PRTP Application Instructions

Applications for the Fall 2006 and Spring 2007 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).

Non-credit applicants for the Spring 2007 PRTP must submit a $25 non-refundable application fee. Make the check or money order payable to Northern Arizona University.
APPLICATION FORM (Please print or type)

I am applying for: (Please circle ONE) Fall 2006 or Spring 2007

I am applying as: (Please circle ONE) Credit Non-credit

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 ________________________________
STUDENT HEALTH DATA

&

MEDICAL EXAMINATION FORM

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)

Student's name: _________________________________________________________

(Last)     (First)    (MI)

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<th>Height (without shoes) Ft._____ Inches</th>
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<th>Resting pulse rate</th>
<th>Blood Pressure: _______ / _______</th>
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Can distinguish between the colors of red, green, amber: Yes _____ No _____

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