

How to fill out the NMLEA Application Packets for CBW & BPOT



- *Required Forms for Law Enforcement*
- *Common Reasons for Return*



How to fill out the NMLEA Application Packet

Course Objectives:

- Prepare the various forms for approval to attend CBW or Law Enforcement Officer training to the requirements of NMLEA Board rules.
- Demonstrate the requirements to other preparers.
- Demonstrate an understanding of the statutory and NMLEA Board requirements for certification as a law enforcement officer and how they correspond to the forms.

Why this course?

- Agency turnover of personnel performing packet preparation.
- Frustration with returns (Agencies and NMLEA).
- Lack of clear understanding of the requirements.
- It's better for everyone if it's done right the first time.
- A perception that the rules keep changing.

Who needs to apply?

Law Enforcement:

- All commissioned law enforcement officers (Includes part-time).

Reserve officers are not covered under the act.

When must the Packet be submitted?

Law Enforcement:

- Within 30 days of hire (10.29.9.10 B.1 NMAC)

B. Application Requirements

(1) An applicant for training or for certification, or his department, must submit the

initial application for admission/certification and all necessary paperwork within 30 days of the initial hire date for said applicant.

(2) Non-compliance with the 30 day application requirement will result in

assignment to class after completion of all other requirements herein on a space available basis only

-- no special consideration will be given the applicant and the applicant must have his commission

suspended if he exceeds one year from initial hire date.

The Forms



CBW Applicant Packet Checklist

New Mexico Department of Public Safety Training Center
 4491 Cerrillos Road, Santa Fe, New Mexico 87507
 (505)827-9751—(800)621-9911 (NM Only)—Fax: (505)827-3449—www.dps.nm.org/training/

CERTIFICATION BY WAIVER OF PREVIOUS TRAINING PAPERWORK CHECKLIST

The following documents must be submitted for approval and verification of eligibility to attend the Certification by Waiver Program and Recertification Program. Incomplete applications will be returned.

ITEMS REQUIRED BY ALL APPLICANTS

- Letter addressed to the Director requesting approval to attend the Certification by Waiver (CBW) program.
- Form No. LEA-11 - Employment History Form.
- Form No. LEA-13 - Training Status Verification Form (Certification by Waiver of Previous Training).
- Notarized proof of completion of a basic law enforcement academy from a recognized law enforcement academy.
- Notarized certificate from a law enforcement Spanish class. Individuals without a certificate must successfully pass the NMLEA Spanish challenge exam during training.
- Documentation of the basic police academy course curriculum that was completed for basic law enforcement certification with beginning and ending dates of the basic training program including total number of basic academy training hours completed.
- Copy of P.O.S.T. certified training transcript, (if available)
- Copy of all advanced training certificates and in-service training certificates completed. Credit will only be given to training certificates that indicate the specific number of hours of training completed. No credit will be given for certificates that do not indicate hours of training.

Mail Entire Packet to:
 New Mexico Department of Public Safety
 Training Center, DPS/TRD
 4491 Cerrillos Road, Santa Fe, NM 87507

CBW Location: _____
 CBW Dates: _____

DPS Use Only:

- Basic Bureau CBW Review by: _____ Date _____
- Regional CBW Academy Review by: _____ Date _____

- Incomplete - Returned to applicant Date returned: _____
- Complete - Forwarded to Deputy Director Date forwarded: _____

Final Computation of Training Hours:

Basic Academy Hrs _____ Advanced/In-service Hours _____ Experience _____
 CBW Hrs _____ Total Hours: _____

DPS Use Only

- Director Approval By: _____ Date Approved _____
 - Director Rejected By: _____ Date Rejected _____
- Date notification sent to applicant: _____

- Cert. by Waiver
 Law
 Enforcement
 Checklist

Law Enforcement Cert by Waiver Candidates

- Letter to Director
- Form LEA-11
- Form LEA-13
- Notarized copy of certificate of graduation from academy.
- Notarized copy of certificate from a Survival Spanish class.
- Course curriculum (subject areas) and hours (in each subject) from the academy.
- If they're attending NMLEA CBW, the tuition (\$250 agency, \$350 civilian).

LETTER TO DIRECTOR

- Brief letter requesting review of prior training and certification for approval into the Certification by Waiver training course.

LEA-11

EMPLOYMENT HISTORY

Print Applicant's Name _____

Applicant's Address _____

City _____

State _____

Zip _____

Contact Phone Number _____

Contact email _____

1. Please print or type all employment for the past five years.
2. Please print all law enforcement experience regardless of dates.
3. Use additional sheets if necessary.

Beginning Employment Date:	<input type="text"/>	<input type="text"/>	Ending Employment Date:	<input type="text"/>	<input type="text"/>
	Month	Year		Month	Year
Name of Employer: _____					
Address: _____					
City: _____					
Beginning Employment Date:	<input type="text"/>	<input type="text"/>	Ending Employment Date:	<input type="text"/>	<input type="text"/>
	Month	Year		Month	Year
Name of Employer: _____					
Home Address: _____					
City: _____					
Beginning Employment Date:	<input type="text"/>	<input type="text"/>	Ending Employment Date:	<input type="text"/>	<input type="text"/>
	Month	Year		Month	Year
Name of Employer: _____					
Home Address: _____					
City: _____					

■ Employment History

LEA-11

EMPLOYMENT HISTORY

Print Applicant's Name _____

Applicant's Address _____

City _____

State _____

Zip _____

Contact Phone Number _____

Contact email _____

1. Please print or type all employment for the past five years.
2. Please print all law enforcement experience regardless of dates.
3. Use additional sheets if necessary.

Beginning Employment Date:	<input type="text"/>	<input type="text"/>	Ending Employment Date:	<input type="text"/>	<input type="text"/>
	Month	Year		Month	Year
Name of Employer: _____					
Address: _____					
City: _____					
Beginning Employment Date:	<input type="text"/>	<input type="text"/>	Ending Employment Date:	<input type="text"/>	<input type="text"/>
	Month	Year		Month	Year
Name of Employer: _____					
Home Address: _____					
City: _____					
Beginning Employment Date:	<input type="text"/>	<input type="text"/>	Ending Employment Date:	<input type="text"/>	<input type="text"/>
	Month	Year		Month	Year
Name of Employer: _____					
Home Address: _____					
City: _____					

- Only needs to be sent in for CBW candidates.
- Must go back 5 years and **all** law enforcement employment.

LEA-13



Status Verification Form Certification by Waiver of Previous Training

State of New Mexico
Department of Public Safety
Training & Recruiting Division
4491 Cerrillos Road
Santa Fe NM 87507
(505) 827-9251

Applicant Section

APPLICANT: Please write legibly or type the information in this section

I, _____ do hereby authorize any and all persons, organizations and agencies to release, furnish and exchange any and all information relating to me for the purpose of determining my eligibility and suitability to be certified as a law enforcement officer in the State of New Mexico. This authorizes release to the New Mexico DPS Training and Recruiting Division and _____ I do hereby release from any and all liability all persons or entities disclosing information pursuant to this release.

Name (Last, First, MI)	Social Security Number	Date of Birth (Month, Day, Year)
Previous State or Federal Agency Certification	Certification/License #	Type of Certification <input type="checkbox"/> Full-Time <input type="checkbox"/> Part-time <input type="checkbox"/> Reserve <input type="checkbox"/> Other:
Last Employing Agency	Date of Separation	Reason for Separation <input type="checkbox"/> Retired <input type="checkbox"/> Resigned <input type="checkbox"/> Terminated (Explain on separate sheet)
I certify that under the penalty of perjury that the above information is true. I understand that any falsification of the above information is grounds for denial or revocation of my New Mexico Law Enforcement Officer certification.		Subscribed and sworn before me this _____ day of _____.
Signature of Applicant _____ Date _____		By _____ (Attach Seal Here) Signature _____ Notary Public for the State of _____ And the County of _____ My Commission Expires: _____

Previous Law Enforcement Certifying State or Federal Agency Section

State/Federal Official: Please verify the information above, and provide the information below

The information provided by the applicant is: Correct Incorrect (Explain on separate sheet)

Employment History

(Please indicate all records of this applicant, most recent full-time employment first)

Agency	City, State	Rank/Position	Date Began	Date Separated	Month	Day	Year

Training History

(Please indicate all basic/entry level law enforcement training of this applicant that is mandated by your agency or state)

Course Name/Type	Location	Length (hours)	Date Began	Date Completed	Month	Day	Year

Status

Type of Certification	Level of Certification	Status of Certification	In Compliance With Mandated Continuing Ed. Requirements?
<input type="checkbox"/> Law Enforcement Officer	<input type="checkbox"/> Basic <input type="checkbox"/> Supervisory	<input type="checkbox"/> Current <input type="checkbox"/> Expired	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Limited Authority	<input type="checkbox"/> Intermediate <input type="checkbox"/> Mid-Mgt	<input type="checkbox"/> Decertified/Revoked	<input type="checkbox"/> N/A no requirement
<input type="checkbox"/> Other:	<input type="checkbox"/> Advanced <input type="checkbox"/> Executive	<input type="checkbox"/> Other:	<input type="checkbox"/> N/A Other:

A disciplinary/misconduct record exists for this applicant Yes No Date certification will expire: _____

Signature of Authorized Federal/State Official _____ Date _____ Agency _____

- Status Verification Form
- Common problems
 - Not completely filled out
 - **Bottom** Must be filled out by Previous Law Enforcement Certifying State or Federal Agency

Proof of Basic LE Academy

- Needs to be a notarized copy of certificate or diploma of completion.

Spanish Certificate

- Must have completed 16 hours or more of a law enforcement Spanish course.
- They can challenge the test without the training.
- One online course that is accepted is www.spanishonpatrol.com

Basic Academy Course Curriculum, Hours, dates attended

POST Transcript

In-service Training Certificates

- For the training certificates to be considered the certificate must have **total training hours** on them.

Return After Separation With No Break in Service

- *Required Forms for Law Enforcement*



CSNB Checklist

**CONTINUATION OF SERVICE
REACTIVATION OF NM CERTIFICATION
PAPERWORK CHECKLIST**

The following documents must be submitted for approval and verification of eligibility to be recognized as not having a break in service and re-activation of your NM Law Enforcement Certification. **Incomplete applications will be returned.**

ITEMS REQUIRED BY ALL APPLICANTS

- Letter** addressed to the Director requesting approval of recognition of no break in law enforcement service and re-activation of NM Certification.
- Form No. LEA-6** – Criminal History Affidavit.
- Form No. LEA-11A** – Employment History Form.
- Form No. LEA-13A** – Training Status Verification Form (One per employing agency must be submitted).
- Copy** of any P.O.S.T. or Federal certified training transcript. (if available)
- Copy** of all advanced training certificates and in-service training certificates completed.

Mail Entire Packet to:
New Mexico Department of Public Safety
Training Center, DPS/TRD
4491 Cerrillos Road, Santa Fe, NM 87507

DPS Use Only:

Review by: _____ Date _____

Incomplete - Returned to applicant Date returned: _____

Complete - Forwarded to Deputy Director Date forwarded: _____

Computation of Training Hours:
Basic Academy Hrs _____ Advanced/In-service Hours _____ Experience: _____
Total Hours: _____

Director Approval By: _____ Date Approved _____

Director Rejected By: _____ Date Rejected _____

Date notification sent to applicant: _____

- Letter to Director
- Form LEA-6
- Form LEA-11A
- Form LEA-13A
- **Copy** of any P.O.S.T. or Federal certified training transcript. (if available)
- **Copy** of all advanced training certificates and in-service training certificates completed

LEA-6

APPLICANT AFFIDAVIT CRIMINAL HISTORY

Have you ever been **arrested**? (Include juvenile offenses) (Attach separate pages if necessary.)
 Yes No If yes, explain charge, circumstance and date of occurrence along with **attaching offense/incident reports and court record of final disposition**:

Have you ever been **convicted** of any crime? (Attach separate pages if necessary.)
 Yes No If yes, explain charge, circumstance and date of occurrence along with **attaching offense/incident reports and court record of final disposition**.

Have you ever been **pardoned**, entered into a **pre-prosecution diversion** program, or received a **suspended** or **deferred** sentence for any crime?

Yes No If yes, explain charge, circumstance and date of occurrence along with **attaching offense/incident reports and court record of final disposition**.

Have you ever been the **subject** of an administrative investigation for law enforcement officer misconduct, or received any administrative discipline as a law enforcement officer? (Attach separate pages if necessary.)

Yes No If yes, explain charge, circumstance and date of occurrence:

Have you ever served in the armed forces of the United States?

Yes No If yes, attach a notarized copy of DD214 with character of service.

I certify the above is true and correct to the best of my knowledge.

Applicant Name _____ Date of Birth _____
(Print name)

Applicant Signature _____

State of New Mexico }
County of _____ } SS

On this _____ day of _____, _____, before me personally appeared

_____ known to me to be the person whose name is subscribed to
(Applicant)

the above instrument and acknowledged the same to be his/her own free act and deed.

Notary Public _____ My commission expires: _____
(SEAL)

- Applicant Affidavit
- Common reasons for return:
- Applies to juvenile crimes too.
- All “yes” responses require a copy of offense incident reports and Judgment and Sentencing



LEA-6

APPLICANT AFFIDAVIT CRIMINAL HISTORY

Have you ever been **arrested**? (Include juvenile offenses) (Attach separate pages if necessary.)

Yes No If yes, explain charge, circumstance and date of occurrence along with **attaching offense/incident reports and court record of final disposition**:

Have you ever been **convicted** of any crime? (Attach separate pages if necessary.)

Yes No If yes, explain charge, circumstance and date of occurrence along with **attaching offense/incident reports and court record of final disposition**.

Have you ever been **pardoned**, entered into a **pre-prosecution diversion** program, or received a **suspended** or **deferred** sentence for any crime?

Yes No If yes, explain charge, circumstance and date of occurrence along with **attaching offense/incident reports and court record of final disposition**.

Have you ever been the **subject** of an administrative investigation for law enforcement officer misconduct, or received any administrative discipline as a law enforcement officer? (Attach separate pages if necessary.)

Yes No If yes, explain charge, circumstance and date of occurrence:

Have you ever served in the armed forces of the United States?

Yes No If yes, attach a notarized copy of DD214 with character of service.

I certify the above is true and correct to the best of my knowledge.

Applicant Name _____ Date of Birth _____
(Print name)

Applicant Signature _____

State of New Mexico }
County of _____ } SS

On this _____ day of _____, _____, before me personally appeared

_____ known to me to be the person whose name is subscribed to
(Applicant)

the above instrument and acknowledged the same to be his/her own free act and deed.

Notary Public _____ My commission expires: _____
(SEAL)

- DD214 not attached.
- Submit letter of explanation on other than honorable and uncharacterized discharges from the military.
- Submit letter on any misconduct.



LEA-11A

EMPLOYMENT HISTORY

Print Applicant's Name _____

Applicant's Address _____

City _____

State _____

Zip _____

Contact Phone Number _____

Contact email _____

1. Please print or type all employment for the past five years.
2. Please print all law enforcement experience regardless of dates.
3. Use additional sheets if necessary.

Beginning Employment Date:	<input type="text"/>	<input type="text"/>	Ending Employment Date:	<input type="text"/>	<input type="text"/>
	Month	Year		Month	Year
Name of Employer: _____					
Address: _____					
City: _____					
Beginning Employment Date:	<input type="text"/>	<input type="text"/>	Ending Employment Date:	<input type="text"/>	<input type="text"/>
	Month	Year		Month	Year
Name of Employer: _____					
Address: _____					
City: _____					
Beginning Employment Date:	<input type="text"/>	<input type="text"/>	Ending Employment Date:	<input type="text"/>	<input type="text"/>
	Month	Year		Month	Year
Name of Employer: _____					
Address: _____					
City: _____					

- Employment History
- All law enforcement history. Must show that there was no break in service exceeding 2 years.

LEA-13A



Status Verification Form Certification by Waiver of Previous Training

State of New Mexico
Department of Public Safety
Training & Recruiting Division
4491 Cerrillos Road
Santa Fe NM 87507
(505) 827-9251

Applicant Section

APPLICANT: Please write legibly or type the information in this section

I, _____ do hereby authorize any and all persons, organizations and agencies to release, furnish and exchange any and all information relating to me for the purpose of determining my eligibility and suitability to be certified as a law enforcement officer in the State of New Mexico. This authorizes release to the New Mexico DPS Training and Recruiting Division and _____ I do hereby release from any and all liability all persons or entities disclosing information pursuant to this release.

Name (Last, First, MI)	Social Security Number	Date of Birth (Month, Day, Year)
Previous State or Federal Agency Certification	Certification/License #	Type of Certification <input type="checkbox"/> Full-Time <input type="checkbox"/> Part-time <input type="checkbox"/> Reserve <input type="checkbox"/> Other:
Last Employing Agency	Date of Separation	Reason for Separation <input type="checkbox"/> Retired <input type="checkbox"/> Resigned <input type="checkbox"/> Terminated (Explain on separate sheet)
I certify that under the penalty of perjury that the above information is true. I understand that any falsification of the above information is grounds for denial or revocation of my New Mexico Law Enforcement Officer certification.		Subscribed and sworn before me this _____ day of _____.
Signature of Applicant _____ Date _____		By _____ (Attach Seal Here) Signature _____ Notary Public for the State of _____ And the County of _____ My Commission Expires: _____

Previous Law Enforcement Certifying State or Federal Agency Section

State/Federal Official: Please verify the information above, and provide the information below

The information provided by the applicant is: Correct Incorrect (Explain on separate sheet)

Employment History

(Please indicate all records of this applicant, most recent full-time employment first)

Agency	City, State	Rank/Position	Date Began	Date Separated	Month	Day	Year
			Date Began	Date Separated			
			Date Began	Date Separated			
			Date Began	Date Separated			
			Date Began	Date Separated			
			Date Began	Date Separated			

Training History

(Please indicate all basic/entry level law enforcement training of this applicant that is mandated by your agency or state)

Course Name/Type	Location	Length (hours)	Date Began	Date Completed	Month	Day	Year
			Date Began	Date Completed			
			Date Began	Date Completed			
			Date Began	Date Completed			

Status

Type of Certification	Level of Certification	Status of Certification	In Compliance With Mandated Continuing Ed. Requirements?
<input type="checkbox"/> Law Enforcement Officer	<input type="checkbox"/> Basic <input type="checkbox"/> Supervisory	<input type="checkbox"/> Current <input type="checkbox"/> Expired	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Limited Authority	<input type="checkbox"/> Intermediate <input type="checkbox"/> Mid-Mgt	<input type="checkbox"/> Decertified/Revoked	<input type="checkbox"/> N/A no requirement
<input type="checkbox"/> Other:	<input type="checkbox"/> Advanced <input type="checkbox"/> Executive	<input type="checkbox"/> Other:	<input type="checkbox"/> N/A Other:

A disciplinary/misconduct record exists for this applicant Yes No Date certification will expire: _____

Signature of Authorized Federal/State Official _____

Date _____

Agency _____

- Status Verification Form
- Common problems
 - Not completely filled out
 - Must be filled out by Previous Law Enforcement Certifying Local, State, County, or Federal Agency. **One per employing agency.**

POST Transcript

In-service Training Certificates

Only for updating permanent training file. Not required for re-certification.

How to fill out the NMLEA BPOT Application Packet



- *Required Forms for Law Enforcement*
- *Common Reasons for Return*



BPOT Applicant Packet Checklist

POLICE OFFICER TRAINING PAPERWORK CHECKLIST

The following documents must be submitted for enrollment in the New Mexico Department of Public Safety Training Center's Basic Police Officer Training Program, or New Mexico Regional Academy Program. **Incomplete applications will be returned.**

ITEMS REQUIRED BY ALL APPLICANTS

- Form No. LEA-1** – Application for Admission/Certification.
- Form No. LEA-2** – Employment Verification. Form must have original signatures.
- Form No. LEA-3** – Medical Examination Procedures, Medical History Statement and Medical Selection Guidelines. Examination must be dated within one year prior to admission to applicable program. Must have original signatures. (pages 1-17).
- Form No. LEA-4** – Current Psychological Examination. Form must have original signatures. Examination must include psychologist's narrative and be dated within one year prior to admission to applicable programs.
- Form No. LEA-5** – Fingerprint Affidavit. Form must have original signatures. . *Submit only after FBI and DPS clearances have been received.*
- Form No. LEA-6** – Applicant Affidavit. Form must have original signatures.
- Form No. LEA-8** – Waiver of Liability. Form must have original signatures.
- Form No. LEA-9** – Release of Information. Form must have original signatures.
- Notarized** copy of high school diploma, G.E.D. certificate or college diploma.
- Form No. LEA-12** – Applicant Affidavit of United States Citizenship or proof of U.S. citizenship issued by an official government agency. **Hospital birth records and baptismal records are not acceptable. Photocopies of birth certificates and Naturalization papers are not legal under New Mexico Law.**
- Form No. LEA-14** – Physical Fitness Verification. Form must have original signatures.
- Form No. LEA-82** - Agency Employment Action. Form must have been previously submitted by employing agency or attached to this application.
- Notarized** copy of current valid driver's license.
- Notarized** copy of DD214 form (if applicant has had military service) must have character of service.

Mail Entire Packet to:
 New Mexico Department of Public Safety
 Training Center, DPS/TRD, ATTN: BASIC
 4491 Cerrillos Road, Santa Fe, NM 87507

DPS Use Only: DPS Use Only:

- Basic Bureau Review by: _____ Date _____
- Regional Academy Review by: _____ Date _____
- Incomplete - Returned to agency/academy _____ Date returned: _____
- Approved by Deputy Director _____ Date approved: _____
- Date Permanent file created: _____ File number _____

- Skills manger profile created by _____ Date _____
- Profile creation pending. Reason: _____

Academy Location: _____

Academy Dates _____

- Overall list of items needed to complete the packet.
- All items on the list are required.

Form LEA-1

BASIC TRAINING AND RE-CERTIFICATION REQUEST

CHECK APPROPRIATE CATEGORY	
Law Enforcement Officer	Public Safety Telecommunicator
<input type="checkbox"/> NMDPS Basic Training	<input type="checkbox"/> NMDPS Basic Public Safety Telecommunicator Training
<input type="checkbox"/> Certification by Waiver of Previous Training	<input type="checkbox"/> Certification by Waiver of Previous Training
<input type="checkbox"/> Previously New Mexico Certified	<input type="checkbox"/> NM Regional/Satellite Academy
<input type="checkbox"/> Previously Certified in another State	
<input type="checkbox"/> NM Regional/Satellite Academy	

Please type or print all information. Incomplete applications will be returned.

Name:				
	Last	First	Middle	Maiden
Date of Birth:	Place of Birth:		Social Security Number:	Race:
				Sex:
Applicant Mailing Address:	Street or P.O. Box			
(Applicant Telephone Number) ()	City	State	Zip	
AGENCY NAME:				
Agency Contact Person:	Name/Title:		Telephone Number	
Agency Mailing Address:	Street or P.O. Box			
	City	State	Zip	
Date of Employment:	Date of L.E. Commission:		Job Title:	
I certify that the foregoing information supplied by me is true and correct.				
Applicant Signature			Date	
DPS Use Only		DPS Use Only		
<input type="checkbox"/> Registry Input Processed By _____		<input type="checkbox"/> Training Processed By _____		
<input type="checkbox"/> Certification #: _____		<input type="checkbox"/> Permanent File#: _____		
Retired Law Enforcement Officer:		<input type="checkbox"/> Yes <input type="checkbox"/> No		

Application for Admission/Certification.

Form LEA-1

BASIC TRAINING AND RE-CERTIFICATION REQUEST

CHECK APPROPRIATE CATEGORY	
Law Enforcement Officer	Public Safety Telecommunicator
<input type="checkbox"/> NMDPS Basic Training	<input type="checkbox"/> NMDPS Basic Public Safety Telecommunicator Training
<input type="checkbox"/> Certification by Waiver of Previous Training	<input type="checkbox"/> Certification by Waiver of Previous Training
<input type="checkbox"/> Previously New Mexico Certified	<input type="checkbox"/> NM Regional/Satellite Academy
<input type="checkbox"/> Previously Certified in another State	
<input type="checkbox"/> NM Regional/Satellite Academy	

■ Common reasons for return:

Please type or print all information. Incomplete applications will be returned.

Name:				
	Last	First	Middle	Maiden
Date of Birth:	Place of Birth:		Social Security Number:	Race:
				Sex:
Applicant Mailing Address:	<small>Street or P.O. Box</small>			
(Applicant Telephone Number) ()	City	State	Zip	
AGENCY NAME:				
Agency Contact Person:	Name/Title:		Telephone Number	
Agency Mailing Address:	<small>Street or P.O. Box</small>			
	City	State	Zip	
Date of Employment:	Date of L.E. Commission:		Job Title:	
I certify that the foregoing information supplied by me is true and correct.				
Applicant Signature			Date	
DPS Use Only		DPS Use Only		
<input type="checkbox"/> Registry Input Processed By _____		<input type="checkbox"/> Training Processed By _____		
<input type="checkbox"/> Certification #: _____		<input type="checkbox"/> Permanent File#: _____		
Retired Law Enforcement Officer:		<input type="checkbox"/> Yes <input type="checkbox"/> No		

Form LEA-1

BASIC TRAINING AND RE-CERTIFICATION REQUEST

CHECK APPROPRIATE CATEGORY	
Law Enforcement Officer <input type="checkbox"/> NMDPS Basic Training <input type="checkbox"/> Certification by Waiver of Previous Training <input type="checkbox"/> Previously New Mexico Certified <input type="checkbox"/> Previously Certified in another State <input type="checkbox"/> NM Regional/Satellite Academy	Public Safety Telecommunicator <input type="checkbox"/> NMDPS Basic Public Safety Telecommunicator Training <input type="checkbox"/> Certification by Waiver of Previous Training <input type="checkbox"/> NM Regional/Satellite Academy

Please type or print all information. Incomplete applications will be returned.

Name:		Last		First		Middle		Maiden	
Date of Birth:		Place of Birth:		Social Security Number:		Race:		Sex:	
Applicant Mailing Address:		Street or P.O. Box							
(Applicant Telephone Number) ()		City		State		Zip			
AGENCY NAME:									
Agency Contact Person:		Name/Title:				Telephone Number			
Agency Mailing Address:		Street or P.O. Box							
		City		State		Zip			
Date of Employment:		Date of L.E. Commission:				Job Title:			
I certify that the foregoing information supplied by me is true and correct.									
_____ Applicant Signature					_____ Date				
DPS Use Only					DPS Use Only				
<input type="checkbox"/> Registry Input Processed By _____					<input type="checkbox"/> Training Processed By _____				
<input type="checkbox"/> Certification #: _____					<input type="checkbox"/> Permanent File#: _____				
Retired Law Enforcement Officer:					<input type="checkbox"/> Yes <input type="checkbox"/> No				

- Not the Original.
- Date of Employment v. Date of Commission.
- No Signature.
- Applicants home address is required

LEA-3, Pg 1-6

MEDICAL EXAMINATION PROCEDURE

admission to a Basic Police Officer Training (BPOT) or Certification by Waiver of Previous Training at the Academy or an accredited regional/satellite academy, all applicants must undergo a medical examination by a licensed physician. This examination must be conducted in accordance with the Medical Selection Guidelines. The examination is considered valid for 1 year. The Academy will provide standard medical examination forms to be completed by the examining physician.

Following are the minimum requirements for the medical examination:

History

Applicant must complete, sign and date the Medical History Statement.

Physician's Examination

The examining physician will review the applicant's Medical History Statement and the Medical Selection Guidelines (Section G of 10.29.17 NMAC - Tab 2 of Reference Guide) prior to completing, signing, and dating the Medical Selection Report.

Required Tests

Following laboratory tests are required:

Results outside of established norms must be recorded and explained on page 17 of this section.)

Blood Chemistry (Chem 20 or equivalent)

Complete Blood Count (CBC)

Complete Urinalysis (not Dipstick)

Serology (RPR or equivalent)

Tuberculosis (Mantoux)

Electrocardiogram (ECG) (Resting)

Chest X-ray (CXR) **Only required if #5 is positive.**

Drug Screen (THC, Cocaine, Amphetamines, Opiates, Barbiturates, Methadone, Methaqualone, Phenpropoxyphene, Benzodiazepines, Alcohol, Anabolic Steroids)

Physically Excludable Conditions

A "Potentially Excludable Condition," as used in the Medical Selection Guidelines, means condition or conditions that result in test results outside of the established standard or generally accepted medical norms. Any potentially excludable condition must be identified and explained by the examining physician on a separate form.

Physical Performance Screening Standards

All applicants must demonstrate a minimum fitness level as measured by five tests that identify specific fitness. These tests are measured at the 40th percentile and based upon standards established by the Insular Research. BPOT applicants must meet or exceed the passing score for each test to be enrolled in the Accredited regional/satellite academy. Fitness screening standards are listed in the Physical Performance Information. BPOT applicants are required to complete the 1.5 mile run and 300 meter run at the 60th percentile and CBW applicants are required to complete the 1.5 mile run and 300 meter run at the 60th percentile and the two agility courses prior to certification.

Physical Conditioning Program

The physical conditioning program involves exercise that focuses on cardio-respiratory endurance (aerobics), speed, and neuromuscular coordination (agility, balance, etc.). Exercise sessions are both high intensity and low intensity. Specific information on the Physical Conditioning Program is detailed in the Physical Performance Information.

■ Medical Exam Procedure.

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MEDICAL HISTORY STATEMENT

The New Mexico Statute 29-7-6 requires that law enforcement officer applicants be examined by a licensed physician to ensure that the applicant is free of any physical defect or medical conditions which might adversely affect job performance or the applicant's ability to successfully complete a prescribed basic law enforcement course.

The information you provide in this statement is extremely important. This statement will be reviewed by the examining physician prior to evaluating your qualifications for the position of law enforcement officer. Therefore, please fill out the questionnaire completely and accurately. Please note that: (a) all statements are subject to verification, and (b) deliberate inaccuracies or incomplete statements may bar or remove you from employment.

This Statement was designed to explore those areas that bear directly upon the physical demands of the position for which you are applying. A thorough and accurate evaluation of this information will contribute to sound employment decisions benefiting both you and your potential employer.

This Statement is confidential. If hired, the information you provide will be a part of your medical records. When answering "Yes/No" questions, place an "X" in the appropriate box. If you are unable to answer a question for any reason, place a "?" in the "Yes" box.

Name Last _____ First _____ Middle _____	Date of Birth Month / Day / Year ____ / ____ / ____	Social Security No. In accordance with the Federal Privacy Act of 1974, disclosure is voluntary. The SSN will be used for identification purposes to ensure that proper records are maintained. ____ - ____ - ____
Address Street or P.O. Box _____ City _____ State _____ Zip _____	Work () _____ - _____ Home () _____ - _____	

I, the undersigned, do hereby consent to undergo a medical examination, including blood specimens, X-rays, skin tests, immunizations, and other examinations which the examiners may consider necessary to complete the medical evaluation.

Signature in Full: _____ Date Completed: _____

■ No Signature.

■ Not the Original.

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MEDICAL HISTORY STATEMENT

1. Have you been medically examined for employment in this agency before? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes," your name at the time?																							
2. Please list all medications you regularly use, including vitamins, birth control pills, laxatives, aspirins, antihistamines, tranquilizers, and weight reducing aids.																							
3. Please list any medicines you have taken in the last two months (<i>prescription and non-prescription</i>).																							
4. Name any drugs to which you may have ever had an allergic reaction.																							
5. Please list any other substance to which you are allergic, including food, insect stings, etc.																							
6. Please list your last three hospitalizations, beginning with most recent (<i>excluding routine childbirth</i>).																							
Reason	Hospital/City	Month	Year																				
Reason	Hospital/City	Month	Year																				
Reason	Hospital/City	Month	Year																				
7. Please list any operations you may have had which are not listed above.																							
8. If a parent, grandparent, brother or sister has had any of the following diseases, please check the correct spaces.																							
	Mother	Father	Other																				
DISEASE																							
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																				
Cancer/Tumor	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																				
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																				
	Mother	Father	Other																				
DISEASE																							
Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																				
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																				
Hereditary or Familial Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																				
Have you ever been exposed to any of the following, whether at home, work, or in any other setting? <table border="0"> <tr> <td>9.</td> <td><input type="checkbox"/> Yes</td> <td><input type="checkbox"/> No</td> <td><input type="checkbox"/> Prolonged loud noises?</td> </tr> <tr> <td>10.</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/> Substances which irritated your skin or eyes?</td> </tr> <tr> <td>11.</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/> Sprays or powders for insects or plants?</td> </tr> <tr> <td>12.</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/> Prolonged X-rays or other radiations?</td> </tr> <tr> <td>13.</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/> Dusty conditions such as sandblasting, grinding or drilling of rock, coal, silica, asbestos, or asbestos products?</td> </tr> </table>				9.	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Prolonged loud noises?	10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Substances which irritated your skin or eyes?	11.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Sprays or powders for insects or plants?	12.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Prolonged X-rays or other radiations?	13.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Dusty conditions such as sandblasting, grinding or drilling of rock, coal, silica, asbestos, or asbestos products?
9.	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Prolonged loud noises?																				
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Substances which irritated your skin or eyes?																				
11.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Sprays or powders for insects or plants?																				
12.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Prolonged X-rays or other radiations?																				
13.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Dusty conditions such as sandblasting, grinding or drilling of rock, coal, silica, asbestos, or asbestos products?																				
Have a bad reaction to: 14. <input type="checkbox"/> <input type="checkbox"/> High environmental temperatures? 15. <input type="checkbox"/> <input type="checkbox"/> Low environmental temperature?																							

- Medical History Statement, cont'd.
- Questions 9-123 If unable to answer place a question mark in the yes box.
- Do not leave any blanks

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MEDICAL HISTORY STATEMENT

	Yes	No	
16.	<input type="checkbox"/>	<input type="checkbox"/>	Have you been rejected by the military for health reasons?
17.	<input type="checkbox"/>	<input type="checkbox"/>	Were you ever in the Armed Services? If "Yes", please enter the following:
18.	<input type="checkbox"/>	<input type="checkbox"/>	Did you receive a medical discharge?
Have you ever had a claim for the following:			
19.	<input type="checkbox"/>	<input type="checkbox"/>	An occupational disease?
20.	<input type="checkbox"/>	<input type="checkbox"/>	An industrial accident?
21.	<input type="checkbox"/>	<input type="checkbox"/>	Have you any claim now pending for the above?
If you have ever had or now have any of the following, please check the appropriate spaces.			
			Yes No
22.	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis
23.	<input type="checkbox"/>	<input type="checkbox"/>	Pneumonia
24.	<input type="checkbox"/>	<input type="checkbox"/>	Bronchitis
25.	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema
26.	<input type="checkbox"/>	<input type="checkbox"/>	Asthma
27.	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure
28.	<input type="checkbox"/>	<input type="checkbox"/>	Heart Murmur, Heart Disease
29.	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic Fever
30.	<input type="checkbox"/>	<input type="checkbox"/>	Encephalitis, Meningitis
31.	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy, Convulsions
32.	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma
33.	<input type="checkbox"/>	<input type="checkbox"/>	Duodenal or Stomach Ulcer
34.	<input type="checkbox"/>	<input type="checkbox"/>	Gall Bladder Trouble
35.	<input type="checkbox"/>	<input type="checkbox"/>	Liver Trouble or Hepatitis
36.	<input type="checkbox"/>	<input type="checkbox"/>	Hiatal or Diaphragmatic Hernia
37.	<input type="checkbox"/>	<input type="checkbox"/>	Sickle Cell Disease
38.	<input type="checkbox"/>	<input type="checkbox"/>	Anemia
39.	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes (Sugar Disease)
40.	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease
41.	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatism
42.	<input type="checkbox"/>	<input type="checkbox"/>	Varicose Veins
43.	<input type="checkbox"/>	<input type="checkbox"/>	Phlebitis
44.	<input type="checkbox"/>	<input type="checkbox"/>	Hay Fever
45.	<input type="checkbox"/>	<input type="checkbox"/>	Typhoid Fever
46.	<input type="checkbox"/>	<input type="checkbox"/>	Scarlet Fever
47.	<input type="checkbox"/>	<input type="checkbox"/>	Valley Fever (Coccidioidomycosis)
48.	<input type="checkbox"/>	<input type="checkbox"/>	Histoplasmosis
49.	<input type="checkbox"/>	<input type="checkbox"/>	Venereal Disease (VD, Syphilis, Gonorrhea)
50.	<input type="checkbox"/>	<input type="checkbox"/>	Cancer
51.	<input type="checkbox"/>	<input type="checkbox"/>	Hyperthyroidism
52.	<input type="checkbox"/>	<input type="checkbox"/>	Hypothyroidism
53.	<input type="checkbox"/>	<input type="checkbox"/>	Allergic Rhinitis
54.	<input type="checkbox"/>	<input type="checkbox"/>	Other (Explain Below)

55.	<input type="checkbox"/>	<input type="checkbox"/>	Have you gained or lost more than 10 pounds in past two years without trying to do so?
56.	<input type="checkbox"/>	<input type="checkbox"/>	Have you had any changes in your appetite in the past six months?
57.	<input type="checkbox"/>	<input type="checkbox"/>	Have you noticed unusual fatigue or weakness recently?
58.	<input type="checkbox"/>	<input type="checkbox"/>	Have you been told by a doctor that you had trouble with your thyroid gland?
59.	<input type="checkbox"/>	<input type="checkbox"/>	Have you noticed changes in your hair or skin color or texture?
60.	<input type="checkbox"/>	<input type="checkbox"/>	Have you had changes in the size or color of a mole (dark growth) or wart in past year?
61.	<input type="checkbox"/>	<input type="checkbox"/>	Do you have a skin rash, burning, itching or other skin sensitivity?
62.	<input type="checkbox"/>	<input type="checkbox"/>	Have you had any skin cancers removed?
63.	<input type="checkbox"/>	<input type="checkbox"/>	Have you had bleeding gums in the past year?
64.	<input type="checkbox"/>	<input type="checkbox"/>	Do you have frequent nosebleeds for no apparent reason?
65.	<input type="checkbox"/>	<input type="checkbox"/>	Do you frequently have sinus trouble?
66.	<input type="checkbox"/>	<input type="checkbox"/>	Do you have colds more than twice a month?
67.	<input type="checkbox"/>	<input type="checkbox"/>	Have you ever coughed up blood?

■ Medical History Statement, cont'd.

■ Common reasons for return:

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MEDICAL HISTORY STATEMENT

	Yes	No			
16.	<input type="checkbox"/>	<input type="checkbox"/>	Have you been rejected by the military for health reasons?		
17.	<input type="checkbox"/>	<input type="checkbox"/>	Were you ever in the Armed Services? If "Yes", please enter the following:		
18.	<input type="checkbox"/>	<input type="checkbox"/>	Did you receive a medical discharge?		
Have you ever had a claim for the following:					
19.	<input type="checkbox"/>	<input type="checkbox"/>	An occupational disease?		
20.	<input type="checkbox"/>	<input type="checkbox"/>	An industrial accident?		
21.	<input type="checkbox"/>	<input type="checkbox"/>	Have you any claim now pending for the above?		
If you have ever had or now have any of the following, please check the appropriate spaces.					
				Yes	No
22.	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
23.	<input type="checkbox"/>	<input type="checkbox"/>	Pneumonia	<input type="checkbox"/>	<input type="checkbox"/>
24.	<input type="checkbox"/>	<input type="checkbox"/>	Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>
25.	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema	<input type="checkbox"/>	<input type="checkbox"/>
26.	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>
27.	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
28.	<input type="checkbox"/>	<input type="checkbox"/>	Heart Murmur, Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>
29.	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>
30.	<input type="checkbox"/>	<input type="checkbox"/>	Encephalitis, Meningitis	<input type="checkbox"/>	<input type="checkbox"/>
31.	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy, Convulsions	<input type="checkbox"/>	<input type="checkbox"/>
32.	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>
33.	<input type="checkbox"/>	<input type="checkbox"/>	Duodenal or Stomach Ulcer	<input type="checkbox"/>	<input type="checkbox"/>
34.	<input type="checkbox"/>	<input type="checkbox"/>	Gall Bladder Trouble	<input type="checkbox"/>	<input type="checkbox"/>
35.	<input type="checkbox"/>	<input type="checkbox"/>	Liver Trouble or Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>
36.	<input type="checkbox"/>	<input type="checkbox"/>	Hiatal or Diaphragmatic Hernia	<input type="checkbox"/>	<input type="checkbox"/>
37.	<input type="checkbox"/>	<input type="checkbox"/>	Sickle Cell Disease		
38.	<input type="checkbox"/>	<input type="checkbox"/>	Anemia		
39.	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes (Sugar Disease)		
40.	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease		
41.	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatism		
42.	<input type="checkbox"/>	<input type="checkbox"/>	Varicose Veins		
43.	<input type="checkbox"/>	<input type="checkbox"/>	Phlebitis		
44.	<input type="checkbox"/>	<input type="checkbox"/>	Hay Fever		
45.	<input type="checkbox"/>	<input type="checkbox"/>	Typhoid Fever		
46.	<input type="checkbox"/>	<input type="checkbox"/>	Scarlet Fever		
47.	<input type="checkbox"/>	<input type="checkbox"/>	Valley Fever (Coccidioidomycosis)		
48.	<input type="checkbox"/>	<input type="checkbox"/>	Histoplasmosis		
49.	<input type="checkbox"/>	<input type="checkbox"/>	Venereal Disease (VD, Syphilis, Gonorrhea)		
50.	<input type="checkbox"/>	<input type="checkbox"/>	Cancer		
51.	<input type="checkbox"/>	<input type="checkbox"/>	Hyperthyroidism		
52.	<input type="checkbox"/>	<input type="checkbox"/>	Hypothyroidism		
53.	<input type="checkbox"/>	<input type="checkbox"/>	Allergic Rhinitis		
54.	<input type="checkbox"/>	<input type="checkbox"/>	Other (Explain Below)		
55.	<input type="checkbox"/>	<input type="checkbox"/>	Have you gained or lost more than 10 pounds in past two years without trying to do so?		
56.	<input type="checkbox"/>	<input type="checkbox"/>	Have you had any changes in your appetite in the past six months?		
57.	<input type="checkbox"/>	<input type="checkbox"/>	Have you noticed unusual fatigue or weakness recently?		
58.	<input type="checkbox"/>	<input type="checkbox"/>	Have you been told by a doctor that you had trouble with your thyroid gland?		
59.	<input type="checkbox"/>	<input type="checkbox"/>	Have you noticed changes in your hair or skin color or texture?		
60.	<input type="checkbox"/>	<input type="checkbox"/>	Have you had changes in the size or color of a mole (dark growth) or wart in past year?		
61.	<input type="checkbox"/>	<input type="checkbox"/>	Do you have a skin rash, burning, itching or other skin sensitivity?		
62.	<input type="checkbox"/>	<input type="checkbox"/>	Have you had any skin cancers removed?		
63.	<input type="checkbox"/>	<input type="checkbox"/>	Have you had bleeding gums in the past year?		
64.	<input type="checkbox"/>	<input type="checkbox"/>	Do you have frequent nosebleeds for no apparent reason?		
65.	<input type="checkbox"/>	<input type="checkbox"/>	Do you frequently have sinus trouble?		
66.	<input type="checkbox"/>	<input type="checkbox"/>	Do you have colds more than twice a month?		
67.	<input type="checkbox"/>	<input type="checkbox"/>	Have you ever coughed up blood?		

- Missing boxes – the columns on the right hand side of the page are overlooked. (#'s 40-54)

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MEDICAL HISTORY STATEMENT

	Yes	No	
68.	<input type="checkbox"/>	<input type="checkbox"/>	Have you had a chest X-ray in the past two years?
69.	<input type="checkbox"/>	<input type="checkbox"/>	Do you often cough up a large amount of mucus?
70.	<input type="checkbox"/>	<input type="checkbox"/>	Have you ever had a positive TB (Tuberculosis) skin test?
71.	<input type="checkbox"/>	<input type="checkbox"/>	Do you have unusual shortness of breath?
72.	<input type="checkbox"/>	<input type="checkbox"/>	Do your ankles or feet often swell?
73.	<input type="checkbox"/>	<input type="checkbox"/>	Have you had a feeling of pressure or tightness in your chest in the past year?
74.	<input type="checkbox"/>	<input type="checkbox"/>	Have you had a pain in your chest in the past year?
75.	<input type="checkbox"/>	<input type="checkbox"/>	Do you sometimes wake up at night short of breath?
76.	<input type="checkbox"/>	<input type="checkbox"/>	Do you get pains or cramps in the back of your legs while walking?
77.	<input type="checkbox"/>	<input type="checkbox"/>	Do you get pains or cramps in your legs at night?
78.	<input type="checkbox"/>	<input type="checkbox"/>	Do you smoke cigarettes? How many per day_____?
79.	<input type="checkbox"/>	<input type="checkbox"/>	Do you use any forms of tobacco?
80.	<input type="checkbox"/>	<input type="checkbox"/>	Do you sometimes have severe soaking sweats at night?
81.	<input type="checkbox"/>	<input type="checkbox"/>	Have you had an electrocardiogram (ECG,EKG) in the past two years?
82.	<input type="checkbox"/>	<input type="checkbox"/>	Do you suffer from indigestion or heartburn?
83.	<input type="checkbox"/>	<input type="checkbox"/>	Is swallowing painful or difficult for you?
84.	<input type="checkbox"/>	<input type="checkbox"/>	Do you frequently have pain in your stomach or abdomen?
85.	<input type="checkbox"/>	<input type="checkbox"/>	Do you frequently take antacid medications, such as Tums or Alka Seltzers?
86.	<input type="checkbox"/>	<input type="checkbox"/>	Have you vomited blood or coffee ground-like materials?
87.	<input type="checkbox"/>	<input type="checkbox"/>	Have you ever had jaundice?
88.	<input type="checkbox"/>	<input type="checkbox"/>	Are your bowel movements ever black or bloody?
89.	<input type="checkbox"/>	<input type="checkbox"/>	Are your bowel movements ever painful?
90.	<input type="checkbox"/>	<input type="checkbox"/>	Have you ever had hemorrhoids?
91.	<input type="checkbox"/>	<input type="checkbox"/>	Do you frequently get up at night to urinate (pass water)?
92.	<input type="checkbox"/>	<input type="checkbox"/>	Do you ever have difficulty stopping or starting urination?
93.	<input type="checkbox"/>	<input type="checkbox"/>	Have you had pain or burning with urination?
94.	<input type="checkbox"/>	<input type="checkbox"/>	Has your urine ever been red, black, brown, or bloody?
95.	<input type="checkbox"/>	<input type="checkbox"/>	Have you ever been told by a doctor that you had sugar or pus in your urine?
96.	<input type="checkbox"/>	<input type="checkbox"/>	Have you ever had a bladder or kidney infection?
97.	<input type="checkbox"/>	<input type="checkbox"/>	Have you ever passed kidney stones or gravel?
98.	<input type="checkbox"/>	<input type="checkbox"/>	Have you ever had a hernia (rupture)? If "Yes", was it surgically repaired?_____
99.	<input type="checkbox"/>	<input type="checkbox"/>	Have you ever had a minor back sprain? If "Yes," please answer the following: How many times have you had an attack of this condition?_____ How many days were you unable to work because of this condition?____
100.	<input type="checkbox"/>	<input type="checkbox"/>	Have you ever had a severe back injury or episode of severe back pain? If "Yes," please answer the following: How many times have you had an attack of this condition?_____ How many days were you unable to work because of this condition?____
101.	<input type="checkbox"/>	<input type="checkbox"/>	Have you ever had problems with low back pain?
102.	<input type="checkbox"/>	<input type="checkbox"/>	Have you ever had a problem with any bones or joints, including fractures, dislocations, limitation of movement, stiffness, or pain? If "Yes," please describe the problems: _____
103.	<input type="checkbox"/>	<input type="checkbox"/>	Have you had any fainting spells or seizures?
104.	<input type="checkbox"/>	<input type="checkbox"/>	Have you had a skull fracture or a head injury which made you unconscious?
105.	<input type="checkbox"/>	<input type="checkbox"/>	Do you suffer from migraine headaches or other bad headaches?
106.	<input type="checkbox"/>	<input type="checkbox"/>	When you have a headache is it relieved by aspirin?

- Medical History Statement, cont'd.
- Common reasons for return:
- Missing Boxes
- Read question 106 carefully.

LEA-3, Pg 11

MEDICAL HISTORY STATEMENT

107. Do you have earaches or ear infections often?
108. Do you have ringing or buzzing noises in your ear?
109. Do you sometimes have difficulty hearing what is said to you?
110. Have you had any serious eye infection or injury?
111. Does your eye sight ever blur?
112. Have you had any sudden loss in your vision?

MEN ONLY

113. Have you ever been told by a doctor that you had prostate trouble?
114. Have you ever had an infection in your prostate gland?
115. Have you ever had swelling or pain in your scrotum or testicles?

WOMEN ONLY

116. Do you have monthly menstrual periods?
117. What was the date of your last period? _____
118. Are your menstrual periods painful?
119. When was your last pap smear? _____
120. Have you ever noticed any unusual lumps in your breasts?
121. Have you ever noticed a discharge from your nipples when you were neither pregnant nor nursing?
122. How many times have you been pregnant? _____
123. Have you ever had complications during pregnancy or following the delivery of a child?

124. Describe anything else which you feel may be important in your medical history, including any conditions not specifically referred to in the preceding questions.

I certify that all statements in this Medical History Statement are true and complete, and I understand that any misstatements of material facts may subject me to disqualification or dismissal.

Signature in Full _____

Date Statement Completed _____

- Medical History Statement, cont'd.
- Common reasons for return:
- All questions are required if they apply.
- Signature and date on bottom.

LEA-EV

VISION ACCOMMODATION REQUEST

1. Applicant Name (Last, First, Middle)	2. Birth Date (Mo./ Day/Year)
3. Department	
Eye and Vision Accommodation <small>This applicant exceeds minimum standards for uncorrected Distant vision: > 20/100 as tested on Section 1.1, page 12, of Medical form LEA-3. Agency must attest below to requiring the officer to wear corrective lenses at all times while functioning in an official capacity in the performance of their law enforcement duties.</small>	
I, _____ certify that _____ Please type or print Department Head Applicant	
As a member of this agency will wear corrective lenses at all times while in the official performance of their duties.	
Department Head Signature _____	
State of New Mexico } County of _____}SS	
On this _____ day of _____, _____, before me personally appeared _____ known to me to be the person whose name is subscribed Department Head	
to the above instrument and acknowledged the same to be his/her own free act and deed.	
Notary Public _____ My commission expires: _____	
(SEAL)	

LEA-CV

COLOR VISION ACCOMODATION FIELD EXAM

1. Applicant Name (Last, First, Middle)	2. Birth Date (Mo./ Day/Year)
3. Department	
<p>Color Vision Accommodation Field Exam This applicant failed to meet the minimum standards for color vision as tested on Section 1.3, page 12, section 1.3 of Medical form LEA-3. Applicants that fail the Ishihara (24 Plate Edition) have recourse of taking the Farnsworth-Munsell 100-hue Test. If this test is also failed the field test may be administered and the employing agency must attest below to the administration and successful completion of the field accommodation exam. Both field tests must be passed at 100%.</p> <p>FIRST TEST: With five vehicles parked next to each other, applicant correctly identifies the color of five vehicles. 100% accuracy is required.</p> <p><input type="checkbox"/> Red vehicle correctly identified <input type="checkbox"/> Blue vehicle correctly identified <input type="checkbox"/> Green vehicle correctly identified <input type="checkbox"/> Brown vehicle correctly identified <input type="checkbox"/> Gray vehicle correctly identified</p> <p><input type="checkbox"/> Applicant failed to correctly identify all vehicles correctly (100%).</p> <p>SECOND TEST: With five individuals gathered in the same room, all wearing similar clothing, i.e. hat, shirt, pants, applicant will correctly identify the individual suspect wearing the Red baseball style cap, Brown shirt, and Blue pants.:</p> <p>Suspect#1: Green baseball style cap, Blue shirt, and Blue pants. Suspect #2: Red baseball style cap, Green shirt, and Brown pants. Suspect #3: Blue baseball style cap, Red shirt, and Blue pants. Suspect #4: Red baseball style cap, Brown shirt, and Blue pants. Suspect #5: Brown baseball style cap, Green shirt, and Blue pants.</p> <p><input type="checkbox"/> Suspect correctly identified <input type="checkbox"/> Applicant failed to correctly identify correct suspect.</p>	
<p>I, _____ certify that the listed field exam for color vision was <small>Please type or print Department Head</small> conducted on _____ by _____ on <small>Applicant Officer/Department representative</small> (date) _____ and the results listed are correct.</p> <p>Department Head Signature _____</p> <p>State of New Mexico } County of _____ }SS</p> <p>On this _____ day of _____, _____, before me personally appeared _____ known to me to be the person whose name is subscribed <small>Department Head</small> to the above instrument and acknowledged the same to be his/her own free act and deed. Notary Public _____ My commission expires: _____</p> <p>(SEAL)</p>	

LEA-3, Pg 13

Applicant Name (Last, First, Middle)		
SECTION TWO Ears and Hearing		
Minimum Hearing Standards for Police Officers		
The average hearing level (HL) at the test frequencies, 500, 1000, and 2000 Hz will not exceed 25dB in either ear, and no single hearing level will exceed 30 dB at any of these test frequencies in either ear.		
Hearing loss at 3000 Hz will not exceed 40 dB HL in either ear.		
2.1 Hearing Acuity (Audiogram Required) Right (Decibels) Left (Decibels) (Hertz) 500 _____ (Hertz) 500 _____ 1000 _____ 1000 _____ 2000 _____ 2000 _____ 3000 _____ 3000 _____	Record the values at each Hz level _____ Name of Examiner (Please Print) NM Lic. # _____ Signature <input type="checkbox"/> Audiologist <input type="checkbox"/> Other	Potentially Excludable Condition <input type="checkbox"/>
2.2 Acute Otitis Media, Otitis Externa, and Mastoiditis 2.3 Inner/Middle/Outer Ear Disorder Affecting Equilibrium		<input type="checkbox"/> <input type="checkbox"/>
The conditions listed in Section Three through Section Thirteen are not meant to be exclusive. If the examining physician feels (an)other unstated condition(s) may adversely impact the ability of the candidate to perform the essential tasks of the job, it (they) should be noted for further evaluation. PHYSICIAN - please mark box if condition exists. Also, initial sections indicating examinations performed.		
SECTION THREE Nose, Throat and Mouth		
<input type="checkbox"/> 3.1 Loss of Sense of Smell <input type="checkbox"/> 3.2 Aphonia, Speech Loss or Speech Defects Initials: _____ <input type="checkbox"/> 3.3 Deformities Interfering with the Proper Fitting of a Gas Mask		
Head (Note any defect, disease or injury involving eyes, ears, nose, throat or mouth)		Dentistry Recommended <input type="checkbox"/> Yes <input type="checkbox"/> No
Lungs	Date Chest X-rays Taken	Chest X-rays Normal <input type="checkbox"/> Yes <input type="checkbox"/> No (report may be attached)

■ Ears and Hearing

■ Common reasons for return:

LEA-3, Pg 13

Applicant Name (Last, First, Middle)		
SECTION TWO Ears and Hearing		
Minimum Hearing Standards for Police Officers		
The average hearing level (HL) at the test frequencies, 500, 1000, and 2000 Hz will not exceed 25dB in either ear, and no single hearing level will exceed 30 dB at any of these test frequencies in either ear.		
Hearing loss at 3000 Hz will not exceed 40 dB HL in either ear.		
2.1 Hearing Acuity (Audiogram Required) Record the values at each Hz level Right (Decibels) Left (Decibels) (Hertz) 500 _____ (Hertz) 500 _____ 1000 _____ 1000 _____ 2000 _____ 2000 _____ 3000 _____ 3000 _____ If the hearing examination has been completed by a person other than the physician signing on Page 17, please indicate below: Name of Examiner (Please Print) _____ NM Lic. # _____ Signature <input type="checkbox"/> Audiologist <input type="checkbox"/> Other _____	Potentially Excludable Condition <input type="checkbox"/>	
2.2 Acute Otitis Media, Otitis Externa, and Mastoiditis 2.3 Inner/Middle/Outer Ear Disorder Affecting Equilibrium	<input type="checkbox"/> <input type="checkbox"/>	
The conditions listed in Section Three through Section Thirteen are not meant to be exclusive. If the examining physician feels (an)other unstated condition(s) may adversely impact the ability of the candidate to perform the essential tasks of the job, it (they) should be noted for further evaluation. PHYSICIAN - please mark box if condition exists. Also, initial sections indicating examinations performed.		
SECTION THREE Nose, Throat and Mouth		
<input type="checkbox"/> 3.1 Loss of Sense of Smell <input type="checkbox"/> 3.2 Aphonia, Speech Loss or Speech Defects <input type="checkbox"/> 3.3 Deformities Interfering with the Proper Fitting of a Gas Mask		
Head (Note any defect, disease or injury involving eyes, ears, nose, throat or mouth)		Dentistry Recommended <input type="checkbox"/> Yes <input type="checkbox"/> No
Lungs	Date Chest X-rays Taken	Chest X-rays Normal <input type="checkbox"/> Yes <input type="checkbox"/> No (report may be attached)

- Values at each Hz level are not recorded.
- If hearing exam is completed by someone other than Physician signing on page 17 then form needs to be signed.
- Form LEA-EH is required if value(s) are over minimum standard

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Applicant Name (Last, First, Middle)					
SECTION FOUR <u>Peripheral Vascular System</u>					
<input type="checkbox"/> 4.1 Hypertension <input type="checkbox"/> 4.2 Varicose Veins <input type="checkbox"/> 4.3 Venous Insufficiency <input type="checkbox"/> 4.4 Peripheral Vascular Diseases <input type="checkbox"/> 4.5 Thrombophlebitis					
Initials: _____					
SECTION FIVE <u>Heart and Cardiovascular System</u>					
Type of Action (Active)	Blood Pressure	Pulse Rate	Sounds	Rhythm	
<input type="checkbox"/> Running in Place	/				
<input type="checkbox"/> Other					
Type of Action (At Rest)					
Pulses (record strength)	R	L	Note any Abnormality	R	L
femoral					
popliteal					
dorsal pedes					
<input type="checkbox"/> 5.1 Congenital Heart Disease <input type="checkbox"/> 5.2 Valvular Heart Disease <input type="checkbox"/> 5.3 Coronary Artery Disease <input type="checkbox"/> 5.4 ECG Abnormalities (if associated with organic heart disease) - See Medical Selection Guidelines for specific abnormalities. <input type="checkbox"/> 5.5 Angina <input type="checkbox"/> 5.6 Congestive Heart Failure <input type="checkbox"/> 5.7 Cardiomyopathy <input type="checkbox"/> 5.8 Active Pericarditis, Endocarditis, and Myocarditis					
Initials: _____					
SECTION SIX <u>Respiratory System</u>					
<input type="checkbox"/> 6.1 Active Pulmonary Tuberculosis <input type="checkbox"/> 6.2 Chronic Bronchitis <input type="checkbox"/> 6.3 Active Asthma <input type="checkbox"/> 6.4 Chronic Obstructive Pulmonary Disease <input type="checkbox"/> 6.5 Bronchiectasis and Pneumothorax <input type="checkbox"/> 6.6 Pneumonectomy <input type="checkbox"/> 6.7 Acute/Chronic Mycotic Diseases					
Initials: _____					
SECTION SEVEN <u>Gastrointestinal System</u>					
<input type="checkbox"/> 7.1 Colitis <input type="checkbox"/> 7.2 Esophageal Disorders <input type="checkbox"/> 7.3 Hemorrhoids <input type="checkbox"/> 7.4 Pancreatitis <input type="checkbox"/> 7.5 Gall Bladder Disorders <input type="checkbox"/> 7.6 Active Peptic Ulcer Disease <input type="checkbox"/> 7.7 Symptomatic Inguinal, Umbilical, Ventral, Femoral or Incisional Hernias <input type="checkbox"/> 7.8 Malignant Disease of the Liver, Gall Bladder, Pancreas, Esophagus, Stomach, Small / Large Bowel, Rectum or Anus <input type="checkbox"/> 7.9 Gastrointestinal Bleeding <input type="checkbox"/> 7.10 Active or Chronic Hepatitis <input type="checkbox"/> 7.11 Cirrhosis of the Liver					
Initials: _____					

■ Sections 4-7

■ Common reasons for return:

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Applicant Name (Last, First, Middle)					
SECTION FOUR <u>Peripheral Vascular System</u>					
<input type="checkbox"/> 4.1 Hypertension <input type="checkbox"/> 4.2 Varicose Veins <input type="checkbox"/> 4.3 Venous Insufficiency <input type="checkbox"/> 4.4 Peripheral Vascular Diseases <input type="checkbox"/> 4.5 Thrombophlebitis					
Initials: _____					
SECTION FIVE <u>Heart and Cardiovascular System</u>					
Type of Action (Active)	Blood Pressure	Pulse Rate	Sounds	Rhythm	
<input type="checkbox"/> Running in Place	/				
<input type="checkbox"/> Other					
Type of Action (At Rest)					
Pulses (record strength)	R	L	Note any Abnormality	R	L
femoral					
popliteal					
dorsal pedes					
<input type="checkbox"/> 5.1 Congenital Heart Disease <input type="checkbox"/> 5.2 Valvular Heart Disease <input type="checkbox"/> 5.3 Coronary Artery Disease <input type="checkbox"/> 5.4 ECG Abnormalities (if associated with organic heart disease) - See Medical Selection Guidelines for specific abnormalities. <input type="checkbox"/> 5.5 Angina <input type="checkbox"/> 5.6 Congestive Heart Failure <input type="checkbox"/> 5.7 Cardiomyopathy <input type="checkbox"/> 5.8 Active Pericarditis, Endocarditis, and Myocarditis					
Initials: _____					
SECTION SIX <u>Respiratory System</u>					
<input type="checkbox"/> 6.1 Active Pulmonary Tuberculosis <input type="checkbox"/> 6.2 Chronic Bronchitis <input type="checkbox"/> 6.3 Active Asthma <input type="checkbox"/> 6.4 Chronic Obstructive Pulmonary Disease <input type="checkbox"/> 6.5 Bronchiectasis and Pneumothorax <input type="checkbox"/> 6.6 Pneumonectomy <input type="checkbox"/> 6.7 Acute/Chronic Mycotic Diseases					
Initials: _____					
SECTION SEVEN <u>Gastrointestinal System</u>					
<input type="checkbox"/> 7.1 Colitis <input type="checkbox"/> 7.2 Esophageal Disorders <input type="checkbox"/> 7.3 Hemorrhoids <input type="checkbox"/> 7.4 Pancreatitis <input type="checkbox"/> 7.5 Gall Bladder Disorders <input type="checkbox"/> 7.6 Active Peptic Ulcer Disease <input type="checkbox"/> 7.7 Symptomatic Inguinal, Umbilical, Ventral, Femoral or Incisional Hernias <input type="checkbox"/> 7.8 Malignant Disease of the Liver, Gall Bladder, Pancreas, Esophagus, Stomach, Small / Large Bowel, Rectum or Anus <input type="checkbox"/> 7.9 Gastrointestinal Bleeding <input type="checkbox"/> 7.10 Active or Chronic Hepatitis <input type="checkbox"/> 7.11 Cirrhosis of the Liver					
Initials: _____					

- No Initials
- Blood Pressure
- Pulse Rate
- Sounds
- Rhythm
- Pulses at femoral, popliteal and dorsal pedes arteries

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Applicant Name (Last, First, Middle) _____

People with communicable diseases must be evaluated relevant to their ability to train for and perform essential tasks without posing a direct threat to the health and safety to themselves and others.

SECTION EIGHT Genitourinary System

- 8.1 Pregnancy
- 8.2 Nephrectomy
- 8.3 Acute Nephritis
- 8.4 Nephrotic Syndrome
- 8.5 Acute Renal/ Urinary Calculi
- 8.6 Renal Transplant
- 8.7 Renal Failure
- 8.8 Hydrocele and Varicocele (symptomatic)
- 8.9 Malignant Diseases of Bladder, Kidney, Ureter, Cervix, Ovaries, Breast, Prostate, etc.
- List specific disease(s) _____
- 8.10 Active Venereal Diseases
- 8.11 Urinary Tract Infection
- 8.12 Polycystic Kidney Disease
- 8.13 Pelvic Inflammatory Disease
- 8.14 Cervicitis
- 8.15 Endometriosis
- 8.16 Bartholin Gland Abscess
- 8.17 Vaginitis
- 8.18 Inflammatory Disorders
- 8.19 Presence of Illicit Drugs

Initials: _____

SECTION NINE Endocrine and Metabolic Systems

- 9.1 Untreated Thyroid Disease
- 9.2 Diabetes Mellitus
- 9.3 Adrenal Dysfunctions
- 9.4 Hypoglycemia
- 9.5 Pituitary Dysfunction
- 9.6 Thyroid Tumor

Initials: _____

SECTION TEN Skin and Collagen Diseases

- 10.1 Serious Dermatological Disorders
- 10.2 Lupus Erythematosus
- 10.3 Contact Allergies (of a serious or relevant nature)

Initials: _____

SECTION ELEVEN Musculoskeletal System

- 11.1 Disorders that Limit Motor Performance
- 11.2 Cervical Spine or Lumbosacral Fusion
- 11.3 Degenerative Cervical or Lumbar Disc Disease (if symptomatic)
- 11.4 Extremity Amputation
- 11.5 Osteomyelitis
- 11.6 Muscular Dystrophy
- 11.7 Loss in Motor Ability from Tendon or Nerve Injury/Surgery
- 11.8 Arthritis

■ Sections 8-11

■ Common reasons
for return:

■ No initials
(**Doctor's Initials**)

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Applicant Name (Last, First, Middle)			
SECTION ELEVEN Musculoskeletal System (Continued)			
<input type="checkbox"/> 11.9 Joint Conditions <input type="checkbox"/> 11.10 Coordinated Balance <input type="checkbox"/> 11.11 Herniated Disc (symptomatic) <input type="checkbox"/> 11.12 Spinal Deviations <input type="checkbox"/> 11.13 Fracture Deformities (symptomatic)			
Initials: _____			
Musculo-Skeletal (Test flexibility by bending, stooping, squatting, and by head, arm, leg and finger motions.)			
Spine	Toe Touch (distance from floor)	Symmetry	Posture X-rays Recommended <input type="checkbox"/> Yes <input type="checkbox"/> No
Upper Extremities	Limited Function		Missing Parts
Lower Extremities	Limited Function		Missing Parts
Skin (scars, varicosities, disease, abnormalities - nature and severity)			
SECTION TWELVE Hematopoietic and Lymphatic Systems			
<input type="checkbox"/> 12.1 Anemia (all) <input type="checkbox"/> 12.2 Polycythemia <input type="checkbox"/> 12.3 Sickle Cell Trait <input type="checkbox"/> 12.4 Sickle Cell Disease <input type="checkbox"/> 12.5 Hematopoietic Disorders (including malignancies) <input type="checkbox"/> 12.6 Hemophilia			
Initials: _____			
SECTION THIRTEEN Nervous System			
<input type="checkbox"/> 13.1 Epilepsy <input type="checkbox"/> 13.2 Cerebral Palsy <input type="checkbox"/> 13.3 Movement Disorders <input type="checkbox"/> 13.4 Cerebral Aneurysms <input type="checkbox"/> 13.5 Syncope <input type="checkbox"/> 13.6 Progressive Neurological Diseases <input type="checkbox"/> 13.7 Peripheral Nerve Disorder <input type="checkbox"/> 13.8 Narcolepsy <input type="checkbox"/> 13.9 Cerebral Vascular Accident <input type="checkbox"/> 13.10 Central Nervous System Infections			
Initials: _____			
Nervous System (Describe any pathology or abnormal reflexes.)			

■ Sections 11-13

■ Common reasons for return:

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Applicant Name (Last, First, Middle)			
SECTION ELEVEN Musculoskeletal System (Continued)			
<input type="checkbox"/> 11.9 Joint Conditions <input type="checkbox"/> 11.10 Coordinated Balance <input type="checkbox"/> 11.11 Herniated Disc (symptomatic) <input type="checkbox"/> 11.12 Spinal Deviations <input type="checkbox"/> 11.13 Fracture Deformities (symptomatic)			Initials: _____
Musculo-Skeletal (Test flexibility by bending, stooping, squatting, and by head, arm, leg and finger motions.)			
Spine	Toe Touch (distance from floor)	Symmetry	Posture X-rays Recommended <input type="checkbox"/> Yes <input type="checkbox"/> No
Upper Extremities	Limited Function	Missing Parts	
Lower Extremities	Limited Function	Missing Parts	
Skin (scars, varicosities, disease, abnormalities - nature and severity)			
SECTION TWELVE Hematopoietic and Lymphatic Systems			
<input type="checkbox"/> 12.1 Anemia (all) <input type="checkbox"/> 12.2 Polycythemia <input type="checkbox"/> 12.3 Sickle Cell Trait <input type="checkbox"/> 12.4 Sickle Cell Disease <input type="checkbox"/> 12.5 Hematopoietic Disorders (including malignancies) <input type="checkbox"/> 12.6 Hemophilia			Initials: _____
SECTION THIRTEEN Nervous System			
<input type="checkbox"/> 13.1 Epilepsy <input type="checkbox"/> 13.2 Cerebral Palsy <input type="checkbox"/> 13.3 Movement Disorders <input type="checkbox"/> 13.4 Cerebral Aneurysms <input type="checkbox"/> 13.5 Syncope <input type="checkbox"/> 13.6 Progressive Neurological Diseases <input type="checkbox"/> 13.7 Peripheral Nerve Disorder <input type="checkbox"/> 13.8 Narcolepsy <input type="checkbox"/> 13.9 Cerebral Vascular Accident <input type="checkbox"/> 13.10 Central Nervous System Infections			Initials: _____
Nervous System (Describe any pathology or abnormal reflexes.)			

- No Initials (doctor's)
- Toe Touch distance from floor
- Symmetry
- X-rays recommended

LEA-3, Pg 17

Applicant Name (Last, First, Middle) _____

Please indicate the following lab tests were administered to the applicant and were within normal limits.
 (Please explain any test results outside of normal limits below). **It is not necessary to submit the actual lab paperwork to DPS.**

Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	1. Blood Chemistry (Chem 20 or equivalent)
<input type="checkbox"/>	<input type="checkbox"/>	2. Complete Blood Count
<input type="checkbox"/>	<input type="checkbox"/>	3. Complete Urinalysis (not Dipstick)
<input type="checkbox"/>	<input type="checkbox"/>	4. Serology (RPR or equivalent)
<input type="checkbox"/>	<input type="checkbox"/>	5. Tuberculosis (Mantoux)
<input type="checkbox"/>	<input type="checkbox"/>	6. Electrocardiogram (ECG) (Resting)
<input type="checkbox"/>	<input type="checkbox"/>	7. Chest X-ray (CXR) ONLY REQUIRED IF #5 IS POSITIVE
<input type="checkbox"/>	<input type="checkbox"/>	8. Drug Screen (THC, Cocaine, Amphetamines, Opiates, Barbiturates, Methadone, Methaqualone, Phencyclidine, Propoxyphene, Benzodiazepines, Alcohol, Anabolic Steroids)

STATEMENT OF CONDITION

I have personally examined the applicant:

The applicant **has passed** the minimum medical standards as established by the New Mexico Law Enforcement Academy Board without exclusions.

The applicant **has one or more potentially excludable conditions** from the minimum medical standards as established by the New Mexico Law Enforcement Academy Board, but **can perform the functions** of a law enforcement officer with accommodations. (Please explain below.)

The applicant **has one or more potentially excludable conditions** from the minimum medical standards as established by the New Mexico Law Enforcement Academy Board, and **cannot perform the functions** of a law enforcement officer. (Please explain below.)

Section Item #	Explanation (attach additional sheets if necessary)

New Mexico Law (NMSA 1978, §29-7-6 A (5)), requires that a candidate for law enforcement officer only be examined by a licensed physician.

Licensed Physician's Signature _____ Date _____

Print Name _____ M.D. D.O.

Address _____

City _____ State _____ Zip _____

Phone _____ NM Medical License # _____

Other State _____ Medical License # _____

Print or type contact information, or attach a business card. Missing or illegible entries will be returned.

■ Statement of Condition

■ Common reasons for return:

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Applicant Name (Last, First, Middle) _____

Please indicate the following lab tests were administered to the applicant and were within normal limits.
(Please explain any test results outside of normal limits below). **It is not necessary to submit the actual lab paperwork to DPS.**

Yes No

1. Blood Chemistry (Chem 20 or equivalent)

2. Complete Blood Count

3. Complete Urinalysis (not Dipstick)

4. Serology (RPR or equivalent)

5. Tuberculosis (Mantoux)

6. Electrocardiogram (ECG) (Resting)

7. Chest X-ray (CXR) **ONLY REQUIRED IF #5 IS POSITIVE**

8. Drug Screen (THC, Cocaine, Amphetamines, Opiates, Barbiturates, Methadone, Methaqualone, Phencyclidine, Propoxyphene, Benzodiazepines, Alcohol, Anabolic Steroids)

STATEMENT OF CONDITION

I have personally examined the applicant:

The applicant **has passed** the minimum medical standards as established by the New Mexico Law Enforcement Academy Board without exclusions.

The applicant **has one or more potentially excludable conditions** from the minimum medical standards as established by the New Mexico Law Enforcement Academy Board, but **can perform the functions** of a law enforcement officer with accommodations. (Please explain below.)

The applicant **has one or more potentially excludable conditions** from the minimum medical standards as established by the New Mexico Law Enforcement Academy Board, and **cannot perform the functions** of a law enforcement officer. (Please explain below.)

Section Item #	Explanation (attach additional sheets if necessary)

New Mexico Law (NMSA 1978, §29-7-6A (5)), requires that a candidate for law enforcement officer only be examined by a licensed physician.

Licensed Physician's Signature _____ Date _____

Print Name _____ M.D. D.O.

Address _____

City _____ State _____ Zip _____

Phone _____ NM Medical License # _____

Other State _____ Medical License # _____

Print or type contact information, or attach a business card. Missing or illegible entries will be returned.

- Physician has checked box 2, but hasn't indicated why (or is illegible).
- Physician has checked box 3, but the agency sent in anyway.
- Narrative illegible

LEA-3, Pg 17

Applicant Name (Last, First, Middle) _____

Please indicate the following lab tests were administered to the applicant and were within normal limits.
(Please explain any test results outside of normal limits below). **It is not necessary to submit the actual lab paperwork to DPS.**

Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	1. Blood Chemistry (Chem 20 or equivalent)
<input type="checkbox"/>	<input type="checkbox"/>	2. Complete Blood Count
<input type="checkbox"/>	<input type="checkbox"/>	3. Complete Urinalysis (not Dipstick)
<input type="checkbox"/>	<input type="checkbox"/>	4. Serology (RPR or equivalent)
<input type="checkbox"/>	<input type="checkbox"/>	5. Tuberculosis (Mantoux)
<input type="checkbox"/>	<input type="checkbox"/>	6. Electrocardiogram (ECG) (Resting)
<input type="checkbox"/>	<input type="checkbox"/>	7. Chest X-ray (CXR) ONLY REQUIRED IF #5 IS POSITIVE
<input type="checkbox"/>	<input type="checkbox"/>	8. Drug Screen (THC, Cocaine, Amphetamines, Opiates, Barbiturates, Methadone, Methaqualone, Phencyclidine, Propoxyphene, Benzodiazepines, Alcohol, Anabolic Steroids)

STATEMENT OF CONDITION

I have personally examined the applicant:

The applicant **has passed** the minimum medical standards as established by the New Mexico Law Enforcement Academy Board without exclusions.

The applicant **has one or more potentially excludable conditions** from the minimum medical standards as established by the New Mexico Law Enforcement Academy Board, but **can perform the functions** of a law enforcement officer with accommodations. (Please explain below.)

The applicant **has one or more potentially excludable conditions** from the minimum medical standards as established by the New Mexico Law Enforcement Academy Board, and **cannot perform the functions** of a law enforcement officer. (Please explain below.)

Section Item #	Explanation (attach additional sheets if necessary)

New Mexico Law (NMSA 1978, §29-7-6 A (5)), requires that a candidate for law enforcement officer only be examined by a licensed physician.

Licensed Physician's Signature _____ Date _____

Print Name _____ M.D. D.O.

Address _____

City _____ State _____ Zip _____

Phone _____ NM Medical License # _____

Other State _____ Medical License # _____

Print or type contact information, or attach a business card. Missing or illegible entries will be returned.

- Physician's signature missing.
- No Date
- Done by someone other than a licensed physician (P.A., CFNP, RN).
- Contact information missing/illegible

LEA-4

PSYCHOLOGICAL EXAMINATION (refer to 10.29.9.12 NMAC)

The testing and interviewing performed to determine and applicant's suitability to serve as a law enforcement officer in New Mexico will be designed, administered, and scored in such a manner that it insures that no applicant is discriminated against for reasons of age, sex, race, or cultural heritage.

- Psychological testing shall include: a. A measure of reading ability. b. A measure of psychopathology c. A measure of normal personality functioning.
- A face to face interview with the applicant.
- Submission of a detailed written narrative report and this form (LEA-4), with the completed application, will be mailed to the Department of Public Safety at the above address.
- If the applicant is **not recommended** for certification, the examining psychologist is directed to submit LEA-4 and the Narrative Report to the Department of Public Safety **within thirty (30) days of the determination**. **In addition, the applicant must be informed of their right to appeal under 10.29.9.12 (C) NMAC (see reverse side of form).**

Psychological Statement of Applicant	
The following statements are being made for the purpose of obtaining a psychological evaluation. I understand that the information submitted is for evaluation purposes. (Applicant must check a response for each question.)	
	Yes No
1. Have you ever been hospitalized or committed, either voluntarily or involuntarily, to any institution for the treatment of any mental or emotional disorder?	<input type="checkbox"/> <input type="checkbox"/>
2. Have you ever received treatment for any substance abuse related disorder?	<input type="checkbox"/> <input type="checkbox"/>
3. Have you ever been treated by any physician, psychologist, psychiatrist, or counselor for any mental or emotional disorder?	<input type="checkbox"/> <input type="checkbox"/>
4. Have you ever been the subject of a psychological or psychiatric examination ordered by the court or Employer? (This Includes Pre-Employment Examinations.)	<input type="checkbox"/> <input type="checkbox"/>
5. Have you ever received a psychological rejection of "Applicant is Not Recommended for employment as a law enforcement officer at this time"? If yes, when _____.	<input type="checkbox"/> <input type="checkbox"/>
6. I understand my appeal rights under 10.20.9.12 NMAC.	<input type="checkbox"/> <input type="checkbox"/>
I HEREBY AUTHORIZE RELEASE OF THIS REPORT TO MY EMPLOYING AGENCY AND NM THE DEPARTMENT OF PUBLIC SAFETY TRAINING CENTER.	
Name of Applicant _____	Applicant Signature _____
Date of Birth: _____	Print or Type _____ Date _____
Mental Examination Certificate	
I am a licensed/certified psychologist in the State of _____. I have reviewed the New Mexico law enforcement officer job description. I have reviewed the test data and conducted a face-to-face the interview of the above named individual in order to screen for any apparent indicators of psychopathology, or significant mental or emotional difficulties which could reasonably be predicted to interfere with the applicant's intended duties as a law enforcement officer or from successfully completing a prescribed basic law enforcement training as required by the Law Enforcement Training Act.	
I conclude the following:	
<input type="checkbox"/> Applicant IS RECOMMENDED WITHOUT RESERVATION for certification pending the successful completion of a NMDPS approved training academy.	
<input type="checkbox"/> Applicant IS NOT RECOMMENDED for employment as a law enforcement officer at this time.	
Please print or type	
Name of Evaluator _____	License/Certification# _____
State of issue _____	Contact/Office Telephone No. _____
Office Mailing Address	
Street or P.O. Box _____	City _____ State _____ Zip _____
Email address: _____	
Reading ability test performed:	<input type="checkbox"/> WRAT <input type="checkbox"/> Nelson-Denny <input type="checkbox"/> Other _____
Psychopathology test performed:	<input type="checkbox"/> MMPI-2 <input type="checkbox"/> PAI <input type="checkbox"/> Million-3 <input type="checkbox"/> Other _____
Normal personality test:	<input type="checkbox"/> 16 PF <input type="checkbox"/> Leader <input type="checkbox"/> IPI <input type="checkbox"/> Other _____
Evaluator Signature _____	Date _____

- Psychological Examination Form
- Common reasons for return:
- Physician has not checked a box.
- Missing signatures
- Not the original.
- No narrative report attached.

LEA-5

FINGERPRINT AFFIDAVIT *(refer to 10.29.9.13 NMAC)*

I certify that two sets of fingerprint cards of _____ were

_____ Please Type or Print Applicant Name
submitted to New Mexico Department of Public Safety Records Section at 4491 Cerrillos Road, Santa Fe, NM 87507, for both the Federal Bureau of Investigation and the New Mexico Department of Public Safety records check.

It was determined that the applicant has not been:

- Convicted of or pled guilty to, or entered a plea of nolo contendere to any felony charge or, within the three-year period immediately preceding their application, to any violation of any federal or state law or local ordinance relating to:
 - Aggravated assault, theft,
 - Driving while intoxicated,
 - Controlled substances or
 - Other crime involving moral turpitude and
 - Has not been released or discharged under dishonorable conditions from any of the armed forces of the United States.

I also certify that:

NMDPS Records Section Clearance has been received and a copy is attached.

FBI Records Clearance has been received and a copy is attached.

NCIC TRIPLE I Clearance has been received and a copy is attached.

Note: Do not send this form (LEA-5) to the New Mexico Law Enforcement Academy until you have received both clearances.

Please Type or Print Department

Department Head Name: _____

Department Head Signature: _____

State of New Mexico }
County of _____}SS

On this _____ day of _____, _____, before me personally

appeared _____ known to me to be the person

whose name is subscribed to the above instrument and acknowledged the same to be

his/her own free act and deed.

Notary Public _____ My commission expires: _____

(SEAL)

Note-The applicant will not receive state certification until this form is received.

- Fingerprint Affidavit
- NMSA 29-7-6.A (4)
- Common reasons for return:

LEA-5

FINGERPRINT AFFIDAVIT *(refer to 10.29.9.13 NMAC)*

I certify that two sets of fingerprint cards of _____ were

_____ Please Type or Print Applicant Name
submitted to New Mexico Department of Public Safety Records Section at 4491 Cerrillos Road, Santa Fe, NM 87507, for both the Federal Bureau of Investigation and the New Mexico Department of Public Safety records check.

It was determined that the applicant has not been:

- Convicted of or pled guilty to, or entered a plea of nolo contendere to any felony charge or, within the three-year period immediately preceding their application, to any violation of any federal or state law or local ordinance relating to:
 - Aggravated assault, theft,
 - Driving while intoxicated,
 - Controlled substances or
 - Other crime involving moral turpitude and
 - Has not been released or discharged under dishonorable conditions from any of the armed forces of the United States.

I also certify that:

NMDPS Records Section Clearance has been received and a copy is attached.

FBI Records Clearance has been received and a copy is attached.

NCIC TRIPLE I Clearance has been received and a copy is attached.

Note: Do not send this form (LEA-5) to the New Mexico Law Enforcement Academy until you have received both clearances.

Please Type or Print Department

Department Head Name: _____

Department Head Signature: _____

State of New Mexico }
County of _____}SS

On this _____ day of _____, _____, before me personally
appeared _____ known to me to be the person

whose name is subscribed to the above instrument and acknowledged the same to be
his/her own free act and deed.

Notary Public _____ My commission expires: _____

(SEAL)

Note-The applicant will not receive state certification until this form is received.

- Missing/not submitted
- We don't get the original fingerprint cards – they go to the DPS Records.
- Copies of clearances are not attached
- Will not be able to take Certification exam until this is received!

LEA-6

APPLICANT AFFIDAVIT CRIMINAL HISTORY

Have you ever been **arrested**? (Include juvenile offenses) (Attach separate pages if necessary.)
 Yes No If yes, explain charge, circumstance and date of occurrence along with **attaching offense/incident reports and court record of final disposition**.

Have you ever been **convicted** of any crime? (Attach separate pages if necessary.)
 Yes No If yes, explain charge, circumstance and date of occurrence along with **attaching offense/incident reports and court record of final disposition**.

Have you ever been **pardoned**, entered into a **pre-prosecution diversion** program, or received a **suspended** or **deferred** sentence for any crime?
 Yes No If yes, explain charge, circumstance and date of occurrence along with **attaching offense/incident reports and court record of final disposition**.

Have you ever been the **subject** of an **administrative investigation** for law enforcement officer, or telecommunicator misconduct, or received any administrative discipline as a law enforcement officer? (Attach separate pages if necessary.)

Yes No If yes, explain charge, circumstance and date of occurrence:

Have you ever served in the armed forces of the United States?

Yes No If yes, attach a notarized copy of DD214 with character of service.

I certify the above is true and correct to the best of my knowledge.

Applicant Name _____ Date of Birth _____
(Print name)

Applicant Signature _____

State of New Mexico }
County of _____ }SS

On this _____ day of _____, _____, before me personally appeared _____
(Applicant) known to me to be the person whose name is subscribed to

the above instrument and acknowledged the same to be his/her own free act and deed.

Notary Public _____ My commission expires: _____
(SEAL)

- Applicant Affidavit
- Common reasons for return:
- Applies to juvenile crimes too.
- All “yes” responses require a copy of offense incident reports and Judgment and Sentencing.

LEA-6

APPLICANT AFFIDAVIT CRIMINAL HISTORY

Have you ever been **arrested**? (Include juvenile offenses) (Attach separate pages if necessary.)

Yes No If yes, explain charge, circumstance and date of occurrence along with **attaching offense/incident reports and court record of final disposition**:

Have you ever been **convicted** of any crime? (Attach separate pages if necessary.)

Yes No If yes, explain charge, circumstance and date of occurrence along with **attaching offense/incident reports and court record of final disposition**.

Have you ever been **pardoned**, entered into a **pre-prosecution diversion** program, or received a **suspended** or **deferred** sentence for any crime?

Yes No If yes, explain charge, circumstance and date of occurrence along with **attaching offense/incident reports and court record of final disposition**.

Have you ever been the **subject** of an **administrative investigation** for law enforcement officer, or telecommunicator misconduct, or received any administrative discipline as a law enforcement officer? (Attach separate pages if necessary.)

Yes No If yes, explain charge, circumstance and date of occurrence:

Have you ever served in the armed forces of the United States?

Yes No If yes, attach a notarized copy of DD214 with character of service.

I certify the above is true and correct to the best of my knowledge.

Applicant Name _____ Date of Birth _____
(Print name)

Applicant Signature _____

State of New Mexico }
County of _____ } SS

On this _____ day of _____, _____, before me personally appeared _____ known to me to be the person whose name is subscribed to _____ (Applicant)

the above instrument and acknowledged the same to be his/her own free act and deed.

Notary Public _____ My commission expires: _____
(SEAL)

- DD214 not attached.
- Submit letter of explanation on other than honorable and uncharacterized discharges from the military.
- Submit letter of explanation on any reported misconduct.



LEA-8

WAIVER OF LIABILITY

Applicant Name (Please Print) _____
Home Address _____
Home Telephone No. _____
Next of Kin _____ Relationship _____

I, the undersigned, hereby waive any claim for any injury against the New Mexico Department of Public Safety Training Center, any member of the staff, any of its employees or any trainee, which I may either directly or indirectly sustain as a result of my participation in any part or phase of the training and instruction I will receive at the Training center or other locations selected for the giving of training or supervision. This agreement shall be binding upon the undersigned, his heirs, and assignees.

Signature of Applicant _____

State of New Mexico }
County of _____ } SS

On this _____ day of _____, _____, before me personally
Appeared _____ known to me to be the person

Applicant

whose name is subscribed to the above instrument and acknowledged the same to be his/her own free act and deed.

Notary Public _____ My commission expires: _____

(SEAL)

■ Waiver of Liability

LEA-9

RELEASE OF INFORMATION

To Whom It May Concern:

Having made application with New Mexico Department of Public Safety Training Center, it is my understanding that a comprehensive investigation of my background may be conducted in connection with this application.

I do hereby give the officials of the Training Center the authority to conduct such an investigation and do hereby authorize the release of any and all information requested by the Training Center pertaining to my work history, any arrest information, and other general qualifications for fitness.

Applicant Name _____

Please Print

Signature of Applicant _____

State of New Mexico }
County of _____}SS

On this _____ day of _____, _____, before me personally

appeared _____ known to me to be the person

Applicant

whose name is subscribed to the above instrument and acknowledged the same to be

his/her own free act and deed.

Notary Public _____ My commission expires: _____

(SEAL)

Release of Information

LEA-12

APPLICANT AFFIDAVIT
of
UNITED STATES CITIZENSHIP (Law Enforcement Officers)
or **LEGAL RESIDENCY (Telecommunicators only)**

APPLICANT

I certify that I am a citizen of the United States of America or a legal resident. Official documentation of my citizenship or legal residency has been presented to the witness, who is the agency head or designee.

Applicant Name: _____
Please print or type.

Applicant Signature: _____

WITNESS (Agency head or designee)

I certify that I have reviewed official documentation indicating the above applicant is a citizen of the United States of America or legal resident.

Witness Name: _____
Please print or type.

Witness Signature: _____

Type of documentation:

- Birth Certificate (Must be issued by a government agency)
Issued by: _____ Document # _____
- Passport
Issued by: _____ Document # _____
- Naturalization Papers
Issued by: _____ Document # _____
- Resident card or Paperwork (*for telecommunicators only*)
Issued by: _____ Document # _____

State of New Mexico }
County of _____ }SS

On this _____ day of _____, _____, before me personally appeared

_____ and _____ known to me to

Applicant and Witness
be the persons whose names are subscribed to the above instrument and acknowledged the same to be his/her own free act and deed.

Notary Public: _____ My commission expires: _____
(SEAL)

- Applicant Affidavit of US Citizenship.
- Common reasons for return:

LEA-12

APPLICANT'S AFFIDAVIT
of
UNITED STATES CITIZENSHIP (Law Enforcement Officers)
or **LEGAL RESIDENCY (Telecommunicators only)**

APPLICANT

I certify that I am a citizen of the United States of America or a legal resident. Official documentation of my citizenship or legal residency has been presented to the witness, who is the agency head or designee.

Applicant Name: _____
Please print or type.

Applicant Signature: _____

WITNESS (Agency head or designee)

I certify that I have reviewed official documentation indicating the above applicant is a citizen of the United States of America or legal resident.

Witness Name: _____
Please print or type.

Witness Signature: _____

Type of documentation:

- Birth Certificate (Must be issued by a government agency)
Issued by: _____ Document # _____
- Passport
Issued by: _____ Document # _____
- Naturalization Papers
Issued by: _____ Document # _____
- Resident card or Paperwork (*for telecommunicators only*)
Issued by: _____ Document # _____

State of New Mexico }
County of _____}SS

On this _____ day of _____, _____, before me personally appeared
_____ and _____ known to me to
Applicant and Witness
be the persons whose names are subscribed to the above instrument and acknowledged the same to be his/her own free act and deed.

Notary Public: _____ My commission expires: _____
(SEAL)

- No witness signature.
- Hospital Birth records and Baptismal records are not acceptable.
- Don't send Birth Certificates

LEA-82

- If applicant is commissioned, the Entry Level Firearms section must be completed.
- If form has already been submitted then please attach a copy.

Agency Employment Action

Date of Action: _____

Employment (new hire) **Promotion**

Separation/Other Action:

Resigned Military Retired Deceased Terminated
 Decommissioned Only Medical _____
 Other _____

Submitted by _____ Signature _____
Chief/Designee

Date _____ Title or Rank _____

Agency _____ Telephone _____

Employee Information

Name _____
First Middle Last Maiden

Address _____

Date of Birth _____ SS# _____ Gender _____

Ethnic Origin _____ Rank or Classification _____

Date of Current Employment _____ Date of Current Commission _____

DPS Certification Number _____ Certification Date _____

Entry Level Firearms Training/Qualification (For new hires without active certification)
ENTRY LEVEL FIREARMS TRAINING/QUALIFICATION (10.29.9.14)

Sixteen (16) hour handgun training: Eight (8) hour shotgun training (if issued):

Day Time Score: Date: _____ Night Time Score: Date: _____

Print Name of DPS Certified Firearms Instructor _____ DPS Certification Number _____
Instructor Signature _____ Contact # _____

DPS Use Only: Permanent File # _____
Registry input by: _____ Certification Verified by: _____ Firearms Qual. Processed by: _____

Notarized copies of Records

- High School, GED or College diploma
- Certified transcripts in lieu of a diploma must show the date of graduation.
- Current Valid Driver's License.
- For ex-military, DD214 form with characterization of service.

How to get the forms

- 2008 DPS Training Reference Guide 1st Revision
- Available at the DPS Training Center
- DPS Training website:
www.dps.nm.org/training/
(Adobe Acrobat required)

Final Comments?

Good Luck!

Hopefully, no more of
this.....

