



Carroll County Sheriff's Office
Waiver of Liability
Pre-Employment Physical Agility Test

All applicants for Law Enforcement, Correctional Deputy I (Entry-Level), & Court Security Deputy positions with the Carroll County Sheriff's Office must pass the following fitness standards to continue in the hiring process.

Physical Agility Test Course

The course consists of a series of ten (10) interspersed individual tasks, arranged in a continuous format that are viewed as being essential (physical) job related tasks for Law Enforcement / Correctional training:

- Running - 300 meters
Horizontal Jump- a distance of four (4) feet
Climbing over an object - over an object four (4) feet
Jumping Down - Four (4) feet
Climbing Steps - Ascend/Descend two (2) flights of stairs
Serpentine - Changing direction in run
Low Crawling - 24-inch-high obstacle
Vertical Jump - Low Hurdle - fifteen (15) inches
Moving/Dragging Weight (160-pound dummy) - Move thirty (30) feet
Handgun Trigger Pull & Slide Manipulation

The obstacle course must be completed in 3 minutes and 10 seconds for Deputy Sheriff Recruit applicants. There is no time limit for Court Security Deputy, Certified Deputy First Class, Certified Deputy Sheriff Probationer, or Correctional Deputy I (Entry-Level) applicants; however, those applicants must successfully complete the course.

TO BE COMPLETED BY APPLICANT:

I, _____, I hereby release the Carroll County Sheriff's Office from any and all liability that may occur as a result of my voluntary participation in the physical agility testing administered by the Carroll County Sheriff's Office.

APPLICANT'S NAME (PRINT CLEARLY): _____

APPLICANT'S NAME SIGNATURE: _____ DATE: _____

SOCIAL SECURITY NUMBER: _____ DATE OF BIRTH: _____

TO BE COMPLETED BY PHYSICIAN:

I certify that I have reviewed the above requirements and it is my opinion that the above-named applicant can perform the elements of this test without undue risk to himself/herself.

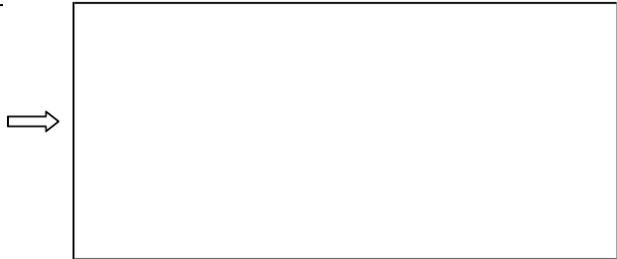
PHYSICIAN'S NAME: _____

PHYSICIAN'S ADDRESS: _____

PHYSICIAN'S TELEPHONE: _____

PLACE IMPRINT OF DOCTOR'S OFFICE STAMP HERE

Physician's Office MUST indicate if no stamp is available, and physician MUST also sign in this box to indicate same.



PHYSICIAN'S ORIGINAL SIGNATURE: _____ DATE: _____

This waiver of liability is valid for six months from the date of physician's signature.

~~~~~PHYSICIANS ONLY may contact CCSO at 410-386-2610 with any questions regarding this test. ~~~~~