ARKANSAS STATE POLICE

ASP 89B
Eff. 03/29/2024

Physical Fitness Assessment
Medical Release Form

Physical Fitness Assessment tests will not be scheduled until this completed form is submitted to the Arkansas State Police.

Date: _____ Patient Name: _____

To ensure minimum levels of fitness, Arkansas State Police applicants will be assessed to determine their physical ability levels. All portions of the assessment must be completed for the assessment to be valid. This form is valid for one year.

An instructional video is available on the ASP website at:
https://www.dps.arkansas.gov/law-enforcement/arkansas-state-police/recruiting/trooper-recruiting/

The physical fitness assessment will consist of the events listed below:

Timed Events:

- 6 Laps running around a rectangular course (320 yards total). Each lap includes a 5' jump, run up and down a 5' tall ramp with a 30-degree incline/decline, change directions, and hurdle two 18" obstacles.
- 6 repetitions each of pulling and pushing the Physical Control Simulator in a 180-degree arc with 80 pounds of resistance.
- 10 burpees, 5 to chest and 5 to back, interspersed with 9 vaults over a 3-foot vault-rail.

Not timed – must be completed without stopping:

- Carry a 100-pound torso bag 50 feet while keeping the bag above knee level with arms bent

PHYSICIAN/PRIMARY CARE PROVIDER (PCP) RECOMMENDATION

I HAVE READ THE DESCRIPTION OF THE PHYSICAL FITNESS TEST. IT IS MY OPINION THAT THE ABOVE-NAMED INDIVIDUAL IS CAPABLE OF SAFELY PARTICIPATING IN VIGOROUS PHYSICAL ACTIVITY WITH NO RESTRICTIONS. ISSUES OF PARTICULAR CONCERN INCLUDE- BUT ARE NOT LIMITED TO – CARDIOVASCULAR DISEASES, ASTHMA, SERIOUS LUNG DISEASE, SIGNIFICANT MUSCULOSKELETAL CONDITIONS AND HISTORY OF EXERTIONAL RHABDOMYOLYSIS AND RISK FACTORS FOR RHABDOMYOLYSIS (SUCH AS THYROID DISEASE, RENAL DISEASE, STATIN USE, SICKLE CELL TRAIT, AND SICKLE CELL DISEASE)

☐ **This individual is capable of participating in the physical fitness assessment.**

☐ **It is not recommended that the individual participate in the physical fitness assessment at this time.**

Physician (print and sign): _____ Date: _____

Name of Clinic: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____