

# CANDIDATE APPLICATION PACKET



## **MINIMUM QUALIFICATIONS FOR TROOPER SCHOOL CLASS**

Per MS Code § 45-3-9, at the time of appointment, applicant shall be twenty-one (21) years of age, a citizen of the United States, a resident of the State of Mississippi, and of good moral character. The applicant shall have a high school diploma or GED.

### **I. APPLICATION**

You are to complete ALL SECTIONS of the application and provide the following attachments:

- A. Photocopy of your Driver License.
- B. Certified copy of transcripts.
- C. Certified copy of your Birth Certificate.
- D. Copy of DD-214, if applicable.

These items might take some time to obtain, so you will need to request them as soon as possible in order to meet the application deadline. The attachments will become the property of MDPS and will not be returned to you. No application will be accepted unless it is complete, and all required documents are attached. Once the application has been approved, information will be forwarded via mail, email, or phone regarding the next step in the process. The entire process consists of:

1. Application Approval.
2. Computerized Testing (Reading).
3. Agility/PT/Drug Test and Minnesota Multiphasic Personality Inventory (MMPI).
4. Structured Oral Process (SOP).
5. Candidate Profile Summary (CPS).
6. Fingerprinting, Polygraph and Psychological Screening; and
7. Begin Trooper School

### **II. DRUG SCREEN AND PHYSICAL EXAM**

Each applicant must pass a drug screening. If you are taking any prescribed medications, you will need to provide proof of your prescription(s) at the time of the drug screening.

### **III. PHYSICAL TRAINING TESTING DAY**

Physical training and a drug screen will be given should your application be accepted. If any applicant fails to complete any part of the physical training test, they will be given ten (10) minutes to rest and one additional attempt to complete that part of the test, with the exception of the run, which will have a rest period of twenty (20) minutes. The applicant must complete any failed portion before going to the next exercise. It is not advisable to drink highly caffeinated beverages/energy drinks or consume any enhanced energy products prior to participating in, or during the course of, the agility/physical testing process. This could affect your physical test results and may disqualify you from the process.

You must be able to complete the following physical test requirements:

- 1) Run one mile in nine (9) minutes and fifteen (15) seconds for males, or eleven (11) minutes for females; and 2) properly execute the following exercises: agility run, twenty-five (25) push-ups in two (2) minutes for males and fifteen (15) push-ups in two (2) minutes for females.

Any applicant who fails any part of this phase of testing will be immediately disqualified from the candidate process.

Send the completed application packet to:

MISSISSIPPI DEPARTMENT OF PUBLIC SAFETY  
ATTN: Administrative Operations Division  
P. O. Box 958/Box A2  
Jackson, MS 39205

For additional questions or concerns related to the candidate application process, please contact the Administrative Operations Division at 601-987-1259 or email us at [adminop@dps.ms.gov](mailto:adminop@dps.ms.gov).

**DO NOT SEND ANY APPLICATIONS TO THE MISSISSIPPI STATE PERSONNEL BOARD**

**MHSP CANDIDATE BACKGROUND APPLICATION**

**EQUAL OPPORTUNITY EMPLOYER**

Mail To:  
MS Department of Public Safety/Highway Safety Patrol  
ATTN: Administrative Operations Division  
P. O. Box 958/Box A2  
Jackson, MS 39205



Date: \_\_\_\_\_

All information pertaining to this document is true and complete to the best of my knowledge. I fully understand that any misrepresentation herein may lead to a rejection of my application, removal of my name from the list of eligibles, and/or dismissal from this process.

No  Yes

**PERSONAL HISTORY**

Full Name: \_\_\_\_\_ 2. SSN: \_\_\_\_\_  
Last First Middle

List all other names you have used including nicknames, maiden name, etc. If you have ever used any surname other than your true name, during what period and under what circumstances were these names used?

\_\_\_\_\_  
\_\_\_\_\_

Have you ever legally changed your name?

No  Yes

Date Place Court

Date of Birth \_\_\_\_\_

Driver License No./State \_\_\_\_\_

Place of Birth \_\_\_\_\_

Has your privilege to operate a motor vehicle ever been suspended or revoked?  No  Yes

Marital Status \_\_\_\_\_

If yes, explain fully: \_\_\_\_\_  
\_\_\_\_\_

Are you a citizen of Mississippi? Yes  No

For how long? \_\_\_\_\_

Are you a citizen of the United States? Yes  No

For how long? \_\_\_\_\_

If you have been naturalized: Date: \_\_\_\_\_

Certificate No. \_\_\_\_\_

Contact number: \_\_\_\_\_

Provide email address: \_\_\_\_\_

**POLYGRAPH QUESTIONNAIRE**

Candidates must complete and submit a polygraph questionnaire to be considered for the Mississippi Highway Safety Patrol's trooper school. Candidate application packets are not complete until the polygraph questionnaire has been submitted. Please use the link below to access the form:

<https://form.jotform.com/222404269144047>



**REFERENCES**

List three references who have known you well during the past five years and who are responsible adults of reputable standing in their communities. Example: property owners, business owners, professionals clergy, etc. Also list three social acquaintances in your own age group. Do not include relatives in either list.

<b>REFERENCES:</b>			
(a) Complete Name _____	No. Yrs. Acq. _____	Occupation _____	
Home Address _____	Business Address _____		
City, State _____	Home Phone _____	Business Phone _____	
(b) Complete Name _____	No. Yrs. Acq. _____	Occupation _____	
Home Address _____	Business Address _____		
City, State _____	Home Phone _____	Business Phone _____	
(c) Complete Name _____	No. Yrs. Acq. _____	Occupation _____	
Home Address _____	Business Address _____		
City, State _____	Home Phone _____	Business Phone _____	
<b>SOCIAL ACQUAINTANCES:</b>			
(a) Complete Name _____	No. Yrs. Acq. _____	Occupation _____	
Home Address _____	Business Address _____		
City, State _____	Home Phone _____	Business Phone _____	
(b) Complete Name _____	No. Yrs. Acq. _____	Occupation _____	
Home Address _____	Business Address _____		
City, State _____	Home Phone _____	Business Phone _____	
(c) Complete Name _____	No. Yrs. Acq. _____	Occupation _____	
Home Address _____	Business Address _____		
City, State _____	Home Phone _____	Business Phone _____	

**EMPLOYMENT**

List chronologically ALL EMPLOYMENT, including summer and part-time. **Begin with most recent.**

Current or Most Recent Employer:	Address:		Phone Number:	
Job Title:	Supervisor's Name:		Number Supervised by You	
Date Employed (Mo./Yr.)	Starting Salary: \$ Per	Ending Salary: \$ Per	Reason for Leaving	
Date Separated (Mo./Yr.)	Duties:			
<input type="radio"/> Full-Time				
<input type="radio"/> Part-Time				

Employer:	Address:		Phone Number:	
Job Title:	Supervisor's Name:		Number Supervised by You	
Date Employed (Mo./Yr.)	Starting Salary: \$ Per	Ending Salary: \$ Per	Reason for Leaving	
Date Separated (Mo./Yr.)	Duties:			
<input type="radio"/> Full-Time				
<input type="radio"/> Part-Time				

Employer:	Address:		Phone Number:
Job Title:	Supervisor's Name:		Number Supervised by You
Date Employed (Mo./Yr.)	Starting Salary: \$ Per	Ending Salary: \$ Per	Reason for Leaving
Date Separated (Mo./Yr.)	Duties:		
<input type="radio"/> Full-Time <input type="radio"/> Part-Time			

Employer:	Address:		Phone Number:
Job Title:	Supervisor's Name:		Number Supervised by You
Date Employed (Mo./Yr.)	Starting Salary: \$ Per	Ending Salary: \$ Per	Reason for Leaving
Date Separated (Mo./Yr.)	Duties:		
<input type="radio"/> Full-Time <input type="radio"/> Part-Time			

Have you ever been dismissed or asked to resign from any employment/position you have held?

- No  
 Yes

Employer's Name

Date

Reason:

Are you now employed by an agency of the Federal or State government?

Yes  No

Have you been employed by the Federal Government within the past 90 days?

Yes  No

Agency

Location

**MILITARY RECORD**

Have you ever served on active duty in the Armed Forces of the United States?  Yes  No

Branch of Service: \_\_\_\_\_

Dates Served From \_\_\_\_\_ to \_\_\_\_\_

Military Operation: \_\_\_\_\_

Rank: \_\_\_\_\_

Type Discharge:

Type Release from active duty:

Honorable

Expiration of Enlistment

Hardship

Retired

Dishonorable

Other \_\_\_\_\_

Other (Explain) \_\_\_\_\_

Reserve Status:  None  Active  Inactive

Discharge Date: \_\_\_\_\_

Are you a member of the National Guard or other Reserve Unit?  Yes  No

Branch:  Army  Navy  Air Force  Marine Corps  Coast Guard

If you are in a pay status requiring drills, meetings or camps, give Unit and Location. \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

If you were ever disciplined while in the military service, please explain circumstances in detail. List dates, nature of offense, type of court-martial or company punishment, whichever is applicable, and disposition of charges. Show any and all fines, restrictions and confinement in detail.

Offense	Type of Court Martial	Disposition of Charge	Fine, Restrictions & Confinement

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**COURT RECORD**

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Have you ever been arrested or charged with a felony violation?  Yes  No

If yes, list all felony violations and any convictions of any crime by any court pending or non-pending (against you). (Add attachment if applicable.)

Date	Place	Charge	Final Disposition

Have you ever been arrested or charged with a misdemeanor violation?  Yes  No

If yes, list all misdemeanor violations and any convictions of any crime by any court pending or non-pending (against you). (Add attachment if applicable.)

Date	Place	Charge	Final Disposition

Have you ever been a party to any civil (garnishments, bankruptcy, etc.), quasi-criminal or chancery action, in County, Circuit or Chancery Court?  Yes  No (Give date, place, court, names or parties involved, nature of action, and final disposition.)

Date	Court	Parties Involved	Nature of Action	Final Disposition

Have you ever received a traffic citation/ticket?  Yes  No If yes, list all traffic citations pending or non-pending (against you). (Add attachment if applicable)

Date	Place	Charge	Final Disposition





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## AUTHORIZATION TO RELEASE INFORMATION FORM

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Applicant, please read the following release statement carefully before signing and addressing in the designated space below.

Date: \_\_\_\_\_

TO WHOM IT MAY CONCERN:

I, \_\_\_\_\_, have made application to the Mississippi Department of Public Safety/ Mississippi Highway Safety Patrol and desire them to be informed of my past records and character whether it be financial, academic, military, medical, employment, judicial, or personal references. I the undersigned, being under no disability whatsoever, hereby authorize the release of all such information, privileged or otherwise, the Department of Public Safety and its representatives, and release all contributing parties of such information from any charges or liabilities whatsoever and through the furnishing of said information.

SIGNATURE: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

\_\_\_\_\_

**Selective Service Registration**

As required by Section 25-9-351(a), Mississippi Code Annotated, 1972:

- (a) Every male between the ages of eighteen (18) and twenty-six (26) who is required to register under the federal Military Selective Service Act, 50, USCS App. 4453, and is seeking employment with the State of Mississippi shall submit to the person, commission, board or agency to which his application is submitted satisfactory documentation of his compliance with the draft registration requirements of the Military Service Act.

If you fall into one of the following categories listed below, you will not be required to register:

**Persons not Required to be Registered:**

- a. The following persons are not required to be registered:
- (1) Aliens legally admitted to the United States as non-immigrants under section 101(a)(15) of the Immigration and Nationality Act, as amended (66 STAT. 153; 8 U.S.C. 1101) and who continue to maintain the non-immigrant status; e.g., visitor for business or pleasure, foreign diplomatic representatives, technical attaches of foreign embassies and legations, consuls general, consuls, vice consuls, diplomatic agents, members of NATO or other international organizations who are not United States citizens and members of their families, educational exchange students, and representatives for foreign information media.
  - (2) Commissioned officers, warrant officers and enlisted men who are active duty in the Army, the Navy, the Air Force, the Marine Corps, and the Coast Guard, and commissioned officers of the National Oceanic Atmospheric Administration and the regular Public Health Service.
  - (3) Cadets at the United States Military Academy, the United States Air Force Academy, the United States Coast Guard Academy, and midshipmen at the United States Naval Academy.
  - (4) Students enrolled in the officer procurement program at the following military colleges, the curriculum of which has been approved by the Secretary of Defense:  

The Citadel (Charleston, SC)  
North Georgia College (Dahlonega, GA)  
Norwich University (Northfield, VT)  
Virginia Military Institute (Lexington, VA)
  - (5) Members of the reserve components of the Armed Forces, the Coast Guard and the Public Health Service while on duty. Active duty in the Public Health Service must be performed by officers of the Reserve of the Public Health Service while assigned to staff of any of the various offices and bureaus of the Public Health Service, including the National Institutes of Health, or while assigned to the Coast Guard, the Bureau of Prisons of the Department of Justice, the Environmental Protection Agency of the National Oceanic and Atmospheric Administration, or while assigned to assist Indian Tribes, groups, bands or communities pursuant to PL 568, 83<sup>rd</sup> Congress, as amended.
- b. A person who is hospitalized or incarcerated at the time specified for his registration shall be exempt from registration during the period of confinement. Upon his release he shall present himself for registration.

**NAME:** \_\_\_\_\_  
**SOCIAL SECURITY NUMBER:** \_\_\_\_\_  
**SELECTIVE SERVICE ID:** \_\_\_\_\_

MISSISSIPPI DEPARTMENT OF PUBLIC SAFETY

This rider is regarding Public Law 104-208, passes by the 104th Congress, 2nd Session, effective September 30, 1996.

The Law. Title 18, U.S.C., Section 922 (g) (9) makes it against the law for anyone who has been convicted of a misdemeanor crime of domestic violence to possess any firearm or ammunition.

"Misdemeanor crime of domestic violence" is generally defined as any offense-whether or not explicitly described in a statute as a crime of domestic violence-which has, as its factual basis, the use or attempted use of physical force, or the threatened use of a deadly weapon, committed by the victim's current or former domestic partner, parent, or guardian. As defined in the Gun Control Act, a misdemeanor crime of domestic violence means an offense that:

- (1) is a misdemeanor under federal or state law; and
(2) has, as an element, the use or attempted use of physical force, or the threatened use of a deadly weapon, committed by a current or former spouse, parent, or guardian of the victim, by a person with whom the victim shares a child in common, by a person who is cohabiting with or has co-habited with the victim as a spouse, parent or guardian, or by a person similarly situated to a spouse, parent, or guardian of the victim.

The law further provides that a person shall not be considered to have been convicted of such an offense for purposes of this chapter, unless:

- (1) the person was represented by counsel in the case, or knowingly and intelligently waived the right to counsel in the case; and
(2) in the case of a prosecution for an offense described in the paragraph for which a person was entitled to a jury trial in the jurisdiction in which the case was tried, either
(a) the case was tried by a jury, or
(b) the person knowingly and intelligently waived the right to have the case tried by a jury, by guilty plea or otherwise.

The law further states that "A person shall not be considered to have been convicted of such an offense for purposes of this chapter if the conviction has been expunged or set aside or is an offense for which the person has been pardoned or has had civil rights restored...unless the pardon, expungement or restoration of civil rights expressly provides that the person may not ship, transport, possess or receive firearms."

HAVE YOU EVER BEEN CONVICTED OF A MISDEMEANOR CRIME OF DOMESTIC VIOLENCE WITHIN THE MEANING OF THE STATUTE? YES \_\_\_\_\_ NO \_\_\_\_\_

If you answered "yes" to this question, please provide the following information with respect to the conviction:

Court/Jurisdiction \_\_\_\_\_
Docket/Case Number \_\_\_\_\_
Statute/Charge \_\_\_\_\_
Date Sentenced \_\_\_\_\_

(NOTE: Any person who makes any false affidavit or knowingly swears or affirms falsely to any matter or thing required by the terms of this application to be sworn to or affirmed, is guilty of perjury and upon conviction, shall be punishable by fine or imprisonment for a term not exceeding ten years.)

I hereby certify that, to the best of my information and belief, all of the information provided by me in this rider is true, correct, complete and made in good faith. I understand that false or fraudulent information provided herein is criminally punishable pursuant to federal and state law.

Name: \_\_\_\_\_ Date: \_\_\_\_\_
Signature

STATE OF MISSISSIPPI
COUNTY OF \_\_\_\_\_

Before me this day personally appeared \_\_\_\_\_, who being duly sworn, deposes and says that the information contained in this rider is true and correct to the best of his/her knowledge.

Signature of Applicant

Sworn and subscribed before me, this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_\_.

My Commission expires:

Notary Public, State of Mississippi



## PAST MEDICAL HISTORY EVALUATION

The questionnaire is designated to ensure your entire medical history is thoroughly documented to the best of your knowledge based on the 2018 National Fire Protection Agency Occupational Medical Program Standards and reviewed by a licensed healthcare provider prior to beginning any occupational training. If you are being treated by a physician, or other medical provider, for any chronic medical condition it is advised to obtain additional documentation from your primary provider detailing your chronic medical condition before your physical evaluation by the UMMC Provider(s).

	YES	NO		YES	NO
<b>Cardiovascular/ Respiratory</b>			<b>Neurological/Head/Neck/Spine</b>		
Heart Murmur			Stroke		
Irregular Heart Rate			Seizure		
Peripheral Vascular Disease			▪ Have you experienced a seizure in the past 5 years?		
Palpitations			Head trauma/ Concussions		
Angina (chest pain)			Facial trauma/ injury		
Coronary Artery Disease			Neck trauma/ injury		
MI/ Heart Attack			Skull/facial deformities		
Recurrent Syncope/ "pass out"			Multiple Sclerosis		
Congestive Heart Failure			Myasthenia Gravis		
Heart Block			Muscular Dystrophy/Atrophy		
Prosthetic Valve			Narcolepsy		
Hypertension			Migraine Headaches		
Thoracic/Abdominal Aneurysm			Scoliosis		
Cardiomyopathy			<b>Ears/ Nose/Throat</b>		
Cardiac Pacemaker			Vertigo/ "dizziness"		
Implanted Cardiac Defibrillator			Hearing loss		
Carotid Stenosis			Use of assistive hearing devices		
Pericarditis/Endocarditis			Otitis externa		
Heart/Lung Transplant			Otitis Media/ "recent ear infection"		
High Cholesterol			Allergic Rhinitis		
Rheumatic Fever			Nose bleeds		
Asthma			Sinusitis		
▪ Do you use a daily inhaler?			<b>Eyes/Vision</b>		
▪ Do you use a rescue inhaler?			Glasses/contact		
▪ Have you been to the ER for asthma in the past 2 years?			Color Blindness		

<ul style="list-style-type: none"> <li>▪ Have you been hospitalized for asthma in the past 2 years?</li> </ul>			Glaucoma/Cataracts		
<ul style="list-style-type: none"> <li>▪ Have you been on steroid therapy in the past 2 years?</li> <li>▪ Are you short of breath with exercise/temp extremes?</li> </ul>			Retinal Detachment with history of surgical repair		
COPD/ Emphysema			Progressive Retinopathy		
Pulmonary Embolism			<b>Skin</b>		
Pneumonia (>2 times in a year)			Metastatic Skin Cancer (carcinoma/melanoma)		
Tuberculosis			Eczema		
Pulmonary Hypertension			Psoriasis		
Reactive Airway Disease			Burns/Skin Grafts		
Obstructive Sleep Apnea			Raynaud's Phenomenon		
<ul style="list-style-type: none"> <li>▪ Do you wear a CPAP to sleep?</li> </ul>			Neurofibromatosis		
Pleural Effusion			Urticaria without cause		
Cystic Fibrosis			Cystic Acne		

	YES	NO		YES	NO
<b>Abdominal/Gastrointestinal</b>			<b>Reproductive</b>		
Hernia (with/without repair)			Pregnancy (current or past)		
Gastrointestinal Cancer			Dysmenorrhea		
Crohn's Disease			Endometriosis		
Inflammatory Bowel Disease			Ovarian Cysts		
Hepatitis			Testicular Torsion		
Ulcerative Colitis			Epididymitis		
Jaundice			<b>Blood/Bleeding Disorder</b>		
Cirrhosis			Sickle Cell Disorder		
Peptic Ulcers			Hemophilia		
Cholecystitis			Anemia		
GL Bleed			D.I.C.		
Pancreatitis			Von Willebrand's Disease		
Diverticulitis			DVT/ Blood Clots		
Weight Loss Surgery			Factor II, V, VII, X, XII Deficiency		
Gastritis			<b>Musculoskeletal</b>		
<b>Renal/Urinary</b>			Joint Repair		
Kidney Stones			Amputation		
Pyelonephritis			Bone Grafts		
Kidney UTI's			Shoulder Dislocations		
Interstitial Cystitis			Osteomyelitis/Osteochondritis		
Renal Failure (with/without dialysis)			Upper/lower extremity injuries		

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Medical Condition	YES	NO	Medical Condition	YES	NO
<b>Endocrine/Immune</b>			<b>Mental/Psychiatric</b>		
Type 1 Diabetes			Depression		
Type 2 Diabetes			Anxiety		
Hyperthyroid			Attention Deficit Disorder		
Hypothyroid			ADHD		
Goiter			Bipolar Disorder		
Addison's Disease			Anorexia		
Cushing's Disease			Bulimia		
Graves' Disease			Binge Eating		
Rheumatoid Arthritis			Obsession Compulsive Disorder		
Multiple Sclerosis			Schizophrenia		
HIV/AIDS			Insomnia		
Lupus			Autism		
Scleroderma			Tourette's		
Celiac Disease			Alcohol Abuse		
Guillain-Barre Syndrome			Substance Abuse		
Chronic Lyme Disease			Previous Suicide Attempt		

If you answered yes to any of the above medical conditions, please provide a detailed history in the space below. Please list any additional medical history if not listed above.

Medical Condition	Year Diagnosed	Receiving Medication/Treatment YES/NO	Description
		YES/NO	
		YES/NO	
		YES/NO	
		YES/NO	
		YES/NO	

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Please list all current routine medications (prescription and over the counter) below.

Medication	Dosage	Frequency	Reason for Taking

List all known medication allergies: \_\_\_\_\_

Please provide surgical history below.

Surgery	Date/Year



Public Safety  
Support Division

Patient Demographic Sheet – Please Print

Employment Information

Social Security # - Social Security number is needed to help identify patient in the Electronic Health Record system	Employer Name
Last Name	Employer Address
Middle Name	City/State/Zip Code
Home Address	Work Phone #
City/State/Zip Code	Emergency Contact
Date of Birth	Address of Emergency Contact
Religion	City/State/Zip code
Home Phone #	Phone # of Emergency Contact
Mothers First Name	Name of Preferred Pharmacy
Patient Email Address	

Mission Statement: Our mission is to provide the highest level of training, planning, research and medical support to public safety agencies across Mississippi and to help improve the health of safety professionals.