



# ALEXANDRIA COLLEGE

## POLICE TRAINING & EDUCATION: Physician's Evaluation Form



Student Name: \_\_\_\_\_  
(Please print the name of the student)

Date of Exam: \_\_\_\_\_

The student named above is applying for admission to the professional peace officers education program at Alexandria Technical and Community College. Students will be required to meet the following physical requirements at the start of the program:

### 1 Please review **AND CHECK** ☒ each item before signing below:

- ☐ Run a sustained mile at the start of the semester and 6 miles by the end
- ☐ Perform dynamic takedowns and prisoner restraint techniques safely while maintaining control of their own body weight as well as their partner's body weight
- ☐ Complete physically demanding obstacle courses including running, jumping, pulling themselves over a 6-foot wall, and dragging a 165 lb. dummy for 25 yards
- ☐ Lift heavy objects, chase and wrestle with resisting suspects
- ☐ Have and maintain healthy body composition and BMI
- ☐ Be able to be exposed to CEW (conducted electrical weapons), CS gas, and OC pepper spray
- ☐ Wear a duty belt for hours at a time
- ☐ Stand unassisted and hold up a 6 to 7-pound long gun for an extended period of time
- ☐ Hold up a 6 to 7-pound long gun while walking/running, bending, crouching, squatting, and reloading
- ☐ Transition and maintain the weight of a long gun while drawing and moving to a handgun (approx. 2 pounds), under stressful situations
- ☐ Fire semi-automatic pistols, rifles, and shotguns
- ☐ Stand for long periods of time
- ☐ Drive and operate a motor vehicle dynamically and evasively

### 2 Please initial next to **one** of the following statements before signing below:

Provider  
Initials

The applicant's medical examination and history show they are **physically capable of participating** in the program without posing a serious threat to their own health and safety or that of other students and staff. ✓

Provider  
Initials

Based on the applicant's medical examination and history, it is **recommended they not be admitted** to the program as it may pose a serious threat to their own health and safety or that of other students and staff. ✗

### Please Print:

Provider Name: \_\_\_\_\_

Provider's Area of Expertise: \_\_\_\_\_

Name of Firm/Clinic: \_\_\_\_\_

Address of Clinic: \_\_\_\_\_

City: \_\_\_\_\_

State: \_\_\_\_\_ ZIP: \_\_\_\_\_

Phone Number: \_\_\_\_\_

### 3 Provider Signature: \_\_\_\_\_ By signing this form, I acknowledge I have read and verified the requirements for the named student



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