uncontrolled Thyroid Disease;

8.5.d.9.B. Diabetes Mellitus - Potential excludability requires a case by case assessment by a physician designated by the Law Enforcement Training Subcommittee as to the control of diabetes and presence and severity of symptoms and complications;

8.5.d.9.C. Adrenal Dysfunction - Including but not limited to Addison's Disease and Cushing's Disease;

8.5.d.9.D. Insulin Reactions; and

8.5.d.9.E. Untreated Thyroid Malignancy.

8.5.d.10. Musculoskeletal System. -- With regard to the musculoskeletal system, the examining physician shall note any condition that may interfere with the applicant's ability to perform essential job tasks listed in this section as well as any of the following conditions:

8.5.d.10.A. Disorders that limit motor function;

8.5.d.10.B. Cervical Spine or Lumbar Sacral Fusion;

8.5.d.10.C. Degenerative Cervical or Lumbar Disc Disease (if symptomatic);

8.5.d.10.D. Extremity amputation;

8.5.d.10.E. Osteomyelitis;

8.5.d.10.F. Muscular Dystrophy;

8.5.d.10.G. Loss in the motor ability from tendon or nerve injury/surgery - In an area relevant to the applicant's performing the essential tasks of the job;

8.5.d.10.H. Arthritis - If the applicant possesses this condition with no functional impairment, then the condition is non-excludable;

8.5.d.10.I. Coordinated balance;

8.5.d.10.J. Symptomatic Herniated Disc; and

8.5.d.10.K. Spinal Deviations.

8.5.d.11. Hematopoietic and Lymphatic Systems. -- With regard to the hematopoietic and lymphatic systems, the examining physician shall note any of the following conditions:

8.5.d.11.A. Hematopoietic disorders (including malignancies), e.g., SCD, thalassemia, G6PSD, etc.; and

8.5.d.11.B. Hemophilia.

8.5.d.12. Nervous System. -- With regard to the nervous system, the examining physician

shall note any condition that may interfere with the applicant's ability to perform essential job tasks listed in this section as well as any of the following conditions:

8.5.d.12.A. Seizure disorder (all types);

8.5.d.12.B. Cerebral Palsy;

8.5.d.12.C. Movement disorders, e.g., Parkinson's;

8.5.d.12.D. Cerebral Aneurysms;

8.5.d.12.E. Syncope;

8.5.d.12.F. Progressive Neurological Diseases - Including but not limited to Multiple Sclerosis and Huntington's Chorea;

8.5.d.12.G. Peripheral Nerve Disorder - Including but not limited to Polyneuritis, Mononeuritis, and Neurofibromatosis;

8.5.d.12.H. Narcolepsy;

8.5.d.12.I. Cerebral vascular accident; and

8.5.d.12.J. Central nervous system infections.

8.5.d.13. Any condition listed in this subsection of the rule that requires further evaluation, beyond that offered by the applicant's physician, shall be conducted at the applicant's expense.
