RHODE ISLAND MUNICIPAL POLICE TRAINING ACADEMY
PHYSICAL FITNESS 40TH PERCENTILE ENTRY STANDARDS

1 Minute Push-Ups

	Age<20	20-29	30-39	40-49	50-59	60-69
Male	29.0	29.0	24.0	18.0	13.0	10.0
Female	15.0	15.0	11.0	9.0	n/d	n/d

1.5 Mile Run

	Age<20	20-29	30-39	40-49	50-59	60-69
Male	12:38	12:38	13:04	13:49	15:03	16:46
Female	14:50	14:50	15:38	16:21	18:07	20:06

1 Minute Sit-ups

	Age<20	20-29	30-39	40-49	50-59	60-69
Male	41.0	38.0	35.0	29.0	24.0	19.0
Female	32.0	32.0	25.0	20.0	14.0	6.0

300 Meter Run

	Age<20	20-29	30-39	40-49	50-59	60-69
Male	59.0	59.0	58.9	72.0	83.2	n/d
Female	71.0	71.0	79.0	94.0	n/d	n/d

Town of Portsmouth, Rhode Island
2200 East Main Road
Portsmouth, RI 02871
(401) 683-9118

October, 2020

Fitness Test Release Form

(Completed Form MUST be brought to the Physical Fitness Examination)

To the Applicant:

Please complete this form and **sign it in the presence of a notary public.** Also, present the enclosed copy of the minimum physical fitness standards to your physician prior to your examination.

I, (print your name) _____, have read the minimum physical fitness standards for candidacy to the Portsmouth Police Department. I wish to maintain my candidacy and undergo the physical fitness examination. For these purposes I agree as follows:

1. To undergo, at my own expense, a physical examination conducted by a physician of my own choosing, who is licensed to perform such physical examinations, relevant to my ability to undergo the physical fitness examination required of candidates to the Portsmouth Police Department, and

2. To present this form and the enclosed copy of the minimum physical fitness standards to my chosen physician prior to my physical examination.

Release

I, (print your name) _____, hereby state that I volunteer to undertake the physical fitness test administered by the Portsmouth Police Department in order to maintain my candidacy to said department according to the Minimum Physical Fitness Standards presented to me this day. I therefore release and absolve the Town of Portsmouth and the Police Chief, their designees, assigns and successors in interest from any and all liability whatsoever which may result from or be in any way related to my participation in said Minimum Physical Fitness Standards test at any time now or in the future.

In witness whereof I give this release knowingly and of my own free will hereby binding myself, and my heirs, assigns, executors and administrators.

Date:_____ Signature_____
(Applicant)

State: _____

County:_____

Subscribed and sworn before me this _____day of _____, A.D. 20___.

_____
Notary Public

PORTSMOUTH POLICE DEPARTMENT
2270 EAST MAIN ROAD
PORTSMOUTH, RHODE ISLAND 02871-4021
(401) 683-0300

COLONEL BRIAN P. PETERS
CHIEF OF POLICE

FITNESS TEST MEDICAL CERTIFICATE

Dear Physician:

The following named individual has submitted an application to become a Police Officer with the Portsmouth Department.

Candidate Name: _____ **Date of Birth:** _____

Address:_____**Town/City:**_____**State:**_____

The Portsmouth Police Department and the Rhode Island Department of Public Safety/Municipal Police Training Academy (RIDPS/MPTA) requires each candidate to bring a completed Physical Fitness Test Certificate to the Physical Fitness Test before he/she will be allowed to participate in the test. A statement must be obtained from a licensed physician that the candidate is of sufficient physical conditioning to undergo a Physical Fitness test. The Fitness Test Medical Certificate **must** be completed within six (6) months of the Physical Fitness testing date.

Attached to this form is a listing of the minimum physical fitness standards a candidate must attain. We ask that your evaluation be based upon these criteria. Thank you for your assistance.

PHYSICIAN'S STATEMENT

I have examined the above-named individual on _____.
(Date)

After reviewing each of the four (4) events, I find him/her to be of sufficient physical conditioning to allow the candidate to participate in the Portsmouth Police Department and RIDPS/MPTA Physical Fitness Test.

Comments (if any): _____

_____
Physician's Signature

(Please type or print:)

Physician's Name: _____

Address: _____

Telephone Number: _____

Revised 03/12