



For Office use only <input type="checkbox"/> Registrar <input type="checkbox"/> Program Manager <input type="checkbox"/> Coordinator <input type="checkbox"/> Application Complete RECRUIT NUMBER

Recruit Firefighter Program Registration

Data Privacy Warning

The legible information provided by you on this form will be used solely and exclusively for providing you and like applicants with services. Your social security number is classified as private data. It is used to track your student records for programs that you have participated in with the Connecticut Fire Academy. The only consequence of not providing all of the information on this form is that the service may be delayed, restricted, or withheld. Further, personal data retrieval will be delayed.

Please print clearly or type the information requested below

Recruit Applicant Information

Student I.D. # _____ - _____ Male Female

Your I.D. consists of the FIRST (3) Letters of your LAST Name and the LAST (4) Numbers of your Social Security Number.

Last Name: _____ First Name: _____ M.I.: _____

Home Address: _____

City / Town: _____ State: _____ Zip: _____

Email Address: _____@_____.

Phone No's: Home: (____) ____ - _____ Work: (____) ____ - _____ Cell: (____) ____ - _____

If Different from Home Address, complete below

Mailing Address: _____

City / Town: _____ State: _____ Zip: _____

Fire Department Registration

Fire Department / Organization: _____, _____
Fire Department Name City/Town

As Chief of the _____ Fire Department I hereby authorize the above applicant to participate in the Connecticut Fire Academy's Recruit Firefighter Program and therefore, understand that the above-named individual will be covered by Workers Compensation Insurance while participating in such training, and that the Department of Emergency Services and Public Protection, its commissioners, officers, agents or employees shall not be liable for any injuries sustained during such training.

I also confirm that the applicant is an employee of the Fire Department or affiliated as a member or volunteer of the Fire Department for a minimum of 6 months and has documented proof of meeting the department's Medical and Physical Fitness requirements, is emotionally fit to perform firefighting evolutions without special considerations, and where applicable, to meet the 29 CFR 1910.134 standard for the use of respirators (Self Contained Breathing Apparatus). The applicant is also at least 18 years of age, has a high school diploma or GED, and has the general capacity for adult learning.

Chief's Name: _____ Chief's Signature: _____

Billing or Payment Information

Course Title: **Recruit Firefighter** Course Number: _____ Date(s): ____/____/____ to ____/____/____

Tuition: **\$6,075.00**

[] Payment will be made by City / Town / FD Purchase Order # _____

[] Please Bill City/Town/FD Name: _____ Fire Chief's Initials: _____

Payments being made other than FD Purchase Order or Billing must be made at time of Registration.

[] Payment by Check (Make check payable to CFPC / Course Number)

[] Payment by Credit Card

Visa or Master Card # _____ Exp. Date: ____/____

Card Holder Name (printed): _____

Card Holder's Signature: _____

Applicants using the Veterans Education Benefits must contact the CFA VA Benefit Coordinator William Trisler at 860-264-9225 or william.trisler@ct.gov at the time of application.

Please Mail or Fax Application with Payment / Information at least one week prior to Program Start Date to:

Connecticut Fire Academy
34 Perimeter Road
Windsor Locks, Connecticut 06069-1069
Tel.: (860) 627-6363 Fax: (860) 654-1889

Recruit Firefighter Program
Fire Department Registration – Section 1



Last Name: _____ First Initial: _____ M.I.: _____

Recruit No. _____
(Office Only)

Fire Department Contact Information
To Be Completed by Fire Department Staff

General Contact Information

Chief's Office: Fire Chiefs Name: _____
Phone (_____) _____ - _____ ext.: _____ Fax (_____) _____ - _____
Email: _____ Cell (_____) _____ - _____
Mailing Address: _____
City / Town: _____ Zip: _____

Point of Contact Information

Who will be the "Primary" Point of Contact (POC) for the department during the Recruit Training Program? What person would be contacted for the most efficient supervisory oversight in routine circumstances and recruit progress? Please note, however, that all issues requiring a fire department contact will be made to the level of supervision outlined and required in the Recruit Program Rules and Regulations.

Primary F.D. POC Rank: _____ Name: _____
Phone (_____) _____ - _____ ext.: _____ Fax (_____) _____ - _____
Email: _____ Cell (_____) _____ - _____

Emergency Contact Person(s)

In the event contact needs to be made after regular business hours ("after hours"), please contact: (ex.: Shift Commander, Training Officer, Chief(s) or Dispatch). This number must have the capability of being answered after normal Fire Department business hours.

Shift Commander / Dispatcher Phone (_____) _____ - _____
1. Name: _____ Rank: _____ Phone (_____) _____ - _____
2. Name: _____ Rank: _____ Phone (_____) _____ - _____



Last Name: _____ First Initial: _____ M.I.: _____

Recruit No. _____
(Office Only)

For personnel hired by a municipality or who have a current physical per Department Regulations or Policy

Medical Examination Confirmation

To Be Completed by Fire Department Staff

The Recruit has been determined to be medically and physically able to perform the duties of the position including, but not limited to, the use of a respirator as the result of a Fire Department **Pre-Employee Medical Examination** on _____.
Date

The Recruit has been determined to be medically and physically able to perform the duties of the position including, but not limited to, the use of a respirator as the result of a **Fire Department Medical Examination** on _____.
Date

Signature: _____
(Chief of Department) Date

Chief's Name: _____
Please Print

For personnel who DO NOT have a current Fire Department Physical

Medical Certification

To Be Completed by Fire Department Physician

Recruit applicants who have not had a **Pre-Employment** fire department physical or **Medical Examination** in the past 12 months will be required to consult their fire department physician and complete the certification information below.

I, _____, have examined _____ on _____.
Physician's Printed Name Employee's Name Date

in accordance with the recruit's sponsoring fire department's Medical Examination procedures or the Connecticut Fire Academy's Medical Certification Guidelines.

In addition, I have examined the sponsoring fire department's firefighter job description, and/or National Fire Protection Association (NFPA) 1582. I can confirm from the medical and physical examination that the recruit does not have the presence of any medical or physical conditions which would prevent the individual from performing the essential firefighter job tasks without posing significant risk, and I have determined that the recruit is medically and physically able to perform the duties of the position including, but not limited to, the use of a respirator.

Physician's Signature

For Questions or Clarification concerns dealing with Fire Department Physicals, Contact the Recruit Program Manager at 860 264-9260 or toll free 1-877-528-3473 Ext. 260 or via email at: eric.munsell@ct.gov

IAFF/IAFF Candidate Physical Abilities Test

Class 56 requires a CPAT (Candidate Physical Ability Test) card issued no earlier than August 31, 2013

Date current CPAT card issued: _____

Recruit Firefighter Program



Last Name: _____ First Initial: _____ M.I.: _____

Recruit No. _____
(Office Only)

Healthcare Provider Information
To Be Completed by Fire Department Staff

In the event of a medical emergency requiring advance level of care, the Connecticut Fire Academy uses the Bradley International Airport Fire Department Paramedics for R-5 coverage and either the Windsor Locks, Suffield or East Granby Ambulance as the R-2 provider.

For “routine” medical emergencies or evaluations, the Suffield Medical Associates Walk-In Clinic is normally used. There is a CVS Pharmacy conveniently located near the Suffield Medical Associates for prescriptions etc. Additionally, Johnson Memorial Hospital, in Stafford Springs may also be used for routine evaluations and care of orthopedic injuries.

Please check with your “Risk Management” officer or Worker’s Compensation provider if this not their desired provider for this location of the state.

If required, please provide the information for the nearest recommended Healthcare provider to the Connecticut Fire Academy. If possible we will make every attempt to see your recruit(s) use the listed provider if needed.

Provider Name: _____

Address: _____

Phone: (____) _____ - _____ ext.: _____ Fax (____) _____ - _____



Last Name: _____ First Initial: _____ M.I.: _____

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(Office Only)

Fire, Live Fire, and Flashover Survival Training
To Be Completed by Fire Department Staff

As the Chief of the _____ Fire Department, I hereby authorize the above applicant to participate in Fire Training, Live Fire and Flashover Simulator Training and experience, and therefore understand that the above mentioned member will be covered by my department's worker's compensation insurance while participating in such training, and the Commission on Fire Prevention and Control, its commissioners, officers, agents or employees shall not be held liable for any injuries sustained during such training. The applicant is considered by my department's standards to be physically and emotionally fit to perform firefighting evolutions without special consideration, and where applicable, to meet CFR 1910.134, regulation for the use of respirators.

I further understand that the Commission on Fire Prevention and Control, its commissioners, officers, agents or employees shall not be held liable for damage to the above mentioned member's protective clothing and equipment while participating in Fire Training, Live Fire and Flashover Simulator training.

I understand that during Recruit and Live Fire Training, and while properly wearing prescribed Structural Firefighting Personal Protective and other clothing, there is the risk of personal injury not limited to abrasion, contusion, laceration, thermal and/or steam burn(s).

Signature: _____
(Chief of Department)

Date

Chief's Name: _____
Please Print

Recruit Signature: _____



Last Name: _____ First Initial: _____ M.I.: _____

Recruit No. _____
(Office Only)

Clothing Issue
To Be Completed by Recruit

A standard Recruit Uniform is required to be worn by the recruit when they are attending Classes, Skill Sessions or Connecticut Fire Academy endorsed events.

The recruit is also required to wear their Fire Department’s standard daily work wear (FD Class B Work Shirt, Navy Trousers, Black or Navy Socks and Black Shoes or Work Boots) for the First day of class, Graduation and Special Events.

Each recruit will be issued the following to be worn when required during the program:

- Five (5) Red Recruit T-shirts
- Two (2) Red Recruit Sweat Shirts
- Two (2) pair of Grey PT Shorts
- One (1) pair of Sweat Pants

The Red Recruit items will be collected at the end of the program.

Please circle the size of the items below:

T-Shirt Size	Small	Medium	Large	X-Large	XX-Large
Sweat Shirt Size	Small	Medium	Large	X-Large	XX-Large
Sweat Pants Size	Small	Medium	Large	X-Large	XX-Large
Shorts Size	Small	Medium	Large	X-Large	XX-Large



Last Name: _____ First Initial: _____ M.I.: _____

Recruit No. _____
 (Office Only)

Physical Activity Readiness Questionnaire (PAR-Q)
To Be Completed by Recruit

CSEP approved Sept 12 2011 version

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.

SECTION 1 - GENERAL HEALTH

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 does not limit your current ability 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 Section 3 to sign the form. You do not need to complete Section 2.

- › Start becoming much more physically active – start slowly and build up gradually.
- › Follow the Canadian 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 CSEP Certified Exercise Physiologist* (CSEP-CEP) or CSEP Certified Personal Trainer* (CSEP-CPT).
- › If you are over the age of 45 yrs. and NOT accustomed to regular vigorous physical activity, please consult a qualified exercise professional (CSEP-CEP) before engaging in maximal effort exercise.



If you answered YES to one or more of the questions above, please GO TO SECTION 2.



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 PARmed-X for Pregnancy before becoming more physically active OR
- › Your health changes – please answer the questions on Section 2 of this document and/or talk to your doctor or qualified exercise professional (CSEP-CEP or CSEP-CPT) before continuing with any physical activity programme.



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Last Name: _____ First Initial: _____ M.I.: _____

Recruit No. _____
 (Office Only)

Physical Activity Readiness Questionnaire (PAR-Q)
To Be Completed by Recruit

SECTION 2 - CHRONIC MEDICAL CONDITIONS

Please read the questions below carefully and answer each one honestly: check YES or NO.		YES	NO
1.	Do you have Arthritis, Osteoporosis, or Back Problems?	<input type="checkbox"/> If yes, answer questions 1a-1c	<input type="checkbox"/> 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)	<input type="checkbox"/>	<input type="checkbox"/>
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)?	<input type="checkbox"/>	<input type="checkbox"/>
1c.	Have you had steroid injections or taken steroid tablets regularly for more than 3 months?	<input type="checkbox"/>	<input type="checkbox"/>
2.	Do you have Cancer of any kind?	<input type="checkbox"/> If yes, answer questions 2a-2b	<input type="checkbox"/> 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?	<input type="checkbox"/>	<input type="checkbox"/>
2b.	Are you currently receiving cancer therapy (such as chemotherapy or radiotherapy)?	<input type="checkbox"/>	<input type="checkbox"/>
3.	Do you have Heart Disease or Cardiovascular Disease? This includes Coronary Artery Disease, High Blood Pressure, Heart Failure, Diagnosed Abnormality of Heart Rhythm	<input type="checkbox"/> If yes, answer questions 3a-3e	<input type="checkbox"/> 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)	<input type="checkbox"/>	<input type="checkbox"/>
3b.	Do you have an irregular heart beat that requires medical management? (e.g. atrial fibrillation, premature ventricular contraction)	<input type="checkbox"/>	<input type="checkbox"/>
3c.	Do you have chronic heart failure?	<input type="checkbox"/>	<input type="checkbox"/>
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)	<input type="checkbox"/>	<input type="checkbox"/>
3e.	Do you have diagnosed coronary artery (cardiovascular) disease and have not participated in regular physical activity in the last 2 months?	<input type="checkbox"/>	<input type="checkbox"/>
4.	Do you have any Metabolic Conditions? This includes Type 1 Diabetes, Type 2 Diabetes, Pre-Diabetes	<input type="checkbox"/> If yes, answer questions 4a-4c	<input type="checkbox"/> If no, go to question 5
4a.	Is your blood sugar often above 13.0 mmol/L? (Answer YES if you are not sure)	<input type="checkbox"/>	<input type="checkbox"/>
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?	<input type="checkbox"/>	<input type="checkbox"/>
4c.	Do you have other metabolic conditions (such as thyroid disorders, pregnancy-related diabetes, chronic kidney disease, liver problems)?	<input type="checkbox"/>	<input type="checkbox"/>
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)	<input type="checkbox"/> If yes, answer questions 5a-5b	<input type="checkbox"/> 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)	<input type="checkbox"/>	<input type="checkbox"/>
5b.	Do you also have back problems affecting nerves or muscles?	<input type="checkbox"/>	<input type="checkbox"/>



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Last Name: _____ First Initial: _____ M.I.: _____

Recruit No. _____
 (Office Only)

Physical Activity Readiness Questionnaire (PAR-Q)
To Be Completed by Recruit

Please read the questions below carefully and answer each one honestly: check YES or NO.		YES	NO
6.	Do you have a Respiratory Disease? This includes Chronic Obstructive Pulmonary Disease, Asthma, Pulmonary High Blood Pressure	<input type="checkbox"/> If yes, answer questions 6a-6d	<input type="checkbox"/> 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)	<input type="checkbox"/>	<input type="checkbox"/>
	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?	<input type="checkbox"/>	<input type="checkbox"/>
	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?	<input type="checkbox"/>	<input type="checkbox"/>
	6d. Has your doctor ever said you have high blood pressure in the blood vessels of your lungs?	<input type="checkbox"/>	<input type="checkbox"/>
7.	Do you have a Spinal Cord Injury? This includes Tetraplegia and Paraplegia	<input type="checkbox"/> If yes, answer questions 7a-7c	<input type="checkbox"/> 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)	<input type="checkbox"/>	<input type="checkbox"/>
	7b. Do you commonly exhibit low resting blood pressure significant enough to cause dizziness, light-headedness, and/or fainting?	<input type="checkbox"/>	<input type="checkbox"/>
	7c. Has your physician indicated that you exhibit sudden bouts of high blood pressure (known as Autonomic Dysreflexia)?	<input type="checkbox"/>	<input type="checkbox"/>
8.	Have you had a Stroke? This includes Transient Ischemic Attack (TIA) or Cerebrovascular Event	<input type="checkbox"/> If yes, answer questions 8a-c	<input type="checkbox"/> 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)	<input type="checkbox"/>	<input type="checkbox"/>
	8b. Do you have any impairment in walking or mobility?	<input type="checkbox"/>	<input type="checkbox"/>
	8c. Have you experienced a stroke or impairment in nerves or muscles in the past 6 months?	<input type="checkbox"/>	<input type="checkbox"/>
9.	Do you have any other medical condition not listed above or do you live with two chronic conditions?	<input type="checkbox"/> If yes, answer questions 9a-c	<input type="checkbox"/> If no, read the advice on page 4
	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?	<input type="checkbox"/>	<input type="checkbox"/>
	9b. Do you have a medical condition that is not listed (such as epilepsy, neurological conditions, kidney problems)?	<input type="checkbox"/>	<input type="checkbox"/>
	9c. Do you currently live with two chronic conditions?	<input type="checkbox"/>	<input type="checkbox"/>

Please proceed to Page 4 for recommendations for your current medical condition and sign this document.



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Last Name: _____ First Initial: _____ M.I.: _____

Recruit No. _____
(Office Only)

Physical Activity Readiness Questionnaire (PAR-Q) *To Be Completed by Recruit*

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:

- › 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 yrs. and NOT accustomed to regular vigorous physical activity, please consult a qualified exercise professional (CSEP-CEP) before engaging in maximal effort exercise.



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

- › You should seek further information from a licensed health care professional before becoming more physically active or engaging in a fitness appraisal and/or visit a or qualified exercise professional (CSEP-CEP) 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 PARmed-X for Pregnancy before becoming more physically active OR
- › Your health changes - please talk to your doctor or qualified exercise professional (CSEP-CEP) before continuing with any physical activity programme.

SECTION 3 - DECLARATION

- › You are encouraged to photocopy the PAR-Q+. You must use the entire questionnaire and NO changes are permitted.
- › The Canadian Society for Exercise Physiology, the PAR-Q+ Collaboration, 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.
- › 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.
- › Please read and sign the declaration below:

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:
Canadian Society for Exercise Physiology
www.csep.ca

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.



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Last Name: _____ First Initial: _____ M.I.: _____

Recruit No. _____
(Office Only)

Program Review
To Be Completed by Fire Department Staff and Recruit

The Recruit applicant and a Fire Department designee have reviewed the following information with the recruit applicant prior to attending the Recruit Firefighter Program.

- Recruit Rules & Regulations
- Physical Fitness Training Overview

Signature: _____
(Recruit Applicant)

_____ Date

Signature: _____
Signature (Chief of Department or Designee)

_____ Date

Chief's Name: _____
Please Print