JOHNSON COUNTY SHERIFF'S OFFICE
ESSENTIAL FUNCTION TEST
CONSENT FORM, WAIVER OF LIABILITY & PHYSICIAN'S RELEASE

The undersigned applicant for a law enforcement position with the Johnson County Sheriff's Office and the County of Johnson (hereinafter collectively "County") hereby voluntarily authorizes the County staff and its agents and/or representatives to administer and conduct an Essential Function Test to measure my ability to perform the essential job functions and duties which are inherent to the law enforcement position to which I am applying.

GENERAL DESCRIPTION OF THE ESSENTIAL FUNCTION TESTING AND THE ASSOCIATED RISKS

I understand that this testing includes the following tasks wearing the clothes of my choice, (workout clothing recommended):

1. **One and one-half (1 ½) mile run (16 minutes, 28 seconds)**
2. **Vertical jump (16")**
3. **One minute sit-ups (29)**
4. **Twenty-five (25) push-ups**
5. **Three hundred (300) meter run (71 seconds)**

Having reviewed the forgoing, I expressly acknowledge that I understand the following:

♦ That the above testing descriptions serve only as a summary of the tasks to be performed.

♦ That participating in this testing presents a risk and the danger of serious bodily injury or death, and there exists the possibility of certain changes in my bodily functions during this test, including, but not limited to: light headedness, breathlessness, chest discomfort, muscle cramps, joint strains or sprains, occasional irregular heartbeats, changes in blood pressure and in rare cases, stroke, heart attack or heart failure.

♦ That there exists the possibility of certain significant changes in my bodily functions occurring during this testing. In this regard, I understand that I may stop the testing at any time I choose.

♦ That the County and it's staff are under no obligation to monitor my physical condition, however, in the event abnormalities appear obvious to the personnel observing the testing, my participation may be stopped immediately pending a medical assessment.

♦ That at the option of the County, I will not be permitted to participate in the testing if I present a systolic blood pressure greater than 150 mmHg or a diastolic blood pressure greater than 100 mmHg immediately preceding the evaluation.

CONSENT TO ESSENTIAL FUNCTION TESTING

By signing below, I expressly agree to the following:

♦ I have read the foregoing general description of the Essential Function Testing and the associated risks and I understand its contents.

♦ I further acknowledge that I have had the opportunity to have my personal physician review the components of the Essential Function Test to determine if I am capable of completing all parts of the testing and my physician's statement appears below.

♦ I expressly voluntarily authorize the County to administer the Essential Function Testing to me.

♦ I am voluntarily participating in this testing.

WAIVER OF LIABILITY FOR INJURIES ASSOCIATED WITH PARTICIPATION IN THE ESSENTIAL FUNCTION TESTING

By signing below, I expressly agree to the following:

♦ Any questions that have occurred to me have been answered to my satisfaction.

♦ I hereby assume the risk of any bodily injury, discomfort or death resulting from my participation in this application and testing process and the Essential Function Test, and fully release and discharge the Johnson County Sheriff's Office and the County of Johnson, their elected and appointed officers and officials, or any other representatives acting on their behalf, for and against any and all claims, demands, actions, and/or causes of actions arising out of any bodily injury, discomfort or death incurred by me as a result of my participation in the County's Essential Function Test or the testing and application process, on behalf of myself, my heirs, personal representatives and assigns.

_____ _____

Applicant's Signature Date

_____

Printed Name of Applicant

_____

Witness

_____
Printed Name of Witness

PHYSICIAN'S STATEMENT

I am a licensed physician who has examined the applicant, _____ and reviewed the preceding guidelines of the Essential Functions Test and I know of no reason that the applicant should not or could not participate in this test, which is scheduled to be held in _____ (month) of 20___.

_____ _____
Physician's Signature Date

_____ _____
Printed Name of Physician Physician's Address