



RHODE ISLAND MUNICIPAL POLICE TRAINING ACADEMY PHYSICAL FITNESS 40TH PERCENTILE ENTRY STANDARDS



1 Minute Push-Ups

	Age<20	20-29	30-39	40-49	50-59	60-69
Male	29.0	29.0	24.0	18.0	13.0	10.0
Female	15.0	15.0	11.0	9.0	n/d	n/d

1.5 Mile Run

	Age<20	20-29	30-39	40-49	50-59	60-69
Male	12:38	12:38	13:04	13:49	15:03	16:46
Female	14:50	14:50	15:38	16:21	18:07	20:06

1 Minute Sit-ups

	Age<20	20-29	30-39	40-49	50-59	60-69
Male	41.0	38.0	35.0	29.0	24.0	19.0
Female	32.0	32.0	25.0	20.0	14.0	6.0

300 Meter Run

	Age<20	20-29	30-39	40-49	50-59	60-69
Male	59.0	59.0	58.9	72.0	83.2	n/d
Female	71.0	71.0	79.0	94.0	n/d	n/d



JOHNSTON POLICE DEPARTMENT

Chief of Police, Richard S. Tamburini

FITNESS TEST MEDICAL CERTIFICATE

Dear Physician:

The following named individual has submitted an application to become a Police Officer with the Johnston Department.

Candidate Name: _____ Date of Birth: _____ Address: _____ Town/City: _____ State: _____

The Johnston Police Department and the Rhode Island Department of Public Safety/Municipal Police Training Academy (RIDPS/MPTA) requires each candidate to bring a completed Physical Fitness Test Certificate to the Physical Fitness Test before he/she will be allowed to participate in the test. A statement must be obtained from a licensed physician that the candidate is of sufficient physical conditioning to undergo a Physical Fitness test. The Fitness Test Medical Certificate **must** be completed within six (6) months of the Physical Fitness testing date.

Attached to this form is a listing of the minimum physical fitness standards a candidate must attain. We ask that your evaluation be based upon these criteria. Thank you for your assistance.

PHYSICIAN'S STATEMENT

I have examined the above-named individual on _____.
(Date of Exam)

After reviewing each of the four (4) events, I find him/her to be of sufficient physical conditioning to allow the candidate to participate in the Johnston Police Department and RIDPS/MPTA Physical Fitness Test.

Comments (if any): _____

Physician's Signature

(Please type or print:)

Physician's Name: _____

Address: _____

Telephone Number: _____

Revised 07/14