

MISSISSIPPI STATE TROOPER



CADET CLASS

67

CANDIDATE APPLICATION PACKET



COLONEL
RANDY C. GINN
DIRECTOR

STATE OF MISSISSIPPI
TATE REEVES, GOVERNOR
DEPARTMENT OF PUBLIC SAFETY
MISSISSIPPI HIGHWAY SAFETY PATROL
SEAN J. TINDELL, COMMISSIONER

LT. COLONEL
MALACHI J. SANDERS
DEPUTY DIRECTOR

September 7, 2022

Dear Applicant,

Thank you for your interest in becoming a Mississippi State Trooper. The first step in the Trooper School candidate process is meeting the minimum qualifications below and completing the application.

MINIMUM QUALIFICATIONS FOR TROOPER SCHOOL CLASS 67

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. Applicant shall have a high school diploma or GED.

I. APPLICATION

THIS APPLICATION MUST BE RECEIVED BY THE MHSP ADMINISTRATIVE OPERATIONS DIVISION BY THE CLOSE OF BUSINESS ON **October 14, 2022.** You are to complete ALL SECTIONS of the application and provide the following attachments:

- A. Photocopy of your Driver's 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
- 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

A physical training test and 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 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 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, 25 push-ups in two (2) minutes for males and 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.

Good luck, and thank you for your interest in becoming a Mississippi State Trooper!

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.

DO NOT SEND ANY APPLICATIONS TO THE MISSISSIPPI STATE PERSONNEL BOARD

Sincerely,



Randy C. Ginn, Colonel
Director, MHSP
Assistant Commissioner, DPS

MDPS/MHSP PATROL BACKGROUND APPLICATION

Date: _____

Mail To:

MS Department of Public Safety

MS Highway Safety Patrol

Post Office Box 958/Box A2

Jackson, MS 39205

Attn: MHSP Administrative Operations Division

NOTICE: Application **MUST** be typewritten or clearly printed. ALL questions **MUST** be answered. If a question is not applicable, so state. APPLICATIONS WHICH ARE NOT COMPLETE AND LEGIBLE WILL NOT BE CONSIDERED. IF SPACE PROVIDED IS NOT SUFFICIENT FOR COMPLETE ANSWERS, OR YOU WISH TO FURNISH ADDITIONAL INFORMATION, ATTACH 8 1/2 x 11 SHEETS OF PAPER AND NUMBER ANSWERS TO CORRESPOND WITH QUESTIONS.

PERSONAL HISTORYFull 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 _____

Marital Status _____

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

If yes, explain fully: _____

Are you a citizen of Mississippi? Yes ☐ No ☐Are you a citizen of the United States? Yes ☐ No ☐

For how long? _____

For how long? _____

If you have been naturalized: Date: _____

Certificate No. _____

Provide email address: _____

RESIDENCES

1. Present Address:						
Street and Number	City	County	State	Zip Code	Telephone	

2. Mailing Address: _____

Street and Number	City	County	State	Zip Code	Telephone
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3. List chronologically ALL of your residences for the past 10 years. (Include addresses while attending school if away from home.) **Begin with most recent.**

[illegible]

EDUCATION

Do you have a high school diploma? _____

Do you have a GED certificate?

Date Received: _____

Name of High School	Location	Dates		Date Diploma Received
		FROM	TO	

[illegible]

Were you ever dismissed from a school, or were any disciplinary actions including scholastic probation ever taken against you during your scholastic career?

☐ **No**☐ Yes

School	Date	Type of Action
--------	------	----------------

LICENSE, CERTIFICATE, REGISTRATION (A copy of the appropriate license or certificate must be attached if required by the job description)					
Title/Type	License Number	Name of Licensing Agency	Specialization	Certification Date (Orig.)	Expiration Date

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.

REFERENCES:			
(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 _____	
SOCIAL ACQUAINTANCES:			
(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="checkbox"/> Full-Time				
<input type="checkbox"/> 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="checkbox"/> Full-Time				
<input type="checkbox"/> 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="checkbox"/> Full-Time			
<input type="checkbox"/> 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="checkbox"/> Full-Time			
<input type="checkbox"/> 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

COURT RECORD

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	Details

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	Details

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	Details

RELATIVES

ALL APPLICANTS MUST GIVE COMPLETE INFORMATION CONCERNING THEIR RELATIVES. If you have been married more than once, give the requested information concerning each former husband or wife. Even if a relative is deceased, give all the information requested, and indicate last residence and year of death. Include step brothers and sisters, half brothers and sisters, and if you or your wife have step-parents, legal guardians, or others who have reared you instead of your parents, the requested information should be furnished concerning them as well as your real parents.

Complete Name (no initials) and Address	Occupation, Name and Address of Firm where Employed	Date and Place of Naturalization
FATHER Name _____ Address _____ Age _____ Place of Birth _____		
MOTHER Name _____ Address _____ Age _____ Place of Birth _____		
WIFE OR HUSBAND Name _____ Address _____ Age _____ Place of Birth _____		
CHILDREN Name _____ Address _____ Age _____ Place of Birth _____		
Name _____ Address _____ Age _____ Place of Birth _____		
Name _____ Address _____ Age _____ Place of Birth _____		
Name _____ Address _____ Age _____ Place of Birth _____		
BROTHERS AND SISTERS Name _____ Address _____ Age _____ Place of Birth _____		
Name _____ Address _____ Age _____ Place of Birth _____		

Complete Name (no initials) and Address	Occupation, Name and Address of Firm where Employed	Date and Place of Naturalization
Name _____ Address _____ Age _____ Place of Birth _____		
Name _____ Address _____ Age _____ Place of Birth _____		

CLICK HERE TO RESET/CEAR FORM



ALL APPLICANTS

Attach an unmounted full face photograph of yourself, not larger than 2 ¾ by 2 ½ inches. Print your name plainly on the back of the photograph. The photograph must have been taken not more than 3 months prior to the date of this application. YOUR APPLICATION WILL NOT BE CONSIDERED UNLESS AN APPROPRIATE PHOTOGRAPH IS INCLUDED.

**ALL RECORDS SUBMITTED BECOME THE PROPERTY OF THE
STATE OF MISSISSIPPI**

I understand that all appointments are probationary for a period of one year, during which time the employee must demonstrate his fitness for continued employment by the Department of Public Safety. I also understand that any appointment tendered me will be contingent upon the results of a complete character and fitness investigation and I am aware that willfully withholding information or making false statements on this application will be the basis for dismissal from the Department of Public Safety, and I agree to these conditions.

(Signature of the applicant as usually written.)

APPLICANT'S AFFIDAVIT

**STATE OF MISSISSIPPI
COUNTY OF _____**

Personally came and appeared before me, the undersigned authority in and for said county and state, the within named _____, who acknowledged to me that he/she signed and delivered the above and foregoing waiver on the date therein mentioned and for the purpose therein expressed.

GIVEN under my hand and seal of office, this ____ day of _____, 20__.

NOTARY PUBLIC

My Commission Expires:

EQUAL OPPORTUNITY EMPLOYER

AUTHORITY TO RELEASE INFORMATION FORM

Please read the following release form carefully and enter your signature, address, and the date in the designated spaces. **THIS FORM MUST BE NOTARIZED.**

DATE: _____

TO WHOM IT MAY CONCERN:

Having made application to the State of Mississippi, the Department of Public Safety/Mississippi Highway Safety Patrol and desiring them to be informed of my past record and character, whether it be financial, academic, military, medical, employment, judicial, or personal reference, I, the undersigned, being under no disability whatsoever, hereby authorize the release of all such information, privileged or otherwise, to the Department of Public Safety and its representatives, and release all contributing parties of such information from any charges or liability whatsoever because of furnishing said information.

SIGNATURE: _____

ADDRESS: _____

STATE OF MISSISSIPPI
COUNTY OF _____

Personally came and appeared before me, the undersigned authority in and for said county and state, the within named _____, who acknowledged to me that he/she signed and delivered the above and foregoing waiver on the date therein mentioned and for the purpose therein expressed.

GIVEN under my hand and seal of office, this ____ day of _____, 20__.

NOTARY PUBLIC

My Commission Expires:

**THIS APPLICATION INVALID UPON EXPIRATION OF NOTARY PUBLIC SIGNATURE
OR ONE (1) YEAR FROM DATE OF APPLICANT SIGNATURE**

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, 83rd 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: _____



COLONEL
RANDY C. GINN
DIRECTOR

STATE OF MISSISSIPPI
TATE REEVES, GOVERNOR
DEPARTMENT OF PUBLIC SAFETY
MISSISSIPPI HIGHWAY SAFETY PATROL
SEAN J. TINDELL, COMMISSIONER

LIEUTENANT COLONEL
CHARLES HAYNES
MBI DIRECTOR

DATE: September 01, 2022

TO: MHSP Candidate

FROM: Lieutenant Colonel Charles Haynes
MBI Jackson

SUBJECT: Candidate Application and Polygraph Questionnaire

Greetings:

Candidates must complete a polygraph questionnaire to be considered for the Mississippi Highway Safety Patrol's (MHSP) Trooper School. Please use the link below to access and complete the form:

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

To access the polygraph questionnaire, candidates must type the above link into an internet browser. Please contact the MHSP Administrative Operations Division at 601-987-1259 if you have questions or concerns.

Kindest Regards,

Charles Haynes, LTC

MISSISSIPPI DEPARTMENT OF PUBLIC SAFETY

This rider is regarding Public Law 104-208, passed 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 a 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 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 _____
Dates 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 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: _____
Signature

Date: _____

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 my knowledge.

Signature of Applicant

Sworn and subscribed before me, this _____ day of _____ 20__

My Commission expires:

Notary Public, State of Mississippi



Mississippi Center for Emergency Services
Public Safety Support Division
2500 North State Street • Jackson, Mississippi 39216
Phone: 601.815.6060 • Fax: 601.984.4504
publicsafetysupport@umc.edu

August 22, 2022

Congratulations prospective MHP Cadet,

You will be participating in a pre-employment medical screening that will take place in October 2022. Mississippi Highway Patrol will provide the exact time and date for your physical. Please complete in its entirety, the attached past medical history and demographic information forms and **return the forms with your completed application**. The results from your medical screening will be entered into the University of Mississippi Medical Center's electronic medical record system for safe keeping. Your insurance will not be billed and any reference to insurance can be left blank for the purposes of this screening.

The night before the screening begin hydrating well with primarily water. The morning of the screening, please eat breakfast, hydrate and take your usual medications. Please, wear comfortable athletic clothes and shoes. Glasses and corrective lenses must also be worn. Female candidates are required to bring a copy of a current pap smear (within the last 12 months). Diabetics are required to bring a current HemoglobinA1C result (within last 6 months) of 8.0 or below. **Please refrain from using energy drinks, caffeinated beverages and/or pre-workout drinks/supplements until after your medical screening has been completed.** These items are known to cause elevations in blood pressure which can and will result in medical disqualification from the MHP Cadet Training Program. You will need to bring **all** medications you are currently taking, including daily use over the counter medications, herbal supplements and vitamins. If you have had a surgery within the last 12 months, you will need to bring a letter from the treating physician stating you have been cleared for activity with no restrictions. It is mandatory that you provide **all** supplemental documents with you at the time of your medical screening.

In addition to the above, you are required to bring a cashier's check (you may obtain this from your local banking institution) made out to the University of Mississippi Medical Center or (UMMC) in the amount of **\$89.00** on the day of your medical screening.

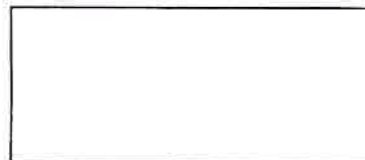
Any questions can be addressed to the UMMC Public Safety Support Division email provided below.

Email: publicsafetysupport@umc.edu

Thank you!

A handwritten signature in black ink, appearing to read 'Jeremy Benson'.

Jeremy Benson, BS, CCP
Emergency Transport Manager
University Mississippi Medical Center
O: 601-815-6243



PAST MEDICAL HISTORY EVALUATION

The questionnaire is designed 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 Standard 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
Cardiovascular/Respiratory			Neurological/Head/Neck/Spine		
Heart Murmur			Stroke		
Irregular Heart Rate			Seizures		
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/ "passing out"			Multiple Sclerosis		
Congestive Heart Failure			Myasthenia Gravis		
Heart Block			Muscular Dystrophy/Atrophy		
Prosthetic Valve			Narcolepsy		
Hypertension			Migraine Headaches		
Thoracic/Abdominal Aneurysm			Scoliosis		
Cardiomyopathy			Ears/ Nose/Throat		
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?			Eyes/Vision		
▪ Do you use a rescue inhaler?			Glasses/contacts		
▪ Have you been to the ER for asthma in the past 2 years?			Color Blindness		

▪ Have you been hospitalized for asthma in the past 2 years?			Glaucoma/Cataracts		
▪ Have you been on steroid therapy in the past 2 years?			Retinal Detachment with history of surgical repair		
▪ Are you short of breath with exercise/temp extremes?					
COPD/ Emphysema			Progressive Retinopathy		
Pulmonary Embolism			Skin		
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		
▪ Do you wear a CPAP to sleep?			Neurofibromatosis		
Pleural Effusion			Urticaria without cause		
Cystic Fibrosis			Cystic Acne		

YES NO		YES NO	
Abdominal/Gastrointestinal		Reproductive	
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		Blood/Bleeding Disorders	
Cirrhosis		Sickle Cell Disease	
Peptic Ulcers		Hemophilia	
Cholecystitis		Anemia	
GI Bleed		D.I.C.	
Pancreatitis		Von Willebrand's Disease	
Diverticulitis		DVT/ Blood Clots	
Weight Loss Surgery		Factor II, V, VII, X, XII Deficiency	
Gastritis		Musculoskeletal	
Renal/Urinary		Joint Repair	
Kidney Stones		Amputations	
Pyelonephritis		Bone Grafts	
Recurrent 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
Endocrine/Immune			Mental/Psychiatric		
Type 1 Diabetes			Depression		
Type 2 Diabetes			Anxiety		
Hyperthyroid			Attention Deficit Disorder		
Hypothyroid			ADHD		
Golter			Bipolar Disorder		
Addison's Disease			Anorexia		
Cushing's Disease			Bulimia		
Graves' Disease			Binge Eating		
Rheumatoid Arthritis			Obsessive 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	Description
		YES/NO	
		YES/NO	
		YES/NO	
		YES/NO	
		YES/NO	

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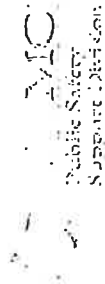
Please list all current routine medications (prescription and over the counter) below.

Medication	Dosage	Frequency	Reason for Taking

List all known medication allergies: _____

Please provide surgical history below.

Surgery	Date/Year



Patient Demographic Sheet - Please Print

Employment Information

Social Security # - Note: Social security number is needed to help identify patients in the Electronic Health Record system		Employer Name
Last Name		Employer Address
First Name		City/State/Zip code
Middle Name		
Maiden Name (females only)		
Home Address		Work Phone #
City/State/Zip code		Reginal Office Location
Date of Birth		Emergency Contact
Race		Relationship to Patient
Religion		Address of Emergency Contact
Home Phone #		City/State/Zip code
Cell Phone #		Phone # of Emergency Contact
Mother's First Name		Name of Preferred Pharmacy
Mother's Maiden Name		
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.