



EMPLOYMENT APPLICATION

Receipt No.

For Office Use Only

MAIL COMPLETED APPLICATION TO:

**LETHBRIDGE REGIONAL POLICE SERVICE
HUMAN RESOURCES UNIT
135 – 1 Avenue, South
Lethbridge, Alberta, T1J 0A1**

For more information about opportunities with the Lethbridge Regional Police Service
<http://www.lethbridgepolice.ca/>

1. An essential component in the selection process of the Lethbridge Regional Police Service is a background investigation. Information gathered will be used to assess the suitability of the Applicant for a police career. There will be a security check on the Applicant and members of their family.
2. All questions must be answered. If a question is not applicable, mark *N/A*. attach a note explaining the reason any question is left blank.
3. All information supplied is subject to verification by investigation. False statements can disqualify or result in dismissal if employed.
4. Complete this form by printing in ink. Neatness and legibility are of the utmost importance.
5. If extra space is required, attach additional pages to this application.
6. Postal codes must be supplied for each address given.
7. No information received from inquiries concerning information in this application will be released to the applicant.

All of the items below must be submitted with your application:

- | | |
|--|--|
| <input type="checkbox"/> Copy of High School Diploma
<input type="checkbox"/> Certified copy of High School Transcript
<input type="checkbox"/> Completed Personal Disclosure Form
<input type="checkbox"/> Driving Record Abstract – last three years
<i>(Out of Province Applicants must supply their Provincial Equivalent)</i>
<input type="checkbox"/> Copy of Birth Certificate and/or Canadian Citizenship or Legal Permanent Resident documentation
<input type="checkbox"/> Copy of A-PREP <i>(Alberta- Physical Readiness Evaluation for Police Officer Applicants)</i> results – certified within the last 6 months
<input type="checkbox"/> Copy of Certificate of Standard First Aid – <i>certified within the last 36 months</i>
<input type="checkbox"/> Copy of Certificate in Cardiopulmonary Resuscitation (CPR) "Level B" – <i>certified within the last 12 months</i>
➤ Applicants without Standard First Aid or CPR should check with the individual police agency he/she is applying to for additional information on how to meet this requirement... | <input type="checkbox"/> Pardon <i>(if applicable)</i>
<input type="checkbox"/> Copy of Vision Report
<input type="checkbox"/> Copy of Hearing Report
<input type="checkbox"/> Post-Secondary Documents <i>(if applicable)</i>
<input type="checkbox"/> Attached <input type="checkbox"/> Yet To Be Arranged with Agency |
|--|--|

LAST NAME	GIVEN NAME	MIDDLE NAME
FULL ADDRESS	CITY	PROVINCE
	POSTAL CODE	
EMAIL ADDRESS	TELEPHONE NO. (RES.) []	TELEPHONE NO. (BUS.) []
		TELEPHONE NO. (OTHER) []

Other than the name(s) listed above, please list any name change(s), or name(s) you may have used in the past.

NAME CHANGE FROM:	NAME CHANGE TO:	DATE OF CHANGE YYYY YYYY YYYY
DRIVER'S LICENCE	PROVINCE	CLASS(ES)
	LICENCE NUMBER	DATE OF ISSUE YYYY MM DD

Personal information on this Employment Application is being collected under the authority of the Freedom of Information & Protection of Privacy Act (FOIP) Section 33(c). It will be used to determine your suitability, eligibility or qualifications for employment. Questions about the use or collection of this information should be directed to the FOIP Program Administrator.

The Human Resources Unit is constantly reviewing recruiting initiatives across Canada. To assist us with our future planning, please indicate how you learned about this employment opportunity:

- Career Fair
 Newspaper
 Radio/T.V.
 College Posting
 Police Officer
 Other _____

EDUCATION AND TRAINING													
<i>Proof of education will be required prior to engagement</i>													
HIGH SCHOOL		Circle highest grade completed		NAME OF SCHOOL				LOCATION		<input type="checkbox"/> HIGH SCHOOL DIPLOMA <input type="checkbox"/> EQUIVALENCY DIPLOMA			
10		11		12		13							
COLLEGE, BUSINESS SCHOOL, OR TECHNICAL SCHOOL				NAME OF SCHOOL				LOCATION					
PROGRAM OR COURSE								START DATE		FINISH DATE			
LENGTH OF COURSE		GRADE POINT AVERAGE		CERTIFICATE, DIPLOMA, OR LICENCE AWARDED? (IF NOT – PLEASE PROVIDE DETAILS)						YYYY		MM	
				<input type="checkbox"/> YES <input type="checkbox"/> NO									
COLLEGE, BUSINESS SCHOOL, OR TECHNICAL SCHOOL				NAME OF SCHOOL				LOCATION					
PROGRAM OR COURSE								START DATE		FINISH DATE			
LENGTH OF COURSE		GRADE POINT AVERAGE		CERTIFICATE, DIPLOMA, OR LICENCE AWARDED? (IF NOT – PLEASE PROVIDE DETAILS)						YYYY		MM	
				<input type="checkbox"/> YES <input type="checkbox"/> NO									
UNIVERSITY		NAME OF SCHOOL				LOCATION							
PROGRAM OR COURSE								START DATE		FINISH DATE			
LENGTH OF COURSE		GRADE POINT AVERAGE		CERTIFICATE, DIPLOMA, OR DEGREE AWARDED? (IF NOT – PLEASE PROVIDE DETAILS)						YYYY		MM	
				<input type="checkbox"/> YES <input type="checkbox"/> NO									
UNIVERSITY		NAME OF SCHOOL				LOCATION							
PROGRAM OR COURSE								START DATE		FINISH DATE			
LENGTH OF COURSE		GRADE POINT AVERAGE		CERTIFICATE, DIPLOMA, OR DEGREE AWARDED? (IF NOT – PLEASE PROVIDE DETAILS)						YYYY		MM	
				<input type="checkbox"/> YES <input type="checkbox"/> NO									
UNIVERSITY		NAME OF SCHOOL				LOCATION							
PROGRAM OR COURSE								START DATE		FINISH DATE			
LENGTH OF COURSE		GRADE POINT AVERAGE		CERTIFICATE, DIPLOMA, OR DEGREE AWARDED? (IF NOT – PLEASE PROVIDE DETAILS)						YYYY		MM	
				<input type="checkbox"/> YES <input type="checkbox"/> NO									
I. Q. A. S.		<i>(International Qualifications Assessment Standards – Certificate - if applicable)</i>											
		<i>For International applicants only – Please state the highest level education achieved.</i>											
				NAME OF SCHOOL				LOCATION					
PROGRAM OR COURSE								START DATE		FINISH DATE			
LENGTH OF COURSE		GRADE POINT AVERAGE		CERTIFICATE, DIPLOMA, OR DEGREE AWARDED? (IF NOT – PLEASE PROVIDE DETAILS)						YYYY		MM	
				<input type="checkbox"/> YES <input type="checkbox"/> NO									
LANGUAGES SPOKEN													
LANGUAGES WRITTEN													

ADDITIONAL EDUCATION INCLUDING COURSES, WORKSHOPS, AND SEMINARS. (ATTACH AN ADDITIONAL PAPER IF NECESSARY)

ADDITIONAL COMPUTER SKILLS, TRAINING, COURSES, ETC ... (ATTACH AN ADDITIONAL PAPER IF NECESSARY)

HAVE YOU EVER WRITTEN THE ACT (*ALBERTA COMMUNICATION TEST*), THE CAAT (*CANADIAN ADULT ACHIEVEMENT TEST*), OR THE WCT (*WRITTEN COMMUNICATION TEST*)? YES (*if YES – Where & When*) NO

HAVE YOU EVER WRITTEN THE APCAT (*ALBERTA POLICE APPLICANT COGNITIVE ABILITY TEST*)? YES (*if YES – Where & When*) NO

HAVE YOU EVER APPLIED FOR A POSITION WITH THIS OR ANY OTHER POLICE AGENCY? YES (*if YES – Where & When*) NO

LIST ALL APPLICATIONS TO THIS OR ANY OTHER POLICE AGENCIES

POLICE AGENCY	APPLICATION DATE			STATUS (describe reason for non-selection)
	YYYY	MM	DD	

HAVE YOU EVER TAKEN A POLYGRAPH OR COMPUTER VOICE STRESS ANALYSIS EXAMINATION? YES NO

AGENCY WHERE POLYGRAPH OR COMPUTER VOICE STRESS ANALYSIS EXAMINATION WAS COMPLETED	YYYY	MM	DD
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REASON FOR POLYGRAPH OR COMPUTER VOICE STRESS ANALYSIS EXAMINATION

HAVE YOU EVER BEEN FINGERPRINTED? YES NO

REASON FOR FINGERPRINTING

EMPLOYMENT HISTORY

*Begin with your most recent employer and continue in reverse time order.
Provide history for the last ten (10) years if applicable.
Provide an explanation for all gaps in employment.*

**MOST
RECENT**

EMPLOYER'S NAME

TELEPHONE NUMBER

[]

EMPLOYER'S ADDRESS

POSTAL CODE

NAME OF IMMEDIATE SUPERVISOR

TELEPHONE NUMBER

[]

START DATE

FINISH DATE

POSITION HELD

YYYY

MM

YYYY

MM

DUTIES/RESPONSIBILITIES

REASON FOR LEAVING

2nd

EMPLOYER'S NAME

TELEPHONE NUMBER

[]

EMPLOYER'S ADDRESS

POSTAL CODE

NAME OF IMMEDIATE SUPERVISOR

TELEPHONE NUMBER

[]

START DATE

FINISH DATE

POSITION HELD

YYYY

MM

YYYY

MM

DUTIES/RESPONSIBILITIES

REASON FOR LEAVING

3rd

EMPLOYER'S NAME

TELEPHONE NUMBER

[]

EMPLOYER'S ADDRESS

POSTAL CODE

NAME OF IMMEDIATE SUPERVISOR

TELEPHONE NUMBER

[]

START DATE

FINISH DATE

POSITION HELD

YYYY

MM

YYYY

MM

DUTIES/RESPONSIBILITIES

REASON FOR LEAVING

REFERENCES

Please list five (5) adults, not related to you and not previous employers, whom we may contact as references to provide competent judgment of your personal character, temperament, and work habits.

NAME		GIVEN NAMES		RELATIONSHIP	
FULL ADDRESS					POSTAL CODE
TELEPHONE NO. (RES.) []	TELEPHONE NO. (BUS.) []	OCCUPATION			YEARS KNOWN

NAME		GIVEN NAMES		RELATIONSHIP	
FULL ADDRESS					POSTAL CODE
TELEPHONE NO. (RES.) []	TELEPHONE NO. (BUS.) []	OCCUPATION			YEARS KNOWN

NAME		GIVEN NAMES		RELATIONSHIP	
FULL ADDRESS					POSTAL CODE
TELEPHONE NO. (RES.) []	TELEPHONE NO. (BUS.) []	OCCUPATION			YEARS KNOWN

NAME		GIVEN NAMES		RELATIONSHIP	
FULL ADDRESS					POSTAL CODE
TELEPHONE NO. (RES.) []	TELEPHONE NO. (BUS.) []	OCCUPATION			YEARS KNOWN

NAME		GIVEN NAMES		RELATIONSHIP	
FULL ADDRESS					POSTAL CODE
TELEPHONE NO. (RES.) []	TELEPHONE NO. (BUS.) []	OCCUPATION			YEARS KNOWN

CREDIT HISTORY*Please complete the following information.*

NAME											
MAIDEN NAME / OTHER NAMES USED											
DATE OF BIRTH YYYY MM DD			EMPLOYER'S NAME								
CURRENT ADDRESS					FROM YYYY MM DD			TO YYYY MM DD			
CITY			PROVINCE		COUNTRY			POSTAL CODE			
PREVIOUS ADDRESS					FROM YYYY MM DD			TO YYYY MM DD			
CITY			PROVINCE		COUNTRY			POSTAL CODE			
PREVIOUS ADDRESS					FROM YYYY MM DD			TO YYYY MM DD			
CITY			PROVINCE		COUNTRY			POSTAL CODE			
PREVIOUS ADDRESS					FROM YYYY MM DD			TO YYYY MM DD			
CITY			PROVINCE		COUNTRY			POSTAL CODE			
PREVIOUS ADDRESS					FROM YYYY MM DD			TO YYYY MM DD			
CITY			PROVINCE		COUNTRY			POSTAL CODE			
DRIVER'S LICENCE	PROVINCE		CLASS(ES)		LICENCE NUMBER			DATE OF ISSUE YYYY MM DD			
CREDIT CARDS	TYPE		ISSUING INSTITUTION			CURRENT BALANCE OWING			EXPIRATION DATE YYYY MM		
2	TYPE		ISSUING INSTITUTION			CURRENT BALANCE OWING			EXPIRATION DATE YYYY MM		
3	TYPE		ISSUING INSTITUTION			CURRENT BALANCE OWING			EXPIRATION DATE YYYY MM		
4	TYPE		ISSUING INSTITUTION			CURRENT BALANCE OWING			EXPIRATION DATE YYYY MM		
OFFICE USE ONLY											
FILE MANAGER											
DATE SENT (Fax)			YYYY	MM	DD	DATE RECEIVED (Fax)			YYYY	MM	DD

SECURITY CLEARANCE DECLARATION

**FILE
MANAGER**
OFFICE USE ONLY

This page contains detailed information regarding you, your family, and associates.

This information is required to determine your eligibility for employment.

THIS INFORMATION WILL BE HELD IN STRICTEST CONFIDENCE.

Please print legibly. Ensure that all sections are completed. Additional sheets should follow suggested format.

LAST NAME		FIRST NAME		MIDDLE NAME		PREFERRED FIRST NAME	
MAIDEN / OTHER NAMES USED							
FULL ADDRESS			CITY		PROVINCE		POSTAL CODE
TELEPHONE NUMBER []							
DATE OF BIRTH		SEX		PLACE OF BIRTH (INCLUDE CITY / COUNTRY BORN)			
YYYY	MM	DD	<input type="checkbox"/> Male	<input type="checkbox"/> Female			
MARITAL STATUS							
<input type="checkbox"/> Single		<input type="checkbox"/> Married		<input type="checkbox"/> Common-law / Domestic Partner		<input type="checkbox"/> Separated	<input type="checkbox"/> Divorced
If you checked married, common-law or domestic partner, please give full name and date of birth of your partner.							
SURNAME / MAIDEN NAME / OTHER NAMES USED		FIRST NAME		MIDDLE NAME		DATE OF BIRTH	
						YYYY	MM
DD							
YOU MUST PROVIDE A PHOTOCOPY OF ONE OF THE FOLLOWING DOCUMENTS THAT PERTAINS TO YOU:							
<input type="checkbox"/> YOUR DRIVER'S LICENCE			<input type="checkbox"/> YOUR PASSPORT			<input type="checkbox"/> YOUR PROOF OF CITIZENSHIP	
HAVE YOU APPLIED FOR EMPLOYMENT/CONTRACT WORK/VOLUNTEER WORK WITH ANY POLICE SERVICE IN THE PAST?							
<input type="checkbox"/> YES				<input type="checkbox"/> NO			
POSITION APPLIED FOR				DIVISION / SECTION			
IN CHRONOLOGICAL ORDER, <i>MOST RECENT FIRST</i> , PLEASE PROVIDE THE ADDRESSES OF EVERY LOCATION WHERE YOU HAVE LIVED IN THE LAST 10 YEARS, AND THE NAMES OF PERSONS WHOM LIVED WITH YOU. PLEASE ESTIMATE THE AGE IF THE EXACT DATE(S) OF BIRTH CANNOT BE OBTAINED. USE NEXT PAGE OR ATTACH ADDITIONAL SHEETS IF REQUIRED.							
ADDRESS		CITY		PROVINCE		POSTAL CODE	
FROM		TO					
YYYY	MM	DD	YYYY	MM	DD		
NAME OF PERSON(S) WHO SHARE ADDRESS WITH YOU			TELEPHONE NUMBER		RELATIONSHIP		SEX
[]			[]				<input type="checkbox"/> Male
							<input type="checkbox"/> Female
NAME OF PERSON(S) WHO SHARE ADDRESS WITH YOU			TELEPHONE NUMBER		RELATIONSHIP		SEX
[]			[]				<input type="checkbox"/> Male
							<input type="checkbox"/> Female
NAME OF PERSON(S) WHO SHARE ADDRESS WITH YOU			TELEPHONE NUMBER		RELATIONSHIP		SEX
[]			[]				<input type="checkbox"/> Male
							<input type="checkbox"/> Female
ADDRESS		CITY		PROVINCE		POSTAL CODE	
FROM		TO					
YYYY	MM	DD	YYYY	MM	DD		
NAME OF PERSON(S) WHO SHARED ADDRESS WITH YOU			TELEPHONE NUMBER		RELATIONSHIP		SEX
[]			[]				<input type="checkbox"/> Male
							<input type="checkbox"/> Female
NAME OF PERSON(S) WHO SHARED ADDRESS WITH YOU			TELEPHONE NUMBER		RELATIONSHIP		SEX
[]			[]				<input type="checkbox"/> Male
							<input type="checkbox"/> Female
NAME OF PERSON(S) WHO SHARED ADDRESS WITH YOU			TELEPHONE NUMBER		RELATIONSHIP		SEX
[]			[]				<input type="checkbox"/> Male
							<input type="checkbox"/> Female

SECURITY CLEARANCE DECLARATION (Continued)

Attach an additional sheet(s) if required – following the suggested format.

ADDRESS	CITY	PROVINCE	POSTAL CODE	FROM YYYY	M M	D D	TO YYYY	M M	D D
NAME OF PERSON(S) WHO SHARED ADDRESS WITH YOU			TELEPHONE NUMBER []	RELATIONSHIP		SEX <input type="checkbox"/> Male <input type="checkbox"/> Female	DATE OF BIRTH YYYY M M D D		
			TELEPHONE NUMBER []	RELATIONSHIP		SEX <input type="checkbox"/> Male <input type="checkbox"/> Female	DATE OF BIRTH YYYY M M D D		
			TELEPHONE NUMBER []	RELATIONSHIP		SEX <input type="checkbox"/> Male <input type="checkbox"/> Female	DATE OF BIRTH YYYY M M D D		
ADDRESS	CITY	PROVINCE	POSTAL CODE	FROM YYYY	M M	D D	TO YYYY	M M	D D
NAME OF PERSON(S) WHO SHARED ADDRESS WITH YOU			TELEPHONE NUMBER []	RELATIONSHIP		SEX <input type="checkbox"/> Male <input type="checkbox"/> Female	DATE OF BIRTH YYYY M M D D		
			TELEPHONE NUMBER []	RELATIONSHIP		SEX <input type="checkbox"/> Male <input type="checkbox"/> Female	DATE OF BIRTH YYYY M M D D		
			TELEPHONE NUMBER []	RELATIONSHIP		SEX <input type="checkbox"/> Male <input type="checkbox"/> Female	DATE OF BIRTH YYYY M M D D		
ADDRESS	CITY	PROVINCE	POSTAL CODE	FROM YYYY	M M	D D	TO YYYY	M M	D D
NAME OF PERSON(S) WHO SHARED ADDRESS WITH YOU			TELEPHONE NUMBER []	RELATIONSHIP		SEX <input type="checkbox"/> Male <input type="checkbox"/> Female	DATE OF BIRTH YYYY M M D D		
			TELEPHONE NUMBER []	RELATIONSHIP		SEX <input type="checkbox"/> Male <input type="checkbox"/> Female	DATE OF BIRTH YYYY M M D D		
			TELEPHONE NUMBER []	RELATIONSHIP		SEX <input type="checkbox"/> Male <input type="checkbox"/> Female	DATE OF BIRTH YYYY M M D D		
ADDRESS	CITY	PROVINCE	POSTAL CODE	FROM YYYY	M M	D D	TO YYYY	M M	D D
NAME OF PERSON(S) WHO SHARED ADDRESS WITH YOU			TELEPHONE NUMBER []	RELATIONSHIP		SEX <input type="checkbox"/> Male <input type="checkbox"/> Female	DATE OF BIRTH YYYY M M D D		
			TELEPHONE NUMBER []	RELATIONSHIP		SEX <input type="checkbox"/> Male <input type="checkbox"/> Female	DATE OF BIRTH YYYY M M D D		
			TELEPHONE NUMBER []	RELATIONSHIP		SEX <input type="checkbox"/> Male <input type="checkbox"/> Female	DATE OF BIRTH YYYY M M D D		

**SECURITY CLEARANCE DECLARATION
(Continued)**

Attach an additional sheet(s) if required – following the suggested format.

ADDRESS				CITY	PROVINCE	POSTAL CODE	FROM YYYY	MM	DD	TO YYYY	MM	DD
NAME OF PERSON(S) WHO SHARED ADDRESS WITH YOU				TELEPHONE NUMBER []			RELATIONSHIP	SEX <input type="checkbox"/> Male <input type="checkbox"/> Female		DATE OF BIRTH YYYY MM DD		
NAME OF PERSON(S) WHO SHARED ADDRESS WITH YOU				TELEPHONE NUMBER []			RELATIONSHIP	SEX <input type="checkbox"/> Male <input type="checkbox"/> Female		DATE OF BIRTH YYYY MM DD		
NAME OF PERSON(S) WHO SHARED ADDRESS WITH YOU				TELEPHONE NUMBER []			RELATIONSHIP	SEX <input type="checkbox"/> Male <input type="checkbox"/> Female		DATE OF BIRTH YYYY MM DD		
ADDRESS				CITY	PROVINCE	POSTAL CODE	FROM YYYY	MM	DD	TO YYYY	MM	DD
NAME OF PERSON(S) WHO SHARED ADDRESS WITH YOU				TELEPHONE NUMBER []			RELATIONSHIP	SEX <input type="checkbox"/> Male <input type="checkbox"/> Female		DATE OF BIRTH YYYY MM DD		
NAME OF PERSON(S) WHO SHARED ADDRESS WITH YOU				TELEPHONE NUMBER []			RELATIONSHIP	SEX <input type="checkbox"/> Male <input type="checkbox"/> Female		DATE OF BIRTH YYYY MM DD		
NAME OF PERSON(S) WHO SHARED ADDRESS WITH YOU				TELEPHONE NUMBER []			RELATIONSHIP	SEX <input type="checkbox"/> Male <input type="checkbox"/> Female		DATE OF BIRTH YYYY MM DD		
ADDRESS				CITY	PROVINCE	POSTAL CODE	FROM YYYY	MM	DD	TO YYYY	MM	DD
NAME OF PERSON(S) WHO SHARED ADDRESS WITH YOU				TELEPHONE NUMBER []			RELATIONSHIP	SEX <input type="checkbox"/> Male <input type="checkbox"/> Female		DATE OF BIRTH YYYY MM DD		
NAME OF PERSON(S) WHO SHARED ADDRESS WITH YOU				TELEPHONE NUMBER []			RELATIONSHIP	SEX <input type="checkbox"/> Male <input type="checkbox"/> Female		DATE OF BIRTH YYYY MM DD		
NAME OF PERSON(S) WHO SHARED ADDRESS WITH YOU				TELEPHONE NUMBER []			RELATIONSHIP	SEX <input type="checkbox"/> Male <input type="checkbox"/> Female		DATE OF BIRTH YYYY MM DD		
ADDRESS				CITY	PROVINCE	POSTAL CODE	FROM YYYY	MM	DD	TO YYYY	MM	DD
NAME OF PERSON(S) WHO SHARED ADDRESS WITH YOU				TELEPHONE NUMBER []			RELATIONSHIP	SEX <input type="checkbox"/> Male <input type="checkbox"/> Female		DATE OF BIRTH YYYY MM DD		
NAME OF PERSON(S) WHO SHARED ADDRESS WITH YOU				TELEPHONE NUMBER []			RELATIONSHIP	SEX <input type="checkbox"/> Male <input type="checkbox"/> Female		DATE OF BIRTH YYYY MM DD		
NAME OF PERSON(S) WHO SHARED ADDRESS WITH YOU				TELEPHONE NUMBER []			RELATIONSHIP	SEX <input type="checkbox"/> Male <input type="checkbox"/> Female		DATE OF BIRTH YYYY MM DD		

FAMILY MEMBERS

**SECURITY CLEARANCE DECLARATION
(Continued)**

Attach an additional sheet(s) if required – following the suggested format.

Applicants must list all names, relationship, sex, date of birth, address and phone number of the applicant's immediate relatives AND of the immediate relatives of the current and/or former spouse, domestic partner, common-law, or significant other. Attach additional sheets if required.

- **Immediate relatives include parents, stepparents, guardians, current and/or former spouse, domestic partner, common-law, or significant other, as well as, children, stepchildren, adopted children, brothers, sisters, step-brothers/sisters, adopted brothers/sisters, who are age 12 or over. This includes individuals who are alive or deceased.**

SURNAME / MAIDEN NAME / OTHER NAMES USED		FIRST NAME	MIDDLE NAME	COMMON NAME USED		DATE OF BIRTH YYYY M M D D	
RELATIONSHIP	ADDRESS	CITY	PROVINCE	POSTAL CODE	TELEPHONE NUMBER []		
SURNAME / MAIDEN NAME / OTHER NAMES USED		FIRST NAME	MIDDLE NAME	COMMON NAME USED		DATE OF BIRTH YYYY M M D D	
RELATIONSHIP	ADDRESS	CITY	PROVINCE	POSTAL CODE	TELEPHONE NUMBER []		
SURNAME / MAIDEN NAME / OTHER NAMES USED		FIRST NAME	MIDDLE NAME	COMMON NAME USED		DATE OF BIRTH YYYY M M D D	
RELATIONSHIP	ADDRESS	CITY	PROVINCE	POSTAL CODE	TELEPHONE NUMBER []		
SURNAME / MAIDEN NAME / OTHER NAMES USED		FIRST NAME	MIDDLE NAME	COMMON NAME USED		DATE OF BIRTH YYYY M M D D	
RELATIONSHIP	ADDRESS	CITY	PROVINCE	POSTAL CODE	TELEPHONE NUMBER []		
SURNAME / MAIDEN NAME / OTHER NAMES USED		FIRST NAME	MIDDLE NAME	COMMON NAME USED		DATE OF BIRTH YYYY M M D D	
RELATIONSHIP	ADDRESS	CITY	PROVINCE	POSTAL CODE	TELEPHONE NUMBER []		
SURNAME / MAIDEN NAME / OTHER NAMES USED		FIRST NAME	MIDDLE NAME	COMMON NAME USED		DATE OF BIRTH YYYY M M D D	
RELATIONSHIP	ADDRESS	CITY	PROVINCE	POSTAL CODE	TELEPHONE NUMBER []		
SURNAME / MAIDEN NAME / OTHER NAMES USED		FIRST NAME	MIDDLE NAME	COMMON NAME USED		DATE OF BIRTH YYYY M M D D	
RELATIONSHIP	ADDRESS	CITY	PROVINCE	POSTAL CODE	TELEPHONE NUMBER []		
SURNAME / MAIDEN NAME / OTHER NAMES USED		FIRST NAME	MIDDLE NAME	COMMON NAME USED		DATE OF BIRTH YYYY M M D D	
RELATIONSHIP	ADDRESS	CITY	PROVINCE	POSTAL CODE	TELEPHONE NUMBER []		
SURNAME / MAIDEN NAME / OTHER NAMES USED		FIRST NAME	MIDDLE NAME	COMMON NAME USED		DATE OF BIRTH YYYY M M D D	
RELATIONSHIP	ADDRESS	CITY	PROVINCE	POSTAL CODE	TELEPHONE NUMBER []		
SURNAME / MAIDEN NAME / OTHER NAMES USED		FIRST NAME	MIDDLE NAME	COMMON NAME USED		DATE OF BIRTH YYYY M M D D	
RELATIONSHIP	ADDRESS	CITY	PROVINCE	POSTAL CODE	TELEPHONE NUMBER []		
SURNAME / MAIDEN NAME / OTHER NAMES USED		FIRST NAME	MIDDLE NAME	COMMON NAME USED		DATE OF BIRTH YYYY M M D D	
RELATIONSHIP	ADDRESS	CITY	PROVINCE	POSTAL CODE	TELEPHONE NUMBER []		

FAMILY MEMBERS

**SECURITY CLEARANCE DECLARATION
(Continued)**

Attach an additional sheet(s) if required – following the suggested format.

SURNAME / MAIDEN NAME / OTHER NAMES USED		FIRST NAME	MIDDLE NAME	COMMON NAME USED		DATE OF BIRTH YYYY MM DD	
RELATIONSHIP	ADDRESS	CITY	PROVINCE	POSTAL CODE	TELEPHONE NUMBER []		
SURNAME / MAIDEN NAME / OTHER NAMES USED		FIRST NAME	MIDDLE NAME	COMMON NAME USED		DATE OF BIRTH YYYY MM DD	
RELATIONSHIP	ADDRESS	CITY	PROVINCE	POSTAL CODE	TELEPHONE NUMBER []		
SURNAME / MAIDEN NAME / OTHER NAMES USED		FIRST NAME	MIDDLE NAME	COMMON NAME USED		DATE OF BIRTH YYYY MM DD	
RELATIONSHIP	ADDRESS	CITY	PROVINCE	POSTAL CODE	TELEPHONE NUMBER []		
SURNAME / MAIDEN NAME / OTHER NAMES USED		FIRST NAME	MIDDLE NAME	COMMON NAME USED		DATE OF BIRTH YYYY MM DD	
RELATIONSHIP	ADDRESS	CITY	PROVINCE	POSTAL CODE	TELEPHONE NUMBER []		
SURNAME / MAIDEN NAME / OTHER NAMES USED		FIRST NAME	MIDDLE NAME	COMMON NAME USED		DATE OF BIRTH YYYY MM DD	
RELATIONSHIP	ADDRESS	CITY	PROVINCE	POSTAL CODE	TELEPHONE NUMBER []		
SURNAME / MAIDEN NAME / OTHER NAMES USED		FIRST NAME	MIDDLE NAME	COMMON NAME USED		DATE OF BIRTH YYYY MM DD	
RELATIONSHIP	ADDRESS	CITY	PROVINCE	POSTAL CODE	TELEPHONE NUMBER []		
SURNAME / MAIDEN NAME / OTHER NAMES USED		FIRST NAME	MIDDLE NAME	COMMON NAME USED		DATE OF BIRTH YYYY MM DD	
RELATIONSHIP	ADDRESS	CITY	PROVINCE	POSTAL CODE	TELEPHONE NUMBER []		
SURNAME / MAIDEN NAME / OTHER NAMES USED		FIRST NAME	MIDDLE NAME	COMMON NAME USED		DATE OF BIRTH YYYY MM DD	
RELATIONSHIP	ADDRESS	CITY	PROVINCE	POSTAL CODE	TELEPHONE NUMBER []		
SURNAME / MAIDEN NAME / OTHER NAMES USED		FIRST NAME	MIDDLE NAME	COMMON NAME USED		DATE OF BIRTH YYYY MM DD	
RELATIONSHIP	ADDRESS	CITY	PROVINCE	POSTAL CODE	TELEPHONE NUMBER []		
SURNAME / MAIDEN NAME / OTHER NAMES USED		FIRST NAME	MIDDLE NAME	COMMON NAME USED		DATE OF BIRTH YYYY MM DD	
RELATIONSHIP	ADDRESS	CITY	PROVINCE	POSTAL CODE	TELEPHONE NUMBER []		
SURNAME / MAIDEN NAME / OTHER NAMES USED		FIRST NAME	MIDDLE NAME	COMMON NAME USED		DATE OF BIRTH YYYY MM DD	
RELATIONSHIP	ADDRESS	CITY	PROVINCE	POSTAL CODE	TELEPHONE NUMBER []		
SURNAME / MAIDEN NAME / OTHER NAMES USED		FIRST NAME	MIDDLE NAME	COMMON NAME USED		DATE OF BIRTH YYYY MM DD	
RELATIONSHIP	ADDRESS	CITY	PROVINCE	POSTAL CODE	TELEPHONE NUMBER []		
SURNAME / MAIDEN NAME / OTHER NAMES USED		FIRST NAME	MIDDLE NAME	COMMON NAME USED		DATE OF BIRTH YYYY MM DD	
RELATIONSHIP	ADDRESS	CITY	PROVINCE	POSTAL CODE	TELEPHONE NUMBER []		

SECURITY CLEARANCE DECLARATION

(Continued)

Attach an additional sheet(s) if required – following the suggested format.

<p>1. Have you ever been convicted of any criminal offence in Canada or in any other country for which a pardon, or the equivalent, of a pardon was or was not granted? (Attach Pardon Document)</p>	<p><input type="checkbox"/> YES <input type="checkbox"/> NO</p>
<p>2. Are you now, or have you ever been investigated, arrested, or charged in Canada or in any other country for an offence of any kind? If yes – explain on separate sheet.</p>	<p><input type="checkbox"/> YES <input type="checkbox"/> NO</p>
<p>3. Have you ever been found guilty of an offence in Canada or in any other country when you were under the age of 18? If yes – explain on separate sheet.</p>	<p><input type="checkbox"/> YES <input type="checkbox"/> NO</p>
<p>4. Are you associated with any companies, or businesses, not listed on your application? <input type="checkbox"/> Owner <input type="checkbox"/> Director <input type="checkbox"/> Controlling Share Holder <input type="checkbox"/> Other _____</p>	<p><input type="checkbox"/> YES <input type="checkbox"/> NO</p>
<p>5. Are you a member of any clubs or organizations? If yes – explain which _____</p>	<p><input type="checkbox"/> YES <input type="checkbox"/> NO</p>
<p>6. If you answered yes to the previous question, do you hold a position in that club or organization? <input type="checkbox"/> President <input type="checkbox"/> Chair <input type="checkbox"/> Director <input type="checkbox"/> Other _____</p>	<p><input type="checkbox"/> YES <input type="checkbox"/> NO</p>
<p>7. In the past 10 years, have you been involved in any lawsuits or civil actions?</p>	<p><input type="checkbox"/> YES <input type="checkbox"/> NO</p>

If you have answered "YES" to any of the above questions, attach an additional sheet providing complete details regarding the specific incident, including what occurred, when, where, and why. If pardoned, attach Pardon documentation.

STATEMENT OF CONSENT

I HEREBY CONSENT THAT any and all information pertaining to a Criminal Record registered in my name with the National Repository for Criminal Records in Canada may be provided to authorized persons at the Lethbridge Regional Police Service. I recognize that an employee of the Lethbridge Regional Police is in a position of trust within the community and I hereby consent to the Lethbridge Regional Police Service performing a VS (Vulnerable Sector) search of my name in the National Repository for Criminal Records. I understand that a VS search is a search that will check for pardoned sex offences. I further consent, if requested, to attend the Identification Section of the Lethbridge Regional Police Service for fingerprint confirmation. I further agree to absolutely release, discharge, and absolve the Lethbridge Regional Police Service, the City of Lethbridge Regional and its employees from all claims, losses, or damages including indirect or consequential, occasioned by me during, or as a result of any investigation for a Criminal Record.

Dated this _____ day of _____, 20_____

SIGNATURE

PRINTED NAME OF WITNESS

WITNESS SIGNATURE



Alberta

VISION REPORT

Examination MUST have been completed within 12 months of application.

NAME OF APPLICANT		SURNAME	GIVEN NAMES	INITIAL
ADDRESS OF APPLICANT				
CITY	PROVINCE	POSTAL CODE	DATE OF BIRTH YYYY	MM DD

VISION STANDARDS FOR POLICE OFFICER APPLICANTS

OPTOMETRIST / OPHTHALMOLOGIST	NAME OF OPTOMETRIST/OPHTHALMOLOGIST	DATE OF EXAMINATION YYYY	MM DD
ADDRESS OF OPTOMETRIST / OPTHALMOLOGIST			
			TELEPHONE NUMBER []
UNCORRECTED VISUAL ACUITY – NORMAL At least 20/40 (6/12) with both eyes open		APPLICANT STANDARD <input type="checkbox"/> YES <input type="checkbox"/> NO	
FARSIGHTEDNESS – NORMAL Not greater than +2.00 D, spherocivalent in the least hyperopic eye		APPLICANT STANDARD <input type="checkbox"/> YES <input type="checkbox"/> NO	
BEST CORRECTED VISUAL ACUITY – NORMAL At least 20/20 (6/6) with both eyes open		APPLICANT STANDARD <input type="checkbox"/> YES <input type="checkbox"/> NO	
COLOUR VISION – NORMAL Pass Ishihara (Book or Titmus) without any colour corrective (e.g. X-Chrom, Chromagen) lenses		APPLICANT STANDARD <input type="checkbox"/> YES <input type="checkbox"/> NO	
<i>NOTE: Farnsworth Vision Test – is recommended for unsuccessful Ishihara Tests</i>		APPLICANT STANDARD	
Pass Farnsworth D-15 without any colour corrective (e.g. X-Chrom, Chromagen) lenses		<input type="checkbox"/> YES <input type="checkbox"/> NO	
DEPTH PERCEPTION – NORMAL Stereo acuity of 80 seconds of arc or better		APPLICANT STANDARD <input type="checkbox"/> YES <input type="checkbox"/> NO	
LATERAL PHORIA FAR – NORMAL No more than 5 eso or 5 exo		APPLICANT STANDARD <input type="checkbox"/> YES <input type="checkbox"/> NO	
If No – please provide additional information, which documents that the person is unlikely to experience double vision when fatigued or functioning in reduced visual environments...			
LATERAL PHORIA NEAR – NORMAL No more than 6 eso or 10 exo		APPLICANT STANDARD <input type="checkbox"/> YES <input type="checkbox"/> NO	
If No – please provide additional information, which documents that the person is unlikely to experience double vision when fatigued or functioning in reduced visual environments...			

PERIPHERAL VISION Peripheral visual field limits with a 5 mm white target at 33cm (or a target with similar angular size with respect to the candidate’s viewing distance) should be no less than the limits given below. In addition, no blind spots should be present within these limits other than the physiological blind spot. Limits for the various meridians are: <ul style="list-style-type: none"> • Temporal (0° meridian) 75° • Superior-temporal (45° meridian) 40° • Superior (90° meridian) 35° • Superior-nasal (135° meridian) 35° • Nasal (180° meridian) 45° • Nasal-inferior (225° meridian) 35° • Inferior (270° meridian) 55° • Inferior-temporal (315° meridian) 70° 		APPLICANT STANDARD <input type="checkbox"/> YES <input type="checkbox"/> NO	
OCULAR DISEASE – NORMAL Free from diseases that impair visual performance as indicated by the standards above, or will produce sudden, unpredictable incapacitation of the visual system.		APPLICANT STANDARD <input type="checkbox"/> YES <input type="checkbox"/> NO	
CORRECTIVE SURGERY		HAVE YOU EVER HAD CORRECTIVE SURGERY? <input type="checkbox"/> YES <input type="checkbox"/> NO	
PROCEDURE TYPE – Please indicate which procedure from the list below...		DATE OF PROCEDURE YYYY MM DD	
<input type="checkbox"/> Corneal Refractive Surgery	Allowed; however, the candidate must meet additional requirements and must provide specific documentation on vision stability and night vision using Recruit Selection Standards approved forms available through any Alberta Municipal Police Service, or from the Manager of First Nations Policing for the Alberta Solicitor General and Public Security.		
<input type="checkbox"/> Pseudophakic Intra-Ocular Lenses	Allowed; however, the candidate must meet additional requirements and must provide specific documentation on Alberta Police Recruit Selection Standards approved forms...		
<input type="checkbox"/> Phakic Intra-Ocular Lens Implants (Piol)	Certain designs are allowed; however, the candidate must meet additional requirements and must provide specific documentation on vision stability and night vision using the Alberta Police Recruit Selection Standards approved forms...		
<input type="checkbox"/> Orthokeratology, Corneal Transplants, and Intra-Stromalcorneal Rings	Not allowed.		
NIGHT VISION – Only required if an Applicant had Corrective Surgery Obtain minimum scores on at least 2 of the 3 following tests (all testing is done binocularly with, or without, any spectacle or contact lens correction): <ol style="list-style-type: none"> 1. Bailey-Lovie Low Contrast Acuity in Room Illumination: minimum acuity of 0.20 logMAR 2. Bailey-Lovie High Contrast Acuity in Dim Illumination: minimum acuity of 0.30 logMAR 3. Bailey-Lovie Low Contrast Acuity in Dim Illumination: minimum acuity of 0.58 logMAR 		APPLICANT STANDARD <input type="checkbox"/> YES <input type="checkbox"/> NO	
SIGNATURE OF DOCTOR		DATE YYYY MM DD	
SIGNATURE OF APPLICANT		DATE YYYY MM DD	

Note: *All vision test results will be verified by a Pre-Employment Occupational Health and Safety Medical prior to employment.*



Alberta

**HEARING
REPORT**

Examination MUST have been completed within 12 months of application.

NAME OF APPLICANT		SURNAME	GIVEN NAMES	INITIAL
ADDRESS OF APPLICANT				
CITY	PROVINCE	POSTAL CODE	DATE OF BIRTH YYYY	MM DD

HEARING STANDARDS FOR POLICE OFFICER APPLICANTS

AUDIOLOGIST / OTOLARYNGOLOGIST	NAME OF AUDIOLOGIST/OTOLARYNGOLOGIST:	DATE OF EXAMINATION YYYY	MM	DD
ADDRESS OF AUDIOLOGIST/OTOLARYNGOLOGIST:				
				TELEPHONE NUMBER []

PURE TONE THRESHOLDS IN HL	500	1000	2000	3000	4000
RIGHT EAR					
LEFT EAR					

PLACE A LARGE "X" IN THE APPROPRIATE BOX

I certify that the above named individual Meets Does Not Meet
the hearing requirements for a Police Officer applicant as indicated in Unaided Criteria .

SIGNATURE OF TECHNICIAN/NURSE/DOCTOR	DATE YYYY	MM	DD
SIGNATURE OF APPLICANT	DATE YYYY	MM	DD

Note: *All hearing test results will be verified by a Pre-Employment Occupational Health and Safety Medical prior to employment.*



ALBERTA POLICE RECRUIT SELECTION STANDARDS

SUPPLEMENTARY HEARING INFORMATION FOR AUDIOLOGISTS

The auditory requirements of a police constable's routine duties are such that the constable's life may depend on the ability to hear, localize and understand a variety of environmental and speech sounds, including soft sounds. The constable should hear well enough to avoid undue risk to bystanders and to herself/himself and to protect the public from harm

The hearing requirements of the Alberta Police Recruit Selection Standards were developed based on task and job analysis and an expert opinion. The standard is based on the recognition that, for the police constable, hearing acuity, word discrimination and sound localization are important dimensions of hearing competency required to perform job-related tasks safely and effectively.

Alberta Police Recruit Selection Standards – Hearing Standards

Unaided Criteria I

Pure-tone threshold measured under audiometric earphones shall not exceed 25dB HL in each ear at the following frequencies: 500, 1000, 2000, 3000 and 4000 Hz.

Unaided Criteria II

For each ear, pure-tone thresholds measured under audiometric earphones shall not exceed a four-frequency average (500, 1000, 2000, 3000 Hz) of 25dB HL, thresholds at none of these single frequencies shall exceed 35 dB HL and thresholds at 4000 Hz shall not exceed 45 dB HL. In addition, speech recognition scores shall be 88% or better in each ear at 50dB HL in quiet, using half lists (25 test words) of recorded monosyllabic words presented under standard audiometric earphones. The lists of Northwestern University Test No. 6 are to be used for word discrimination testing, to achieve consistency across test sites. Furthermore, speech recognition scores measured with both ears open in sound field shall be 68% or better at a 5+ signal-to-noise (S/N) ration, when a half-list (25 test words) of recorded monosyllabic words is presented at 50 dB HL. For measurement, both the word list and competing speech noise shall be presented at 0° azimuth (i.e. from one speaker located directly in front of the candidate).

Unaided Criteria IA

Pure-tone thresholds measured under audiometric earphones shall not exceed 40 dB HL in each ear at the following frequencies: 500, 1000, 2000, 3000; and shall not exceed 55 dB HL at 4000 Hz.

- If the standards are met the applicant can proceed to Aided Criteria with a Completely in Canal (CIC) hearing aid.
- If the application does not meet hearing standards, accommodation with a CIC is not allowed.

Aided Criteria

NOTE: Accommodation with CIC hearing aides is allowed. Use of other types of hearing aids is not allowed.

For each ear, narrow-band or warbled-tone thresholds measured in a calibrated sound field at 0° azimuth shall not exceed a four-frequency average (500, 1000, 2000 and 3000 Hz) of 25 dB HL; thresholds at none of these single frequencies shall exceed 35 dB HL, and threshold at 4000 Hz shall not exceed 45 dB HL. Measurements shall be made monaurally in an audiometric sound field with the aided (non-test) ear plugged or, when necessary, effectively masked. (Measurements of aided threshold may also be expressed as real-ear aided response, using probe-microphone measurements with sound pressure levels appropriately converted to hearing levels). In addition, speech recognition scores in sound field shall be 88% or higher in each aided ear (with the non-test ear plugged or appropriately masked) using half-lists (25 words) or recorded, monosyllabic words (Northwestern University NU-6 lists) presented at 50 dB HL in quiet at 0° azimuth. Furthermore, monaurally or binaurally aided speech recognition scores measured in sound field shall be 68% or higher at a +5 dB S/N ration, when NU-6 half lists are presented at 50 dB HL. Both the word list and competing speech noise shall be presented at 0° azimuth. Hearing aids worn shall be adjusted to those settings used in the "Hearing Acuity" portion of this criterion.

PAR-Q+






The Physical Activity Readiness Questionnaire for Everyone

Regular physical activity is fun and healthy, and more people should become more physically active every day of the week. Being more physically active is very safe for MOST people. This questionnaire will tell you whether it is necessary for you to seek further advice from your doctor OR a qualified exercise professional before becoming more physically active.

GENERAL HEALTH QUESTIONS




Please read the 7 questions below carefully and answer each one honestly: check YES or NO.	YES	NO
1) Has your doctor ever said that you have a heart condition OR high blood pressure?	<input type="checkbox"/>	<input type="checkbox"/>
2) Do you feel pain in your chest at rest, during your daily activities of living, OR when you do physical activity?	<input type="checkbox"/>	<input type="checkbox"/>
3) Do you lose balance because of dizziness OR have you lost consciousness in the last 12 months? Please answer NO if your dizziness was associated with over-breathing (including during vigorous exercise).	<input type="checkbox"/>	<input type="checkbox"/>
4) Have you ever been diagnosed with another chronic medical condition (other than heart disease or high blood pressure)?	<input type="checkbox"/>	<input type="checkbox"/>
5) Are you currently taking prescribed medications for a chronic medical condition?	<input type="checkbox"/>	<input type="checkbox"/>
6) Do you have a bone or joint problem that could be made worse by becoming more physically active? Please answer NO if you had a joint problem in the past, but it <u>does not limit your current ability</u> to be physically active. For example, knee, ankle, shoulder or other.	<input type="checkbox"/>	<input type="checkbox"/>
7) Has your doctor ever said that you should only do medically supervised physical activity?	<input type="checkbox"/>	<input type="checkbox"/>

 **If you answered NO to all of the questions above, you are cleared for physical activity. Go to Page 4 to sign the PARTICIPANT DECLARATION. You do not need to complete Pages 2 and 3.**

-  Start becoming much more physically active – start slowly and build up gradually.
-  Follow Canada's Physical Activity Guidelines for your age (www.csep.ca/guidelines).
-  You may take part in a health and fitness appraisal.
-  If you have any further questions, contact a qualified exercise professional such as a Canadian Society for Exercise Physiology - Certified Exercise Physiologist® (CSEP-CEP) or a CSEP Certified Personal Trainer® (CSEP-CPT).
-  If you are over the age of 45 yr and **NOT** accustomed to regular vigorous to maximal effort exercise, consult a qualified exercise professional (CSEP-CEP) before engaging in this intensity of activity.

 **If you answered YES to one or more of the questions above, COMPLETE PAGES 2 AND 3.**

 **Delay becoming more active if:**

-  You are not feeling well because of a temporary illness such as a cold or fever - wait until you feel better
-  You are pregnant - talk to your health care practitioner, your physician, a qualified exercise professional, and/or complete the **ePARmed-X+** at www.eparmedx.com before becoming more physically active
-  Your health changes - answer the questions on Pages 2 and 3 of this document and/or talk to your doctor or qualified exercise professional (CSEP-CEP or CSEP-CPT) before continuing with any physical activity program.

PAR-Q+

FOLLOW-UP QUESTIONS ABOUT YOUR MEDICAL CONDITION(S)

- 1. Do you have Arthritis, Osteoporosis, or Back Problems?**
If the above condition(s) is/are present, answer questions 1a-1c If **NO** go to question 2
- 1a. Do you have difficulty controlling your condition with medications or other physician-prescribed therapies? (Answer **NO** if you are not currently taking medications or other treatments) YES NO
- 1b. Do you have joint problems causing pain, a recent fracture or fracture caused by osteoporosis or cancer, displaced vertebra (e.g., spondylolisthesis), and/or spondylolysis/pars defect (a crack in the bony ring on the back of the spinal column)? YES NO
- 1c. Have you had steroid injections or taken steroid tablets regularly for more than 3 months? YES NO
-
- 2. Do you have Cancer of any kind?**
If the above condition(s) is/are present, answer questions 2a-2b If **NO** go to question 3
- 2a. Does your cancer diagnosis include any of the following types: lung/bronchogenic, multiple myeloma (cancer of plasma cells), head, and neck? YES NO
- 2b. Are you currently receiving cancer therapy (such as chemotherapy or radiotherapy)? YES NO
-
- 3. Do you have Heart Disease or Cardiovascular Disease? This includes Coronary Artery Disease, High Blood Pressure, Heart Failure, Diagnosed Abnormality of Heart Rhythm**
If the above condition(s) is/are present, answer questions 3a-3e If **NO** go to question 4
- 3a. Do you have difficulty controlling your condition with medications or other physician-prescribed therapies? (Answer **NO** if you are not currently taking medications or other treatments) YES NO
- 3b. Do you have an irregular heart beat that requires medical management? (e.g., atrial fibrillation, premature ventricular contraction) YES NO
- 3c. Do you have chronic heart failure? YES NO
- 3d. Do you have a resting blood pressure equal to or greater than 160/90 mmHg with or without medication? (Answer **YES** if you do not know your resting blood pressure) YES NO
- 3e. Do you have diagnosed coronary artery (cardiovascular) disease and have not participated in regular physical activity in the last 2 months? YES NO
-
- 4. Do you have any Metabolic Conditions? This includes Type 1 Diabetes, Type 2 Diabetes, Pre-Diabetes**
If the above condition(s) is/are present, answer questions 4a-4c If **NO** go to question 5
- 4a. Is your blood sugar often above 13.0 mmol/L? (Answer **YES** if you are not sure) YES NO
- 4b. Do you have any signs or symptoms of diabetes complications such as heart or vascular disease and/or complications affecting your eyes, kidneys, and the sensation in your toes and feet? YES NO
- 4c. Do you have other metabolic conditions (such as thyroid disorders, pregnancy-related diabetes, chronic kidney disease, liver problems)? YES NO
-
- 5. Do you have any Mental Health Problems or Learning Difficulties? This includes Alzheimer's, Dementia, Depression, Anxiety Disorder, Eating Disorder, Psychotic Disorder, Intellectual Disability, Down Syndrome**
If the above condition(s) is/are present, answer questions 5a-5b If **NO** go to question 6
- 5a. Do you have difficulty controlling your condition with medications or other physician-prescribed therapies? (Answer **NO** if you are not currently taking medications or other treatments) YES NO
- 5b. Do you **ALSO** have back problems affecting nerves or muscles? YES NO

PAR-Q+

6. Do you have a Respiratory Disease? *This includes Chronic Obstructive Pulmonary Disease, Asthma, Pulmonary High Blood Pressure*

If the above condition(s) is/are present, answer questions 6a-6d If **NO** go to question 7

- 6a. Do you have difficulty controlling your condition with medications or other physician-prescribed therapies? (Answer **NO** if you are not currently taking medications or other treatments) YES NO
-
- 6b. Has your doctor ever said your blood oxygen level is low at rest or during exercise and/or that you require supplemental oxygen therapy? YES NO
-
- 6c. If asthmatic, do you currently have symptoms of chest tightness, wheezing, laboured breathing, consistent cough (more than 2 days/week), or have you used your rescue medication more than twice in the last week? YES NO
-
- 6d. Has your doctor ever said you have high blood pressure in the blood vessels of your lungs? YES NO

7. Do you have a Spinal Cord Injury? *This includes Tetraplegia and Paraplegia*

If the above condition(s) is/are present, answer questions 7a-7c If **NO** go to question 8

- 7a. Do you have difficulty controlling your condition with medications or other physician-prescribed therapies? (Answer **NO** if you are not currently taking medications or other treatments) YES NO
-
- 7b. Do you commonly exhibit low resting blood pressure significant enough to cause dizziness, light-headedness, and/or fainting? YES NO
-
- 7c. Has your physician indicated that you exhibit sudden bouts of high blood pressure (known as Autonomic Dysreflexia)? YES NO

8. Have you had a Stroke? *This includes Transient Ischemic Attack (TIA) or Cerebrovascular Event*

If the above condition(s) is/are present, answer questions 8a-8c If **NO** go to question 9

- 8a. Do you have difficulty controlling your condition with medications or other physician-prescribed therapies? (Answer **NO** if you are not currently taking medications or other treatments) YES NO
-
- 8b. Do you have any impairment in walking or mobility? YES NO
-
- 8c. Have you experienced a stroke or impairment in nerves or muscles in the past 6 months? YES NO

9. Do you have any other medical condition not listed above or do you have two or more medical conditions?

If you have other medical conditions, answer questions 9a-9c If **NO** read the Page 4 recommendations

- 9a. Have you experienced a blackout, fainted, or lost consciousness as a result of a head injury within the last 12 months **OR** have you had a diagnosed concussion within the last 12 months? YES NO
-
- 9b. Do you have a medical condition that is not listed (such as epilepsy, neurological conditions, kidney problems)? YES NO
-
- 9c. Do you currently live with two or more medical conditions? YES NO

GO to Page 4 for recommendations about your current medical condition(s) and sign the PARTICIPANT DECLARATION.

PAR-Q+



If you answered NO to all of the follow-up questions about your medical condition, you are ready to become more physically active - sign the PARTICIPANT DECLARATION below:

- It is advised that you consult a qualified exercise professional (e.g., a CSEP-CEP or CSEP-CPT) to help you develop a safe and effective physical activity plan to meet your health needs.
- You are encouraged to start slowly and build up gradually - 20-60 min of low to moderate intensity exercise, 3-5 days per week including aerobic and muscle strengthening exercises.
- As you progress, you should aim to accumulate 150 minutes or more of moderate intensity physical activity per week.
- If you are over the age of 45 yr and **NOT** accustomed to regular vigorous to maximal effort exercise, consult a qualified exercise professional (CSEP-CEP) before engaging in this intensity of activity.



If you answered YES to one or more of the follow-up questions about your medical condition:

You should seek further information before becoming more physically active or engaging in a fitness appraisal. You should complete the specially designed online screening and exercise recommendations program - the **ePARmed-X+** at www.eparmedx.com and/or visit a qualified exercise professional (CSEP-CEP) to work through the ePARmed-X+ and for further information.



Delay becoming more active if:

- You are not feeling well because of a temporary illness such as a cold or fever - wait until you feel better
- You are pregnant - talk to your health care practitioner, your physician, a qualified exercise professional, and/or complete the **ePARmed-X+** at www.eparmedx.com before becoming more physically active
- Your health changes - talk to your doctor or qualified exercise professional (CSEP-CEP) before continuing with any physical activity program.

- You are encouraged to photocopy the PAR-Q+. You must use the entire questionnaire and NO changes are permitted.
- The PAR-Q+ Collaboration, the Canadian Society for Exercise Physiology, and their agents assume no liability for persons who undertake physical activity. If in doubt after completing the questionnaire, consult your doctor prior to physical activity.

PARTICIPANT DECLARATION

- Please read and sign the declaration below.
- If you are less than the legal age required for consent or require the assent of a care provider, your parent, guardian or care provider must also sign this form.

I, the undersigned, have read, understood to my full satisfaction and completed this questionnaire. I acknowledge that this physical activity clearance is valid for a maximum of 12 months from the date it is completed and becomes invalid if my condition changes. I also acknowledge that a Trustee (such as my employer, community/fitness centre, health care provider, or other designate) may retain a copy of this form for their records. In these instances, the Trustee will be required to adhere to local, national, and international guidelines regarding the storage of personal health information ensuring that they maintain the privacy of the information and do not misuse or wrongfully disclose such information.

NAME _____ DATE _____

SIGNATURE _____ WITNESS _____

SIGNATURE OF PARENT/GUARDIAN/CARE PROVIDER _____

For more information, please contact
www.eparmedx.com or
 Canadian Society for Exercise Physiology
www.csep.ca

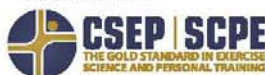
Citation for PAR-Q+

Warburton DER, Jamnik VK, Bredin SSD, and Gledhill N on behalf of the PAR-Q+ Collaboration. The Physical Activity Readiness Questionnaire (PAR-Q+) and Electronic Physical Activity Readiness Medical Examination (ePARmed-X+). *Health & Fitness Journal of Canada* 4(2):3-23, 2011.

Key References

1. Jamnik VJ, Warburton DER, Makarski J, McKenzie DC, Shephard RJ, Stone J, and Gledhill N. Enhancing the effectiveness of clearance for physical activity participation; background and overall process. APNM 36(S1):S3-S13, 2011.
2. Warburton DER, Gledhill N, Jamnik VK, Bredin SSD, McKenzie DC, Stone J, Charlesworth S, and Shephard RJ. Evidence-based risk assessment and recommendations for physical activity clearance; Consensus Document. APNM 36(S1):S266-S298, 2011.

The PAR-Q+ was created using the evidence-based AGREE process (1) by the PAR-Q+ Collaboration chaired by Dr. Darren E. R. Warburton with Dr. Norman Gledhill, Dr. Veronica Jamnik, and Dr. Donald C. McKenzie (2). Production of this document has been made possible through financial contributions from the Public Health Agency of Canada and the BC Ministry of Health Services. The views expressed herein do not necessarily represent the views of the Public Health Agency of Canada or BC Ministry of Health Services.





ALBERTA POLICE RECRUIT SELECTION STANDARDS AUTHORIZATION FOR RELEASE OF INFORMATION

NAME OF APPLICANT	SURNAME	GIVEN NAMES	INITIAL
ADDRESS OF APPLICANT			
CITY	PROVINCE	POSTAL CODE	DATE OF BIRTH YYYY MM DD

I, _____, the undersigned, hereby authorize any person, employer, organization, or physician to provide any information, opinion, reports, records, documents or copies thereof in any form, which may be requested in connection with my application for employment with the Lethbridge Regional Police Service and any subsequent training.

Personal information about me will be used to assess my qualifications and suitability in relation to my application as a police officer as well as research purposes. I consent to the collection, use, disclosure, transmittal, and examination of all information compiled by the Lethbridge Regional Police Service.

Personal information about me that is obtained during the selection process, or any subsequent training and employment, may be disclosed to any law enforcement agency for the purpose for which it was obtained or for any other reason.

I agree to waive any right of action against any person or organization providing information or opinions in compliance with this authorization.

I hereby acknowledge and declare the terms of this authorization for release of information are fully understood by me.

SIGNATURES	SIGNATURE OF APPLICANT:	DATE: YYYY MM DD
NAME OF WITNESS:	SIGNATURE OF WITNESS:	DATE: YYYY MM DD

NOTE: The Witness must be 18 years or older



ALBERTA POLICE RECRUIT SELECTION STANDARDS

C.V.S.A.

EXAMINATION CONSENT

NAME OF APPLICANT	SURNAME	GIVEN NAMES	INITIAL				
ADDRESS OF APPLICANT							
CITY	PROVINCE	POSTAL CODE	DATE OF BIRTH <table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 25%; text-align: center;">YYYY</td> <td style="width: 25%; text-align: center;">MM</td> <td style="width: 25%; text-align: center;">DD</td> <td style="width: 25%;"></td> </tr> </table>	YYYY	MM	DD	
YYYY	MM	DD					

I, _____, the undersigned, hereby voluntarily, without threats, promises of immunity or reward and without duress, coercion of force, agree to take a CVSA examination, to be given to me by a Member of Lethbridge Regional Police Service.

I fully realize I am not obligated to say anything and that anything I say may be given in evidence.

SIGNATURES	SIGNATURE OF APPLICANT:	DATE: <table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 33%; text-align: center;">YYYY</td> <td style="width: 33%; text-align: center;">MM</td> <td style="width: 33%; text-align: center;">DD</td> </tr> </table>	YYYY	MM	DD
YYYY	MM	DD			
NAME OF WITNESS:	SIGNATURE OF WITNESS:	DATE: <table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 33%; text-align: center;">YYYY</td> <td style="width: 33%; text-align: center;">MM</td> <td style="width: 33%; text-align: center;">DD</td> </tr> </table>	YYYY	MM	DD
YYYY	MM	DD			
NOTE: The Witness must be 18 years or older					