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.*

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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. ~~~~*

Revised: 06/2024