1977 POLICE OFFICERS' & FIREFIGHTERS' FUND APPLICATION FOR MEMBERSHIP

State Form 4928 (R20 / 1-25)

Reset Form

1977 POLICE OFFICERS' & FIREFIGHTERS' PENSION AND DISABILITY FUND
One North Capitol Avenue, Suite 001
Indianapolis, Indiana 46204-2014
Telephone: (888) 876-2707 (toll free)
Fax: (317) 974-1616
E-mail: eppa@inprs.in.gov
Website: www.in.gov/inprs

INSTRUCTIONS

1. Type or print using black ink.
2. Complete all applicant information as requested.
3. Do not leave any answer blank, unless instructed to skip.
4. Do not use "N/A" to complete any answer; if "none" applies, write "none".
5. Return the completed, signed, dated, and notarized application using the address on this form or fax.
6. Any incomplete portion of the application will result in a delay in processing.

☐ Check here if you have 1977 Fund service.

* This agency is requesting disclosure of Social Security Numbers in accordance with Internal Revenue Code 3405; disclosure is mandatory, and this form cannot be processed without it.

Name of applicant	Department applying to

IMPORTANT NOTICE

Transfers:
Active 1977 Fund members can separate from one 1977 Fund participating employer to become employed with another participating 1977 Fund employer. Age limitations and physical and mental requirements for admission are waived if re-employment occurs within 180 days after separation. The 180-day limitation does not apply to 1977 Fund members who are reinstated with a police or fire department following a layoff for financial reasons.

Indiana law forbids the initial hiring of a person as a public safety officer if the person is forty (40) years of age or more for a police officer or forty (40) years of age or more for a firefighter at the time of hire.
IC 36-8-8-7(a) provides as follows:

Section 7. (a)Except as provided in subsections (d), (e), (f), (g), (h), (k), (l), and (m):
(1) a police officer who is less than forty (40) years of age; or
(2) a firefighter who is less than forty (40) years of age (SB185)
and who passes the baseline statewide physical and mental examinations required under section 19 of this chapter shall be a member of the 1977 Fund and is not a member of the 1925 Fund, the 1937 Fund, or the 1953 Fund.

IC 36-8-3.5-12 Department members; appointment; qualifications; application; general aptitude test; ratings; eligibility list; vacancies; physical agility test; probation

Section 12. (a) Subject to IC 36-8-4.7, to be appointed to the department, an applicant must be:
(1) a citizen of the United States;
(2) a high school graduate or equivalent; and
(3) at least twenty-one (21) years of age, but under forty (40) years of age.

A former member of the 1977 Fund, who separated more than 180 days from a position covered by the 1977 Fund may be hired if they: (1) pass the statewide baseline physical and local board mental standards; and (2) will complete twenty (20) years of service by age 60 without meeting the maximum age limitations detailed above. In addition, IC 36-8-4.7 provides a waiver for a person not more than forty (40) years and six (6) months of age who has completed twenty (20) years of military service who received or is eligible to receive an honorable discharge.

In addition, IC 36-8-3-21(b) provides that, "(a)n individual may not be employed by a unit after May 31, 1985, as a member of the unit's fire department or as a member of the unit's police department unless the individual meets the conditions for membership in the 1977 fund."

GIVING AN INDIVIDUAL A CONDITIONAL OFFER OF EMPLOYMENT PRIOR TO AGE FORTY (40) FOR FIREFIGHTERS AND AGE FORTY (40) FOR POLICE OFFICERS DOES NOT CONSTITUTE COMPLIANCE WITH THESE STATUTES. THIS APPLICATION MUST BE RECEIVED AND FULLY APPROVED BY INPRS BEFORE THE APPLICANT MAY BE ACTUALLY HIRED BY THE DEPARTMENT. THE APPLICATION MUST BE RECEIVED BEFORE THE APPLICANT REACHES THE AGE OF FORTY (40) FOR A FIREFIGHTER AND THE AGE OF FORTY (40) FOR A POLICE OFFICER UNLESS COVERED UNDER STATUTORY EXCEPTIONS LISTED ABOVE.

35 IAC 2-9-5 states "the local board shall submit certification of the baseline statewide within 6 months of the date of examination. If INPRS receives the certification of the results of the baseline statewide physical examination more than 6 months from the date of examination, the local board has not met the requirements for the transfer of the local board determination under this section."

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Name of applicant

APPLICATION CHECKLIST

These items must be completed before any individual can become a member of the 1977 Fund:

1. Aptitude test has been administered and passed.
2. Agility test has been administered and passed.
3. Conditional offer is extended and statement of understanding and authorization for release of medical information has been signed.
4. Appointing authority has certified that the applicant passed the physical agility exam.
5. The comprehensive medical history has been completed and the baseline statewide examination has been administered.
6. The baseline statewide examination (physical and mental) forms have been signed by a licensed physician indicating that the baseline statewide medical and any additional local standards have been met (mental exam must be interpreted by a licensed physician or psychiatrist/PhD-trained psychologist.)
7. The appropriate specialist reports, if any, are identified and included in the application package.
8. A local pension board member, the pension secretary, and the appointing authority have signed the certification forms indicating the baseline and any local standards have been met.
9. The examination form, all medical testing results, and certification of successful completion of the physical agility, mental, and medical examinations must be forwarded to INPRS. INPRS must approve or deny the application with respect to the baseline physical standards. INPRS also determines if the applicant has any Class 3 excludable conditions.
10. INPRS either approves or denies the application and issues the appropriate determination letter. If the application is approved, the approval letter will also specify whether the applicant has any Class 3 excludable conditions. If the application is denied, the denial letter to the applicant will specify the reason.
11. If the applicant is approved by INPRS, an unconditional offer of employment is made, and the effect of any Class 3 exclusions is explained.
12. If the applicant is approved, the department should begin the enrollment process in the Employer Reporting and Maintenance (ERM) system.
13. If the applicant is denied, the applicant may challenge the denial under the Indiana Administrative Orders and Procedures Act (IC 4-21.5). The administrative review process may also be used with respect to the determination that a Class 3 excludable condition exists.

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PHYSICIAN OR DOCTOR NOTES

INPRS MEDICAL AUTHORITY NOTES

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CONDITIONAL OFFER OF EMPLOYMENT STATEMENT OF UNDERSTANDING

_____ , is applying for the position of
Name of applicant - last, first, middle

_____ with the _____
Police officer or firefighter *City / Town department*

_____
Address of applicant (number and street, city, state and ZIP code)

I, _____ , have received a conditional offer of employment for a
Name of applicant

_____ position with the _____
Name of position *City / Town*

_____ department.
Police or fire

I understand that the offer is conditional on my successfully passing the statewide baseline medical examination and the statewide mental examination, as well as any local medical and mental examination requirements. If I do not pass these examinations and requirements, the offer of employment will be withdrawn.

I further understand that, as a result of tests and examinations, certain diseases or conditions may be identified. These diseases or conditions, if identified, will prevent me from receiving certain Class 3 impairment benefits for a period of four (4) years and will disqualify me from receiving disability benefits from the 1977 Police Officers' and Firefighters' Pension and Disability Fund throughout my employment if the disability is related in any way to the identified disease(s) or condition(s). I have reviewed INPRS Board rules 35 IAC 2-9 and 35 IAC 2-10 and the lists of diseases and conditions set forth herein.

I affirm that I understand the effect the 35 IAC 2-9 and 35 IAC 2-10 may have on my eligibility for benefits in the 1977 Fund and also on my ability to qualify for Class 3 impairment benefits.

Signature of applicant	Date *(mm/dd/yyyy)*

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AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

This information is for official and medically confidential use only and will not be released to unauthorized persons.

_____ , is applying for the position of
Name of applicant - last, first, middle

_____ with the _____
Police officer or firefighter *City / Town department*

_____
Address of applicant (number and street, city, state and ZIP code)

I, _____ an applicant for a position within the department, agree to assist and cooperate with the department, the administrators of the 1977 Police Officers' and Firefighters' Pension and Disability Fund (1977 Fund), and any representative thereof in obtaining the following personal information:

All written or printed information concerning any diagnosis, treatment, or prognosis regarding my physical or mental health; including, but not limited to, all mental and physical health records and alcohol and drug abuse records.

I hereby authorize and request all persons to whom this request (original or copy) is presented, having information relating to or concerning me, to furnish the above-described information to any duly appointed administrator or representative of the 1977 Fund and any officer or individual of the department. I further authorize the department, or the administrators of the 1977 Fund to release this information, as well as the results of any physical examinations performed in connection with this form, to the appropriate local pension board.

I am aware that this information may be of a personal nature and may otherwise be protected by my constitutional, statutory, or common law privileges. I understand that information released and complied pursuant to this authorization shall be treated in a confidential manner. Therefore, I expressly waive all privileges which may attach to such disclosure and shall hold no individual, organization(s), or corporation(s) liable for legal actions for disclosing any of the information herein to the department, a 1977 Fund representative, or a local pension board.

I am also aware that this authorization is subject to revocation at any time, except to the extent a person or institution has already legally acted in reliance on this authorization. If not previously revoked, this authorization will expire on the earlier of: the date I am extended an unconditional offer of employment to become a member of the department; or the date I am officially advised that I am ineligible for membership in the 1977 Fund.

I understand that this information is required to complete my application to become employed as a member of the department and that misrepresentation, falsification of information, or failure to assist and cooperate with the department or the administrators of the 1977 Fund in obtaining the requested information will be considered cause for disqualification from consideration.

Further, I authorize investigation of all statements contained in this form. I understand that omission of facts called for in this application form is also cause for disqualification from further consideration.

I have read the above, understand it, and certify that I will fully and truthfully answer all questions to the best of my knowledge.

Dated this day of , 20

Signature of applicant	Social Security Number of applicant * - -

Subscribed and sworn to me this _____ day of _____, 20 _____ .

Signature of notary public *(No rubber stamp signatures.)*		NOTARY SEAL
Printed name of notary public		
Date commission expires *(mm/dd/yyyy)*	County of residence	

GUIDELINES FOR PHYSICIANS

Name of applicant

This information is designed to help physicians complete the following forms. The medical conditions outlined in these forms may impact on an individual's ability to perform the essential functions of the job for a first-class police officer or firefighter. The application of these guidelines requires a careful consideration of the job duties of a police officer or firefighter and the medical conditions that might affect a person's capability to conduct those duties.

Firefighting and emergency response are very difficult jobs. People in these jobs must perform functions that are physically and psychologically demanding. These functions must often be performed under very difficult conditions. Studies have shown that firefighting and police functions at times require working at near maximal heart rates for prolonged periods of time. Heavy protective equipment (including respirators) and the heat from fire also contribute to the physical load that firefighters must endure.

The available health data on firefighters and police officers is limited. Given the delay between exposure and onset of many occupational illnesses (i.e., latency), current or past health studies of firefighters and police officers may not reflect future health risks. However, it appears that firefighters and police officers have increased risk for injuries, pulmonary disease, cardiovascular disease, cancer, and noise-induced hearing loss. The increased risk for injuries is expected given the demands and circumstances for this work.

BASIC ESSENTIAL JOB FUNCTIONS

I. BASIC ESSENTIAL FUNCTIONS FOR POLICE OFFICERS

- Patrol assigned area on foot or drive a vehicle searching for suspicious activity or situations or checking for persons in need of service.
- Monitor radio and other communication devices to receive assigned runs and to maintain awareness of activities in assigned areas or by other officers.
- Assist citizens with problems such as lost children, injured persons, animal bites, civil disputes, locked doors, vehicle inspections and verifications, or abandoned vehicles.
- Refer persons to appropriate social service agencies when situation warrants.
- Respond to assigned run by driving, walking, or running to specified location, assess situation, determine need for other assistance, and take appropriate action.
- Move people away from danger, including carrying unconscious people, and providing emergency aid to injured people.
- Investigate accidents, extract victims, provide emergency aid, gather evidence, record observations and statements of witnesses and victims, request assistance from other officers or agencies as needed, direct the removal of the vehicles involved, and ensure the area is clear.
- Search crime scenes, take prescribed actions to preserve and protect evidence, and record findings and observations.
- Interview victims, suspects, and witnesses, and record responses and observations.
- Pursue, apprehend, search, and arrest suspects using only necessary force, advise suspects of rights, and transport suspect to detention area.
- Using appropriate equipment and weapons, restrain people from physically striking or injuring others.
- Drive a vehicle at high speed when situation warrants due to nature of emergency.
- Stop drivers of vehicles when traffic violations are observed, verify license and registration data, advise driver of safe driving practices, and issue citations or make arrests as warranted.
- Direct vehicular and pedestrian traffic when congestion occurs or as directed.
- Report as directed to scenes of general emergencies and take appropriate action to protect life and property, such as directing traffic, quarantining an area, assisting individuals in leaving an area, preventing looting, and requesting appropriate assistance.
- Maintain visibility in the community by meeting and talking with citizens, provide information, visit local businesses, and make presentations to school, neighborhood, and civic organizations.
- Write reports and complete forms as required by operating procedure and make oral reports to appropriate personnel.
- Testify in court, prepare for such testimony by reviewing reports and notes, meet with attorneys, and obtain appropriate evidence.
- Participate in training on law enforcement procedures, including firearms, criminal justice, and court procedure, emergency medical aid, and related subjects.
- Maintain uniforms, equipment, and weapons.
- Maintain personal physical fitness.
- Perform related duties as assigned.

II. BASIC ESSENTIAL FUNCTIONS FOR FIREFIGHTERS

- Respond to alarms by reporting to assigned vehicle, riding in or on assigned vehicle to the scene of the emergency or fire.
- Lift, carry, drag, lay, and connect hose lines from hydrants and equipment to scene. Carry resuscitators, tools, and other equipment from vehicle to scene.
- Raise and climb ladders, crawl and walk on roofs and floors, open holes and windows with axes, bars, or hooks for access or ventilation.
- Combat fires by holding nozzles and directing streams of fog, chemicals, or water and move into fire area, including into confined spaces and up stairs.
- Communicate by voice or radio with other firefighters and other emergency personnel to relay observations, equipment needs, and other relevant information.
- Move people away from danger, including carrying unconscious people or holding a life net.
- Provide emergency medical treatment to injured people.
- Remove objects from buildings, place protective covers over objects, and monitor assigned areas for signs of recurrence.
- Conduct fire drills, critique drill participants on emergency procedure, and instruct groups on such procedures.
- Participate in training on firefighting, emergency aid, emergency procedures, and related subjects.
- Maintain departmental equipment and structures, which includes cleaning and washing walls and floors, hanging and drying fire hose, cleaning equipment, and performing preventative maintenance on motorized equipment.
- Maintain personal physical fitness.
- Perform related duties as assigned.

GUIDELINES FOR PHYSICIANS *(continued)*

Name of applicant

ENVIRONMENTAL FACTORS THAT AFFECT JOB FUNCTIONS

I. ENVIRONMENTAL FACTORS FOR POLICE OFFICERS

The essential job functions for a police officer are performed in and affected by the following environmental factors. An officer must:

1. Operate both as a member of a team and independently at incidents of uncertain duration.
2. Face exposure to infectious agents such as hepatitis B or HIV.
3. Perform complex tasks during life-threatening emergencies.
4. Work for long periods of time, requiring sustained physical activity and intense concentration.
5. Face life or death decisions during emergency conditions.
6. Tolerate exposure to grotesque sights and smells associated with major trauma.
7. Make rapid transitions from rest to near maximal exertion without warm-up periods.
8. Use firearms, self-defense equipment and body armor.
9. Be able to physically protect themselves.
10. Be able to communicate with people effectively.

II. ENVIRONMENTAL FACTORS FOR FIREFIGHTERS

The essential job functions for a firefighter are performed in and affected by the following environmental factors. A firefighter must:

1. Operate both as a member of a team and independently at incidents of uncertain duration.
2. Spend extensive time outside exposed to the elements.
3. Experience frequent transition from hot to cold and from humid to dry atmospheres.
4. Tolerate extreme fluctuations in temperature and perform physically demanding work in hot (up to 400° F), humid (up to 100%) atmospheres while wearing equipment that significantly impairs body cooling mechanisms.
5. Work in wet, icy, or muddy areas.
6. Perform a variety of tasks on slippery, hazardous surfaces such as on roof tops or from ladders.
7. Work in areas where sustaining traumatic or thermal injury is possible.
8. Face exposure to carcinogenic dusts such as asbestos, and toxic substances such as hydrogen cyanide, acids, carbon monoxide, or organic solvents either through inhalation or skin contact.
9. Face exposure to infectious agents such as hepatitis B or HIV.
10. Perform complex tasks during life-threatening emergencies.
11. Work for long periods of time, requiring sustained physical activity and intense concentration.
12. Face life or death decisions during emergency conditions.
13. Tolerate exposure to grotesque sights and smells associated with major trauma and burn victims.
14. Make rapid transitions from rest to near maximal exertion without warm-up periods.
15. Operate in environments of high noise, poor visibility, limited mobility, at heights, and in enclosed or confined spaces.
16. Use manual or power tools in the performance of duties.
17. Rely on sense of sight, hearing, smell, and touch to help determine the nature of the emergency, maintain personal safety, and make critical decisions in confused, chaotic, and potentially life-threatening environments.
18. Wear personal protective equipment that weighs approximately fifty (50) pounds while performing the essential functions of the job.
19. Perform physically demanding work while wearing protective pressure breathing equipment with 1.5 inches water column resistance to exhalation at a flow of forty (40) liters per minute.
20. Be able to communicate with people effectively.

Do not leave any questions blank unless the form instructs you to skip questions.

COMPREHENSIVE MEDICAL HISTORY

This section is to be completed by the applicant. ALL QUESTIONS MUST BE ANSWERED. DO NOT ANSWER ANY QUESTION WITH "N/A", instead use "No" or "None".

Name of applicant			Primary telephone number *(with area code)*
Date of birth *(mm/dd/yyyy)*	Age	Gender at birth ☐ Male ☐ Female	Currently identifying as ☐ Male ☐ Female ☐ Non-Binary
What is your present health? ☐ Good ☐ Fair ☐ Poor	Are you having pain or discomfort at this time? ☐ Yes ☐ No		Secondary telephone number *(with area code)*
Occupation applying for:		Name of department applying to:	

A. (1) PERSONAL HISTORY OF APPLICANT *(past medical history)*

Did you have any unusual, complicated, or prolonged childhood illnesses? *If so, provide an explanation.*

HOSPITALIZATIONS *(for non-surgical reasons)*

Year	Nature of Problem	Name of Physician and City	Describe Any Long-lasting or Residual Effects

SURGERIES / OPERATIONS

Year	Type of Surgery	Name of Hospital	Name of Surgeon and City

SERIOUS INJURIES / ACCIDENTS *(no hospitalization required)*

Year	Nature of Injuries	Name of Physician and City	Describe Any Long-lasting or Residual Effects

COMPREHENSIVE MEDICAL HISTORY *(continued)*

Name of applicant

This section is to be completed by the applicant. ALL QUESTIONS MUST BE ANSWERED. DO NOT ANSWER ANY QUESTION WITH "N/A", instead use "No" or "None".

A. (1) PERSONAL HISTORY OF APPLICANT *(past medical history) (continued)*

Have you traveled extensively or resided outside of the United States and Canada? *If so, provide an explanation.*

MILITARY SERVICE

Date Enlisted *(mm/dd/yyyy)*	Date Discharged *(mm/dd/yyyy)*	Branch of Service	Any duty outside of the United States?
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No

Any serious illnesses or injuries sustained while in military service should be listed on the previous page.

List any medications to which you are allergic or which you do not tolerate well.

List any non-medication allergies or sensitivities.

List any and all medications that you are currently taking or that you take on a regular basis.

Medication	Dosage	Reason for Medication	Prescribing Physician

Name of Personal Physician(s)	Address *(number and street, city, state, and ZIP code)*	Telephone Number

Are you presently under a physician's care or the care of any other health care provider for any reason? *If so, provide an explanation.*

Do you have any impairment, disabilities, functional limitations, or restrictions on activities as a result of physical, medical or an emotional condition that may interfere with your ability to perform the essential functions of the job for which you are applying? The essential functions of the job are listed in the CONDITIONAL OFFER OF EMPLOYMENT STATEMENT OF UNDERSTANDING section of this form. *If so, provide an explanation.*

COMPREHENSIVE MEDICAL HISTORY *(continued)*

Name of applicant

This section is to be completed by the applicant. ALL QUESTIONS MUST BE ANSWERED. IF AN ITEM IS NOT APPLICABLE, CHOOSE "NO".

A. (2) REVIEW OF SYSTEMS

Have you had in the past or do you currently have any of the following conditions? *(Check each item.)*

GENERAL	Yes	No
Feel too hot or too cold	☐	☐
Tremors or shaking of hands	☐	☐
Chills or night sweats	☐	☐
Presently following a specific diet	☐	☐
In the past year, had unexplained weight loss/gain	☐	☐
Frequent or recurrent infections	☐	☐
Any unexplained or excessive bleeding	☐	☐
Use any type of braces, supports, or other orthopedic devices that may affect your ability to perform the essential functions of the job for which you are applying?	☐	☐
	☐	☐
SKIN		
Unusual growth on skin	☐	☐
Change in color or size of mole	☐	☐
Swelling or lump in neck, armpits, groin, or breasts	☐	☐
	☐	☐
HEENT		
Wear glasses or contacts	☐	☐
Decreased vision not corrected by glasses/contacts	☐	☐
Blurred vision	☐	☐
Double vision	☐	☐
Pain or inflammation in eyes	☐	☐
Color blindness	☐	☐
Decrease in hearing	☐	☐
Frequent earaches or discharge from the ears	☐	☐
Buzzing or ringing in the ears	☐	☐
Attacks of dizziness, fainting, or loss of consciousness	☐	☐
Frequent or severe nosebleeds	☐	☐
Any significant nasal symptoms	☐	☐
Persistent change or loss in sense of smell or taste	☐	☐
Gums bleed easily	☐	☐
Persistent sores on lips or tongue	☐	☐
Frequent or severe sore throats	☐	☐
Prolonged hoarseness	☐	☐
	☐	☐
RESPIRATORY		
Frequent colds	☐	☐
Attacks of wheezing, whistling, or difficulty breathing	☐	☐
Chronic cough	☐	☐
Blood in sputum	☐	☐
Short of breath during normal activities	☐	☐
	☐	☐
CARDIOVASCULAR		
Pressure, heaviness, or pain in chest	☐	☐
Chest pain radiating to neck, jaw, or down either arm	☐	☐
Irregular heartbeat (palpitation, heart flutter)	☐	☐
Swelling of feet	☐	☐
Pain in either leg on walking short distances	☐	☐
Shortness of breath on lying flat	☐	☐

GENITOURINARY	Yes	No
Get up at night more than two times to urinate	☐	☐
Trouble starting or stopping your stream when you urinate	☐	☐
Frequency, burning, or pain when you urinate	☐	☐
Blood or pus in urine	☐	☐
Swelling or lumps in your testicles (men)	☐	☐
Sore on penis (men)	☐	☐
Now pregnant (women)	☐	☐
Lump in breasts (men and women)	☐	☐
	☐	☐
GASTROINTESTINAL		
Difficulty swallowing	☐	☐
Frequent nausea or vomiting	☐	☐
Abdominal pain	☐	☐
Excessive gas, belching, or bloating	☐	☐
Intolerance of fatty foods	☐	☐
Recent change in bowel habits	☐	☐
Diarrhea lasting more than one (1) week	☐	☐
Blood in stools	☐	☐
Black or tarry stools	☐	☐
	☐	☐
MUSCULOSKELETAL		
Pain in muscles	☐	☐
Pain or restriction of movement in joints	☐	☐
Swelling of any joints	☐	☐
Frequent backaches	☐	☐
Radiating pain from spine into limbs	☐	☐
	☐	☐
HEMATOLOGICAL		
Bruise easily	☐	☐
Bleed excessively after a cut or dental procedure	☐	☐
Sickle cell anemia	☐	☐
	☐	☐
NEUROLOGICAL		
Persistent numbness, tingling, weakness, or paralysis in any body part	☐	☐
Frequent headaches severe enough to limit activities	☐	☐
Sensation of dizziness, lightheadedness, or imbalance	☐	☐
Periods of unconsciousness or fainting	☐	☐
Seizures/convulsions ("fits", "spells", or "falling out")	☐	☐
Persistent drowsiness through the day	☐	☐
Become suddenly sleepy or "sleep attacks" during the day	☐	☐
Have episode of sudden muscle weakness during the day	☐	☐
Tremors or other abnormal movements	☐	☐

COMPREHENSIVE MEDICAL HISTORY *(continued)*

Name of applicant

This section is to be completed by the applicant. ALL QUESTIONS MUST BE ANSWERED. DO NOT ANSWER ANY QUESTION WITH "N/A", instead use "No" or "None".

A. (2) REVIEW OF SYSTEMS *(continued)*

Explain any affirmative responses to the questions in Section A.(2). *NOTE: If you wear contact lenses, indicate below the type (soft, hard) and how long you have worn contacts.*

Do you have a history of any other significant physical conditions, medical problems, or emotional disorders than those listed above? *If so, provide a full explanation.*

A. (3) PERSONAL AND SOCIAL HISTORY

1. Have you ever smoked? *Choose only one of the following options.*

☐ Yes, and currently still smoking
Complete this table then proceed to question 2.

Substance	Amount currently smoking		Total years you smoked
	Number	Frequency	
Cigarettes			
Pipe			
Cigars			
Vaping			

☐ Yes, but do not smoke now
Complete this table then proceed to question 2.

Substance	Amount smoking when you stopped		Year you stopped smoking	Total years you smoked
	Number	Frequency		
Cigarettes				
Pipe				
Cigars				
Vaping				

☐ No. *Proceed to question 2.*

2. Have you ever used smokeless tobacco? *Choose one of the following options*.

☐ Yes
Complete this table then proceed to question 3.

Type	
Usage Amount	
Duration	

☐ No. *Proceed to question 3.*

3. Have you ever drunk alcoholic beverages? Choose only one of the following options.

☐ Yes, and currently still drinking
Complete this table then proceed to question 4.

Substance	Amount currently drinking		Total years you drank
	Quantity and frequency	Number of drinks per week	
Liquor			
Beer			
Wine			

☐ Yes, and do not drink now
Complete this table then proceed to question 4.

Substance	Amount drinking when stopped	Year you stopped drinking	Total years you drank
	Quantity and frequency		
Liquor			
Beer			
Wine			

☐ No. *Proceed to question 7.*

COMPREHENSIVE MEDICAL HISTORY *(continued)*

Name of applicant

This section is to be completed by the applicant. ALL QUESTIONS MUST BE ANSWERED. DO NOT ANSWER ANY QUESTION WITH "N/A", instead use "No" or "None".

A. (3) PERSONAL AND SOCIAL HISTORY *(Continued)*

4. Are you always able to stop drinking when you want to? ☐ Yes ☐ No

5. Has drinking ever created problems for you with your job, family, social life or other obligations? ☐ Yes ☐ No

6. Have you ever gone to anyone for help about your drinking? ☐ Yes ☐ No

A. (3) PERSONAL AND SOCIAL HISTORY *(Continued)*

7. How much of the following do you usually drink each day? *Complete this table then proceed to question 8.*	Cups of Coffee	
	Cups of tea	
	Soft drinks	

8. Have you ever taken illegal drugs? *Choose one of the following options*.

☐ Yes *Complete this table then proceed to question 13*	Type	
	Usage Amount	
	Last Usage	

☐ No. *Proceed to question 13*.

13. Describe your current and previous occupations.

14. Have you ever had any occupational illness, injury, or significant occupational exposure? *If so, provide an explanation.*

I certify that I have reviewed the information and answered the questions set forth in Sections A (1), A (2), and A (3) of this application, and that I have answered truthfully and to the best of my ability.

Signature of applicant	Printed name of applicant	Date *(mm/dd/yyyy)*

1977 POLICE OFFICERS' AND FIREFIGHTERS' FUND APPLICATION FOR MEMBERSHIP

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PHYSICAL EXAMINATION

Name of applicant

This section is to be completed by the examining physician. ALL QUESTIONS MUST BE ANSWERED. DO NOT ANSWER ANY QUESTION WITH "N/A", instead use "No" or "None".

B. (1) GENERAL ***(Check the appropriate column for each entry.)***

		Normal	Abnormal	Number and describe abnormalities in detail.
General appearance		☐	☐	
Skin		☐	☐	
Head and neck		☐	☐	
Eyes:	Conjunctiva	☐	☐	
	Pupils	☐	☐	
	Fundi	☐	☐	
Ear, nose, throat:	External ear	☐	☐	
	Tympanic membrane	☐	☐	
	Septum	☐	☐	
	Teeth, gums	☐	☐	
	Throat, tonsils, tongue	☐	☐	
	Trachea	☐	☐	
Lymph nodes		☐	☐	
Thyroid	Size / nodules	☐	☐	
Breasts		☐	☐	
Chest	Contour	☐	☐	
	Expansion	☐	☐	
Lungs	Rales	☐	☐	
	Ronchi	☐	☐	
	Wheeze	☐	☐	
	Dullness on percussion	☐	☐	
Heart	Rate	☐	☐	
	Rhythm	☐	☐	
	Palpitation	☐	☐	
	Sounds	☐	☐	
	Murmur	☐	☐	
Vessels	Arterial pulses	☐	☐	
	Bruits, carotid and others	☐	☐	
	Varicosities	☐	☐	
Abdomen	Scars	☐	☐	
	Tenderness	☐	☐	
	Masses	☐	☐	
	Hernia	☐	☐	
	Liver	☐	☐	
	Spleen	☐	☐	
Genitalia		☐	☐	
Pelvic (if indicated)		☐	☐	
Prostate (if indicated)		☐	☐	
Rectum (if indicated)		☐	☐	
Spine	Mobility	☐	☐	
	Alignment / curvature	☐	☐	
	Tenderness	☐	☐	
Extremities	Joints	☐	☐	
	Deformity	☐	☐	
	Edema	☐	☐	
Neurological	Gait	☐	☐	
	Coordination	☐	☐	
	Reflexes	☐	☐	
	Sensory	☐	☐	
	Cranial nerves	☐	☐	
	Motor strength	☐	☐	
	Muscle strength	☐	☐	
	Tremors	☐	☐	
Other		☐	☐	

PHYSICAL EXAMINATION *(continued)*

This section is to be completed by the examining physician. ALL QUESTIONS MUST BE ANSWERED. DO NOT ANSWER ANY QUESTION WITH "N/A", instead use "No" or "None".

B. (2) TESTS *(Each of the following tests must be administered to the applicant. Test results should be recorded below or attached.)*

Vital signs ***(Test results should be recorded below or attached.)***

Blood pressure _____ Pulse _____ Respiration _____ Height *(inches)* _____ Weight *(pounds)* _____

BMI _____ % Body Fat by impedance testing _____

Is the vision test included in the medical documentation? ☐ Yes ☐ No

Visual testing (using a Snellen chart or other comparable chart)

Visual acuity	Distant			Near		
uncorrected	___/___	___/___	___/___	___/___	___/___	___/___
	right	*left*	*both*	*right*	*left*	*both*
corrected	___/___	___/___	___/___	___/___	___/___	___/___
	right	*left*	*both*	*right*	*left*	*both*

Color vision (ability to identify red, green, and yellow colors)? ☐ Yes ☐ No

Peripheral vision (at least 140° in the horizontal meridian of each eye without correction)? ☐ Yes ☐ No

Audio testing - should be performed in an ANSI approved "soundproof" booth (ANSI S3.1-1991) with equipment calibrated to ANSI standards (ANSI S 3.6-1989). If a booth is unavailable, the test room sound pressure levels should not exceed those specified in the Federal OSHA noise regulations (29 CFR 1910.95); (July 1, 1992 Edition).

Pulmonary function testing - A minimum of three (3) acceptable Forced Vital Capacity (FVC) maneuvers must be performed and recorded. The best two (2) FVC maneuvers must reveal results that are within 5% of each other. The best Forced Expiratory Volume in One Second (FEVI) are recorded and the FEVI/FVC ratio is then calculated. Additional spirometric functions may be performed if desired or indicated.

Chest x-ray: Posterior-anterior / lateral views / cervical x-ray / thoracic x-ray / lumbar spine x-ray - with interpretation by a radiologist required, Other diagnostic imaging, if indicated.

12-lead ECG (resting) test - with interpretation by a cardiologist or other qualified physician. Other diagnostic testing, if indicated.

Laboratory testing (minimum)

- Complete blood count
- Blood chemistries - fasting glucose, BUN, creatinine. hemoglobin A1c (HbA1c)
- Liver function - SGPT (ALT), SGOT (AST), GGT, LDH, alkaline phosphotase, total protein, albumin, bilirubin (total)
- Urinalysis - SG, blood, protein, glucose, ketones, bilirubin and nitrates required, microscopic evaluation required if any significant abnormalities above have resulted
- HIV testing - if screening test is positive, confirm testing with Western Blot analysis HIV antigen
- Syphilis serology
- Urine drug screen - must test for at least marijuana, cocaine, opiates, amphetamines, PCP, benzodiazepines, and barbiturates. Testing must be performed in accord with the acceptable standards within the field of forensic toxicology and should adhere to all proper chain of custody procedures.
- TBc skin test - applied and interpreted - not to be done if there is a past history of positive PPD or pulmonary TBc

Other requirements

- Treadmill cardiac stress test / Submax (Bruce protocol) treadmill evaluation
- Respirator clearance questionnaire
- Functional movement screening or orthopedic screening, or both as indicated

I, _____ , a licensed physician, certify that I have performed the above tests on
Name of physician

_____ , applicant for appointment to the _____
Name of applicant *Police or fire*

department of _____ .
Name of city / town

I further certify that I had administered or have had administered the above-listed test and examinations to appropriately complete this questionnaire, and that I further certify that I have attached hereto copies of the results of all the tests identified herein.

Signature of licensed physician *(No rubber stamp signatures.)*	Date *(mm/dd/yyyy)*

NOTE TO PHYSICIAN COMPLETING THE MEDICAL EXAMINATION: Do not leave any questions in your examination blank. Answer all of the questions and include all of the original testing results with this examination form. Thank you.

PHYSICIAN IDENTIFYING INFORMATION *(Print or type.)*

Name of physician

Address *(number and street, city, state, and ZIP code)*

Telephone number *(with area code)*	Number issued by Medical Licensing Board

1977 POLICE OFFICERS' AND FIREFIGHTERS' FUND APPLICATION FOR MEMBERSHIP

State Form 4928 (R20 / 1-25)

STATEWIDE BASELINE STANDARDS

Name of applicant

This section is to be completed by the examining physician. ALL QUESTIONS MUST BE ANSWERED. IF AN ITEM IS NOT APPLICABLE, CHOOSE "NO".

Based on the foregoing tests and examinations, I have determined that either does or does not have the following conditions as indicated: _____ *Name of applicant*

(Check each item.)	**Yes**	**No**
1. Vision testing as follows:		
a. Far vision acuity		
1) Corrected binocular vision worse than 20/30;	☐	☐
2) Corrected vision of the worse eye worse than 20/50; or	☐	☐
3) Uncorrected binocular vision worse than 20/100, with the exception that long-term successful users of soft contact lenses do not have to meet this uncorrected standard.	☐	☐
b. Color vision - an inability to identify red, green, and yellow colors.	☐	☐
c. Peripheral vision - uncorrected field-of-vision less than one hundred forty degrees (140°) in the horizontal meridian in each eye.	☐	☐
2. Hearing deficits - A hearing deficit in the pure tonal thresholds (five hundred (500) Hertz, one thousand (1,000) Hertz, two thousand (2,000) Hertz, and three thousand (3,000) Hertz) in the unaided worst ear:		
a. of more than twenty-five (25) decibels in three (3) of the four (4) frequencies;	☐	☐
b. of more than thirty (30) decibels in any one of the first three (3) frequencies; or	☐	☐
c. an average loss within the four (4) frequencies of more than thirty (30) decibels.	☐	☐
3. Communicable diseases: Any communicable disease or condition that poses a significant risk of substantial harm to the health and safety of the applicant, co-workers, or members of the public with whom the applicant will come in contact during the course of employment.	☐	☐
4. Suddenly incapacitating diseases or condition: Any disease or condition (physical or mental) that could incapacitate the applicant without sufficient warning to allow the applicant to take preventive measures, thereby imposing a significant risk of substantial harm to the health or safety of the applicant, co-workers, or members of the public with whom the applicant will come in contact during the course of employment (unless such disease or condition can be controlled by medication and the applicant affirms the applicant takes the appropriate medication).	☐	☐
5. Alcoholism or illegal use of drugs as follows:		
a. Any history of alcoholism, unless the applicant has successfully rehabilitated for a period of at least one (1) year, successfully passes an examination for alcohol usage, and the applicant affirms the applicant is no longer engaging in the use of alcohol and has successfully rehabilitated for a period of at least one (1) year preceding the applicant's application for employment.	☐	☐
b. Any history of illegal drug use or evidence of drug abuse, unless the applicant has successfully rehabilitated for a period of at least one (1) year, successfully passes an examination for the use of drugs or drug abuse, and the applicant affirms the applicant is no longer engaging in drug abuse and has successfully rehabilitated for a period of at least one (1) year preceding the applicant's application for employment.	☐	☐

The determination of whether an applicant's condition poses a significant risk of substantial harm will be based on an objective individualized assessment of this applicant's present ability to safely perform the essential functions of the job considering reasonable accommodations to the extent required under the Americans with Disabilities Act. Factors to be considered include the following:

1. The duration of the risk,
2. The nature and severity of the potential harm,
3. The likelihood that the potential harm will occur,
4. The imminence of the potential harm.

Relevant evidence may include input from the applicant, the experience of the applicant in previous similar positions, opinions of medical doctors, rehabilitation counselors, or physical therapists who have expertise in the disability involved, or direct knowledge of the applicant.

Signature of licensed physician *(No rubber stamp signatures.)*	Date *(mm/dd/yyyy)*

PHYSICIAN'S EXPLANATION OF STATEWIDE BASELINE STANDARDS AND APPLICANT'S AFFIRMATIONS

Name of applicant

Complete this section only if answered "yes" on the previous page. ALL QUESTIONS MUST BE ANSWERED. DO NOT ANSWER ANY QUESTION WITH "N/A", instead use "No" or "None".

Vision testing
Physician's explanation: *(Explain the vision condition identified and describe its risk to the health and safety of the applicant, co-workers, or members of the public with whom the applicant will come in contact during the course of employment.)*

Hearing deficits
Physician's explanation: *(Explain the hearing deficit identified and describe its risk to the health and safety of the applicant, co-workers, or members of the public with whom the applicant will come in contact during the course of employment.)*

Communicable diseases
Physician's explanation: *(Identify the communicable disease or condition and describe its risk to the health and safety of the applicant, co-workers, or members of the public with whom the applicant will come in contact during the course of employment.)*

Suddenly incapacitating diseases or conditions
Physician's explanation: *(Identify the suddenly incapacitating disease or condition and describe the risk to the health or safety of the applicant, co-workers, or members of the public with whom the applicant will come in contact during the course of employment; indicate if disease or condition can be successfully controlled by medication and identify the medication.)*

APPLICANT'S AFFIRMATION

I, _____, affirm that I take the appropriate medication, as identified above, to control the above described suddenly incapacitating disease or condition.

Signature of applicant	Date *(mm/dd/yyyy)*

Alcoholism
Physician's explanation: *(Determine and describe whether the applicant has successfully rehabilitated for a period of at least one (1) year and successfully passes an examination for alcohol usage [attach examination results].)*

APPLICANT'S AFFIRMATION

I, _____, affirm that I am no longer engaging in the use of alcohol and have been successfully rehabilitated for a period of at least one (1) year preceding the date of my application for employment.

Signature of applicant	Date *(mm/dd/yyyy)*

Illegal use of drugs
Physician's explanation: *(Determine and describe whether the applicant has successfully rehabilitated for a period of at least one (1) year and successfully passes an examination for the use of drugs or drug abuse [attach examination results].)*

APPLICANT'S AFFIRMATION

I, _____, affirm that I am no longer engaging in drug abuse and have been successfully rehabilitated for a period of at least one (1) year preceding the date of my application for employment.

Signature of applicant	Date *(mm/dd/yyyy)*

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EXCLUDABLE CONDITIONS

This section is to be completed by the examining physician. ALL QUESTIONS MUST BE ANSWERED. IF AN ITEM IS NOT APPLICABLE, CHOOSE "NO".

Based on the foregoing tests and examinations, I have determined that either does or does not have the following conditions as indicated.

_____
Name of applicant

(Check each item and explain all affirmative responses to each item on Addendum A.)

CARDIOVASCULAR SYSTEM	Yes	No
1. A history of myocardial infarction.	☐	☐
2. Angina pectoris or other evidence of coronary artery disease.	☐	☐
3. Congenital heart disease.	☐	☐
4. Hypertrophy or dilation of the heart as evidenced by examination.	☐	☐
5. Pericarditis, endocarditis, or myocarditis unless the examining physician determines that the condition is now stable and unlikely to recur.	☐	☐
6. Arrhythmias.	☐	☐
7. High blood pressure, evidenced by any of the following: a. Any blood pressure reading above one hundred fifty (150) millimeters mercury (for systolic). b. Any blood pressure reading above ninety (90) millimeters mercury (for diastolic). c. Use of antihypertensive medication. However, if systolic and diastolic readings without medication are produced at levels lower than one hundred fifty (150) millimeters mercury (for systolic) and ninety (90) millimeters mercury (for diastolic) on three (3) consecutive days, high blood pressure shall not be an excludable condition.	☐	☐
8. Aneurysm and arteriovenous malformation.	☐	☐
9. Peripheral atherosclerosis or arteriosclerosis, including any of the following peripheral vascular diseases: a. Intermittent claudication b. Buerger's disease c. A phenomenon of repeated thrombophlebitis	☐	☐
10. Heart bypass surgery within the preceding ten (10) years.	☐	☐
11. Primary pulmonary hypertension.	☐	☐
12. Pacemaker implant.	☐	☐
PULMONARY SYSTEM		
13. Bronchiectasis.	☐	☐
14. Bronchial asthma.	☐	☐
15. Emphysema or chronic obstructive pulmonary disease.	☐	☐
16. Pulmonary fibrosis.	☐	☐
17. Pleurisy with effusion or empyema.	☐	☐
18. Any spontaneous pneumothorax unless the examining physician determines that the condition is not likely to persist or recur.	☐	☐
19. Any evidence or history of tuberculosis, sarcoidosis, or congenital cystic disease of the lung, active histoplasmosis, or any other lung pathology unless the examining physician determines that the condition is now stable and unlikely to recur.	☐	☐
20. Tumor or cyst of the lung, pleura, or mediastinal.	☐	☐
RENAL SYSTEM		
21. Evidence of existing renal calculus or ureterovesical calculus, if symptomatic.	☐	☐
22. A history of kidney stones. If there is a history of kidney stones, urological consultation must be sought in order to provide an estimate of the likelihood of the recurrence of long-term incapacitating symptoms. An applicant exhibiting a high likelihood of recurrence must be considered to have an excludable condition.	☐	☐
23. A person who has had a nephrectomy but with a reduced functional remaining kidney will not be considered to have an excludable condition, provided there is no evidence of renal function in the remaining kidney.	☐	☐

RENAL SYSTEM *(continued)*	Yes	No
24. Any chronic nephritis or nephrosis, hydronephrosis, pyelonephrosis, pyelitis, pyelonephritis, or polycystic disease of the kidneys.	☐	☐
25. Urinary tract disease, whether or not the urinary tract has any significant abnormalities at this time, or whether any organic disease is present, or other related disorders adversely affecting the kidneys, excluding urinary tract infections.	☐	☐
26. Any proteinuria which is a result of renal disease.	☐	☐
27. Any malformation of the urinary tract organs, congenital or acquired.	☐	☐
28. Polycystic kidney.	☐	☐
NEUROLOGICAL SYSTEM		
29. Any history of subarachnoid hemorrhage, cerebral aneurysm, or any cerebral vascular disease including any previous stroke within the preceding ten (10) years.	☐	☐
30. Hydrocephalus.	☐	☐
31. Abnormalities from recent head injury, such as severe cerebral concussion or contusion.	☐	☐
32. Neurofibromatosis.	☐	☐
33. Neuropathy or neuralgia, including sciatica.	☐	☐
34. Any seizure disorder within the preceding ten (10) years.	☐	☐
35. Parkinsonism.	☐	☐
36. Huntington's disease (chorea).	☐	☐
37. Multiple sclerosis.	☐	☐
38. Amyotrophic lateral sclerosis (Lou Gehrig's disease).	☐	☐
GASTROINTESTINAL SYSTEM		
39. Pancreatitis.	☐	☐
40. A history of a chronic bowel disorder such as Crohn's disease and ulcerative colitis. An applicant with a history of a bowel obstruction within the preceding ten (10) years shall be considered to have an excludable condition unless the applicant is able to obtain a letter from the treating physician to the examining physician explaining the nature of the obstruction and what was done to cure it.	☐	☐
41. Any hepatitis, chronic or acute, with impairment of liver function.	☐	☐
42. Cirrhosis or varices.	☐	☐
43. Inguinal or femoral hernia, hiatal hernia, if symptomatic, or ventral hernia, if symptomatic.	☐	☐
44. Interabdominal tumor or mass.	☐	☐
45. Any previous gastric resection unless there is sound x-ray evidence provided that there is little chance of recurrence of the condition which caused the first surgery.	☐	☐
46. Active gastric or duodenal ulcer unless the applicant is able to provide x-ray evidence that the ulcer is currently healed. A history of a gastric or duodenal ulcer shall be treated the same as any such active ulcer unless the applicant is able to provide x-ray evidence that the ulcer is currently healed.	☐	☐
47. Any evidence of rectal or prostatic malignancy.	☐	☐
48. Anorexia nervosa or bulimia within three (3) years.	☐	☐
EYE / EAR / NOSE / THROAT (EENT) SYSTEM		
49. Any acute or chronic pathological condition in either eye or the adnexa of the eye.	☐	☐

EXCLUDABLE CONDITIONS *(continued)*

Name of applicant

This section is to be completed by the examining physician or psychiatrist/psychologist*. ALL QUESTIONS MUST BE ANSWERED. IF AN ITEM IS NOT APPLICABLE, CHOOSE "NO".

EYE / EAR / NOSE / THROAT (EENT) SYSTEM *(continued)*	Yes	No
50. Nystagmus of the eye, uncorrected strabismus, glaucoma, and aphakia, whether it is unilateral or bilateral, and active chorioretinitis should be considered for further examination by a qualified eye specialist to determine the likelihood and degree of future impairment.	☐	☐
51. Cataract, retinitis pigmentosa, and any papilledema or tumor.	☐	☐
52. Any retinal exudate, hemorrhage or edema, or detachment of the retina.	☐	☐
53. Inflammatory disease of the retina, the globe, or the other structures within the globe.	☐	☐
54. Heterophoria, hyperphoria, esophoria, or exophoria should be considered for further examination by a qualified eye specialist to determine the likelihood and degree of future impairment.	☐	☐
HEMATOLOGY / ONCOLOGY		
55. Any disease of the blood forming organs or of the blood.	☐	☐
56. Anemia with the hemoglobin lower than twelve (12) grams per hundred cubic centimeters.	☐	☐
57. Polycythemia, leukemia, or any other progressive diseases of the blood system.	☐	☐
58. Hemophilia or other bleeding disorders.	☐	☐
59. Malignant melanoma or, if it had been removed, any evidence of metastatic disease.	☐	☐
60. Hodgkin's disease, lymphadenopathy, lymphomas, or lymphosarcomas.	☐	☐
61. Any malignant tumor of any type unless completely eradicated for at least ten (10) years.	☐	☐
MUSCULOSKELETAL SYSTEM		
62. Any active disease of bones and joints, including active arthritis, osteomyelitis, or marked deformity of the spinal column, including, but not limited to, the following: a. History of laminectomy b. Amputation or deformity of a joint or limb c. Joint reconstruction d. Ligamentous instability e. Joint replacement	☐	☐
63. Herniation of an intervertebral disk.	☐	☐
64. Ankylosing rheumatoid spondylitis.	☐	☐
65. Muscular dystrophy.	☐	☐
METABOLIC / ENDOCRINE SYSTEM		
66. Diabetes requiring insulin or oral hypoglycemics. An individual with diabetes whose condition is effectively controlled by diet alone would not be considered to have an excludable condition. An applicant with a history of hyperglycemia glucosuria or albuminuria must be considered to have an excludable condition unless a report from the physician that treated the applicant can be obtained which assures the absence of diabetes mellitus.	☐	☐

METABOLIC / ENDOCRINE SYSTEM *(continued)*	Yes	No
67. Addison's disease, splenomegaly, or adenopathy secondary to systemic disease or metastasis.	☐	☐
68. Disease of the adrenal gland, pituitary gland, parathyroid gland, or thyroid gland of clinical significance.	☐	☐
69. Nutritional deficiency disease or metabolic disorder.	☐	☐
MISCELLANEOUS		
70. Any current fistula, either congenital or acquired, including tracheostomy.	☐	☐
71. If peripheral edema is present, the cause shall be and the disqualifying disorder identified.	☐	☐
72. Recurrent syncope.	☐	☐
73. Alcohol or drug abuse within five (5) years.	☐	☐
74. Auto immune disorders, including, but not limited to, the following: a. Rheumatoid arthritis and myasthenia gravis. b. Dermatomyositis. c. Scleroderma.	☐	☐
75. Lupus erythematosus.	☐	☐
76. Obesity of such a degree so as to interfere with normal activities including respiration	☐	☐
77. Acquired immune deficiency syndrome (AIDS) or human immunodeficiency virus (HIV) positive, as determined by a blood test.	☐	☐
78. Sexually transmitted diseases should be considered for further examination by a qualified medical specialist to determine the likelihood and degree of future impairment.	☐	☐
79. Narcolepsy or hypersomnolence due to any cause.	☐	☐
80. Organ transplant.	☐	☐
81. Sleep apnea syndrome.	☐	☐
82. Anxiety disorder.*	☐	☐
83. Panic disorder.*	☐	☐
84. Obsessive compulsive disorder.*	☐	☐
85. Post-traumatic stress disorder.*	☐	☐
86. Attention deficit/hyperactivity disorder.*	☐	☐
87. Tourette syndrome.*	☐	☐
88. Depressive disorder.*	☐	☐
89. Bipolar disorder.*	☐	☐
90. Personality disorder.*	☐	☐
91. Substance abuse disorder.*	☐	☐
92. Schizophrenia and other psychotic disorders.*	☐	☐
93. Anorexia nervosa.*	☐	☐
94. Miscellaneous or other significant psychiatric disorder.*	☐	☐
95. Any disqualifying condition under 35 IAC 2-9-6 that has been accommodated by the local appointing authority.	☐	☐
96. Any other significant disease/disorder.	☐	☐

*** Items 82 – 94 on this page must be completed by a licensed psychiatrist/psychologist.**
Provide explanation(s) on next page if there are any excludable conditions noted.

Signature of licensed physician *(No rubber stamp signatures.)*	Date *(mm/dd/yyyy)*
*Signature of licensed psychiatrist/psychologist *(No rubber stamp signatures.)*	Date *(mm/dd/yyyy)*

PHYSICIAN AND PSYCHOLOGIST IDENTIFYING INFORMATION *(Print or type.)*

Name of licensed physician		*Name of licensed psychiatrist/psychologist	
Address *(number and street, city, state, and ZIP code)*		*Address *(number and street, city, state, and ZIP code)*	
Telephone number *(with area code)*	Number issued by Medical Licensing Board	*Telephone number *(with area code)*	*Number issued by Medical Licensing Board

EXCLUDABLE CONDITIONS – ADDENDUM A

Name of applicant

This section is to be completed by the examining physician or doctor. ALL QUESTIONS MUST BE ANSWERED. DO NOT ANSWER ANY QUESTION WITH "N/A", instead use "No" or "None".

Record explanations below for all affirmative responses to items listed as an excludable condition. Print or type. Attach additional sheets, if necessary, including the applicant's name on each page.

ITEM NUMBER	EXPLANATION

EXCLUDABLE CONDITIONS – SPECIALIST'S INFORMATION

Name of applicant

This section is to be completed by the examining physician. ALL QUESTIONS MUST BE ANSWERED. DO NOT ANSWER ANY QUESTION WITH "N/A", instead use "No" or "None".

If any items are answered affirmatively, has the appropriate specialist's report been obtained and included in the applicant's application package?
(Complete the following for each of the items answered affirmatively.)

Specialist's report included? Yes	Specialist's report included? No	Item number of excludable condition	Name and Address *(number and street, city, state, and ZIP code)* of Specialist
☐	☐		
☐	☐		
☐	☐		
☐	☐		
☐	☐		
☐	☐		
☐	☐		
☐	☐		
☐	☐		

CERTIFICATION - BASELINE STATEWIDE MENTAL EXAMINATION

Indiana law mandates administering a mental examination to all applicants to determine if the applicant is mentally suitable to be a member of the department. The mental examination prescribed is the Minnesota Multiphasic Personality Inventory (MMPI-III). (This section is required to be completed before INPRS can process the applicant's application; copies of the results of the mental examination are not required to be sent to INPRS.)

I, _____ , a licensed (psychiatrist / PhD psychologist),
Name of psychiatrist / psychologist

have interpreted the results of the statewide mental examination (the MMPI-III) and have determined that the named applicant,

_____ , has passed the standards established by the local board.
Name of applicant

Signature of licensed psychiatrist / psychologist *(No rubber stamp signatures.)*	Date *(mm/dd/yyyy)*

The examining psychiatrist / psychologist must not have a pre-existing relationship with the applicant.

PSYCHIATRIST / PSYCHOLOGIST IDENTIFYING INFORMATION *(Print or type.)*

Name of psychiatrist / psychologist	
Address *(number and street, city, state, and ZIP code)*	
Telephone number *(with area code)*	Number issued by Medical Licensing Board

1977 POLICE OFFICERS' AND FIREFIGHTERS' FUND APPLICATION FOR MEMBERSHIP

State Form 4928 (R20 / 1-25)

CERTIFICATION BY LOCAL BOARD

The _____ Board ("Board") has determined that

Name of local board

_____ :

Name of applicant

(1) passes the local physical and mental standards, if any, established by the appointing authority for the department; (2) has been determined to be mentally suitable to be a member of the department after being tested using the baseline statewide mental examination (MMPI-III); (3) has successfully met all minimum criteria for the baseline physical examination; (4) has been determined to meet the physical requirements to be a member of the department by virtue of having passed said physical and mental standards; and (5) the examining physician must not have a pre-existing personal relationship with the applicant.

The Board certifies that the statewide mental examination prescribed by the INPRS board was appropriately administered and that the results of the examination were interpreted by a licensed psychiatrist or a licensed PhD psychologist. The Board has attached hereto copies and certification of the results of the physical agility examination required by law, and certification of the results of the baseline statewide mental examination. The Board further certifies that the applicant has satisfied any aptitude, physical agility, or physical and mental standards established by the appointing authority.

Signature of board member *(No rubber stamp signatures.)*	Date *(mm/dd/yyyy)*
Printed name of board member	Telephone number *(with area code)*
Signature of pension secretary *(No rubber stamp signatures.)*	Date *(mm/dd/yyyy)*
Printed name of pension secretary	Telephone number *(with area code)*

CERTIFICATION BY APPOINTING AUTHORITY

This section is required only if there is an accommodation listed.

The appointing authority for the _____ certifies that it has adopted standards
Name of city / town department

or physical agility tests and has administered the tests to _____ , who successfully
Name of applicant

passed the standards. These results have been certified to the local board.

The appointing authority further certifies that:

- it caused to be administered the baseline statewide physical examinations required by law,
- the examination was administered by a licensed physician,
- the applicant successfully met all standards and passed said examination
- no medical examination was performed upon the applicant prior to a conditional offer of employment.
- at the time of the conditional offer of employment, the applicant completed the attached "Statement of Understanding"
- concerning the statewide baseline standards, reasonable accommodations have been made to enable the applicant to successfully perform the essential functions of the job and/or eliminate or effectively reduce the direct threat that would be caused by the presence of the following disease(s) or condition(s):

(list applicable disease(s) or condition(s) referenced in statement above):

- In addition to the statewide required standards, the appointing authority has established the following additional standards as a condition of employment:

(list any additional local standards and/or reasonable accommodations referenced above here):

This section must be completed for ALL SUBMISSIONS.

The appointing authority further certifies that _____ has passed the locally
Name of applicant

prescribed standards and the test results for these standards have been certified by the local board.

The appointing authority for the _____ certifies that
Name of city / town department

_____ is a veteran who has completed at least twenty (20) years of military
Name of applicant

service and received or is eligible to receive an honorable discharge from the below indicated branch(es) of the military.
Check the appropriate branch(es):

☐ United States Army ☐ United States Coast Guard ☐ United States Navy
☐ United States Air Force ☐ United States Marine Corps ☐ Indiana National Guard

APPOINTING AUTHORITY SIGNATURE

Signature of appointing authority *(No rubber stamp signatures.)*	Date *(mm/dd/yyyy)*
Printed name of appointing authority	Telephone number *(with area code)*

1977 POLICE OFFICERS' AND FIREFIGHTERS' FUND APPLICATION FOR MEMBERSHIP

State Form 4928 (R20 / 1-25)

BENEFICIARY INFORMATION

* This agency is requesting disclosure of your Social Security Number in accordance with Internal Revenue Code 3405; disclosure is mandatory and this application cannot be processed without it.

Name of applicant	Social Security Number *	Marital status *(Check one.)*
	- -	☐ Married ☐ Single

Beneficiary Designation:
The designation of a beneficiary may not occur unless the fund member does not have a spouse, surviving children, or dependent parent(s) according to IC 36-8-8-24. A fund member may designate one or more beneficiaries to receive a lump sum of any owed member contributions plus interest if the fund member dies without receiving a retirement benefit, a disability benefit, and without the board returning the fund member contributions. To designate a beneficiary, fill out the *Beneficiary Designation (State Form 54276)*, available on the Police Officers' and Firefighters' Fund (1977 Fund) Member Forms page on the INPRS website at www.inprs.in.gov.

Name of beneficiary	Social Security Number *	Date of birth *(mm/dd/yyyy)*
	- -	

Signature of applicant	Printed name of applicant	Date *(mm/dd/yyyy)*