

**CYPRESS CREEK EMS**  
**TACTICAL OPERATIONAL MEDICAL SUPPORT COURSE**  
Houston, Texas

CONSENT FORM

I \_\_\_\_\_, understand that I will be training in an austere environment during this course and that I may be exposed to the following conditions:

- Chemical munitions exposure (CS gas)
- Helicopter operations
- Team building physical exercises consisting of pushups, pull ups, sit ups, light running, pulling and lifting your own body weight, climbing over and under obstacles, etc.
- Simulated and Blank firing weapons
- Simunition Marking Cartridges for Force vs Forces Scenarios
- Pyrotechnics (distraction devices)
- Darkness within austere field environment
- Field training under physical & psychological stress conditions
- Simulated tactical operations
- Harsh environmental conditions

I understand that every effort will be made to ensure the safety of all participants, but that the possibility of injury exists. I also understand that designated emergency medical personnel will be on-site during training exercises.

I further state that I am in good physical condition and that I have no pre-existing medical conditions that preclude me from participating fully in this field-training course (See the Par-Q form).

I hold the Cypress Creek Emergency Medical Services, Inc., the Federal Bureau of Investigation, Waller County Sheriff's Office, Baylor College of Medicine, and any and all participating agencies, and their instructors harmless for any mishap or injury which may occur.

The Texas Commission on Law Enforcement Officer Standards and Education require that all applicants for this training program submit to a criminal history background check. By signing this form, you hereby submit to such an inquiry. Any and all information obtained pursuant to said inquiry will be held in the strictest confidence. You must not have been convicted of an offense of a class B misdemeanor or above within the last 10 years; Not currently under indictment; Never been convicted of any family violence offense; Not prohibited from operating a motor vehicle; Not prohibited from possessing firearms or ammunition.

I understand that I am responsible for all costs of medical care administered to me.

Signature: \_\_\_\_\_

Printed name: \_\_\_\_\_

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

Witness: \_\_\_\_\_

Printed name: \_\_\_\_\_

*\*This form must be returned and on file prior to the first day of class.  
Email [wnealy@ccems.com](mailto:wnealy@ccems.com) or fax to 281-655-0414*