South Bend Fire Department

1222 South Michigan Street.
South Bend, Indiana 46601

Legal Waiver Form

I, _____(print name) execute this Waiver and Release in favor of the South Bend Fire Department, its officers, employees, and agents conducting the CPAT testing. I am fully aware of the risks and dangers involved, and that unanticipated and unexpected dangers may arise during such activities and I agree to assume all risks of injury to my person and property that may be sustained in connection with preparing for and taking the test.

In consideration for being permitted to take this test and participate in the CPAT test, I, myself, my heirs, legal representatives and assigns, release and hold harmless the City from all claims, demands, and causes of action for all damage, bodily injury or liability of any kind that might accrue to me or arise out of these activities. I hereby agree not to bring suit or other legal action, either State of Federal, based upon any claims against the City arising directly or indirectly from my participation in the CPAT test.

By signing below, I acknowledge that I have read and fully understand the terms of this Release and that I have received and read a copy of the testing protocol. My agreement to this release and attendance, participation, and preparation for the test is voluntary and I am not in any way employed by or an agent of South Bend Fire Department or the City of South Bend.

Printed Name: _____ Notary: _____

Signature: _____ Date: _____

Address: _____ Commission Expiration: _____

_____ [Notary Seal]

_____

Revised 7/22/22

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Medical Clearance Form

I have reviewed the SBFD CPAT video and the eight elements of the South Bend Fire Department Candidate Physical Ability Test and certify that the candidate listed below is under my care and is able to prepare for and perform the elements of the test safely.

Candidate Name:_____

Agency of Application:_____**South Bend Fire Department**_____

Date of Examination: __**June/July 2023**_____
(Expiration date is six months from this date)

Physician Signature:_____

Printed/Typed Physician Name:_____

Office Address: _____

_____

_____

Office Phone: _____

***** **IMPORTANT** *****
This form must be complete and on file or brought with you to the CPAT Mentoring Program or Test before you will be allowed to participate.