PRTP Application Instructions

Applications for the Fall 2005 and Spring 2006 programs are now being accepted. Final acceptance is conditional upon passing a medical exam that must be completed (at the applicants expense dated no more than 120 days prior to the start of the program).
APPLICATION FORM (Please print or type)

I am applying for: (Please circle ONE)  Fall 2005  or  Spring 2006

Name: ______________________________________________

Social Security No.: ___________________________________

Temporary Address: _____________________________________________________________

City:________________________ State:__________ Zip:____________________________

Telephone: (Daytime)_________________ (Evening)_________________________________

Email: ______________________________

Permanent Address/Phone (if different from above):

Address: ______________________________________________________________________

Phone: (________________) __________________________

Date of Birth:__________ Age: ______

Are you currently a full-time college student? ______YES_____NO

   If yes, NAU?_______Other college: ______________________________

If you are a college student, provide the following:

Major: __________________________________________ Minor: ________________________

College semester hours as of application date:_______________ Overall GPA:___________

Driver's License Number: ____________________________State:_____ Expiration Date:_______

How did you hear about this program?____________________________________________________

Send or deliver complete registration packet (this form, relevant work experience form, notarized criminal offense checklist and resume) to:

   Steve Dodd, Director, Park Ranger Training Program
   Northern Arizona University, Parks and Recreation Management
   PO Box 15016, Flagstaff, AZ  86011-5016

I, ______________________________ understand that the Director of the Park Ranger Training Program will make the final determination as to whether I meet the basic qualifications for the Park Ranger Training Program. I also understand that I must clearly and honestly complete the application in order to be considered for the courses.

Date Submitted: ______________

INCOMPLETE REGISTRATION PACKETS WILL BE RETURNED
RELEVANT EXPERIENCE FORM

1. What is your main reason for wanting to enroll in the Park Ranger Training Program at the Northern Arizona University?

2. List any relevant work experience that you may have in the field of park management, resource management, or recreation:

3. List any special interests or hobbies that you have:

4. Interpersonal skills, professional attitude, and physical fitness are all important components of being a park ranger. How would you rate yourself in all three of these areas:

NOTE: Attach additional sheets if necessary. Please submit a resume or other supportive material. You must also submit a list of three (3) references (include addresses and phone numbers).
CRIMINAL OFFENSE CHECKLIST

Full Name (Print):_______________________________

Have you ever been:
Arrested? __Yes __No
Charged by any law enforcement authority? __Yes __No
Convicted of any offense against the law (including "nolo contendere" or "no contest" pleas)? __Yes __No
Charged with any motor vehicle moving violation (e.g. DUI, reckless driving, speeding)? __Yes __No
Involved in a motor vehicle accident? __Yes __No
Subjected to forfeiture of collateral in connection with an arrest? __Yes __No
Imprisoned? __Yes __No
Placed on probation? __Yes __No
Required to appear before a juvenile court for an act that would have been a crime if committed by an adult? __Yes __No
Diagnosed as having mental or emotional problems? __Yes __No
Been treated for drug or alcohol dependency? __Yes __No
Associated in any manner with any group that advocates resistance and/or violence against the Federal Government? __Yes __No
Been fired from any job for any reason? __Yes __No

Are you now:
Charged with an offense by any law enforcement authority? __Yes __No
Presently on bail or out on personal recognizance or other conditional release? __Yes __No
On probation of any type? __Yes __No

If you answered "Yes" to any part of the above questions, give complete details on separate sheet. Include, as a minimum, the date of the offense, charge(s), city and state, name of Law Enforcement Agency involved, and final disposition.

The information that I have provided is true and correct. I understand that any misleading or false information is just cause for refusal of this application. I also understand that false information will result in my dismissal from the Park Ranger Training Program.

__________________________________________
Participant Name (please print or type) Participant Signature

THIS FORM MUST BE NOTARIZED. NOTARY INFORMATION BELOW

State__________________
County__________________
Date__________________
Notary Public______________
My commission expires__________________
Notary Signature ___________________________

Instructions to the Examining Physician
Your patient is applying for admission to a police training program. He/she will be involved in strenuous physical activities that include unarmed defensive tactics with full contact exercises, firearms training with handguns and shotguns and driving motor vehicles in high speed emergency response and pursuit situations. Please consider these issues in evaluating the fitness of the candidate for admission to this program. If you have any questions please contact Steve Dodd, Program Director at (928) 523-8242.

Final acceptance is conditional upon passing a medical exam that must be completed (at the applicants expense dated no more than 120 days prior to the start of the program).
STUDENT HEALTH DATA

To assist in seeing that you receive proper treatment for any illness or injury that might occur during your training, we must have the following information:

Name: ____________________________________________________________________

(Last)     (First)      (Middle)

Are you taking any medication: Yes ___ No ___. If yes, lists the medication and dosage:
_______________________________________________________________________________________

Have you had surgery or been confined to a hospital within the past two years? Yes ___ No ___.
If yes, are you still under a doctor's care for the condition? Yes ___ No ___. If yes, complete the
next line,

Attending Physician's name and phone no. __________________________________________

Are you allergic to any foods, medication, animals, plant life, insects, etc.? Yes -No - " If yes,
describe;
______________________________________________________________________________

Please indicate: Non-Smoker ___ Smoker ___ Heavy ___ Moderate ___ Light ___

Do you have any religious or personal convictions concerning medical treatment of which we
should be aware in obtaining treatment for you? Yes ___ No ___. If yes, describe:
______________________________________________________________________________

Do you have any special diet requirements? Yes ___ No ___. Describe:
______________________________________________________________________________

Do you have any physical or psychological limitations/injuries, recent or old, that might restrict
your full participation in physical activities during training? Yes ___ No ___. If yes, describe:
______________________________________________________________________________

If you are not covered under a personal or employer medical insurance policy, please provide the
medical care facility with information necessary to bill you directly. Your training file will not
accompany you to the doctor or hospital. A photocopy of this form will, so please provide
detailed information. (Use reverse side for additional information.)
MEDICAL EXAMINATION

NAME OF STUDENT:

(Last) ____________________________ (First) ____________________________ (Middle) ____________________________

TO THE PHYSICIAN: This physical examination should ascertain any conditions, which may be aggravated by strenuous physical exercise. The student will engage in running, jumping, wrestling, unarmed self-defense and other physically demanding exercises while enrolled in Peace Officer Basic Training. It is recommended that the student's cardiovascular fitness be measured under stressful conditions. Some recognized instruments are: Stress Treadmill, 12 Minute Walk-Run, 3 Mile Run, 12" Step Test.

Does patient have a medical history of or demonstrate present symptoms of any of the following?

Yes No

___    ___    1. Uncorrected visual deficiency
___    ___    2. Major impairment of the senses
___    ___    3. Asthma
___    ___    4. Breathing difficulties
___    ___    5. Heart Attack
___    ___    6. Angina Pectoris
___    ___    7. Stroke
___    ___    8. Hemorrhage
___    ___    9. Hypertension
___    ___    10. Allergies
___    ___    11. Dizziness
___    ___    12. Fainting
___    ___    13. Backache or injury
___    ___    14. Chronic earache
___    ___    15. Pregnancy
___    ___    16. Communicable diseases
___    ___    17. Amputation
___    ___    18. Prosthetic Devices
___    ___    19. Taking Medication
___    ___    20. Under physician's continuing care

IF THE ANSWER TO ANY OF THE ABOVE IS "YES," PLEASE PROVIDE AN EXPLANATION IN THE COMMENTS SECTION ON THE NEXT PAGE OF THIS FORM.
### MEDICAL EXAMINATION (Continued)

<table>
<thead>
<tr>
<th>Height (without shoes) Ft.</th>
<th>Weight (pounds)</th>
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<tr>
<td>Ft. _____ Inches</td>
<td>_____</td>
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<table>
<thead>
<tr>
<th>Resting pulse rate</th>
<th>Blood Pressure:</th>
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<td>_____ / _____</td>
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<table>
<thead>
<tr>
<th>Vision (without correction)</th>
<th>Vision (with correction)</th>
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<tbody>
<tr>
<td>Right 20/ _____</td>
<td>Left 20/ _____</td>
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<tr>
<th>Can distinguish between the colors of red, green, amber:</th>
<th>Yes</th>
<th>No</th>
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<tbody>
<tr>
<td>Yes _____</td>
<td></td>
<td></td>
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<tr>
<td>No _____</td>
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Comments: (Explain each "Yes" response, indicating the Item Number)

As a result of my physical examination, I have determined that the patient **CAN / CANNOT** (circle one) safely function in all phases of strenuous training.

Typed name and address of examining physician

Signature of Examining Physician

Date of Examination