



# BASIC TRAINING DIVISION STATEMENT OF FITNESS

Washington State Criminal  
Justice Training Commission  
19010 1st Ave. S., Burien, WA 98148  
Phone: (206) 835-7299  
Attach completed form to ACADIS  
Registration Request

WAC 139-05-210, WAC 139-05-230, & WAC 139-10-212 set the physical requirements to attend the WSCJTC Basic Training Academies.

### Recruit/Student Information

Name (LAST, First, Middle):	Agency (Do not abbreviate):	Academy:
-----------------------------	-----------------------------	----------

### PHYSICAL ABILITY TEST (PAT)

This section describes the physical training component of the Basic Training Division. Each recruit is expected to demonstrate and maintain an acceptable level of physical fitness throughout their Academy assignment. For this purpose, each applicant will be expected to participate in a Physical Ability Test (PAT) involving sit-ups, push-ups, and squat thrusts, and meet the applicable standards of each test. To ensure suitability for these types of activities, we suggest that all applicants be examined and approved for participation by a licensed Physician (M.D, D.O.) within six (6) months of the scheduled testing date. To view the Basic Training Division's Physical Ability Guidelines, please visit our website and choose the applicable academy type.

### PROPER USE OF PHYSICAL FORCE (Arrest, Control, and Defensive tactics)

Academy Arrest/Control/Defensive Tactics training curriculum requires each student to be actively involved in the training described below. Consequently, every student will act as both the officer and violator in applying and receiving techniques used to restrain resistive and aggressive individuals. Students will be required to have techniques applied to them during training. Various activities will include but not be limited to:

- Arrest, Control & Defensive Tactics training for up to six continuous hours with only minor breaks
- Full Range of Motion movement of the spine, knees, shoulders, elbows, wrists, and fingers to the point of pain
- Grabbing, wrestling, restraining, and maneuvering resistive partners to the ground or a wall
- Being taken to the gymnasium floor by the arm and handcuffed behind the back
- Striking a heavy bag with elbows, knees, open hand kicks, and punches
- Bending, reaching, crouching, climbing and/or crawling under and over a variety of obstacles while conducting room/vehicle searches and/or firing a handgun

These techniques will be applied and experienced repeatedly over several hours a day, on numerous days during the training. These actions will place repeated stress on the joints of the spine, knees, shoulders, elbows, wrists, and fingers as well as all associated muscles. Students will sustain moderate to high impact on all parts of the body, specifically the thorax, abdomen, and upper/lower back. Training is designed to ensure the safety of the student who is free from health issues and/or physical limitations.

### Agency Administrator Statement

I have reviewed the above physical requirements of the Basic Academy and based upon my knowledge, the applicant listed above can fully and actively participate in such program safely without undue hazard to his/her health.

Name of Agency Administrator or Designee: \_\_\_\_\_ Title: \_\_\_\_\_

Signature of Agency Administrator or Designee: \_\_\_\_\_ Date Signed: \_\_\_\_\_

### Applicant Statement

I have reviewed the above physical requirements of the Basic Academy and believe that I have no existing physical limitations that would preclude me from fully and actively participating in such program safely without undue hazard to my health.

Signature of Applicant: \_\_\_\_\_ Date Signed: \_\_\_\_\_

### Physician Statement (Equivalency Academy Applicants ONLY)

I have reviewed the above physical requirements of the Basic Academy, and it is my professional opinion that the applicant listed above can fully and actively participate in such program safely without undue hazard to his/her health.

Date of Examination: \_\_\_\_\_

Printed Name of Examining Physician: \_\_\_\_\_ Title: \_\_\_\_\_

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

Signature of Examining Physician: \_\_\_\_\_ Date Signed: \_\_\_\_\_