KALAMAZOO VALLEY COMMUNITY COLLEGE
FIRE ACADEMY

Physician's Release Form

Student Name _____

Date of Exam _____

I, a licensed physician, have determined by examination that the above-named applicant, a candidate to the KVCC Fire Academy, is free from any apparent physical, emotional, or mental condition which might adversely affect said applicant's performance as a firefighter and that he/she:

1. Possesses normal hearing, normal color vision, and normal visual functions and acuity in each eye correctable to 20/20. Contact lenses are acceptable. Any vision or hearing exception must be noted by the licensed physician and approved through the Fire Science Coordinator.
2. Is free from any other impediment of the senses, is physically sound, is in possession of all extremities and is well developed physically, with height and weight in relation to each other as indicated by accepted medical standards.
3. Is free from physical defects, chronic diseases, organic diseases, organic or functional conditions, which may tend to impair efficient performance of duty as a firefighter, or which may endanger the lives of the applicant or others.
4. Is in mental and physical condition to sustain and accomplish types of severe physical exertion including but not limited to:
   a. Physical training consisting of running, sit-ups, pushups, etc.
   b. Carrying heavy weights including fire hose, ventilation fans, 150 lb. manikins, ladders
   c. Climbing various ladders up to and including 100'
   d. Confined space entry
   e. Basic rope rescue including rappelling from 5th floor
   f. Entry into and working in encapsulating suits
   g. Extensive use of self-contained breathing apparatus (SCBA)
   h. Operating various charged fire hose lines delivering 100 - 200 gpm
   i. Live burn training, both interior and exterior
   j. Basic water rescue techniques
   k. Similar forms of physical exertion

This document will become a part of said applicant's background investigation and is available to any examining physicians or a fire agency.

_____
Physician Signature

_____
Physician Name (Printed)

_____
Street Address

_____
City/State/Zip Code

_____
Telephone