

AGENCY INFORMATION						
Name of LAW ENFORCEMENT AGENCY where you are employed:						
Agency ADDRESS			CITY		STATE and ZIP code	
Agency's TELEPHONE			Your SUPERVISOR's name			
PERSONAL INFORMATION						
LAST NAME?			FIRST NAME?		MIDDLE NAME?	
RESIDENCE address (street, city, state)					Home TELEPHONE?	
BIRTHDATE	AGE	SEX	HGT	WGT	Is your HEALTH: <input type="checkbox"/> poor <input type="checkbox"/> good <input type="checkbox"/> excellent	
Marital Status <input type="checkbox"/> single <input type="checkbox"/> married (Name of SPOUSE) _____						
Spouse's DAYTIME TELEPHONE?				Spouse's EVENING TELEPHONE?		
Who should we CONTACT in an EMERGENCY? <input type="checkbox"/> Spouse <input type="checkbox"/> Other (Name and relationship) _____						
Their DAYTIME TELEPHONE?				Their EVENING TELEPHONE?		
Do you have any physical defects that would preclude unrestricted regular participation during the SWAT Operators' Immersion Course, in firearms training, physical training, and defensive tactics? <input type="checkbox"/> No <input type="checkbox"/> Yes (explain)						
Have you had any serious illnesses or operations in the last three years? <input type="checkbox"/> No <input type="checkbox"/> Yes (explain)						
Are you capable of performing sustained vigorous physical activity? <input type="checkbox"/> Yes <input type="checkbox"/> No (explain)				Are you taking any prescription medications? <input type="checkbox"/> No <input type="checkbox"/> Yes (list)		
Do you know your blood type? <input type="checkbox"/> No <input type="checkbox"/> Yes (list)				Do you have any allergies to medicines? <input type="checkbox"/> No <input type="checkbox"/> Yes (list them)		
MISCELLANEOUS INFORMATION						
Have you previously attended SWAT schooling? <input type="checkbox"/> No <input type="checkbox"/> Yes (where?)				Are you a participating member of a SWAT or tactical team? <input type="checkbox"/> No <input type="checkbox"/> Yes (assignment?)		
How many years of law enforcement experience do you have? _____				T-Shirt Size <input type="checkbox"/> Sm <input type="checkbox"/> Med <input type="checkbox"/> Lg <input type="checkbox"/> X-Lg <input type="checkbox"/> XX-Lg		