

# CAPE BRETON REGIONAL POLICE

"SERVING WITH YOU - FOR YOU"



Cape Breton Regional Police are seeking upcoming and experienced Police Constables to work in the second largest municipal force in the province, with a well-earned reputation as an innovative and progressive police service. In this full-service agency, you'll have the opportunity to work in 20 different specialized sections and teams in meaningful and satisfying work to ensure public safety and stay connected to our communities.

The Cape Breton Regional Municipality offers a competitive compensation and benefits package:

- \$60,000 - \$109,000 (as of 2025 and after 4 years of service)
- Promotional opportunities
- Salary equal to years of service for Experienced Officers
- Medical, Dental, Vision, Extended Health, Group Insurance, EFAP, etc.
- Nova Scotia Public Service Superannuation Plan
- \$5,000 hiring incentive for Experienced Officers
- [Further information is available in the collective agreement](#)

If you're considering a career in policing, CBRPS and Holland College have partnered together to offer placements in their upcoming classes. This includes paid on-the-job training upon signing a 2-year return to service agreement. For information on their Police Science academic program, [please click here](#).

*Interested applicants must apply using the CBRPS employment application to begin this process.*

For an insider look at CBRPS – check out this video: ["Shape Your Career with the CBRPS"](#)

Plus, you'll enjoy a quality lifestyle on award-winning Cape Breton Island with short commute times, communication connection, and public confidence and trust in your service.

Completed applications may be submitted to:	Application Deadline:
<p>Cape Breton Regional Municipality Attn: Human Resources Department 320 Esplanade, Sydney, N.S. B1P 7B9 Phone: 902-563-5354 Fax: 902-563-5582</p> <p>Or via email to: <a href="mailto:Jobapplications@cbrm.ns.ca">Jobapplications@cbrm.ns.ca</a></p>	<p>Applications will be accepted until all vacancies are filled.</p> <p>For questions or more information, please submit your information <a href="#">here</a>. This will connect you with a member of the Human Resources or CBRPS team.</p>

CBRM is committed to the principles of Employment Equity and Inclusivity. We encourage applications from designated groups, including but not limited to women, visible minorities, indigenous peoples, members of the 2SLGBTQIA+ community, and persons with disabilities. CBRM encourages the need for respect, integrity, diversity, accountability, and the public good.

## **POLICE CONSTABLE APPLICATION**

### **Notices & Instructions:**

- 1.** An essential component in the selection process of the Cape Breton Regional Police Service is background investigation. Information gathered will be used to assess the suitability of the Applicant for a police career. There will be a security check on the Applicant and members of their family.
- 2.** All questions must be answered. If a question is not applicable, mark N/A and attach a note explaining the reason any question is left blank.
- 3.** All information supplied is subject to verification by investigation. False statements can disqualify or result in dismissal if employed.
- 4.** Complete this form by printing in ink. Neatness and legibility are of the utmost importance.
- 5.** If extra space is required, attach additional pages to this application.
- 6.** Postal codes must be supplied for each address given.
- 7.** No information received from inquiries concerning information in this application will be released to the applicant.

**Applicants interested in our partnership with Holland College 's Atlantic Police Academy must complete this application and supply the supporting documentation listed on pages 2 and 3.**

## APPLICATION CHECKLIST

**All forms and requested documentation listed below must be submitted along with this package:**

- Proof of Canadian Citizenship or permanent resident status.
  - For example, a birth certificate, passport, permanent resident card, etc. Must be 19 years of age.
  
- Proof of graduation from the Atlantic Police Academy or an equivalent Police Training facility **OR** Five (5) years uninterrupted recent experience with an accredited Canadian police agency.
  - *All former graduates from the Atlantic Police Academy or equivalent Police Training Facility may be considered.*
  - **Experienced Police Officers are encouraged to apply.** *The CBRPS does not practice a lateral entry process. Successful candidates will not retain their previous rank, compensation, or seniority. Prior service may be recognized when determining starting salary.*
  
- CBRM Pare Medical Clearance Form (Part 1 & 2)
  - Must be completed by a physician
  - Form is included in the application package – PARE tests are valid for 6 months.
  - Candidates must be medically fit in order to be accepted into the program.
  - PARE testing locations may be researched [here](#). An official certificate must be submitted with this application.
  
- Laboratory Requisition Form (**upon request through Human Resources**)
  - Please fill in your name, health card number etc. as indicated on the form within the application before taking to the Blood Collections Department.
  - Results must be faxed to the HR Department at 902-563-5582.
  
- EKG Form (**upon request through Human Resources**)
  - Please fill in your name, health card number etc. as indicated on the form within the application before taking to the Blood Collections Department.
  - Results must be faxed to the HR Department at 902-563-5582.
  
- Visual Examination Form
  - Included in the application package – valid for 1-year.
  
- Hearing Examination Form
  - Included in the application package – valid for 1 year.
  
- CBRM Medical Examination of Fitness for Work Form
  - This form must be completed by the applicant (included in application package).

*The Cape Breton Regional Police Service, in partnership with the people,  
is committed to serve and protect our community.*

[www.cbrps.ca](http://www.cbrps.ca)

- Criminal Record Check and Vulnerable Sector Check
    - Persons who have been found guilty of and/or convicted of a criminal offence must have received an absolute discharge or a pardon. Candidates must submit to a criminal record check from a local police service, and sign the criminal consent form giving permission for a background check.
  
  - Copy of Valid Canadian Driver's License (front and back)
    - Must possess and maintain a valid Canadian driver's license.
  
  - Copy of Driver's Abstract
    - Must indicate an acceptable driving record for last three years.
  
  - Copy of (C.P.R.) Level C. Current Standard First Aid
  
  - Three (3) letters of reference – one must be work-related
- 

**Only applicants selected to proceed in the selection process will be required to complete the phases listed below:**

- Polygraph Examination
- Psychological Screening
- Medical Evaluation
- Security Clearance
- Credit History Check
- Reference Checks
- Drug And Alcohol Screening

LAST NAME		GIVEN NAME		MIDDLE NAME	
FULL ADDRESS		CITY		PROVINCE	
FULL ADDRESS		POSTAL CODE			
EMAIL ADDRESS		TELEPHONE NO. (RES.) [     ]	TELEPHONE NO. (BUS.) [     ]		TELEPHONE NO. (OTHER) [     ]
Other than the name(s) listed above, please list any name change(s), or name(s) you may have used in the past.					
NAME CHANGE FROM:		NAME CHANGE TO:			Date of Change:
NAME CHANGE FROM:		NAME CHANGE TO:			Date of Change:
<b>DRIVER'S LICENCE</b>	PROVINCE	CLASS(ES)	LICENCE NUMBER		Date of Issue:

# EDUCATION AND TRAINING

*Proof of education will be required prior to engagement*

<b>HIGH SCHOOL</b>		<i>Circle highest grade completed</i>		NAME OF SCHOOL		LOCATION		<input type="checkbox"/> HIGH SCHOOL DIPLOMA <input type="checkbox"/> EQUIVALENCY DIPLOMA			
10		11		12		13					
<b>COLLEGE, BUSINESS SCHOOL, OR TECHNICAL SCHOOL</b>				NAME OF SCHOOL		LOCATION					
PROGRAM OR COURSE								START YYYY	DATE MM	FINISH YYYY	DATE MM
LENGTH OF COURSE	GRADE POINT AVERAGE		<input type="checkbox"/> CERTIFICATE <input type="checkbox"/> DIPLOMA <input type="checkbox"/> LICENCE AWARDED? <i>(IF NOT - PLEASE PROVIDE DETAILS)</i> NO								
<b>COLLEGE, SCHOOL SCHOOL, OR BUSINESS TECHNICAL</b>				NAME OF SCHOOL		LOCATION					
PROGRAM OR COURSE								START YYYY	DATE MM	FINISH YYYY	DATE MM
LENGTH OF COURSE	GRADE POINT AVERAGE		<input type="checkbox"/> CERTIFICATE <input type="checkbox"/> DIPLOMA <input type="checkbox"/> LICENCE AWARDED? <i>(IF NOT - PLEASE PROVIDE DETAILS)</i> NO								
<b>UNIVERSITY</b>				NAME OF SCHOOL		LOCATION					
PROGRAM OR COURSE								START YYYY	DATE MM	FINISH YYYY	DATE MM
MAJOR/MINOR											
LENGTH OF COURSE	GRADEPOINT	AVERAGE		<input type="checkbox"/> CERTIFICATE <input type="checkbox"/> DIPLOMA <input type="checkbox"/> DEGREE AWARDED? <i>(IF NOT - PLEASE PROVIDE DETAILS)</i> NO							
<b>UNIVERSITY</b>				NAME OF SCHOOL		LOCATION					
PROGRAM OR COURSE								START YYYY	DATE MM	FINISH YYYY	DATE MM
MAJOR/MINOR											
LENGTH OF COURSE	GRADEPOINT	AVERAGE		<input type="checkbox"/> CERTIFICATE <input type="checkbox"/> DIPLOMA <input type="checkbox"/> DEGREE AWARDED? <i>(IF NOT - PLEASE PROVIDE DETAILS)</i> NO							
<b>UNIVERSITY</b>				NAME OF SCHOOL		LOCATION					
PROGRAM OR COURSE								START YYYY	DATE MM	FINISH YYYY	DATE MM
MAJOR/MINOR											
LENGTH OF COURSE	GRADEPOINT	AVERAGE		<input type="checkbox"/> CERTIFICATE <input type="checkbox"/> DIPLOMA <input type="checkbox"/> DEGREE AWARDED? <i>(IF NOT - PLEASE PROVIDE DETAILS)</i> NO							

The CBRM is committed to the principles of Employment Equity and encourages applications from the designated groups; women, visible minorities, aboriginals and persons with disabilities. CBRM encourages the need for respect, integrity, diversity, accountability and the public good.

Sex: M \_\_\_\_\_ F \_\_\_\_\_ O \_\_\_\_\_

Self-Identity:

Are you a member of an under represented group? Yes or No

Do you require a workplace accommodation? Yes or No

LANGUAGES SPOKEN

LANGUAGES WRITTEN

ADDITIONAL EDUCATION INCLUDING COURSES, WORKSHOPS, AND SEMINARS. (ATTACH AN ADDITIONAL PAPER IF NECESSARY)

Empty space for additional education details.

ADDITIONAL COMPUTER SKILLS, TRAINING, COURSES, ETC ... (ATTACH AN ADDITIONAL PAPER IF NECESSARY)

Empty space for additional computer skills and training details.

HAVE YOU EVER APPLIED FOR A POSITION WITH THIS OR ANY OTHER POLICE AGENCY? YES (if YES - Where & When) OR NO

LIST ALL APPLICATIONS TO THIS OR ANY OTHER POLICE AGENCIES

POLICE AGENCY	APPLICATION DATE			STATUS (describe reason for non-selection)
	YYYY	MM	DD	

HAVE YOU EVER TAKEN A POLYGRAPH EXAMINATION? YES or NO

AGENCY WHERE POLYGRAPH EXAMINATION WAS COMPLETED	YYYY	MM	DD
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REASON FOR POLYGRAPH EXAMINATION

HAVE YOU EVER BEEN FINGERPRINTED? YES or NO

REASON FOR FINGERPRINTING

# EMPLOYMENT HISTORY

*Begin with your most recent employer and continue in reverse time order.  
Provide history for the last ten (10) years if applicable.  
Provide an explanation for all gaps in employment.  
Please note that a typewritten resume will also be required at a point during the selection process.*

<b>MOST RECENT</b>					EMPLOYER'S NAME	TELEPHONE NUMBER [     ]	
EMPLOYER'S ADDRESS					POSTAL CODE		
NAME OF IMMEDIATE SUPERVISOR					TELEPHONE NUMBER [     ]		
START YYYY	DATE MM	FINISH YYYY	DATE MM	POSITION HELD			
DUTIES/RESPONSIBILITIES							
REASON FOR LEAVING							
<b>2nd</b>					EMPLOYER'S NAME	TELEPHONE NUMBER [     ]	
EMPLOYER'S ADDRESS					POSTAL CODE		
NAME OF IMMEDIATE SUPERVISOR					TELEPHONE NUMBER [     ]		
START YYYY	DATE MM	FINISH YYYY	DATE MM	POSITION HELD			
DUTIES/RESPONSIBILITIES							
REASON FOR LEAVING							
<b>3rd</b>					EMPLOYER'S NAME	TELEPHONE NUMBER [     ]	
EMPLOYER'S ADDRESS					POSTAL CODE		
NAME OF IMMEDIATE SUPERVISOR					TELEPHONE NUMBER [     ]		
START YYYY	DATE MM	FINISH YYYY	DATE MM	POSITION HELD			
DUTIES/RESPONSIBILITIES							
REASON FOR LEAVING							





# CREDIT HISTORY

Please complete the following information.

<b>NAME</b>
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<b>MAIDEN NAME / OTHER NAMES USED</b>	<b>Social Insurance Number</b>
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DATE OF BIRTH YYYY	M M	D D	EMPLOYER'S NAME
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CURRENT ADDRESS	<b>FROM</b> YYYY MM DD	<b>TO</b> YYYY MM DD
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CITY	PROVINCE	COUNTRY	POSTAL CODE
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PREVIOUS ADDRESS	<b>FROM</b> YYYY MM DD	<b>TO</b> YYYY MM DD
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CITY	PROVINCE	COUNTRY	POSTAL CODE
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PREVIOUS ADDRESS	<b>FROM</b> YYYY MM DD	<b>TO</b> YYYY MM DD
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CITY	PROVINCE	COUNTRY	POSTAL CODE
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PREVIOUS ADDRESS	<b>FROM</b> YYYY MM DD	<b>TO</b> YYYY MM DD
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CITY	PROVINCE	COUNTRY	POSTAL CODE
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<b>DRIVER'S LICENCE</b>	PROVINCE	CLASS(ES)	LICENCE NUMBER	DATE OF ISSUE:
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<b>CREDIT CARDS</b>	TYPE	ISSUING INSTITUTION	CURRENT BALANCE OWING	<b>EXPIRATION DATE</b> YYYY MM	
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<b>2</b>	TYPE	ISSUING INSTITUTION	CURRENT BALANCE OWING	<b>EXPIRATION DATE</b> YYYY MM	
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<b>3</b>	TYPE	ISSUING INSTITUTION	CURRENT BALANCE OWING	<b>EXPIRATION DATE</b> YYYY MM	
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<b>4</b>	TYPE	ISSUING INSTITUTION	CURRENT BALANCE OWING	<b>EXPIRATION DATE</b> YYYY MM	
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**OFFICE USE ONLY**

<b>FILE MANAGER</b>							
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DATE SENT (Fax)	YYYY	MM	DD	DATE RECEIVED (Fax)	YYYY	MM	DD
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# SECURITY CLEARANCE DECLARATION

**FILE  
MANAGER**

*OFFICE USE ONLY*

This page contains detailed information regarding you, your family, and associates.

This information is required to determine your eligibility for employment.

**THIS INFORMATION WILL BE HELD IN STRICTEST CONFIDENCE.**

Please print legibly. Ensure that all sections are completed. Additional sheets should follow suggested format.

LAST NAME		FIRST NAME		MIDDLE NAME		PREFERRED FIRST NAME	
MAIDEN / OTHER NAMES USED							
FULL ADDRESS			CITY		PROVINCE		POSTAL CODE [ ]
DATE OF BIRTH YYYY MM DD		SEX <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other			PLACE OF BIRTH		
MARITAL STATUS <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Common-law / Domestic Partner <input type="checkbox"/> Separated <input type="checkbox"/> Divorced							
If you checked married, common-law or domestic partner, please give full name and date of birth and Social Insurance Number of your partner.							
SURNAME / MAIDEN NAME / OTHER NAMES USED		FIRST NAME		MIDDLE NAME		DATE OF BIRTH YYYY MM DD	
SOCIAL INSURANCE NUMBER							
HAVE YOU APPLIED FOR EMPLOYMENT/CONTRACT WORK/VOLUNTEER WORK WITH ANY POLICE SERVICE IN THE PAST?							
		<input type="checkbox"/> YES		<input type="checkbox"/> NO			
POSITION APPLIED FOR				DIVISION / SECTION			
<b>IN CHRONOLOGICAL ORDER, MOST RECENT FIRST, PLEASE PROVIDE THE ADDRESSES OF EVERY LOCATION WHERE YOU HAVE LIVED IN THE LAST 10 YEARS, AND THE NAMES OF PERSONS WHO LIVED WITH YOU. PLEASE ESTIMATE THE AGE IF THE EXACT DATE(S) OF BIRTH CANNOT BE OBTAINED. USE NEXT PAGE OR ATTACH ADDITIONAL SHEETS IF REQUIRED.</b>							
ADDRESS		CITY		PROVINCE		POSTAL CODE	FROM YYYY MM DD
							TO YYY MM DD
NAME OF PERSON(S) WHO SHARE ADDRESS WITH YOU		TELEPHONE NUMBER [ ]		RELATIONSHIP		SEX	DATE OF BIRTH YYY MM DD
ADDRESS		CITY		PROVINCE		POSTAL CODE	FROM YYYY MM DD
							TO YYY MM DD
NAME OF PERSON(S) WHO SHARED ADDRESS WITH YOU		TELEPHONE NUMBER [ ]		RELATIONSHIP		SEX	DATE OF BIRTH YYY MM DD

## SECURITY CLEARANCE DECLARATION (Continued)

*Attach an additional sheet(s) if required – following the suggested format.*

ADDRESS	CITY	PROVINCE	POSTAL CODE	FROM YYYY	MM	DD	TO YYYY	MM	DD
NAME OF PERSON(S) WHO SHARED ADDRESS WITH YOU			TELEPHONE NUMBER [    ]	RELATIONSHIP		SEX	DATE OF BIRTH YYYY    MM    DD		
			TELEPHONE NUMBER [    ]	RELATIONSHIP		SEX	DATE OF BIRTH YYYY    MM    DD		
			TELEPHONE NUMBER [    ]	RELATIONSHIP		SEX	DATE OF BIRTH YYYY    MM    DD		
ADDRESS	CITY	PROVINCE	POSTAL CODE	FROM YYYY	MM	DD	TO YYYY	MM	DD
NAME OF PERSON(S) WHO SHARED ADDRESS WITH YOU			TELEPHONE NUMBER [    ]	RELATIONSHIP		SEX	DATE OF BIRTH YYYY    MM    DD		
			TELEPHONE NUMBER [    ]	RELATIONSHIP		SEX	DATE OF BIRTH YYYY    MM    DD		
			TELEPHONE NUMBER [    ]	RELATIONSHIP		SEX	DATE OF BIRTH YYYY    MM    DD		
ADDRESS	CITY	PROVINCE	POSTAL CODE	FROM YYYY	MM	DD	TO YYYY	MM	DD
NAME OF PERSON(S) WHO SHARED ADDRESS WITH YOU			TELEPHONE NUMBER [    ]	RELATIONSHIP		SEX	DATE OF BIRTH YYYY    MM    DD		
			TELEPHONE NUMBER [    ]	RELATIONSHIP		SEX	DATE OF BIRTH YYYY    MM    DD		
			TELEPHONE NUMBER [    ]	RELATIONSHIP		SEX	DATE OF BIRTH YYYY    MM    DD		
ADDRESS	CITY	PROVINCE	POSTAL CODE	FROM YYYY	MM	DD	TO YYYY	MM	DD
NAME OF PERSON(S) WHO SHARED ADDRESS WITH YOU			TELEPHONE NUMBER [    ]	RELATIONSHIP		SEX	DATE OF BIRTH YYYY    MM    DD		
			TELEPHONE NUMBER [    ]	RELATIONSHIP		SEX	DATE OF BIRTH YYYY    MM    DD		
			TELEPHONE NUMBER [    ]	RELATIONSHIP		SEX	DATE OF BIRTH YYYY    MM    DD		

# FAMILY MEMBERS

## SECURITY CLEARANCE DECLARATION

(Continued)

Attach an additional sheet(s) if required – following the suggested format.

Applicants must list all names, relationship, date of birth, address and phone number of their \*immediate relatives AND of the immediate relatives of their current and/or former spouse, domestic partner, common-law, or significant other.

- \*Immediate relatives include parents, stepparents, guardians, current and/or former spouse, domestic partner, common-law, or significant other, as well as children, stepchildren, adopted children, brothers, sisters, step-brothers/sisters, adopted brothers/sisters, age 12 or over. This includes persons who are deceased.

SURNAME / MAIDEN NAME / OTHER NAMES USED		FIRST NAME	MIDDLE NAME	COMMON NAME USED		DATE OF BIRTH YYYY    M M    D D	
RELATIONSHIP	SEX	ADDRESS	CITY	PROVINCE	POSTAL CODE	TELEPHONE NUMBER [    ]	
SURNAME / MAIDEN NAME / OTHER NAMES USED		FIRST NAME	MIDDLE NAME	COMMON NAME USED		DATE OF BIRTH YYYY    M M    D D	
RELATIONSHIP	SEX	ADDRESS	CITY	PROVINCE	POSTAL CODE	TELEPHONE NUMBER [    ]	
SURNAME / MAIDEN NAME / OTHER NAMES USED		FIRST NAME	MIDDLE NAME	COMMON NAME USED		DATE OF BIRTH YYYY    M M    D D	
RELATIONSHIP	SEX	ADDRESS	CITY	PROVINCE	POSTAL CODE	TELEPHONE NUMBER [    ]	
SURNAME / MAIDEN NAME / OTHER NAMES USED		FIRST NAME	MIDDLE NAME	COMMON NAME USED		DATE OF BIRTH YYYY    M M    D D	
RELATIONSHIP	SEX	ADDRESS	CITY	PROVINCE	POSTAL CODE	TELEPHONE NUMBER [    ]	
SURNAME / MAIDEN NAME / OTHER NAMES USED		FIRST NAME	MIDDLE NAME	COMMON NAME USED		DATE OF BIRTH YYYY    M M    D D	
RELATIONSHIP	SEX	ADDRESS	CITY	PROVINCE	POSTAL CODE	TELEPHONE NUMBER [    ]	
SURNAME / MAIDEN NAME / OTHER NAMES USED		FIRST NAME	MIDDLE NAME	COMMON NAME USED		DATE OF BIRTH YYYY    M M    D D	
RELATIONSHIP	SEX	ADDRESS	CITY	PROVINCE	POSTAL CODE	TELEPHONE NUMBER [    ]	
SURNAME / MAIDEN NAME / OTHER NAMES USED		FIRST NAME	MIDDLE NAME	COMMON NAME USED		DATE OF BIRTH YYYY    M M    D D	
RELATIONSHIP	SEX	ADDRESS	CITY	PROVINCE	POSTAL CODE	TELEPHONE NUMBER [    ]	
SURNAME / MAIDEN NAME / OTHER NAMES USED		FIRST NAME	MIDDLE NAME	COMMON NAME USED		DATE OF BIRTH YYYY    M M    D D	
RELATIONSHIP	SEX	ADDRESS	CITY	PROVINCE	POSTAL CODE	TELEPHONE NUMBER [    ]	
SURNAME / MAIDEN NAME / OTHER NAMES USED		FIRST NAME	MIDDLE NAME	COMMON NAME USED		DATE OF BIRTH YYYY    M M    D D	
RELATIONSHIP	SEX	ADDRESS	CITY	PROVINCE	POSTAL CODE	TELEPHONE NUMBER [    ]	
SURNAME / MAIDEN NAME / OTHER NAMES USED		FIRST NAME	MIDDLE NAME	COMMON NAME USED		DATE OF BIRTH YYYY    M M    D D	
RELATIONSHIP	SEX	ADDRESS	CITY	PROVINCE	POSTAL CODE	TELEPHONE NUMBER [    ]	

# FAMILY MEMBERS

## SECURITY CLEARANCE DECLARATION

(Continued)

Attach an additional sheet(s) if required – following the suggested format.

SURNAME / MAIDEN NAME / OTHER NAMES USED		FIRST NAME		MIDDLE NAME		COMMON NAME USED		DATE OF BIRTH YYYY	MM	DD
RELATIONSHIP	SEX	ADDRESS	CITY	PROVINCE	POSTAL CODE	TELEPHONE NUMBER [ ]				
SURNAME / MAIDEN NAME / OTHER NAMES USED		FIRST NAME		MIDDLE NAME		COMMON NAME USED		DATE OF BIRTH YYYY	MM	DD
RELATIONSHIP	SEX	ADDRESS	CITY	PROVINCE	POSTAL CODE	TELEPHONE NUMBER [ ]				
SURNAME / MAIDEN NAME / OTHER NAMES USED		FIRST NAME		MIDDLE NAME		COMMON NAME USED		DATE OF BIRTH YYYY	MM	DD
RELATIONSHIP	SEX	ADDRESS	CITY	PROVINCE	POSTAL CODE	TELEPHONE NUMBER [ ]				
SURNAME / MAIDEN NAME / OTHER NAMES USED		FIRST NAME		MIDDLE NAME		COMMON NAME USED		DATE OF BIRTH YYYY	MM	DD
RELATIONSHIP	SEX	ADDRESS	CITY	PROVINCE	POSTAL CODE	TELEPHONE NUMBER [ ]				
SURNAME / MAIDEN NAME / OTHER NAMES USED		FIRST NAME		MIDDLE NAME		COMMON NAME USED		DATE OF BIRTH YYYY	MM	DD
RELATIONSHIP	SEX	ADDRESS	CITY	PROVINCE	POSTAL CODE	TELEPHONE NUMBER [ ]				
SURNAME / MAIDEN NAME / OTHER NAMES USED		FIRST NAME		MIDDLE NAME		COMMON NAME USED		DATE OF BIRTH YYYY	MM	DD
RELATIONSHIP	SEX	ADDRESS	CITY	PROVINCE	POSTAL CODE	TELEPHONE NUMBER [ ]				
SURNAME / MAIDEN NAME / OTHER NAMES USED		FIRST NAME		MIDDLE NAME		COMMON NAME USED		DATE OF BIRTH YYYY	MM	DD
RELATIONSHIP	SEX	ADDRESS	CITY	PROVINCE	POSTAL CODE	TELEPHONE NUMBER [ ]				
SURNAME / MAIDEN NAME / OTHER NAMES USED		FIRST NAME		MIDDLE NAME		COMMON NAME USED		DATE OF BIRTH YYYY	MM	DD
RELATIONSHIP	SEX	ADDRESS	CITY	PROVINCE	POSTAL CODE	TELEPHONE NUMBER [ ]				
SURNAME / MAIDEN NAME / OTHER NAMES USED		FIRST NAME		MIDDLE NAME		COMMON NAME USED		DATE OF BIRTH YYYY	MM	DD
RELATIONSHIP	SEX	ADDRESS	CITY	PROVINCE	POSTAL CODE	TELEPHONE NUMBER [ ]				
SURNAME / MAIDEN NAME / OTHER NAMES USED		FIRST NAME		MIDDLE NAME		COMMON NAME USED		DATE OF BIRTH YYYY	MM	DD
RELATIONSHIP	SEX	ADDRESS	CITY	PROVINCE	POSTAL CODE	TELEPHONE NUMBER [ ]				
SURNAME / MAIDEN NAME / OTHER NAMES USED		FIRST NAME		MIDDLE NAME		COMMON NAME USED		DATE OF BIRTH YYYY	MM	DD
RELATIONSHIP	SEX	ADDRESS	CITY	PROVINCE	POSTAL CODE	TELEPHONE NUMBER [ ]				
SURNAME / MAIDEN NAME / OTHER NAMES USED		FIRST NAME		MIDDLE NAME		COMMON NAME USED		DATE OF BIRTH YYYY	MM	DD
RELATIONSHIP	SEX	ADDRESS	CITY	PROVINCE	POSTAL CODE	TELEPHONE NUMBER [ ]				

## SECURITY CLEARANCE DECLARATION

(Continued)

*Attach an additional sheet(s) if required – following the suggested format.*

1. Have you ever been convicted of any criminal offence in <b>Canada</b> or <b>in any other country</b> for which a pardon, or the equivalent of a pardon was or was not granted? (Attach Pardon Document)	<input type="radio"/> YES <input type="radio"/> NO
2. Are you now, or have you ever been investigated, arrested, or charged in <b>Canada</b> or <b>in any other country</b> for an offence of any kind? <b>If yes</b> – explain on separate sheet.	<input type="radio"/> YES <input type="radio"/> NO
3. Have you ever been found guilty of an offence in <b>Canada</b> or <b>in any other country</b> when you were under the age of 18? <b>If yes</b> – explain on separate sheet.	<input type="radio"/> YES <input type="radio"/> NO
4. Are you associated with any companies, or businesses, not listed on your application? <input type="radio"/> Owner <input type="radio"/> Director <input type="radio"/> Controlling Share Holder <input type="radio"/> Other	<input type="radio"/> YES <input type="radio"/> NO
5. Are you a member of any clubs or organizations? <b>If yes</b> – explain which	<input type="radio"/> YES <input type="radio"/> NO
6. If you answered yes to the previous question, do you hold a position in that club or organization? <input type="radio"/> President <input type="radio"/> Chair <input type="radio"/> Director <input type="radio"/> Other	<input type="radio"/> YES <input type="radio"/> NO
7. In the past 10 years, have you been involved in any lawsuits or civil actions?	<input type="radio"/> YES <input type="radio"/> NO

**If you have answered "YES" to any of the above questions, attach an additional sheet providing complete details regarding the specific incident, including what occurred, when, where, and why. If pardoned, attach Pardon documentation.**

### STATEMENT OF CONSENT

I HEREBY CONSENT THAT any and all information pertaining to a Criminal Record registered in my name with the National Repository for Criminal Records in Canada may be provided to authorized persons at the Cape Breton Regional Police Service (CBRPS). I recognize that an employee of the CBRPS is in a position of trust within the community and I hereby consent to the CBRPS performing a VS (Vulnerable Sector) search of my name in the National Repository for Criminal Records. I understand that a VS search is a search that will check for pardoned sex offences. I further consent, if requested, to attend the Identification Section of the CBRPS for fingerprint confirmation. I further agree to absolutely release, discharge, and absolve the CBRPS, the Cape Breton Regional Municipality and its employees from all claims, losses, or damages including indirect or consequential, occasioned by me during, or as a result of any investigation for a Criminal Record.

Dated this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_

SIGNATURE

PRINTED NAME OF WITNESS

WITNESS SIGNATURE

# REFERENCES

*Please list eight (8) adults (3 must be close personal friends, not related to you, and not previous employers, who we may contact as references to provide competent judgment of your personal character, temperament, and work habits.  
(Please note that at any point during the selection process three (3) letters of reference of which one must be a work reference, , will also be required in addition to those listed below)*

LAST NAME		GIVEN NAMES		RELATIONS HIP	
FULL ADDRESS					POSTAL CODE
TELEPHONE NO. (RES.) [ ] [ ]	TELEPHONE NO. (BUS.) [ ] [ ]	OCCUPATION			YEARS KNOWN
LAST NAME		GIVEN NAMES		RELATIONS HIP	
FULL ADDRESS					POSTAL CODE
TELEPHONE NO. (RES.) [ ] [ ]	TELEPHONE NO. (BUS.) [ ] [ ]	OCCUPATION			YEARS KNOWN
LAST NAME		GIVEN NAMES		RELATIONS HIP	
FULL ADDRESS					POSTAL CODE
TELEPHONE NO. (RES.) [ ] [ ]	TELEPHONE NO. (BUS.) [ ] [ ]	OCCUPATION			YEARS KNOWN
LAST NAME		GIVEN NAMES		RELATIONS HIP	
FULL ADDRESS					POSTAL CODE
TELEPHONE NO. (RES.) [ ] [ ]	TELEPHONE NO. (BUS.) [ ] [ ]	OCCUPATION			YEARS KNOWN
LAST NAME		GIVEN NAMES		RELATIONS HIP	
FULL ADDRESS					POSTAL CODE
TELEPHONE NO. (RES.) [ ] [ ]	TELEPHONE NO. (BUS.) [ ] [ ]	OCCUPATION			YEARS KNOWN
LAST NAME		GIVEN NAMES		RELATIONS HIP	
FULL ADDRESS					POSTAL CODE
TELEPHONE NO. (RES.) [ ] [ ]	TELEPHONE NO. (BUS.) [ ] [ ]	OCCUPATION			YEARS KNOWN
LAST NAME		GIVEN NAMES		RELATIONS HIP	
FULL ADDRESS					POSTAL CODE
TELEPHONE NO. (RES.) [ ] [ ]	TELEPHONE NO. (BUS.) [ ] [ ]	OCCUPATION			YEARS KNOWN
LAST NAME		GIVEN NAMES		RELATIONS HIP	
FULL ADDRESS					POSTAL CODE
TELEPHONE NO. (RES.) [ ] [ ]	TELEPHONE NO. (BUS.) [ ] [ ]	OCCUPATION			YEARS KNOWN





## Applicant Vision Examination Report

## Applicant Information

## To be completed by the applicant

Surname		Given Names		Date of Birth (yyyy-mm-dd)	
Street Address		City	Province	Postal Code (A9A 9A9)	Date of Exam (yyyy-mm-dd)

## Visual Examination

## To be completed by the Ophthalmologist or Optometrist

## Visual Acuity

Any standardized procedures (Landoit Ring, Snellen) may be utilized. No error is allowed per line of symbols.

Uncorrected Right Eye (6/ or 20/)	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Uncorrected Left Eye (6/ or 20/)
Corrected Right Eye (6/ or 20/)	Corrected Left Eye (6/ or 20/)		

Corrected by

 Eyeglasses     Contact Lenses

## Vision Standards Visual Acuity

- Corrected vision (with glasses or contacts): Visual acuity **must** be at least 6/6 (20/20) in one eye and 6/9 (20/30) in the other; **and**
- Uncorrected vision (without glasses or contacts): Visual acuity **must** be at least 6/18 (20/60) in each eye **or** 6/12 (20/40) in one eye and at least 6/30 (20/100) in the other eye.

Meets Standards, both corrected and uncorrected?

 Yes                   No 

## Visual Fields

## Field of Vision Standards

Must be at least 150 degrees continuous along the horizontal meridian and 20 degrees continuous above and below fixation, with both eyes open and examined together.

Meets Standards?

 Yes                   No 

## Colour-Vision

Standardized Ishihara pseudo-isochromatic plates must be utilized. **Testing is to be done without the candidate using any colour correcting aids, such as coloured contact lenses.**

a) Result of standardized Ishihara pseudo-isochromatic plates test

 Passed                   Failed. If so, re-test using Farnsworth D-15.
b) Result of Farnsworth D-15 test (if the applicant failed the plate test). **Attach the results.**
 Passed                   Failed

## Colour-Vision Testing Standards

- Using the standardized Ishihara pseudo-isochromatic plates, if at least 17 of 21 patterns are correctly identified (pass) colour-vision will be considered normal;
- If required, further evaluation will be conducted with the Farnsworth D-15 test. If the applicant passes the Farnsworth D-15 test, the applicant will be considered to meet the minimum colour-vision standards; and
- If the applicant fails both the Ishihara test and the Farnsworth D-15 test, the minimum vision standards for an CBRPS applicant are not met.

Meets Standards?

 Yes                   No

## Ocular Disease / Conditions

Applicant must be free from ocular diseases impairing visual performance. If there is a history or the presence of an ocular disease, further information may be required at the medical examination stage for individual assessment.

Is there any indication of the presence of the following

 Strabismus     Diplopia     Eye Disease specify:

Is there any indication that the applicant could be at risk of experiencing double vision when tired or in an environment with reduced visual cues and/or greater visual strain and/or stress?

 Yes                   No

# Applicant Vision Examination Report

Any other testing performed?  Yes  No

If other testing performed, clarify including test and result:

## Refractive Surgery, including Corneal and Intra-Ocular Lens Procedures

Has the applicant had refraction correction surgery?

Yes  No

If the applicant had refraction correction surgery, please identify the type

LASIK  PRK  Implanted Corrective Lenses (ICL, PIOL)  Other specify:

Date of Surgery (yyyy-mm-dd)

**Standard Post-Refractive Correction Surgery** - Applicant must wait the following time before having a vision examination completed

- Laser-assisted in-situ keratomileusis (LASIK) surgery - thirty (30) days;
- Photorefractive keratectomy (PRK) surgery - ninety (90) days;
- Implanted corrective lenses (ICL, PIOL) surgery with anterior chamber lens - six (6) months; and
- Implanted corrective lenses (ICL, PIOL) surgery with posterior chamber lens - twelve (12) months.

Does the applicant have any history of

Halos  Starbursts  Night Vision Difficulties  Contrast Sensitivity Difficulties

Is the applicant's vision now stable?

Yes  No

Is there currently any increased risk, relative to "normal" eyes, for damage to the eyes upon physical confrontation?

Yes  No

Specify any other acute or chronic problems with the function of the eyes or adnexa, if applicable.

## Declaration, Acknowledgement and Consent

To be completed by the applicant

I declare that the statements made to the Ophthalmologist/Optomterist are complete and correct to the best of my knowledge and that I have not withheld any relevant information or made any misleading statements.

I acknowledge that incomplete forms will be returned to my attention and may result in disqualification of my application.

I acknowledge that my vision examination report is valid for two (2) years from the testing date.

I acknowledge that the cost of this examination, refractive correction surgery, and reports prepared by the Ophthalmologist or optometrist are my responsibility.

I consent that this information be provided to CBRM for pre-selection purposes.

I consent to CBRM contacting the ophthalmologist or optometrist indicated below if clarification of this vision examination is required.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date (yyyy-mm-dd)

## Ophthalmologist or Optometrist

To be completed by the Ophthalmologist or Optometrist

Surname	First Name	Specialty <input type="checkbox"/> Ophthalmologist <input type="checkbox"/> Optometrist	Licence Number
Business Address			Telephone No. (incl. area code)
Signature			Date (yyyy-mm-dd)



# HEARING REPORT

*Please ensure all areas are fully completed.*

<b>NAME OF APPLICANT</b>	SURNAME	GIVEN NAMES	INITIAL
ADDRESS OF APPLICANT			
CITY	PROVINCE	POSTAL CODE	DATE OF BIRTH YYYY   M M   D D

## HEARING STANDARDS FOR POLICE OFFICER APPLICANTS

<b>AUDIOLOGIST</b>	NAME OF AUDIOLOGIST:						DATE OF EXAMINATION YYYY   MM   DD		
ADDRESS OF AUDIOLOGIST:									
						TELEPHONE NUMBER [     ]			
<b>PURE TONE THRESHOLDS IN HZ</b>	<b>250</b>	<b>500</b>	<b>1000</b>	<b>2000</b>	<b>3000</b>	<b>4000</b>	<b>6000</b>	<b>8000</b>	
<b>RIGHT EAR</b>									
<b>LEFT EAR</b>									

**Hearing Requirements:**

- a) Hearing Loss no greater than 30 db in both ears in the 500 to 6,000 Hz frequency range.
- b) Hearing loss no greater than 30 db in the better ear in the 500 to 3000 Hz frequency range;
- c) Hearing loss no greater than 30 db in the worst ear in the 500 to 2900 Hz frequency range, and no more than 50 db in the worst ear at 3000 Hz frequency range.

I certify that the above named individual **MEETS** \_\_\_\_ **DOES NOT MEET** \_\_\_\_  
the hearing requirements for a Police Officer applicant as indicated in above noted requirements.

SIGNATURE OF AUDIOLOGIST	DATE YYYY	MM	DD
SIGNATURE OF APPLICANT	DATE YYYY	MM	DD



# CBRM Medical Examination of Fitness for Work

To be completed by Applicant.

Name: \_\_\_\_\_

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

## 1. Family History

Have any immediate blood relatives ever had:

- |                              | Yes                      | No                       |
|------------------------------|--------------------------|--------------------------|
| 1.1 Diabetes                 | <input type="checkbox"/> | <input type="checkbox"/> |
| 1.2 Heart disease            | <input type="checkbox"/> | <input type="checkbox"/> |
| 1.3 High blood pressure      | <input type="checkbox"/> | <input type="checkbox"/> |
| 1.4 Ulcers or bowel problems | <input type="checkbox"/> | <input type="checkbox"/> |
| 1.5 Mental illness           | <input type="checkbox"/> | <input type="checkbox"/> |
| 1.6 Asthma                   | <input type="checkbox"/> | <input type="checkbox"/> |
| 1.7 Epilepsy                 | <input type="checkbox"/> | <input type="checkbox"/> |
| 1.8 Tuberculosis             | <input type="checkbox"/> | <input type="checkbox"/> |
| 1.9 Cancer                   | <input type="checkbox"/> | <input type="checkbox"/> |
| 1.10 Strokes                 | <input type="checkbox"/> | <input type="checkbox"/> |

## 2. Personal History

- 2.1 Have you ever been refused employment or life insurance because of your health?  Yes  No
- 2.2 Have you ever been regularly exposed to toxic chemicals (such as solvents, asbestos etc.) or excessive noise levels?  Yes  No
- 2.3 Have you any religious medical concerns that might affect your health care?  Yes  No
- 2.4 Do you smoke?  Yes  No  
How much per week? \_\_\_\_\_
- 2.5 Do you drink alcohol?  Yes  No  
How much per week? \_\_\_\_\_
- 2.6 Have you ever had any medical problems due to mind-altering street or addictive drugs?  Yes  No
- 2.7 Have you been off work in the past year because of illness or injury?  Yes  No
- 2.8 Have you ever had any broken bones, back injuries, neck injuries, or shoulder injuries?  Yes  No
- 2.9 Do you suffer from any phobias?  Yes  No
- 2.10 If so, does this concern:
- |                 |                          |
|-----------------|--------------------------|
| flying          | <input type="checkbox"/> |
| confined spaces | <input type="checkbox"/> |
| fire            | <input type="checkbox"/> |
| water           | <input type="checkbox"/> |
| heights         | <input type="checkbox"/> |
| other           | <input type="checkbox"/> |
- 2.11 Do you participate in a regular exercise program?  Yes  No
- 2.12 Do you drink coffee, tea or cola?  Yes  No
- 2.13 Have you ever received WCB benefits?  Yes  No
- 2.14 Have you ever received long term disability benefits (LTD)?  Yes  No

## 3. Medications

- 3.1 Do you take any medications?  Yes  No
- 3.2 Are you allergic to or have you ever had an adverse reaction to any medications?  Yes  No

## 4. Medical History

Do you or have you ever had or been treated for any of the following medical conditions:

- |   | Yes                      | No                       |
|---|--------------------------|--------------------------|
| 4.1 Asthma, bronchitis, pneumonia, pleurisy, tuberculosis or other lung disease | <input type="checkbox"/> | <input type="checkbox"/> |
| 4.2 Disease of the nose or throat   | <input type="checkbox"/> | <input type="checkbox"/> |
| 4.3 Ear disease, loss of balance or dizziness                                   | <input type="checkbox"/> | <input type="checkbox"/> |
| 4.4 Hay fever, allergies or hives   | <input type="checkbox"/> | <input type="checkbox"/> |
| 4.5 Rheumatic fever, heart disease or murmur                                    | <input type="checkbox"/> | <input type="checkbox"/> |
| 4.6 High blood pressure   | <input type="checkbox"/> | <input type="checkbox"/> |
| 4.7 Chest pain, angina or palpitations  | <input type="checkbox"/> | <input type="checkbox"/> |
| 4.8 Varicose veins or phlebitis   | <input type="checkbox"/> | <input type="checkbox"/> |
| 4.9 Bleeding tendency or bruising   | <input type="checkbox"/> | <input type="checkbox"/> |
| 4.10 Diabetes, thyroid disease or other glandular disease                       | <input type="checkbox"/> | <input type="checkbox"/> |
| 4.11 Seizures, fainting or epilepsy   | <input type="checkbox"/> | <input type="checkbox"/> |
| 4.12 Head injury or concussion  | <input type="checkbox"/> | <input type="checkbox"/> |
| 4.13 Stroke or paralysis  | <input type="checkbox"/> | <input type="checkbox"/> |
| 4.14 Severe recurrent headache or migraine                                      | <input type="checkbox"/> | <input type="checkbox"/> |
| 4.15 Loss of or impaired vision or eye disorder                                 | <input type="checkbox"/> | <input type="checkbox"/> |
| 4.16 Psychosis, anxiety, depression or other mental illness                     | <input type="checkbox"/> | <input type="checkbox"/> |
| 4.17 Stomach, duodenal or peptic ulcer  | <input type="checkbox"/> | <input type="checkbox"/> |
| 4.18 Gall bladder disease, jaundice or hepatitis                                | <input type="checkbox"/> | <input type="checkbox"/> |
| 4.19 Diarrhea or bowel disease  | <input type="checkbox"/> | <input type="checkbox"/> |
| 4.20 Kidney disease, kidney stones or bladder disease                           | <input type="checkbox"/> | <input type="checkbox"/> |
| 4.21 Sexually-transmitted disease   | <input type="checkbox"/> | <input type="checkbox"/> |
| 4.22 Skin diseases, rashes, eczema or dermatitis                                | <input type="checkbox"/> | <input type="checkbox"/> |
| 4.23 Bone or joint disease or injury  | <input type="checkbox"/> | <input type="checkbox"/> |
| 4.25 Tropical disease, malaria, dysentery etc.                                  | <input type="checkbox"/> | <input type="checkbox"/> |
| 4.26 Cancer, tumour or growths  | <input type="checkbox"/> | <input type="checkbox"/> |
| 4.27 Other operations, serious illnesses or injuries                            | <input type="checkbox"/> | <input type="checkbox"/> |
| 4.28 (Women) Gynecological disease  | <input type="checkbox"/> | <input type="checkbox"/> |
| 4.29 Motion sickness  | <input type="checkbox"/> | <input type="checkbox"/> |
| 4.30 Dental disease, toothache  | <input type="checkbox"/> | <input type="checkbox"/> |
| 4.31 Weight gain or loss over 10 lbs. in the last year                          | <input type="checkbox"/> | <input type="checkbox"/> |
| 4.32 Date of last tetanus shot _____  | <input type="checkbox"/> | <input type="checkbox"/> |

**Remarks: Give details of any "yes" answers in sections 1-4.**

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**Applicant's Declaration**

I, (name) \_\_\_\_\_ of

(address) \_\_\_\_\_

declare that the above statements made by me for the purposes of my medical examination are true and complete. I understand that any false statements shall be considered sufficient grounds to disqualify me from employment.

I also understand that this information will be treated as medically confidential and will not be forwarded to non-medical personnel.

Results only (i.e. "fitness to work") will be forwarded to hiring unit.

**Signed:** \_\_\_\_\_ **Date:** \_\_\_\_\_

## CBRM Pare Medical Clearance Form – To be completed by Physician

Dear Physician,

### **Subject: Medical Clearance to Undergo the Physical Abilities Requirement Evaluation**

The person who has made this appointment with you is seeking medical clearance to undergo the Physical Abilities Requirement Evaluation (PARE) as part of their application to become a Cape Breton Regional Police Officer.

PARE is an occupational physical abilities test used to assess a person's ability to perform physical demands of police work. **It is a maximal exertion test equivalent to an exercise stress test at the 12 MET level.**

PARE represents a scenario where an officer must get to the scene of a problem, physically control the situation, and carry a person or an object away from the scene. The test is divided into the following three stations:

- 1. An obstacle course** - 400 m long, including obstacles and stairs.
- 2. A push/pull station** - which requires managing a 37 kg (80 lbs.) weight; completing six 180-degree arcs while pushing; performing four controlled falls; and completing six 180 degree arcs while pulling.
- 3. A weightlifting and carrying station** - which requires lifting and carrying a 45 kg (100 lbs.) bag over a distance of 15 m (50 ft.).

The first two sections (the obstacle course and the push/pull station) are timed. Applicants applying for the Cape Breton Regional Police Service must complete these two sections in a time of 4:00 minutes or less.

Please complete, sign, date, and stamp the PARE medical clearance form. Please provide an original copy to patient and keep a photocopy of the form on the patient's medical file. The original copy will be used as proof that the applicant has been medically cleared to undergo the PARE.

Should you require further information regarding the PARE, please contact the CBRM Human Resources Department at: 902-563-5058 or Tyler MacKeigan at: [tcmackeigan@cbrm.ns.ca](mailto:tcmackeigan@cbrm.ns.ca)

Human Resources  
Cape Breton Regional Municipality

# PARE Medical Clearance - Part 1

Patient Information				
Surname	Given Name(s)		Age	
Gender Female ___ Male ___ Other ___	Height (cm)	Weight (kg)	Resting Heart Rate	Resting Blood Pressure
Risk Factors <span style="float: right;">MEI</span>				
<b>Note to Physician</b>				
The Physical Abilities Requirement Evaluation (PARE) is a maximal physical exertion test equivalent to an exercise stress test at the 12 Metabolic Equivalent for Task (MET) level. The following are risk factors to consider when assessing suitability for PARE.				
Section A - For all Individuals - Pulmonary and Musculoskeletal Restrictions				
If yes to <b>any one</b> risk factor in Section A, patient should not undertake PARE.				
Pulmonary obstruction / restriction that would prevent maximal testing.	Yes	No		
Needs to use a short acting inhaler immediately prior to participate in maximal testing. (Short acting inhalers can only be used after the test if needed. Long acting or combined inhalers are allowed.)	___ Yes	___ No		
Musculoskeletal restrictions that could interfere with strenuous activities or maximal testing.	Yes	No		
Section B - For all Individuals - High or Very High Cardiovascular Risk Factors (ATP III I & CMAJ <sup>2</sup> )				
If yes to <b>one or more</b> risk factors in Section B, it is recommended to send the patient to an exercise stress test before clearing for PARE.				
Previous CVA, MI, vascular surgery or any clinical evidence of atherosclerosis	Yes	No		
Diabetes <sup>3</sup>	Yes ___	No		
Metabolic Syndrome	Yes ___	No		
Section C - For Men > Age 40 and Women > Age 50 - Coronary Artery Disease Risk Factors (ACSM <sup>4</sup> & CSEP <sup>5</sup> )				
If yes to <b>two or more</b> risk factors in Section C, it is recommended to send the patient for an exercise stress test before clearing for PARE.				
Family history of premature cardiovascular disease	Yes	No		
Cigarette smoking	Yes	No		
Hypertension <sup>6</sup>	Yes	No		
Dyslipidemia	Yes	No		
Abnormal fasting glucose level	Yes	No		
Obesity <sup>7</sup>	Yes	No		
Physical inactivity	Yes	No		
Section D - Exercise Stress Test (when required)				
Clinically positive for ischemia				No
Electrically positive for ischemia				No
Number of MET reached (12 MET are required prior to undertaking PARE)	Y e s			
Additional tests (if needed, specify)				
Medical References				
1) Detection, Evaluation and Treatment of High Blood Cholesterol in Adults. (Adult Treatment Panel III). National Institute of Health. National Heart, Lung and Blood Institute.				
2) Recommendations for the Management of Dyslipidemia and the Prevention of Cardiovascular Disease: 2003 update. CMAJ appendix 2003; 168 (9) 921-924.				
3) Report of the Expert Committee on the Diagnosis and Classification of Diabetes Mellitus. Diabetes Care. 2003; 26 (supp 1):S5-S20.				
4) American College of Sports Medicine, Cited in ACSM Guidelines for Exercise Testing and Prescription, Seventh Edition. 2006.				
5) Canadian Society of Exercise Physiology. Professional Fitness & Lifestyle Consultant. Resource Manual. 2004.				
6) Canadian Recommendations for the Management of Hypertension (2005)				
7) Canadian Guidelines for Body Weight Classification in Adults (2003)				

## PARE Medical Clearance - Part 2

Patient Information				
Surname		Given Name(s)		Age
Gender Female ___ Male ___ Other	Height (cm)	Weight (kg)	Resting Heart Rate	Resting Blood Pressure
Physician's Recommendations				
After reviewing Part 1 of the PARE medical clearance and evaluating the following risk factors: <ul style="list-style-type: none"><li>• Pulmonary Obstruction / Restriction</li><li>• Musculoskeletal Restrictions</li><li>• High or Very High Cardiovascular Risk Factors</li><li>• Coronary Artery Disease Risk Factors</li><li>• Exercise Stress Test to 12 MET, if applicable</li></ul> it is my professional opinion that the above named patient is: <input type="checkbox"/> Medically fit to undertake the Physical Abilities Requirement Evaluation. <input type="checkbox"/> Not medically fit to undertake the Physical Abilities Requirement Evaluation.				
Comments				
			<b>Physician's stamp</b>	

\_\_\_\_\_  
Physician's signature

\_\_\_\_\_  
Date (yyyy-mm-dd)





## CAPE BRETON REGIONAL POLICE RECRUIT SELECTION STANDARDS

### AUTHORIZATION FOR RELEASE OF INFORMATION

<b>NAME OF APPLICANT</b>	SURNAME	GIVEN NAMES	INITIAL
ADDRESS OF APPLICANT			
CITY	PROVINCE	POSTAL CODE	DATE OF BIRTH YYYY   M M   D D

I, \_\_\_\_\_, the undersigned, hereby authorize any person, employer, organization, or physician to provide any information, opinion, reports, records, documents or copies thereof in any form, which may be requested in connection with my application for employment with the Cape Breton Regional Police Service and any subsequent training.

Personal information about me will be used to assess my qualifications and suitability in relation to my application as a police officer as well as research purposes. I consent to the collection, use, disclosure, transmittal, and examination of all information compiled by the Cape Breton Regional Police Service.

Personal information about me that is obtained during the selection process, or any subsequent training and employment, may be disclosed to any law enforcement agency for the purpose for which it was obtained or for any other reason.

I agree to waive any right of action against any person or organization providing information or opinions in compliance with this authorization.

I hereby acknowledge and declare the terms of this authorization for release of information are fully understood by me.

<b>SIGNATURES</b>	SIGNATURE OF APPLICANT:	DATE: YYYY   M M   D D
NAME OF WITNESS:	SIGNATURE OF WITNESS:	DATE: YYYY   M M   D D
<b>NOTE: The Witness must be 18 years or older</b>		