State of New Hampshire

DEPARTMENT OF SAFETY

Robert L. Quinn, Commissioner of Safety

Division of State Police

James H. Hayes Safety Building, 33 Hazen Drive, Concord, NH 03305

Telephone: 603-223-8813

Colonel Mark B. Hall

Director

Dear Doctor / Physician Assistant / Nurse Practitioner:

Please print:

Your patient's name _____ *Date of birth*_____

*Address*_____

is planning to participate in the fitness assessment test given to NH State Police Trooper I applicants. The test involves sit-ups, push-ups, and a 1½-mile timed run.

Applicants must have EACH SECTION BELOW <u>COMPLETED IN FULL</u> in order to participate.

VISUAL ACUITY: **Stereoscopic <u>20/100 uncorrected vision is required</u> for eligibility for the position. If applicant wears corrective lenses, test and record <u>with</u> <u>and</u> <u>without lenses</u>. If applicant does not wear corrective lenses, mark "N/A" for acuities on line b. <u>Color perception is required</u>. Moderate or severe Color Vision Deficiency will render a candidate ineligible. Mild Color Vision Deficiency is acceptable.**

a. **Without corrective lenses: Right: 20/ Left: 20/ Binocular: 20/ Depth perception:**
b. With corrective lenses: Right: 20/ Left: 20/ Binocular: 20/ **Color perception:**
c. Pupils: Equal? Reactive?
d. Form fields of vision (temporal)
(Record degrees of fields obtained by instrumentation or confrontation above)
Right eye: Left eye: Each eye on zero line:
e. Note evidence of disease or injury:

CARDIOVASCULAR SYSTEM (Complete each block)

Type of Activity:	Blood Pressure	Pulse Rate	Sounds	Rhythm
a. At rest:				
b. Immediately following moderate exercise:				
******Moderate exercise may include jumping jacks and/or running in place for 3 minutes.******				
c. Three minutes after moderate exercise:				
d. Note circulation to extremities:				
e. Note any abnormalities:				

____ I know of no reason why this applicant may not participate in the physical fitness test.

____ I recommend the applicant NOT participate in the physical fitness test.

Provider's Name (Please print): _____ **Tel. No. :** (_____)_____

Provider's Signature: _____**Today's Date:** _____

Address: _____