

MEDICAL EXAMINATION PROCEDURE

Prior to admission to a Basic Police Officer Training (BPOT) or Certification by Waiver of Previous Training (CBW) program at the Academy or an accredited regional/satellite academy, all applicants must undergo a medical examination conducted by a licensed physician. This examination must be conducted in accordance with the Medical Selection Guidelines. The examination is considered valid for 1 year. The Academy will provide standard medical examination forms to be completed by the examining physician.

The following are the minimum requirements for the medical examination:

Medical History

The applicant must complete, sign and date the Medical History Statement.

Physician's Examination

The examining physician will review the applicant's Medical History Statement and the Medical Selection Guidelines (Subsection G of 10.29.9.17 NMAC - Tab 2 of Reference Guide) prior to completing, signing, and dating the Medical Examination Report.

Laboratory Tests

The following laboratory tests are required:

(Test results outside of established norms must be recorded and explained on page 17 of this section.)

1. Blood Chemistry (Chem 20 or equivalent)
2. Complete Blood Count (CBC)
3. Complete Urinalysis (not Dipstick)
4. Serology (RPR or equivalent)
5. Tuberculosis (Mantoux)
6. Electrocardiogram (ECG) (Resting)
7. Chest X-ray (CXR) **Only required if #5 is positive.**
8. Drug Screen (THC, Cocaine, Amphetamines, Opiates, Barbiturates, Methadone, Methaqualone, Phencyclidine, Propoxyphene, Benzodiazepines, Alcohol, Anabolic Steroids)

Potentially Excludable Conditions

The term "Potentially Excludable Condition," as used in the Medical Selection Guidelines, means conditions and/or laboratory results outside of the established standard or generally accepted medical norms. Any potentially excludable condition must be identified and explained by the examining physician on a separate form.

Fitness Screening Standards

All BPOT applicants must demonstrate a minimum fitness level as measured by five tests that identify specific areas of physical fitness. These tests are measured at the 40th percentile and based upon standards established by the Institute for Aerobics Research. BPOT applicants must meet or exceed the passing score for each test to be enrolled in the Academy or an accredited regional/satellite academy. Fitness screening standards are listed in the Physical Performance Information Section. BPOT applicants are required to complete the 1.5 mile run and 300 meter run at the 60th percentile and the two agility courses prior to certification. CBW applicants are required to complete the 1.5 mile run and 300 meter run at the 50th percentile and the two agility courses prior to certification.

Review Physical Conditioning Program

The physical conditioning program involves exercise that focuses on cardio-respiratory endurance (aerobics), strength, power, speed, and neuromuscular coordination (agility, balance, etc.). Exercise sessions are both high intensity and high impact. Specific information on the Physical Conditioning Program is detailed in the Physical Performance Information Section.

Review Job Description, Essential Job Tasks, and Academy Related Physical Stresses

The examining physician will review the police officer description as well as the essential job tasks found behind Tab 3 of the Reference Guide.

Physician's Certification

The examining physician must consider the following for each applicant:

- Medical History Statement
- Physical Examination
- Laboratory Results
- Potentially Excludable Conditions
- Fitness Screening Standards
- Essential Job Tasks
- Job Description
- Academy Related Physical Stresses

Subsequent to the review of the above, the physician will indicate one of the following:

1. The applicant **has passed** the minimum medical standards as established by the New Mexico Law Enforcement Academy Board without exclusions, or;
2. The applicant **has one or more potentially excludable conditions** from the minimum medical standards as established by the New Mexico Law Enforcement Academy Board, but **can perform the functions** of a law enforcement officer with accommodations (explanation attached), or;
3. The applicant **has one or more potentially excludable conditions** from the minimum medical standards as established by the New Mexico Law Enforcement Academy Board, and **cannot perform the functions** of a law enforcement officer (explanation attached).

Non-Conformance

If an applicant is found to possess:

1. A laboratory result or results outside of normal reference ranges, and/or;
2. Any "potentially excludable condition(s)" which has been identified on the appropriate form, examining physician will note the condition(s) and/or result(s) on the Medical Examination Report and indicate what accommodations, if any, can be provided to the applicant.

Applicants who are found to be in non-conformance will have their application reviewed by the physician and the employer. The employer will make a decision as to whether any particular proposed accommodation is acceptable and reasonable.

Academy Review

The Academy reserves the right to determine if the applicant has any condition(s) which may pose a direct threat to the applicant's safety and/or the safety of others in attending and participating in all aspects of the training program. Applicants who come to the Academy, either with or without accommodation(s), can be determined by the Director to possess a physical/medical condition that presents a threat to the applicant's safety and/or that of others. Admission to the Academy may be denied, provided no reasonable accommodations can be found.

Appeal

If an applicant considers him/herself protected by the Americans with Disabilities Act, and is rejected by the Employer, he/she may pursue recourse through the courts.

If an applicant is rejected due to a medical condition of particular severity, he/she can appeal to the Medical Review Board - which is a subcommittee of the New Mexico Law Enforcement Academy Board.

If the Academy Director has rejected the applicant, he/she may appeal to the Medical Review Board. In this instance, the Director, who is a member of the Medical Review Board, shall excuse him/herself from the appeal.

Refer to 10.29.9.17 NMAC for additional information concerning Medical Review Procedures.

PHYSICAL PERFORMANCE INFORMATION

The applicant being examined must obtain a medical clearance to participate in the Basic Police Officer Training (BPOT) or Certification by Waiver of Previous Training (CBW) program at the Academy or at an accredited regional/satellite academy. Both programs require a certain level of physical activity as follows:

- (1) Fitness Standards, screening for BPOT and certification for BPOT and CBW
- (2) Agility Courses
- (3) Academy Related Stressors:
 - (a) Physical Conditioning Program
 - (b) Defensive Tactics Training
 - (c) Firearms Training
 - (d) Academic Requirements

1. Fitness Standards

Prior to entering a BPOT the applicant is screened for a minimum fitness level as measured by a battery of five tests with two potential alternates. These tests are based upon the 40th percentile as established by the Institute for Aerobics Research. Applicants must meet the minimum standard or they will be dismissed from the BPOT program. BPOT applicants are required to complete the 1.5 mile run and 300 meter run at the 60th percentile and the two agility courses prior to certification. CBW applicants are required to complete the 1.5 mile run and 300 meter run at the 50th percentile and the two agility courses prior to certification. See pages 4 and 6.

2. Agility Courses

The applicant must perform simulated job tasks while wearing a ten (10) lb. weight, which represents standard duty equipment. **Agility Course 1 - Pursuit:** must be completed in 3 minutes and 5 seconds. **Agility Course 2 - Rescue:** must be completed in 42 seconds. See page 5.

3. Academy-Related Physical Stressors:

3a. Physical Conditioning Program

The BPOT fitness program involves a minimum of 1 hour per day, 3 days a week. The program focuses on cardio-respiratory endurance (aerobics), strength, muscular endurance, speed, agility and balance. Exercise routines may consist of sprinting, long-distance runs of 3 to 5 miles, circuit training calisthenics, a circuit containing agility exercises, a circuit containing power exercises, lifting free weights, floor aerobics and step aerobics. Exercise sessions are both high intensity and high impact.

3b. Defensive Tactics Training

This training will include mat impacts from takedown techniques, aerobic body activity, joint stretching and full range of motion movement. Leg stress may result from kneeling, twisting, turning, standing up and standing for long periods of time. Body stress may result from trunk twisting, bending, hand and grip strength, finger/hand dexterity and eye/hand coordination exercises.

3c. Firearms Training

Applicant needs the ability to maintain continuous good balance, stand for long periods of time, hold a three pound object in an extended arm position long periods, moderate to strong gripping ability, good finger and hand dexterity. Applicant will also need average or above average eye and hand coordination, kneeling ability, and possess uncorrected or corrected visual acuity of 20/30 in both eyes combined.

3d. Academic Requirements

Applicant will sit for long periods of time and maintain a forward leaning position at a table or desk and must possess normal hearing ability, normal writing dexterity and writing ability.

ENTRY FITNESS STANDARDS - 40th PERCENTILE

#1 Upper Body Strength

1 minute maximum number of push-ups

Age	Male	Female <i>Modified</i>	Female <i>Full Body</i>
20-29	29	23	15
30-39	24	19	11
40-49	18	13	9
50-59	13	12	9
60+	10	5	9

#2 Muscular Endurance

1 minute maximum number of sit-ups

Age	Male	Female
< 20	41	32
20-29	38	32
30-39	35	25
40-49	29	20
50-59	24	14
60+	19	6

#5 Flexibility

sit and reach -inches

Age	Male	Female
< 20	16.5	20.5
20-29	16.5	19.3
30-39	15.5	18.3
40-49	14.3	17.3
50-59	13.3	16.8
60+	12.5	15.5

#3 Aerobic Power

1 ½ mile run

Age	Male	Female
< 20	12:29	15:05
20-29	12:29	15:05
30-39	12:53	15:56
40-49	13:50	17:11
50-59	15:14	19:10
60+	17:19	20:55

Altitude Adjustments for 1 ½ Mile Run

Under 5000 ft. No adjustment
 5000-5999 ft. add 30 seconds
 6000-6999 ft. add 40 seconds
 7000-8000 ft. add 50 seconds
 Above 8000 ft. add 60 seconds

#4 Anaerobic Power

300 meter run

Age	Male	Female
< 20	59.0	71.0
20-29	59.0	71.0
30-39	58.9	79.0
40-49	72.0	94.0
50-59	83.2	94.0
60+	83.2	94.0

EXIT PHYSICAL AGILITY STANDARDS

Course #1 - Pursuit and Control

Officer is seated in his/her vehicle with seatbelt in use and wearing a 10-pound weight belt around waist to simulate gunbelt.

As the timed exercise begins the officer will:

A - Undo seatbelt and open the vehicle door.

B - Run 30 feet and open building door.

C - Cross threshold (4 feet) and run up two flights of stairs and pause for 60 seconds.

Rise & Run of 7"x11" is standard, 8"x10" or 6"x12" are acceptable variations. Standard floor landings are 10' high. It is appropriate, if only one floor is available, to run up, run down, run up and pause for 60 seconds. There is no restriction on how the officer negotiates the stairs. Run down the stairs and out the door.

D - Run 100 feet from door to a 5-foot high platform, run up steps to the top of the 5-foot platform and jump down. A ladder or ramps are acceptable variations to getting on top of the platform.

E - Run 37.5 feet, turn & reverse, run 37.5 feet, turn & reverse, run 25 feet to a 6 foot high wall and scale it. The wall is constructed of cinder block, unpainted with a smooth top. If the applicant chooses, he or she may drag a rigid aid or object 10 feet from the side of the wall and use it as a platform to scale the wall. The rigid aid or object will have handles, a flat top, weigh 50 lbs. and be 25" tall.

F - After scaling the wall, run 50 feet to a handcuff/arrest simulator, pull arms down, touch ends and hold for 60 seconds. Arrest simulator is 5' high with 60-lbs. resistance in right arm and 40 lbs. in left arm. End of exercise.

Time - 3 min. 5 sec.

Course #2 - Rescue

Officer is standing at starting point wearing a 10-pound weight belt around waist to simulate gunbelt.

On signal the officer will:

A - Run 30 feet straight ahead and jump across a 4-foot wide barrier. The barrier is low to the ground, e.g. ditch, highway divider, etc.

B - Run 12.5 feet and climb, jump or hurdle over a 3-foot high barrier. The barrier is to resemble a fence or low wall, no more than 4" wide and at least 8' long made of metal or wood.

C - Run 12.5 feet to the back of vehicle equivalent to a full-sized police vehicle and push it 30 feet on a flat surface in the direction of a clear area where a victim extraction will take place. The car is occupied by a dummy (victim) wearing a seatbelt and weighing 190 lbs.

+ or - 10 lbs. The dummy **must** meet standards established by the NMLEA.

D - Approach victim's door, open the door, undo seatbelt, pull victim out of the vehicle and drag them 20 feet perpendicular to the direction of the vehicle. End of exercise.

Time - 42 sec.

EXIT FITNESS STANDARDS - 60TH PERCENTILE

Aerobic Power

1.5 mile run (in minutes/seconds)

Age	Male	Female
<20	11:27	13:25
20-29	11:27	13:25
30-39	11:49	14:33
40-49	12:25	15:17
50-59	13:53	17:19
60+	15:20	18:52

Anaerobic Power

300 Meter Run (in seconds)

Age	Male	Female
<20	54.0	61.0
20-29	54.0	61.0
30-39	55.0	71.0
40-49	64.0	79.0
50-59	74.0	79.0
60+	74.0	79.0

EXIT FITNESS STANDARDS - 50TH PERCENTILE

Aerobic Power

1.5 mile run (in minutes/seconds)

Age	Male	Female
<20	11:58	14:15
20-29	11:58	14:15
30-39	12:25	15:14
40-49	13:05	16:13
50-59	14:33	18:05
60+	16:19	20:08

Anaerobic Power

300 Meter Run (in seconds)

Age	Male	Female
<20	56.0	64.0
20-29	56.0	64.0
30-39	57.0	74.0
40-49	67.6	86.0
50-59	80.0	86.0
60+	80.0	86.0

MEDICAL HISTORY STATEMENT

1. Have you been medically examined for employment in this agency before? <input type="checkbox"/> Yes <input type="checkbox"/> No If " Yes," your name at the time? _____									
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 medicines you have taken in the last two months (<i>prescription and non- prescription</i>).									
4. Name any drugs to which you may have ever had an allergic reaction.									
5. Please list any other substance to which you are allergic, including food, insect stings, etc.									
6. Please list your last three hospitalizations, beginning with most recent (<i>excluding routine childbirth</i>).									
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.									
<table border="1" style="margin: auto;"> <tr> <td style="width: 30px; height: 40px; text-align: center; vertical-align: middle;">Mother</td> <td style="width: 30px; height: 40px; text-align: center; vertical-align: middle;">Father</td> <td style="width: 30px; height: 40px; text-align: center; vertical-align: middle;">Other</td> </tr> </table>			Mother	Father	Other	<table border="1" style="margin: auto;"> <tr> <td style="width: 30px; height: 40px; text-align: center; vertical-align: middle;">Mother</td> <td style="width: 30px; height: 40px; text-align: center; vertical-align: middle;">Father</td> <td style="width: 30px; height: 40px; text-align: center; vertical-align: middle;">Other</td> </tr> </table>	Mother	Father	Other
Mother	Father	Other							
Mother	Father	Other							
<u>DISEASE</u>		<u>DISEASE</u>							
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>						
Cancer/Tumor	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>						
High Blood Pressure	<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 radiations?						
13.	<input type="checkbox"/>	<input type="checkbox"/>	Dusty conditions such as sandblasting, grinding or drilling of 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 temperature?						

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

55.	<input type="checkbox"/>	<input type="checkbox"/>	Have you gained or lost more than 10 pounds in 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 changes 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 your 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 any 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 Seltzers?
86.	<input type="checkbox"/>	<input type="checkbox"/>	Have you vomited blood or coffee ground-like materials?
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)? If "Yes", was it surgically repaired?_____
99.	<input type="checkbox"/>	<input type="checkbox"/>	Have you ever had a minor back sprain? If "Yes," please answer the following: 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? If "Yes," please answer the following: 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, dislocations, limitation of movement, stiffness, or pain? If "Yes," please describe the problems: _____
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 HISTORY STATEMENT

107. Do you have earaches or ear infections often?
108. Do you have ringing or buzzing noises in your ear?
109. Do you sometimes have difficulty hearing what is said to you?
110. Have you had any serious eye infection or injury?
111. Does your eye sight ever blur?
112. Have you had any sudden loss in your vision?

MEN ONLY _____

113. Have you ever been told by a doctor that you had prostate trouble?
114. Have you ever had an infection in your prostate gland?
115. Have you ever had swelling or pain in your scrotum or testicles?

WOMEN ONLY _____

116. Do you have monthly menstrual periods?
117. What was the date of your last period? _____

118. Are your menstrual periods painful?
119. When was your last pap smear? _____

120. Have you ever noticed any unusual lumps in your breasts?
121. Have you ever noticed a discharge from your nipples when you were neither pregnant nor nursing?

122. How many times have you been pregnant? _____
123. Have you ever had complications during pregnancy or following the delivery of a child?

-
124. Describe anything else which you feel may be important in your medical history, including any conditions not specifically referred to in the preceding questions.

I certify that all statements in this Medical History Statement are true and complete, and I understand that any misstatements of material facts may subject me to disqualification or dismissal.

Signature in Full

Date Statement Completed

Do not leave any space blank, if not applicable enter "N/A".

Applicant Name (Last, First, Middle)

SECTION TWO Ears and Hearing

Minimum Hearing Standards for Police Officers

The **average** hearing level (HL) at the test frequencies, 500, 1000, and 2000 Hz **will not exceed 25dB** in either ear, and **no single hearing level will exceed 30 dB** at any of these test frequencies in either ear.

Hearing loss at 3000 Hz will **not exceed 40 dB HL** in either ear.

2.1 Hearing Acuity (Audiogram Required)

Record the values at each Hz level

Right (Decibels)	Left (Decibels)
(Hertz) 500 _____	(Hertz) 500 _____
1000 _____	1000 _____
2000 _____	2000 _____
3000 _____	3000 _____

If the hearing examination has been completed by a person other than the physician signing on Page 17, please indicate below:

 Name of Examiner (Please Print) NM Lic. #

 Signature Audiologist
 Other _____

1 or more Potentially Excludable Condition(s)

2.2 Acute Otitis Media, Otitis Externa, and Mastoiditis _____ *(Note any abnormality)*

2.3 Inner/Middle/Outer Ear Disorder Affecting Equilibrium _____ ← *Enter n/a on lines to the left if not applicable*

The conditions listed in Section Three through Section Thirteen are not meant to be exclusive. If the examining physician feels (an) other unstated condition(s) may adversely impact the ability of the candidate to perform the essential tasks of the job, it (they) should be noted for further evaluation.

PHYSICIAN - please mark box if condition exists. Also, initial sections indicating examinations performed.

SECTION THREE Nose, Throat and Mouth

3.1 Loss of Sense of Smell _____ *(Note any abnormality)*

3.2 Aphonia, Speech Loss or Speech Defects _____ ← *Enter n/a on lines to the*

3.3 Deformities Interfering with the Proper Fitting of a Gas Mask _____ *to the left if not applicable*

Initials: _____

3.4 **Head** (Note any defect, disease or injury involving eyes, ears, nose, throat or mouth) _____

Dentistry Recommended

Yes

No

3.5 **Lungs** _____

Date Chest X-rays Taken _____

Chest X-rays Normal

(Note any abnormality) Enter n/a on line if not applicable

(Note any abnormality) Enter n/a on line if not applicable

Yes

No (report may be attached)

PHYSICIAN - please mark box if condition exists. Also, initial sections indicating examinations performed. Do not leave any spaces blank.

Applicant Name (Last, First, Middle)					
SECTION FOUR <u>Peripheral Vascular System</u>					
<input type="checkbox"/> 4.1 Hypertension <input type="checkbox"/> 4.2 Varicose Veins <input type="checkbox"/> 4.3 Venous Insufficiency <input type="checkbox"/> 4.4 Peripheral Vascular Diseases <input type="checkbox"/> 4.5 Thrombophlebitis					
				Initials: _____	
SECTION FIVE <u>Heart and Cardiovascular System</u>					
Type of Action (Active)		<u>Blood Pressure</u>	<u>Pulse Rate</u>	<u>Sounds</u>	<u>Rhythm</u>
<input type="checkbox"/> Running in Place <input type="checkbox"/> Other		/			
Type of Action (At Rest)		/			
Pulses (record strength)	R	L	Note any Abnormality	R	L
femoral					
popliteal					
dorsal pedes					
<input type="checkbox"/> 5.1 Congenital Heart Disease <input type="checkbox"/> 5.2 Valvular Heart Disease <input type="checkbox"/> 5.3 Coronary Artery Disease <input type="checkbox"/> 5.4 ECG Abnormalities (if associated with organic heart disease) - See Medical Selection Guidelines for specific abnormalities. <input type="checkbox"/> 5.5 Angina <input type="checkbox"/> 5.6 Congestive Heart Failure <input type="checkbox"/> 5.7 Cardiomyopathy <input type="checkbox"/> 5.8 Active Pericarditis, Endocarditis, and Myocarditis					
				Initials: _____	
SECTION SIX <u>Respiratory System</u>					
<input type="checkbox"/> 6.1 Active Pulmonary Tuberculosis <input type="checkbox"/> 6.2 Chronic Bronchitis <input type="checkbox"/> 6.3 Active Asthma <input type="checkbox"/> 6.4 Chronic Obstructive Pulmonary Disease <input type="checkbox"/> 6.5 Bronchiectasis and Pneumothorax <input type="checkbox"/> 6.6 Pneumonectomy <input type="checkbox"/> 6.7 Acute/Chronic Mycotic Diseases					
				Initials: _____	
SECTION SEVEN <u>Gastrointestinal System</u>					
<input type="checkbox"/> 7.1 Colitis <input type="checkbox"/> 7.2 Esophageal Disorders <input type="checkbox"/> 7.3 Hemorrhoids <input type="checkbox"/> 7.4 Pancreatitis <input type="checkbox"/> 7.5 Gall Bladder Disorders <input type="checkbox"/> 7.6 Active Peptic Ulcer Disease <input type="checkbox"/> 7.7 Symptomatic Inguinal, Umbilical, Ventral, Femoral or Incisional Hernias <input type="checkbox"/> 7.8 Malignant Disease of the Liver, Gall Bladder, Pancreas, Esophagus, Stomach, Small / Large Bowel, Rectum or Anus <input type="checkbox"/> 7.9 Gastrointestinal Bleeding <input type="checkbox"/> 7.10 Active or Chronic Hepatitis <input type="checkbox"/> 7.11 Cirrhosis of the Liver					
				Initials: _____	

PHYSICIAN - please mark box if condition exists. Also, initial sections indicating examinations performed.
Do not leave any spaces blank.

Applicant Name (Last, First, Middle)

People with communicable diseases must be evaluated relevant to their ability to train for and perform essential tasks without posing a direct threat to the health and safety to themselves and others.

SECTION EIGHT Genitourinary System

- 8.1 Pregnancy
- 8.2 Nephrectomy
- 8.3 Acute Nephritis
- 8.4 Nephrotic Syndrome
- 8.5 Acute Renal/ Urinary Calculi
- 8.6 Renal Transplant
- 8.7 Renal Failure
- 8.8 Hydrocele and Varicocele (symptomatic)
- 8.9 Malignant Diseases of Bladder, Kidney, Ureter, Cervix, Ovaries, Breast, Prostate, etc.
- List specific disease(s) _____
- 8.10 Active Venereal Diseases
- 8.11 Urinary Tract Infection
- 8.12 Polycystic Kidney Disease
- 8.13 Pelvic Inflammatory Disease
- 8.14 Cervicitis
- 8.15 Endometriosis
- 8.16 Bartholin Gland Abscess
- 8.17 Vaginitis
- 8.18 Inflammatory Disorders
- 8.19 Presence of Illicit Drugs

Initials: _____

SECTION NINE Endocrine and Metabolic Systems

- 9.1 Untreated Thyroid Disease
- 9.2 Diabetes Mellitus
- 9.3 Adrenal Dysfunctions
- 9.4 Hypoglycemia
- 9.5 Pituitary Dysfunction
- 9.6 Thyroid Tumor

Initials: _____

SECTION TEN Skin and Collagen Diseases

- 10.1 Serious Dermatological Disorders
- 10.2 Lupus Erythematosus
- 10.3 Contact Allergies (of a serious or relevant nature)

Initials: _____

SECTION ELEVEN Musculoskeletal System

- 11.1 Disorders that Limit Motor Performance
- 11.2 Cervical Spine or Lumbosacral Fusion
- 11.3 Degenerative Cervical or Lumbar Disc Disease (if symptomatic)
- 11.4 Extremity Amputation
- 11.5 Osteomyelitis
- 11.6 Muscular Dystrophy
- 11.7 Loss in Motor Ability from Tendon or Nerve Injury/Surgery
- 11.8 Arthritis

Initials: _____

Do not leave any space blank, if not applicable enter "N/A".

Applicant Name (Last, First, Middle)			
<u>SECTION ELEVEN Musculoskeletal System</u> (Continued)			
<input type="checkbox"/> 11.9 Joint Conditions <input type="checkbox"/> 11.10 Coordinated Balance <input type="checkbox"/> 11.11 Herniated Disc (symptomatic) <input type="checkbox"/> 11.12 Spinal Deviations <input type="checkbox"/> 11.13 Fracture Deformities (symptomatic)			Initials: _____
Musculo-Skeletal (Test flexibility by bending, stooping, squatting, and by head, arm, leg and finger motions.)			
Spine	Toe Touch (distance from floor)	Symmetry	Posture X-rays Recommended <input type="checkbox"/> Yes <input type="checkbox"/> No
Upper Extremities	Limited Function		Missing Parts
Lower Extremities	Limited Function		Missing Parts
Skin (scars, varicosities, disease, abnormalities - nature and severity)			
<u>SECTION TWELVE Hematopoietic and Lymphatic Systems</u>			
<input type="checkbox"/> 12.1 Anemia (all) <input type="checkbox"/> 12.2 Polycythemia <input type="checkbox"/> 12.3 Sickle Cell Trait <input type="checkbox"/> 12.4 Sickle Cell Disease <input type="checkbox"/> 12.5 Hematopoietic Disorders (including malignancies) <input type="checkbox"/> 12.6 Hemophilia			Initials: _____
<u>SECTION THIRTEEN Nervous System</u>			
<input type="checkbox"/> 13.1 Epilepsy <input type="checkbox"/> 13.2 Cerebral Palsy <input type="checkbox"/> 13.3 Movement Disorders <input type="checkbox"/> 13.4 Cerebral Aneurysms <input type="checkbox"/> 13.5 Syncope <input type="checkbox"/> 13.6 Progressive Neurological Diseases <input type="checkbox"/> 13.7 Peripheral Nerve Disorder <input type="checkbox"/> 13.8 Narcolepsy <input type="checkbox"/> 13.9 Cerebral Vascular Accident <input type="checkbox"/> 13.10 Central Nervous System Infections			Initials: _____
Nervous System (Describe any pathology or abnormal reflexes.)			

Applicant Name (Last, First, Middle) _____

Please indicate the following lab tests were administered to the applicant and were within normal limits.
 (Please explain any test results outside of normal limits below). **It is not necessary to submit the actual lab paperwork to DPS.**

Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	1. Blood Chemistry (Chem 20 or equivalent)
<input type="checkbox"/>	<input type="checkbox"/>	2. Complete Blood Count
<input type="checkbox"/>	<input type="checkbox"/>	3. Complete Urinalysis (not Dipstick)
<input type="checkbox"/>	<input type="checkbox"/>	4. Serology (RPR or equivalent)
<input type="checkbox"/>	<input type="checkbox"/>	5. Tuberculosis (Mantoux)
<input type="checkbox"/>	<input type="checkbox"/>	6. Electrocardiogram (ECG) (Resting)
<input type="checkbox"/>	<input type="checkbox"/>	7. Chest X-ray (CXR) <u>ONLY REQUIRED IF #5 IS POSITIVE</u>
<input type="checkbox"/>	<input type="checkbox"/>	8. Drug Screen (THC, Cocaine, Amphetamines, Opiates, Barbiturates, Methadone, Methaqualone, Phencyclidine, Propoxyphene, Benzodiazepines, Alcohol, Anabolic Steroids)

STATEMENT OF CONDITION

I have personally examined the applicant:

The applicant **has passed** the minimum medical standards as established by the New Mexico Law Enforcement Academy Board without exclusions.

The applicant **has one or more potentially excludable conditions** from the minimum medical standards as established by the New Mexico Law Enforcement Academy Board, but **can perform the functions** of a law enforcement officer with accommodations. (Please explain below.)

The applicant **has one or more potentially excludable conditions** from the minimum medical standards as established by the New Mexico Law Enforcement Academy Board, and **cannot perform the functions** of a law enforcement officer. (Please explain below.)

Section Item #	Explanation (attach additional sheets if necessary)

New Mexico Law (NMSA 1978, §29-7-6 A (5)), requires that a candidate for law enforcement officer only be examined by a licensed physician.

Licensed Physician's Signature _____ Date _____

Print Name _____ M.D. D.O.

Address _____

City _____ State _____ Zip _____

Phone _____ NM Medical License # _____

Other State _____ Medical License # _____

Print or type contact information, or attach a business card. Missing or illegible entries will be returned.