White Mountain Apache Fire & Rescue Department
P.O. Box 1929,
612 S. Chief Ave., Whiteriver, AZ 85941
Ph: 928-338-4311 Fax: 928-338-4474

A designated hospital/clinic will be performing your physical examination in 2 visits. The first one will include: fasting blood draw (8-12 hours fasting, a small amount of water allowed and meds), PFT, EKG, body composition, eyes, vital signs, pulmonary function, etc. The second visit will include the treadmill testing and Doctor's interview.

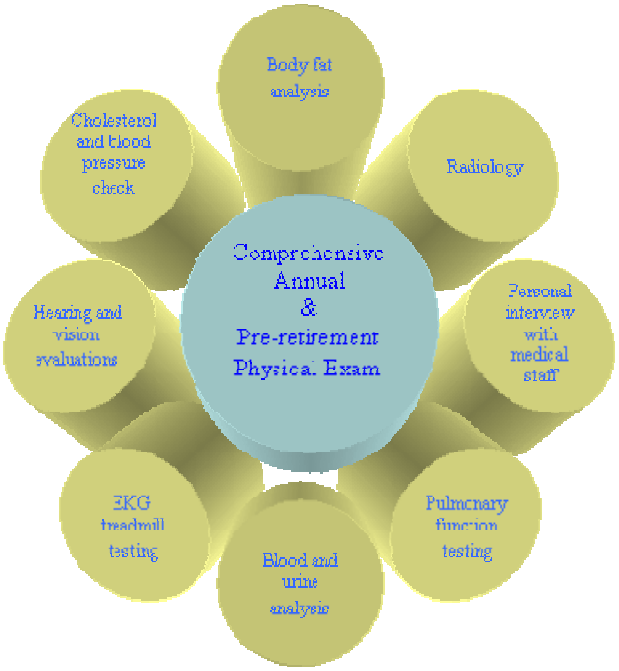
Please fill out all the paperwork as follows (before you come to the physical): All extra paperwork (questioner, check list, TB form, etc.) with name and address as needed.

You will be expected to arrive at the facility at the time scheduled. If you need to cancel the appointment call the appointment desk at least 24-hours in advance or you will not be allowed to receive the examination and may be required to obtain it on your own time.

Do not come to any part of the exam if you are ill, have a fever or are on antibiotics. Remember, cancel in a timely manner!!

We will give you the original results and make another copy for you medical records. You will give the "Physical Exam Summary", "Physical Examination Checklist" and the "Tuberculin Skin Test" to your department.

Note: Ensure your doctor also completes the Annual Medical and Clearance Form for Wildland Firefighters (Arduous Duty).



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Employee Health _____
Occupational Health _____
Wellness Program _____

INFORMATIONAL SHEET

Today's Date: _____ Lab Number: _____

Client Name: _____
Last Middle First

SSN: _____ DOB: _____ Sex: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Dept./Company: White Mountain Apache Fire & Rescue Department

Work Phone: (928) 338-4311 Personal Phone: _____

Emergency Contact Name: _____

Relationship: _____ Phone Number: _____

Client Signature: _____

ORDER: Dr. Nichols/Occupational Health Nurse _____

Radiology

Chest: _____

Lumbar Spine (3 View) _____

Other: _____

Physical Examination Check-List

Date of Service: _____ Department: _____

Employee Name: _____ SSN: _____
Legal Name Please

FIREFIGHTER PHYSICAL

- ☐ Physical Exam w/ Doctor
- ☐ Audiogram
- ☐ Pulmonary Function
- ☐ Metabolic Levels
- ☐ Body Composition
- ☐ 12 Lead EKG
- ☐ Vision

IMMUNIZATIONS

- ☐ Hepatitis A Date: _____
- ☐ Hepatitis B Date: _____
- ☐ Hepatitis A & B Date: _____
- ☐ TB Skin Test Date: _____
- ☐ Tetanus/Diphtheria Date: _____
- ☐ Tetanus/Diphtheria/Pertussia Date: _____

LABS

- ☐ Urine Drug Screen – Alcohol & 9 Drugs
- ☐ Comp. Metabolic , CBC & Cardiac Eval. (Lipid)
- ☐ Hemoglobin A1C
- ☐ Hemocult (over 40)
- ☐ PSA (over 40)

X-Ray (Every 5 years)

- ☐ Chest
- ☐ Lumbar Spine (if applicable)
- ☐ Abdomen (if applicable)

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EMPLOYEE/OCCUPATIONAL HEALTH

TUBERCULIN SKIN TEST

Employee Name: _____ Date of Birth: _____

Department: _____ SSN: _____

The tuberculin skin test is given to determine if you have been exposed to TB Bacillus.

The test is given by injecting a small amount of Tuberculin Purified Protein Derivative (PPD) just under the surface layers of the left forearm. It will need to be read in 48 to 72 hours by a health professional. **IF THE AREA IS RAISED, REDDENED OR HARDENED AFTER 48 TO 72 HOURS, IT MUST BE READ BY A NURSE IN THE EMERGENCY DEPARTMENT.**

You should not take this test if:

1. You have had tuberculosis disease in the past.
2. You have previously had a positive reaction to a PPD.

I have read and understand the above information, had my questions answered, and consent to the tuberculosis skin test. I will have the test read and return the form as required. If the test is questionable or appears positive, I will return to the emergency department.

Signature: _____ Date: _____

PPD _____ cc given: Date: _____ Time: _____

Lot#: _____ Exp. Date: _____ L Forearm by: _____

Test to be read on: _____ After: _____

Reading: _____ mm of reaction. Date: _____

Signature of Health Professional: _____

Comments: _____

Please return this form to the White Mountain Apache Fire & Rescue Department

Medical Examination Report Form

1. Name	2. SSN	3. Date

4. Department/Company:	5. Occupation	6. Sex	7. Date of Birth Age:

8. Reason for present examination.

☐ Employment ☐ Surveillance ☐ Duty Return ☐ DOT ☐

9. Blood Pressure (must take at least two readings to confirm BP in mmHg)

/

/

Firefighter qualified if ≤140/90

Reading	Category
140-159/90-99	Stage 1
160-179/100-109	Stage 2
>180/110	Stage 3

9a. Pulse ☐ Regular ☐ Irregular

9b. Height	9c. Weight	9d. Temp

9e. Remarks

10. Urinalysis is Required. Protein, blood or sugar in the urine may be an indication for further testing to rule out any underlying medical problem.	10a. Sp. Gr.	10b. Protein	10c. Blood	10d. Glucose
	10e.	10f.	10g.	10h.

11. Blood analysis is Required.	11a. CBC	11b. A/G Ratio	11c. BUN/Creatinine	11d. Electrolytes
	11e. HDL	11f. LDL	11g. Total Cholest.	11h. Albumin

11i. Coronary Risk Factors

	Yes	No
Blood Pressure ≥ 140/90	☐	☐
DM or Fasting Glucose ≥ 126mg/dl	☐	☐
Total Cholesterol >200 mg/dl or HDL <40 mg/dl	☐	☐
Family History of CVD in males <55	☐	☐
Age (men >45, women >55)	☐	☐
No regular exercise program	☐	☐
Current tobacco user	☐	☐

11j. Remarks

11k. Physical Activity or Exercise Program

Type of Activity or Exercise: _____

Intensity:	Low _____	Moderate _____	High _____	Duration in Minutes per Session _____
Example:	*Walking*	*Jogging, Cycling*	*Sustained heavy breathing*	Frequency, in Days per Week _____

12. Spirometry 3 good attempts required. Attach all 3 tracings	12a. Actual FVC	12b. Actual FEV1	12c. Actual FEV1/FVC
	12d. %Predicted FVC	12e. %Predicted FEV1	12f. %Pred FEV1/FVC

12i. Examinee Effort	Machine Make/Model	Calibration Date
☐ Good ☐ Fair ☐ Poor		

Technician Name/ID _____ Date _____

Clinical Evaluation

13. Vision

6.4 Far visual acuity less than 20/40 binocular, corrected with contact lenses or spectacles; far visual acuity less than 20/100 binocular for wearers of hard contacts or spectacles, uncorrected; monochromatic vision resulting in inability to use imaging devices; monocular vision; or any eye condition that results in a person not being able to safely perform essential job task shall not be certified as meeting the medical requirements of NFPA 1582, 2003 Edition.

Vision:	Uncorrected			Corrected			Color Vision:
Distant:	R 20/	Both	L 20/	R 20/	Both	L 20/	
Near:	R 20/	Both	L 20/	R 20/	Both	L 20/	Peripheral:

Technician Name/ID _____ Date _____

14. Ears/Hearing

NFPA 1582, 2003 Edition 6.5 Chronic vertigo or impaired balance as demonstrated by the inability to tandem gait walk; on audiometric testing, average hearing loss in the unaided better ear greater than 40 decibels (dB) at 500Hz, 1000Hz and 2000Hz when the audiometric device is calibrated to ANSI Z24.5; or any ear condition (or hearing impairment) that results in a person not being able to safely perform essential job task.

14a. History.

☐ Hearing Loss ☐ High Pitch ☐ Hay Fever/Congestion Now ☐ Sinus Infection

☐ Ear Infection ☐ Ear wax build-up ☐ Dizziness/Vertigo ☐

14b. Audiogram

	250 Hz	500 Hz	1000 Hz	2000 Hz	3000 Hz	4000 Hz	5000 Hz	8000 Hz
Right								
Left								

Technician/Name ID _____ Date _____

Area Examined	Use Code	Remarks (Describe all "Code 1's" in detail).

Use Code : √ – Within normal limits 1 – Significantly Abnormal N/A – Not Examined

15. Head & Neck

NFPA 1582, 2003 Edition 6.3 Defect of skull preventing helmet use or leaving underlying brain unprotected from trauma; any skull or facial deformity that would not allow for successful respiratory facepiece fit test or any head condition that results in a person not being able to safely perform essential job tasks.

15a	Head and neck		
15b	Thyroid		
	Lymph nodes		

15c	Eyes		
	Fundi		
15d	Ears		
16. Nose, Oropharynx, Trachea, Esophagus and Larynx NFPA 1582, 2003 Edition 6.7 Tracheostomy; aphonia; or any nasal, oropharyngeal, tracheal, esophageal or laryngeal condition that results in not being able to safely perform essential job tasks.			
16a	Nose and sinuses		
16b	Mouth and throat		
16c	Teeth		
17. Lungs and Chest Wall NFPA 1582, 2003 Edition 6.8 Active hemoptysis; empyema; pulmonary hypertension; active tuberculosis; obstructive lung disease*; hypoxemia*; Asthma*; or any pulmonary condition that results in a person not being able to safely perform essential job functions.			
17a	Chest and lungs		
	Breast		
17b	Chest X-Ray		
18. Heart and Vascular System NFPA 1582, 2003 Edition 6.9 CAD; cardiomyopathy or CHF; acute pericarditis, endocarditis or myocarditis; syncope, recurrent; medical condition requiring an automatic implantable cardiac defibrillator; 3rd degree AV block, cardiac pacemaker; idiopathic hypertrophic subaortic stenosis; hypertension with evidence of end organ damage or not controlled by approved medications; thoracic or abdominal aortic aneurysm; carotid artery stenosis or obstruction resulting in >50% reduction in blood flow; peripheral vascular disease resulting in symptomatic claudication; or any cardiac condition that results in a person not being able to safely perform essential job tasks.			
18a	Heart		
18b	Peripheral – Vascular		
18c	Exercise Stress Test - No imaging **(must have normal resting ECG and ability to walk 3.0 miles with 45lb weighted vest)**		
19. Abdominal Organs and Gastrointestinal System NFPA 1582, 2003 Edition 6.10 Presence of uncorrected inguinal/femoral hernia regardless of symptoms; or any gastrointestinal condition that results in a person not being able to safely perform essential job task.			
19a	Abdomen		
19b	Inguinal, e.g., hernia		
20. Urinary and Reproductive System NFPA 1582, 2003 Edition 6.11 and 6.12 Renal failure or insufficiency requiring continuous ambulatory peritoneal dialysis (CAPD) or hemodialysis; or any urinary or genital condition that results in a person not being able to safely perform essential job task.			
20a	Urinary		
20b	Genitalia		
20c	Anus and rectum		
	Prostate		
	Proctoscopic		
21. Spine and Axial Skeleton NFPA 1582, 2003 Edition 6.13 Scoliosis of thoracic or lumbar spine with angle >40 degree; history of multiple spinal surgeries or spinal surgery involving fusion of more than 2 vertebrae, diskectomy or laminectomy, or rods that are still in place; any spinal or skeletal condition producing sensory or motor deficit(s) or pain due to radiculopathy or nerve root compression; any spinal or skeletal condition causing pain that frequently or recurrently requires narcotic analgesic medication; cervical, thoracic, lumosacral vertebral factures*; or any spinal or skeletal condition that results in a person not being able to safely perform essential job tasks.			
21a	Spine		
21b	Pelvis		

23. Extremities NFPA 1582, 2003 Edition 6.14 Bone hardware such as metal plates or rods supporting bone during healing; history of total joint replacement; amputation*; chronic non-healing or recent bone grafts; history of more than one dislocation of shoulder*; or any extremity condition that results in a person not being able to safely perform essential job tasks.			
23a	Arms		
	Hands		
23b	Legs		
	Feet		
24. Neurological Disorders NFPA 1582, 2003 Edition 6.15 Ataxias of heredo-degenerative type; cerebral arterosclerosis; hemiparalysis; multiple sclerosis*; myasthenia garvis*; progressive muscular dystrophy or atrophy; uncorrected cerebral aneurysm; all epileptic conditions*; dementia*; Parkinson's disease*; or any neurological condition that results in a person not being able to safely perform essential job tasks.			
24a	Neurologic		
24b			
25. Tumors and Malignant Disease NFPA 1582, 2003 Edition 6.20 Malignant diseases that is newly diagnosed, untreated or currently being treated; any tumor or similar condition that results in a person not being able to safely perform essential job tasks.			
25a			
26. Skin NFPA 1582, 2003 Edition 6.16 Metastatic or locally extensive basal or squamous cell carcinoma or melanoma; any dermatologic condition that would not allow for a successful respiratory facepiece fit test; or any dermatologic condition that results in the person not being able to safety perform essential job tasks.			
26a	Skin		
27. Blood and Blood Forming Organs NFPA 1582, 2003 Edition 6.17 Hemorrhagic states requirement replacement therapy; sickle cell disease; clotting disorders; any hematological condition that results in a person not being able to safely perform essential job tasks.			
27a	Blood & Blood Forming Organs		
28. Endocrine and Metabolic Disorders NFPA 1582, 2003 Edition 6.18 Diabetes mellitus which is treated with insulin; uncontrolled diabetes not treated by insulin; or any endocrine or metabolic condition that results in a person not being able to safely perform essential job tasks.			
28a	Endocrine System		
28b			
29. Chemical, Drugs and Medications NFPA 1582, 2003 Edition 6.22 Tobacco use, narcotics, including methadone; sedative-hypnotics; drugs that prolong prothrombin time, partial thromboplastin time or INR; beta-adrenergic blocking agents; respiratory medication*; any chemical, drug or medication that results in a person not being able to safely perform essential job tasks.			
29a	Tobacco ☐ Yes ☐ No		
29b	Chemical, Drugs & Medications ☐ Yes ☐ No		
Use Code : √ – Within normal limits. 1 – Significantly Abnormal N/A – Not Examined *Refer to NFPA 1582, 2003 Edition, Chapter 6			
30. Other X-ray or laboratory findings.			

31. Recommendations		32. R.N. signature 33. Physician's signature 34. Patient's signature	
35. Work Qualifications	36. Contact Person	37. Date	38. Initial

PRIVACY ACT INFORMATION

The information contained in this form will be used to determine weather an individual considered for firefighting can safely and efficiently perform those duties in a manner that will not unduly risk aggravation, acceleration, or permanently worsening a pre-existing medical condition. Its collection and use are consistent with the provisions of 5 USC 552a (Privacy Act of 1974), 5 USC3301 (Examination, Certification and Appointment), and Executive Orders 12107 (Merit systems Protection Board) and 12564 (Drug Free Federal Workplace).

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PHYSICAL EXAMINATION TIER SUMMARY

Name: _____ SSN: _____

Date of Exam: _____ City/District: _____

This member has been examined by _____ at Summit Healthcare .
Physician's Name Hospital/Clinic

As a result of the examination, this firefighter falls under the tiered medical system as described below.

39.

☐ **TIER 1**: Fit for Duty

☐ **TIER 2** – Fit for Duty: Some decline in health parameters.

☐ **TIER 3** – Clear for Duty: mandatory wellness/fitness referral.

Mandatory Re-Check Date: _____

METS Output: _____

Tiered Reason: _____

- ☐ Repeat Treadmill
- ☐ Body Fat
- ☐ Weight
- ☐ Blood Pressure
- ☐ Consult Only
- ☐ Labs: _____

Recommendations

- ☐ PFT support
- ☐ Dietician support
- ☐ PCP support
- ☐ Other: _____

☐ **TIER 4** – Unfit for Duty: Requires immediate health response.

METS Output: _____

Tiered Reason: _____

- ☐ Repeat Treadmill
- ☐ Body Fat
- ☐ Weight
- ☐ Blood Pressure
- ☐ Consult Only
- ☐ Labs: _____

Recommendations

- ☐ Removal from field operational assignment until sufficient progress is demonstrated.
- ☐ Delayed removal from field operational assignment, provided mandatory regularly schedule requirements are met and sufficient progress is demonstrated.
- ☐ Health Center Re-Checks
- ☐ PFT support
- ☐ Dietician support
- ☐ Immediate referral to PCP and requires medical clearance return to duty.
- ☐ Other: _____

Signature or Member: _____ Date: _____

Signature of Attending Clinician: _____ Date: _____

40. Physician's Tier Summary

Currently, we now place members in one of four tiers to better track and assess their health. These are:

Tier 1: Minimal health parameters to which White Mountain Apache Fire & Rescue members should maintain for field conditioning. ***What does this mean?*** **You are fit-for-duty.**

Tier 2: Health issues noted where interventional support or change is recommended. ***What does this mean?*** **Some of your health parameters are starting to decline when compared to previous health physicals. It's recommended that you reverse this trend and stay healthy.**

Tier 3: Health issues sufficient for mandatory referral for wellness/fitness intervention, but removal from the field is not yet required. ***What does this mean?*** **Noticeable health parameters have declined compared to previous health physicals and/or are in unhealthy ranges. You need to participate in a healthy regiment.**

Tier 4: Health issues sufficient to mandate removal from the field and mandatory referral for wellness/fitness intervention. ***What does this mean?*** **You are not fit-for-duty, thus not cleared to work in the firefighting field. We will help you become better to return you to the firefighting field as soon as possible.**

Health Standard	Tier 1	Tier 2	Tier 3	Tier 4
Body Fat %	< 20% Male <24% Female	20%-24% Male 24%-29% Female	25%-30% Male 30%-34% Female	>30% Male >34% Female
Blood Pressure	<140/90	<140/90	>150/100	>160/110
FEV1/FVC Ratio	< 75%	< 75%	< 65%	< 59%
METS (Stress Test)	> 14.0	13.0 –13.9	12.0-12.9	< 12.0
Blood Sugar HbA1c+	65-99 < 6.5	100-199 6.5-7.4	200-299 >7.5	>300 8.0

1. What if I'm in Tier 4 for one thing and Tier 1 for everything else?
With the exception of Body Fat percentage, levels in any Tier 4 category will make you a Tier 4 candidate.

2. ***What if I'm Tier 4 in only Body Fat percentage, and everything else is OK?***
Elevated Body Fat percentage alone will not automatically make you a Tier 4 candidate, since it is possible to carry elevated body fat and still be healthy. The medical staff will make a decision based on the individual.

3. ***What do I need to do based on my Tier category?***
Tier 1 - Keep up the good work.
Tier 2 - Participate in some lifestyle changes.
Tier 3 - Intervention is required based on the medical recommendation.
Tier 4 - Follow the medical requirements prescribed to return to active duty as quickly as possible.

4. ***Who decides what Tier I am in?***
The medical staff at your annual comprehensive physical will assess your health and will assign you a Tier number.

5. ***Who will remove me from the field?***
The same medical staff, along with the Medical Director, will ultimately decide to remove you from active duty in fire fighting operations.

6. ***Where will I work while in Tier 4?***
An alternative duty may be assigned to you based on your limitations.

HEALTH HISTORY	Yes	No	If "Yes", give details.

List all medications you are currently taking, including those prescribed and over-the-counter (including herbal) and reasons:

Medications	Reason

	Yes	No	
Have you had any surgeries/operations:			
On your back, arm, leg or knee?	☐	☐	
To treat a hernia?	☐	☐	
Varicose Veins	☐	☐	
Other Operations?	☐	☐	
Have you ever been hospitalized?	☐	☐	
	☐	☐	
Allergy – Have you ever had or do you currently have:			
Serious allergies?	☐	☐	
Bad reaction to any medication?	☐	☐	
Advised not to take any medication?	☐	☐	
	☐	☐	
Skin – Have you ever had or do you currently have:			
Hives/eczema or rash?	☐	☐	
Chronic skin problems (cuts slow to heal)?	☐	☐	
Excessive skin dryness?	☐	☐	
Problems with "easy bruising"?	☐	☐	
Chemical or jewelry rash/sensitivity?	☐	☐	
	☐	☐	
Neuro – Have you ever had or do you currently have:			
A psychiatric or emotional problem?	☐	☐	
Numbness/weakness/paralysis?	☐	☐	
Dizziness or fainting spells?	☐	☐	
Severe/frequent or migraine headaches?	☐	☐	
Head injury, concussions or skull fractures?	☐	☐	
Neruological disorders?	☐	☐	
Seizures or blackouts?	☐	☐	
Stroke?	☐	☐	
	☐	☐	
Eyes/Ears – Have you ever had or do you currently have:			
Hearing loss?	☐	☐	
Ringing in ears?	☐	☐	
Other ear problems?	☐	☐	
Glaucoma or cataracts?	☐	☐	

HEALTH HISTORY	Yes	No	If "Yes", give details.
Red eyes?	☐	☐	
Other eye problems (strain from VDT use)?	☐	☐	
Glasses/contacts?	☐	☐	
Date of last vision screen?	☐	☐	
	☐	☐	
Head/Neck – Have you ever had or do you currently have:			
Date of last dental exam?	☐	☐	
Recent problems with teeth/dentures?	☐	☐	
Frequent mouth ulcers/infections?	☐	☐	
Sinus or hay fever?	☐	☐	
Frequent sore throats?	☐	☐	
Frequent nose bleeds?	☐	☐	
Trouble with thyroid?	☐	☐	
Problem requiring radiation treatment to neck?	☐	☐	
	☐	☐	
Lungs – Have you ever had or do you currently have:			
Asthma or wheezing?	☐	☐	
Coughed up any blood?	☐	☐	
Shortness of breath without apparent reasons?	☐	☐	
TB or positive skin test for TB?	☐	☐	
Pneumonia or pleurisy?	☐	☐	
Do you cough everyday, esp. in the morning?	☐	☐	
Pain or tightness in the chest?	☐	☐	
More than three episodes of bronchitis in one year?	☐	☐	
Ever smoked tobacco in any form?	☐	☐	
Had a chest x-ray?	☐	☐	
	☐	☐	
Heart – Have you ever had or do you currently have:			
Rheumatic fever or heart murmur?	☐	☐	
Heart disease?	☐	☐	
Treated for heart condition?	☐	☐	
Unusually cold or bluish-colored hands/feet?	☐	☐	
High blood pressure? If yes, how is it treated?	☐	☐	
Do you have a history of elevated cholesterol?	☐	☐	
Anemia or any blood disease?	☐	☐	
Phlebitis, varicose, blood clots/poor circulation?	☐	☐	
	☐	☐	
GI – Have you ever had or do you currently have:			
Ulcers?	☐	☐	
Hiatal hernia?	☐	☐	

HEALTH HISTORY	Yes	No	If "Yes", give details.
Indigestion, pain or unusual burning in stomach?	☐	☐	
Vomiting blood?	☐	☐	
Bloody/tarry bowel movements?	☐	☐	
Colitis or nervous stomach?	☐	☐	
Yellow jaundice or hepatitis?	☐	☐	
Problems with your pancreas?	☐	☐	
Gallbladder disease?	☐	☐	
Kidneys – Have you ever had or do you currently have:			
Bladder or kidney infections?	☐	☐	
Kidney stones?	☐	☐	
Burning or discomfort on urination?	☐	☐	
Frequent urination?	☐	☐	
Hernia?	☐	☐	
Blood in urine?	☐	☐	
	☐	☐	
Miscellaneous – Have you ever had or do you currently have:			
Diabetes or sugar in your urine?	☐	☐	
Cancer of any kind?	☐	☐	
	☐	☐	
Muscle-Skeletal – Have you ever had or do you currently have:			
Arthritis, rheumatism, neck, back or spine injury?	☐	☐	
Been treated for a back problem?	☐	☐	
Recurrent stiffness or back pain?	☐	☐	
Bursitis or tendonitis?	☐	☐	
Recurrent pulled muscles or sprains?	☐	☐	
Hand or wrist injury or problem?	☐	☐	
Ankle or foot injury or problem?	☐	☐	
Frostbite	☐	☐	
Job requiring heavy lifting or standing?	☐	☐	
Any broken bones?	☐	☐	
	☐	☐	
For Female Only – Have you ever had or do you currently have:			
Menstrual irregularities?	☐	☐	
Recurrent problems of the female organs?	☐	☐	
Breast masses or lumps?	☐	☐	
Do you practice monthly breast self-exams?	☐	☐	
Have you ever had a mammogram?	☐	☐	
Date of last pap smear?	☐	☐	
	☐	☐	
	☐	☐	

HEALTH HISTORY	Yes	No	If "Yes", give details.
For Males Only – Have you ever had or do you currently have:			
Prostate or testicular problems?	☐	☐	_____
Breast tenderness, swelling or lumps?	☐	☐	_____
Do you practice monthly testicular self-exams?	☐	☐	_____
	☐	☐	_____
General Lifestyle I.			
Do you exercise three times per week?	☐	☐	_____
30-40 minutes each time? Type of exercise?	☐	☐	_____
Are you more than 30% above your ideal weight?	☐	☐	_____
Received a tetanus booster in the last 10 yrs.?	☐	☐	_____
Have you been immunized against Hepatitis B?	☐	☐	_____
Do you take any prescription medication?	☐	☐	_____
Do you take non-prescription medication?	☐	☐	_____
	☐	☐	_____
General Lifestyle II.			
Do you participate in a workplace wellness?	☐	☐	_____
Which of the following would you like to see offered and would you participate in?			
Cholesterol screen?	☐		
Blood pressure screen?	☐		
Weight loss?	☐		
Nutrition program?	☐		
Stress management?	☐		
Health risk appraisal?	☐		
Health education program?	☐		
Self-directed exercise?	☐		
Women's/Men's health?	☐		
	☐		
Work History I. Have you ever:			
Been restricted in your work or given light duty?	☐	☐	_____
Left a job because of health problems?	☐	☐	_____
Been injured on the job and treated by a doctor?	☐	☐	_____
Received compensation for an industrial ill/injury?	☐	☐	_____
Been hospitalized in the last five years?	☐	☐	_____
Have you had any illness or injury not asked about?	☐	☐	_____
	☐	☐	_____
Work History II.			
Do you have hobbies? If so what?	☐	☐	_____
Do you moonlight or have a second job?	☐	☐	_____
	☐	☐	_____
	☐	☐	_____

HEALTH HISTORY	Yes	No	If "Yes", give details.
Work History III. Have you ever worked around the following:			
Chemical plant?	☐	☐	_____
Coke oven?	☐	☐	_____
Construction?	☐	☐	_____
Cotton, flax or hemp mill?	☐	☐	_____
Electronics plant?	☐	☐	_____
Farm?	☐	☐	_____
Foundry?	☐	☐	_____
Hazardous waste industry?	☐	☐	_____
Hospital?	☐	☐	_____
Lumbar mill?	☐	☐	_____
Metal production?	☐	☐	_____
Mine?	☐	☐	_____
Nuclear industry?	☐	☐	_____
Paper mill?	☐	☐	_____
Pharmaceutical?	☐	☐	_____
Plastic production?	☐	☐	_____
Pottery mill?	☐	☐	_____
Refinery?	☐	☐	_____
Rubber processing plant?	☐	☐	_____
Sand pit or quarry?	☐	☐	_____
Service station?	☐	☐	_____
Shipyard?	☐	☐	_____
Smelter?	☐	☐	_____
	☐	☐	_____
Have you ever worked with or been exposed to:			
Aldrin?	☐	☐	_____
Arsenic?	☐	☐	_____
Asbestos?	☐	☐	_____
Benzene?	☐	☐	_____
Benzidine?	☐	☐	_____
Beryllium?	☐	☐	_____
BIS chlormethyl ether?	☐	☐	_____
Cadmium?	☐	☐	_____
Carbon disulfide?	☐	☐	_____
Carbon tetrachloride?	☐	☐	_____
Chlorine?	☐	☐	_____
Chlorodane?	☐	☐	_____
Chloroform?	☐	☐	_____
Chloroprene?	☐	☐	_____

HEALTH HISTORY	Yes	No	If "Yes", give details.
Chromates?	☐	☐	
Chromic acid mist?	☐	☐	
Cutting oils?	☐	☐	
DDT?	☐	☐	
Dieldrin?	☐	☐	
Dioxin?	☐	☐	
Dust, coal?	☐	☐	
Dust, sandblasting?	☐	☐	
Dust, other?	☐	☐	
Ethyl dibromide?	☐	☐	
Ethylene oxide?	☐	☐	
Extreme heat or cold?	☐	☐	
Heptachlor?	☐	☐	
Hexachlorobenzene?	☐	☐	
Isocyanates?	☐	☐	
Loud or continuous noise?	☐	☐	
Mercury?	☐	☐	
Methylene chloride?	☐	☐	
Microwaves, lasers?	☐	☐	
Nickel?	☐	☐	
PCB's?	☐	☐	
Pesticides, herbicides?	☐	☐	
Phenois?	☐	☐	
Phosgene?	☐	☐	
Plastics?	☐	☐	
Radioactive materials?	☐	☐	
Roofing materials?	☐	☐	
Rubber?	☐	☐	
Silica?	☐	☐	
Solvents/degreasers?	☐	☐	
Soots and tars?	☐	☐	
Spray painting?	☐	☐	
Tri/Per chloroethylene?	☐	☐	
Vinyl chloride?	☐	☐	
	☐	☐	

List any toxins/chemicals/biological hazards you might currently be expose to: _____

_____

_____

_____

Work History IV. Jobs – Start with the most recent:

Date (Year to Year)	Company	Position	Any Work Hazards

I certify that the above information is true and complete to the best of my knowledge. I hereby give _____ permission to release work-related information to the proper authorities of my employer or the company for which I am a job applicant.

Signature: _____ Date: _____

Examiner: _____ Date: _____

ESSENTIAL FUNCTIONS AND WORK CONDITIONS OF AN ARDOUS DUTY

WILDLAND FIREFIGHTER

Time/Work Volume	Physical Requirements	Environment	Physical Exposures
May include:			
• long hours (minimum of 12 hour shifts) • irregular hours • shift work • time zone changes • multiple and consecutive assignments • pace of work typically set by emergency situations • ability to meet "arduous" level performance testing (the "Pack Test"), which includes carrying a 45 pound pack 3 miles in 45 minutes, approximating an oxygen consumption (VO_2 max) of 45 mL/kg-minute *And up to*: • 14-day assignments	• use shovel, Pulaski, and other hand tools to construct fire lines • lift and carry more than 50# • lifting or loading boxes and equipment • drive or ride for many hours • fly in helicopters and fixed wing airplanes • work independently, and on small and large teams • use PPE (includes hard hat, boots, eyewear, and other equipment) • arduous exertion • extensive walking, climbing • kneeling • stooping • pulling hoses • running • jumping • twisting • bending • rapid pull-out to safety zones • provide rescue or evacuation assistance	• very steep terrain • rocky, loose, or muddy ground surfaces • thick vegetation • down/standing trees • wet leaves/grasses • varied climates (cold/hot/wet/dry/humid/ snow/rain) • varied light conditions, including dim light or darkness • high altitudes • heights • holes and drop offs • very rough roads • open bodies of water • isolated/remote sites • no ready access to medical help	• bright sunshine/UV • burning materials • extreme heat • airborne particulates • fumes, gases • falling rocks and trees • allergens • loud noises • snakes • insects/ticks • poisonous plants • trucks and other large equipment • close quarters, large numbers of other workers • limited/disrupted sleep • hunger/irregular meals • dehydration

Annual Medical History and Clearance Form
Wildland Firefighters (Arduous Duty)

(Print Only) **Firefighter's Name:**	**SSN:**
Name of Employing Agency:	**Date of Birth:**
Position/Job Title:	**Gender: Male ☐ Female ☐**
Home Address: **(Street or PO Box)** **(City, State, Zip)**	**Date of Last Physical Exam:**
Home Phone: ( )	**Work Phone: ( )**

Incomplete forms or missing information may result in a delay clearing you for firefighter duties and prevent you from taking the Pack Test. Submitting information that is misleading or untruthful may result in termination or failure to be cleared as a firefighter. This history form and review do not substitute for routine health care or a periodic health examination conducted by your physician. It is being conducted for occupational purposes only. I certify that all of the information I have provided on this form is complete and accurate to the best of my knowledge. I authorize release of information within this form to the White Mountain Apache Fire & Rescue Department or their representatives for the purpose of medical clearance as an arduous duty wildland firefighter.

Firefighter's Signature:	**Current Date:**

MEDICAL HISTORY

Smoking History
This information is needed since smoking increases your risk for lung cancer and several other types of cancer, chronic bronchitis, emphysema, asbestos related lung diseases, coronary heart disease, high blood pressure, and stroke. Please check your smoking status and complete the associated section:

☐ Current Smoker

Number of cigarettes per day _____
Number of cigars per day _____
Number of pipe bowls per day _____
Total years you have smoked _____

☐ Former Smoker

Number of cigarettes per day _____
Number of cigars per day _____
Number of pipe bowls per day _____
Total years you smoked _____

☐ Never Smoked

Describe Your Physical Activity or Exercise Program Type of Activity or Exercise _____

_____

Intensity: Low _____ Moderate _____ High _____
(*Examples: Walking Jogging, cycling Sustained heavy breathing and perspiration*)

Duration, in Minutes per Session _____
Frequency, in Days per Week _____

Medications **(List all medications you are currently taking, including those prescribed and over-the-counter.)**

_____ _____
_____ _____
_____ _____

Date of last Tetanus (Td) shot:

MEDICAL HISTORY (continued) Do you have, or have you ever had:	Yes	No	Every item checked "Yes" must be explained in the spaces below, specifying the number of the item. Copies of pertinent medical records also may be necessary.
1. Surgery, or advised to have surgery?			
2. Treatment by doctors, healers, or other practitioners for any problem other than minor illnesses?			
3. Treatment for a mental or emotional condition?			
4. Allergies? (If "Yes," describe in box on right)			
5. Any type of eye disease?			
6. Do you wear eyeglasses?			
7. Contact lenses? Hard or Soft (circle one)			
8. Any type of ear disease?			
9. Problem with dizziness or balance?			
10. Any type of skin disease (other than acne)?			
11. Varicose veins, blood clots, or swollen and painful veins?			
12. Anemia?			
13. High blood pressure?			
14. A stroke?			
15. Poor circulation in hands or feet?			
16. Heart disease, heart murmur, chest pain (angina), palpitations (irregular beat), or heart attack?			
17. Problem with passing out, fainting, or losing consciousness?			
18. Any type of lung disease?			
19. Asthma, bronchitis, or emphysema?			
20. A need to use inhalers?			
21. Tuberculosis or a positive TB skin test?			
22. Diabetes?			
23. A need for insulin shots?			
24. Unexplained weight loss or gain?			
25. Joint pain or arthritis?			
26. Loss of use of an arm, leg, finger, or toe?			
27. Back pain, back trouble, or injury?			
28. Tremors, shakiness, or seizures?			
29. Numbness or tingling in hands or feet?			
30. Frequent headaches or migraines?			
31. Any type of stomach or intestine disease?			
32. Hernia?			
33. Hepatitis?			
34. Any type of liver disease?			
35. Blood in the stool or vomited blood?			
36. Any type of kidney or bladder disease?			
37. Kidney stones?			
38. Difficulty or pain with urination?			
39. Diagnosed or treated for alcoholism or alcohol dependence?			
40. Diagnosed as dependent on drugs or treated for drug abuse?			

Firefighter Name (Print Only)_____

MEDICAL SCREENING

Screening Item	Result	Qualifying Standard	Comments
1. Height (inches)		**None**	
2. Weight (pounds)		**None**	
3. Blood Pressure (mm Hg)	/	**Less than or equal to 140/90**	
4. Pulse (beats per minute)		**None**	
5. Hearing (without hearing. aids) **Whispered word at 1 foot from ear (opposite ear should be covered)** **Spoken word at 1 foot from ear (opposite ear should be covered)**	**Heard?** **Right Whisper** ☐ **Left Whisper** ☐ **Right Spoken** ☐ **Left Spoken** ☐	**Threshold shift not greater than 40 dB in the speech frequency range.** **Whisper = about 30 dB** **Spoken = about 60 dB** **(Need to hear a whisper)**	
6. Vision **Uncorrected far:** (Soft contact lense wearers can leave contacts in) **Corrected far:** **Color (Red/Green/Yellow)**	**Right -20/_____** **Left -20/_____** **Right -20/_____** **Left -20/_____** **Can see:** **Red Green Yellow** ☐ ☐ ☐	**Uncorrected far vision of 20/100 or better in each eye** *AND* **Corrected far vision of 20/40 or better in each eye** *AND* **Can see red/green/yellow**	

Findings:

☐ **A. No Significant Findings** – The firefighter meets the qualifying medical standards listed above. The firefighter appears capable of performing the functional requirements of an arduous duty wildland firefighter (see page 2). **Note:** This includes the ability to safely participate in arduous duty performance testing, consisting at a minimum of carrying a 45 pound pack a distance of 3 miles in a period of 45 minutes over level ground (the "Pack Test").

☐ **B. Significant Finding (Uncorrected Far Vision ONLY)** – The firefighter does not meet the uncorrected far vision standard listed above. An acceptable waiver with restriction is to require the possession during duty hours of a second set of corrective lenses. With this restriction, the firefighter appears capable of performing the functional requirements of an arduous duty wildland firefighter (see page 2). **Note:** This includes the ability to safely participate in arduous duty performance testing, consisting at a minimum of carrying a 45 pound pack a distance of 3 miles in a period of 45 minutes over level ground (the "Pack Test").

☐ **C. Significant Medical Findings** - The firefighter does not meet one or more of the qualifying medical standards listed above, OR is not considered capable of performing the functional requirements of an arduous duty wildland firefighter (see page 2), OR is not considered able to safely participate in arduous duty performance testing, consisting at a minimum of carrying a 45 pound pack a distance of 3 miles in a period of 45 minutes over level ground (the "Pack Test").

☐ **D. Final Determination Cannot be Made Based on Available Medical Information** - The following results **(Please List)** were inconclusive and require that further information be provided to the White Mtn. Apache Fire & Rescue from the firefighter's personal health care provider. The firefighter and the White Mtn. Apache Fire & Rescue should contact their Agency representative for further direction. Final recommendation for participation as an arduous duty wildland firefighter cannot be made at this time.

_____ _____ _____
(Print Only)Name - Local Health Care Professional Signature – Local Health Care Professional Date

_____ _____ _____
(Print Only) Address License/Certification Number License/Certification State

_____ (_____)_____
(Print Only) City, State, Zip Telephone Number

Firefighter Name (Print Only)_____

ARDUOUS DUTY WILDLAND FIREFIGHTER CLEARANCE FORM

Local Health Care Professional: Complete the information required below, then detach and provide this page to the firefighter at the end of the medical screening.

Firefighter: You must return this page to the White Mtn. Apache Fire & Rescue prior to taking the Pack Test.

Firefighter Name:_____

Agency, Unit, and Location:_____

☐ Employee **CLEARED** for Arduous Duty Wildland Firefighting and the Pack Test (*Findings **A** or **B** were marked on page 5*)

☐ Second set of corrective lenses (glasses) to meet uncorrected vision standard is required. *(Finding **B** was marked from page 5)*

☐ Employee ***NOT CLEARED*** for Arduous Duty Wildland Firefighting and the Pack Test. Further evaluation is necessary. **Findings discussed with firefighter.** (*Findings **C** or **D** were marked on page 5*)

_____	_____	_____
(Print Only)Name - Local Health Care Professional	Signature – Local Health Care Professional	Date
_____	_____	_____
(Print Only) Address	License/Certification Number	License/Certification State
_____	(_____)_____	
(Print Only) City, State, Zip	Telephone Number	