INDIAN RIVER STATE COLLEGE

Fire Academy

Medical/ Physician's Clearance to Test Form

Name of Participant _____ The purpose of this form is to inform you that the individual named above intends to participate in the Indian River State College Fire Academy Pre-Enrollment Physical Abilities Test (FPAT), conducted in accordance with the Florida Bureau of Fire Standards and Training guidelines.

We recognize that strenuous physical activity may be inadvisable for some individuals. As such, we respectfully request your medical opinion on whether this individual is physically capable of participating in the following test. Please note: **We are not asking you to assume responsibility** for this participant during testing. Rather, we aim to make an informed decision with respect to their participation based on your medical input.

Test Description

The FPAT simulates real-world firefighter tasks and is designed to measure cardiovascular fitness, muscular strength, and endurance under timed conditions. Participants will be required to perform the following:

- **Stair Climb** while carrying a high-rise hose pack
- **Hose Drag and Advance** over a set distance
- **Equipment Carry** involving fire tools or equipment
- **Forcible Entry Simulation** (such as tire *strike with a* sledgehammer)
- **Search Crawl** through a darkened space or tunnel
- **Victim Rescue Drag** using a 165 lb. mannequin
- **Ladder Raise and Extension**
- **Ceiling Breach Simulation** with a pike pole

These tasks are performed consecutively and require sustained physical effort and mental focus.

Physician Evaluation

I have examined this participant and reviewed their medical history. Based on my evaluation:

☐ **Participation is NOT advisable** at this time.
(If you check this box, please do *not* disclose the medical condition.)

☐ **Within a reasonable degree of medical probability, there is no condition or disorder** that would prevent this individual from participating in the physical abilities test as described above.

Date: _____

Signature of Physician:

_____

Printed Name of Physician:

_____

License #: _____

Address of Clinic:

_____

With best regards,
Dr. John Bray, Chair, IRSC Fire Academy