"Medical Clearance Form"

_____ _____ Applicants

Printed Name / D.O.B Signature

The above individual is being asked to take part in a fitness assessment program as part of an overall process to become a Police Officer in Marlborough Massachusetts. The fitness assessment consists of the following exercises:

Event	Purpose	Discussion
Sit-ups	Muscular Endurance	The score is the number of correct full bent leg sit-ups performed in one minute. Your feet are held and your fingertips are tucked behind your ears.
Push Up	Muscular Endurance	The score is the number of correct full body push-ups performed in one minute. Starting in the up position, hands placed slightly wider than shoulder width apart, fingers pointing forward with a straight back. bend your elbows lowering your body towards the floor and touch your chest to the measuring block (approximately four inches from floor) and return to the up position. The Female push-up is a full body push-up
1.5 Mile Run	Cardiovascular	1.5 mile run. You are required to run, walk or jog one and one-half miles Capacity within your allotted time limit. The score is in minutes and seconds. The course will be held at the Marlborough High School track or the Marlborough High School Indoor track

Male

AGE	RUN	SIT-UPS	PUSH-UPS
18-29	12:38	37	29
30-39	12:58	35	24
40-49	14:10	28	16
50-59	15:53	22	11
60 +	17:49	18	9

Female

AGE	RUN	SIT-UPS	PUSH-UPS
18-29	15:05	31	15
30-39	15:56	25	11
40-49	17:38	19	9
50-59	19:43	12	10 / -
60 +	22:03	5	4 / -

By completing this form, you are not assuming any responsibility for our assessment program. If, however, you know of any reason why the participant should not undertake a basic assessment of fitness as listed above, we would be most grateful if you could indicate below. Thank you for your cooperation in this matter.

I have examined the above captioned applicant on the following date _____ and based on my finding:

_____ I know of no reason why the applicant may not participate.

_____ I recommend that the applicant **NOT PARTICIPATE**. Health

Care Provider: _____

Signature of examining health care provider

Health Care Provider Name: _____

Street: _____

City, State, Zip: _____

Phone: _____