Submit Form Reset Form

REPORT OF MEDICAL CONDITION

State Form 47133 (R2 / 1-20)
INDIANA LAW ENFORCEMENT ACADEMY
LAW ENFORCEMENT TRAINING BOARD

INSTRUCTIONS:
1. *Please print legibly in black ink.*
2. *Attach copies of all medical reports from the attending physician and/or hospital, along with this form, to the original Report of Injury / Illness (State Form 47134)*
3. *E-mail forms and attachments to MedicalDocs@ilea.IN.gov.*

SECTION 1 - *TO BE COMPLETED BY ILEA STAFF ONLY.*

Student's last name	Student's first name	Student's middle name	Suffix

Public Safety Identification (PSID) Number	Name of department

Onset of injury or illness (*Check the two boxes that describe when the injury occurred or the illness commenced.)*
☐ At the Academy ☐ Not at the Academy ☐ During training time ☐ During off time

Complaint of injury or illness *(Enter all information available regarding the cause, nature, and symptoms of the injury or illness.)*

Student transported to:
☐ Hendricks County Hospital ☐ Other: _____

Student transported by:
☐ Self ☐ Ambulance *(name / agency)*: _____ ☐ Other: _____

Signature of ILEA staff member sending student for medical treatment	Date *(month, day, year)*	Time *(0000 hours)*

Printed name of ILEA staff member	Title of ILEA staff member

SECTION 2 - *TO BE COMPLETED BY THE PHYSICIAN ONLY.*

PHYSICIAN'S DIAGNOSIS, RECOMMENDED TREATMENT, AND COMMENTS

PHYSICIAN'S RECOMMENDATIONS CONCERNING STUDENT'S ACTIVITIES AT THE ACADEMY

Students at the Indiana Law Enforcement Academy are required to run, jump, wrestle, swim, perform push-ups and sit-ups, and participate in other strenuous activities. Please indicate below what restrictions, if any, the student should observe.

☐ The student should not participate in any of the above-named activities for _____ days.

☐ The student may participate in any of the above-named activities, without restrictions.

☐ The student may participate in any of the above-named activities, with the following restrictions: _____

☐ The student should return for a follow-up examination on: _____ *month, day, year* at _____ *time*

Signature of physician	Date *(month, day, year)*

Printed name of physician	Time *(0000 hours)*