**Montana Public Safety Officer Standards & Training Council**
Website: dojmt.gov/post
2260 Sierra Road East
Helena, MT 59602
Email: mtpost@mt.gov
Phone: (406) 444-9975
Fax: (406) 444-9978

# DECLARATION OF MEDICAL CONDITION

§ 7-32-303, MCA

**Please Note:** *This form is provided for use by employing agencies. This form does not need to be sent to POST.*

**Applicant Information:**

Full Name: _____ Date of Birth: _____

Mailing Address: _____

City, State: _____ Zip/Postal Code: _____

**Agency Information:**

Agency Name: _____ Agency Phone: _____

Mailing Address: _____

City, State: _____ Zip/Postal Code: _____

**Attention Examining Professional:** *The above information must be completed by the requesting agency prior to the examining professional completing and signing this form.*

I certify that I am a Licensed Physician or Health Care Provider, that I am not the applicant's primary care provider, and I have completed an evaluation of the examinee's physical health and have concluded that on this date the examinee is found to be physically qualified for service as a peace officer in Montana.

Provider: _____

Printed Name State License Number Phone Number

Mailing Address: _____

Street City State Zip

_____

Date of Examination(s) Signature Date

**THIS DECLARATION IS NOT PUBLIC INFORMATION AND IS VALID UNLESS WITHDRAWN OR INVALIDATED, AND IT IS VALID ONLY IF SIGNED BY A HEALTH CARE PROVIDER LICENSED BY THE STATE UNDER TITLE 37, MCA.**