

WHITE MOUNTAIN APACHE FIRE & RESCUE DEPARTMENT



RECRUITMENT APPLICATION PACKET

Recruit Contact Form & Checklist

Name of Recruit: _____

Mailing Address: _____

Physical address: _____

Phone Number: _____

- _____ **Date recruit was given Handbook**
- _____ **Date completed Application turned in.**
- _____ **Date High School Diploma/GED Certificate turned in.**
- _____ **Date Tribal, State or Federal Court rap sheet turned in.**
- _____ **Date complete Authorization for Release Forms turned in.**
- _____ **Date complete Physical Examination turned in (*applicant's expense*).**
- _____ **Date copy of valid Arizona Driver's License turned in.**
- _____ **Date current DMV 5-year driving record turned in.**
- _____ **Date copy of Social Security & Tribal ID card (if applicable) turned in.**
- _____ **9th Grade Reading Equivalency (COMPASS) Test turned in.**
- _____ **Date first Ride-A-Long began.**
- _____ **Date Initial Physical Agility Test completed.**
- _____ **Date Criminal Background & Finger Print Clearance Completed.**
- _____ **Date Alcohol/Drug Screen completed.**
- _____ **Date Hired (*Form E Signed*).**
- _____ **Date Orientation Completed.**

Comments: _____



WHITE MOUNTAIN APACHE FIRE & RESCUE DEPARTMENT

PO Box 1929 (612 S. Chief Ave.)

Whiteriver, AZ 85941

Phone: (928) 338-1701

Fax: (928) 338-1710

1. Read all instructions carefully (please print or type).
2. Fill in all areas requested: if NOT APPLICABLE, write N/A, Do Not leave any spaces blank.
3. Type or print information and fill in information neatly and accurately.
4. If additional information is being requested, please supply them with your application.
5. INCOMPLETE APPLICATIONS WILL BE DELAYED AND MAY AFFECT YOUR CHANCES FOR EMPLOYMENT

ASSISTANCE

ASSISTANCE IN FILLING OUT THIS APPLICATION IS AVAILABLE THROUGH THE
WHITE MOUNTAIN APACHE FIRE & RESCUE DEPARTMENT.

*After application has been stamped and received by the White Mountain Apache Fire & Rescue Department, it becomes the property of the White Mountain Apache Fire & Rescue Department (WMAFRD). **NO FUTURE COPIES ARE MADE.** Every question **MUST** Be Answered.

Section A – APPLICATION INFORMATION – Must have Valid Driver’s License on file.

1. POSITION INTERESTED IN: <input type="checkbox"/> Part-Time Firefighter <input type="checkbox"/> Paid On Call <input type="checkbox"/> Other _____		2. DATE OF APPLICATION:	
3. NAME (Last, First, Middle):		4. SOCIAL SECURITY NUMBER:	
5. ADDRESS (P.O. Box Number/Street/Apt. No.):		6. CITY, STATE, ZIP CODE	
7. COMMUNITY YOU LIVE IN:		8. PHONE NUMBER (Home, Work):	
9. TRIBAL AFFILIATION		10. MESSAGE PHONE:	
11. YEAR AT THIS ADDRESS:		12. PRIOR AREA OF RESIDENTS:	
13. HAVE YOU EVER FILED AN APPLICATION WITH THE WMAFRD BEFORE? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE DATES:			
13. HAVE YOU EVER BEEN EMPLOYED WITH THE WMAFRD BEFORE? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE DATES:			
15. ARE YOU CURRENTLY EMPLOYED? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, MAY WE CONTACT YOUR PRESENT EMPLOYER? <input type="checkbox"/> YES <input type="checkbox"/> NO		16. TYPE OF EMPLOYMENT DESIRED: <input type="checkbox"/> FULL-TIME <input type="checkbox"/> PARTTIME <input type="checkbox"/> TEMPORARY <input type="checkbox"/> ON-CALL <input type="checkbox"/> SEASONAL	
17. SHIFTS YOU’RE ABLE AND WILLING TO WORK: <input type="checkbox"/> DAY SHIFT <input type="checkbox"/> EVENING SHIFT <input type="checkbox"/> NIGHT SHIFT <input type="checkbox"/> ROTATING		18. WILL YOU ACCEPT A JOB THAT REQUIRES YOU TO WORK ON WEEKENDS OR HOLIDAYS? <input type="checkbox"/> YES <input type="checkbox"/> NO	
19. WILL YOU TRAVEL, IF REQUIRED? <input type="checkbox"/> YES <input type="checkbox"/> NO		20. IF REQUIRED, WILL YOU UNDERGO A PRE-EMPLOYMENT PHYSICAL? <input type="checkbox"/> YES <input type="checkbox"/> NO	
21. WILL YOU WORK OVERTIME, IF REQUIRED? <input type="checkbox"/> YES <input type="checkbox"/> NO		22. DRIVER’S LICENSE NO.: STATE: TYPE:	
23. HAVE YOU BEEN CONVICTED OF A FELONY IN THE LAST SEVEN (7) YEARS? (Such conviction may be relevant, if work related, but does not bar you from employment). <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, PLEASE EXPLAIN BELOW THE NATURE OF THE OFFENSE, DATE AND LOCATION:			
24. ARE YOU A U.S. CITIZEN? <input type="checkbox"/> YES <input type="checkbox"/> NO IF NO, ARE YOU ELIGABLE TO BE EMPLOYED UNDER A VISA OR ENTRY PERMIT? <input type="checkbox"/> YES <input type="checkbox"/> NO			

Section B – EDUCATION AND TRAINING (LIST MOST RECENT FIRST)

SCHOOL NAME	CITY/STATE	DATES ATTENDED	HIGHEST GRADE COMPLETED	DEGREE/DIPLOMA RECEIVED	TOTAL CREDITS

INDICATE ANY LANGUAGES YOU SPEAK,
READ AND WRITE FLUENTLY:

	FLUENT	GOOD	FAIR
SPEAK			
READ			
WRITE			

Section C – WORK HISTORY (LIST MOST RECENT JOB FIRST AND WORK BACKWARDS)

FROM MO/YR. TO:		JOB TITLE:	
TYPE OF BUSINESS	HRS PER WEEK	STARTING SALARY PER	FINAL SALARY PER
EMPLOYER'S NAME			
NO EMPLOYEES SUPERVISED	COMPLETE ADDRESS		
SUPERVISOR'S NAME	CITY, STATE, ZIP CODE	PHONE NUMBER	
SUPERVISOR'S TITLE	REASON FOR LEAVING		
A DESCRIPTION OF DUTIES AND RESPONSIBILITIES			

FROM MO/YR. TO:		JOB TITLE:	
TYPE OF BUSINESS	HRS PER WEEK	STARTING SALARY PER	FINAL SALARY PER
EMPLOYER'S NAME			
NO EMPLOYEES SUPERVISED	COMPLETE ADDRESS		
SUPERVISOR'S NAME	CITY, STATE, ZIP CODE	PHONE NUMBER	
SUPERVISOR'S TITLE	REASON FOR LEAVING		
A DESCRIPTION OF DUTIES AND RESPONSIBILITIES			

Use the Work History Supplemental if more space is needed.

Section D – MILITARY SERVICE INFORMATION

ARE YOU A VETERN? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, gives dates of service:		
BRANCH OF SERVICE:	DATE OF DISCHARGE:	RANK OF DISCHARGE:
TYPE OF DISCHARGE:	M.O.S.:	
MILITARY RESERVE? <input type="checkbox"/> YES <input type="checkbox"/> NO	ARE YOU CURRENTLY ACTIVE WITH THE MILITARY? <input type="checkbox"/> YES <input type="checkbox"/> NO	
SPECIAL AWARDS:		

Section E – PERSONNEL PROFILE INFORMATION

<input type="checkbox"/> SINGLE <input type="checkbox"/> DIVORCED <input type="checkbox"/> MARRIED <input type="checkbox"/> WIDOW/ER	NUMBER OF DEPENDENTS:
DOES YOUR FAMILY SUPPORT YOUR DESIRE TO BE A MEMBER OF THE WMAFRD? <input type="checkbox"/> YES <input type="checkbox"/> NO	
TELL US WHY YOU WANT TO BE A FIREFIGHTER, WHAT TALENTS AND SKILLS YOU HAVE TO OFFER THE WMAFRD. WHAT EXPECTATIONS YOU HAVE AS A POTENTIAL MEMBER. USE THE BACK FOR MORE SPACE.	

Section F – STATEMENT OF CERTIFICATION – APPLICANT SIGNATURE

If your are selected as a Volunteer, Part-Time, or Paid-On-Call for the White Mountain Apache Fire & Rescue Department, you will be asked to sign a “Letter of Intent”, which briefly states that should the White Mountain Apache Fire & Rescue invest in you by financing the required training for your position (such as structural firefighting, emergency medical technician, wildland firefighting and any continued education in the field of emergency service for firefighter status), you in turn agree to remain active with the White Mountain Apache Fire & Rescue Department for a period of two years after the training in question has been completed. Your other option should you be unable to fulfill this obligation is to repay the expenses to the White Mountain Apache Fire & Rescue. Would you agree to sign such a statement?

YES NO Signature of Applicant _____ Date _____

Section G -- STATEMENT OF CERTIFICATION - APPLICANT SIGNATURE:

By signing this application, I certify under penalty of law that the information provided anywhere in this application is true, correct, and complete to the best of my knowledge and belief. I also acknowledge that, should investigation at any time disclose any misrepresentation, my application may be rejected or my name may be removed from further consideration, and I may be disqualified from further examinations and/or terminated from employment. I also authorize the White Mountain Apache Fire & Rescue Department, to make all necessary and appropriate investigations allowable by law to verify the information provided:

Signature of Applicant _____ Date _____

WORK HISTORY (Supplemental)

FROM MO/YR.		TO:	JOB TITLE:	
TYPE OF BUSINESS	HRS PER WEEK	STARTING SALARY PER	FINAL SALARY PER	
EMPLOYER'S NAME				
NO EMPLOYEES SUPERVISED		COMPLETE ADDRESS		
SUPERVISOR'S NAME		CITY, STATE, ZIP CODE		PHONE NUMBER
SUPERVISOR'S TITLE		REASON FOR LEAVING		
A DESCRIPTION OF DUTIES AND RESPONSIBILITIES				

FROM MO/YR.		TO:	JOB TITLE:	
TYPE OF BUSINESS	HRS PER WEEK	STARTING SALARY PER	FINAL SALARY PER	
EMPLOYER'S NAME				
NO EMPLOYEES SUPERVISED		COMPLETE ADDRESS		
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A DESCRIPTION OF DUTIES AND RESPONSIBILITIES				

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TYPE OF BUSINESS	HRS PER WEEK	STARTING SALARY PER	FINAL SALARY PER	
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White Mountain Apache Fire & Rescue Department
PO Box 1929 (612 S. Chief Ave.)
Whiteriver, AZ 85941
Ph: 928-338-1701 Fax: 928-338-1710
E-mail: mtessay@wmat.us

August 1, 2008

M E M O R A N D U M

TO: New Recruits

FROM: Mark Tessay, Assistant Fire Chief
White Mountain Apache Fire & Rescue Department

SUBJECT: MEDICAL CLEARANCE FORMS

The following six (6) pages of the Annual Medical History and Clearance Form Structure/Wildland Firefighters (Arduous Duty) will be used to complete your physical exam.

Instructions for the form:

- Please print your name on all six (6) pages of this form, and provide all the information requested, including your social security number, date of birth, mailing address, gender and telephone number(s).
- Employing Agency information is the White Mountain Apache Fire & Rescue Department. Address is provided on Page 1.
- Complete the *Medical History Questionnaire*.
- Your doctor will fill out the last two pages: *Medical Screening and Clearance Form*.

If you use the Whiteriver Indian Health Service as your medical provider, you must make an appointment on any working day at 8 am by calling the Whiteriver Service Unit at 338-1863. You should make an appointment that same afternoon.

If you have any questions you can call Out Patient Supervisor Emilia Spear at 338-4911, ext 3554. If you forgot your form, the form can be downloaded from our website.

xc: File



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AUTHORIZATION FOR RELEASE OF INFORMATION

I, _____, do hereby authorize any and all persons, employers, partnerships, corporations, civilian and government entities, military agencies and law enforcement agencies to release available information relating to me for the purpose of determining my suitability to be considered as a potential employee. This includes, but is not limited to all information related to my employment, performance, disciplinary history, character, integrity, reputation, conduct, behavior and fitness for duty. This authorizes release to the White Mountain Apache Fire & Rescue Department.

This release is in addition to and not intended to curtail or diminish the authority and immunity provided by statute. I DO HEREBY RELEASE from any and all liability, all persons or entities disclosing information pursuant to this release.

If hired, this authorization shall remain on file and shall serve as an ongoing authorization for the White Mountain Apache Fire & Rescue Department to update my file at anytime during my employment period.

Print Name

Date

Signature

Date of Birth

Mailing Address

Phone Number

Witness

Date



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.

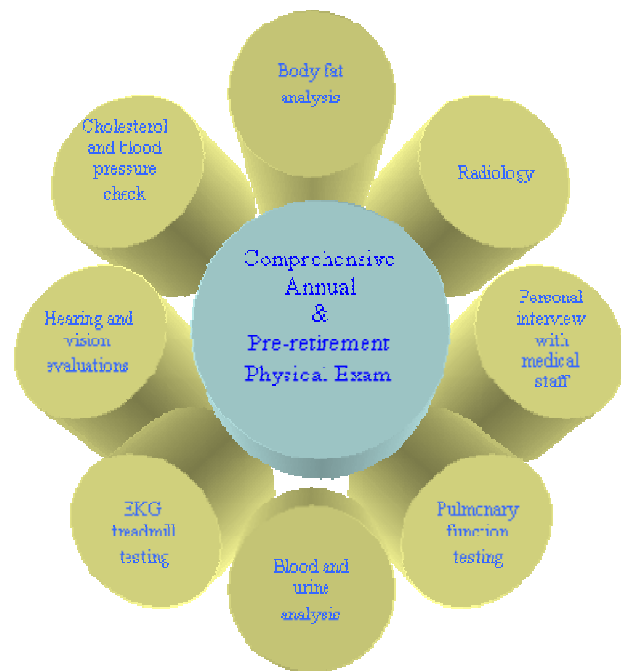
Please fill out all the paperwork as follows (before you come to the physical): All extra paperwork (questioner, check list, TB form, etc.) with name and address as needed.

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).



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)

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



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Ph: 928-338-4311 Fax: 928-338-4474

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. <input type="checkbox"/> Employment <input type="checkbox"/> Surveillance <input type="checkbox"/> Duty Return <input type="checkbox"/> DOT <input type="checkbox"/>																													
9. Blood Pressure (must take at least two readings to confirm BP in mmHg) <div style="display: flex; align-items: center;"> <div style="margin-right: 10px;">/</div> <table border="1" style="border-collapse: collapse; text-align: center;"> <thead> <tr> <th colspan="2">Firefighter qualified if $\leq 140/90$</th> </tr> <tr> <th>Reading</th> <th>Category</th> </tr> </thead> <tbody> <tr> <td>140-159/90-99</td> <td>Stage 1</td> </tr> <tr> <td>160-179/100-109</td> <td>Stage 2</td> </tr> <tr> <td>>180/110</td> <td>Stage 3</td> </tr> </tbody> </table> </div>			Firefighter qualified if $\leq 140/90$		Reading	Category	140-159/90-99	Stage 1	160-179/100-109	Stage 2	>180/110	Stage 3	9a. Pulse <input type="checkbox"/> Regular <input type="checkbox"/> Irregular																
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Reading	Category																												
140-159/90-99	Stage 1																												
160-179/100-109	Stage 2																												
>180/110	Stage 3																												
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																								
			10e.	10f.	10g.	10d. Glucose																							
11. Blood analysis is Required.			11a. CBC	11b. A/G Ratio	11c. BUN/Creatinine																								
			11e. HDL	11f. LDL	11g. Total Cholest.	11d. Electrolytes																							
11i. Coronary Risk Factors			11j. Remarks																										
<table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th></th> <th style="text-align: center;">Yes</th> <th style="text-align: center;">No</th> </tr> </thead> <tbody> <tr> <td>Blood Pressure $\geq 140/90$</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>DM or Fasting Glucose ≥ 126mg/dl</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Total Cholesterol >200 mg/dl or HDL <40 mg/dl</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Family History of CVD in males <55</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Age (men >45, women >55)</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>No regular exercise program</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Current tobacco user</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> </tbody> </table>							Yes	No	Blood Pressure $\geq 140/90$	<input type="checkbox"/>	<input type="checkbox"/>	DM or Fasting Glucose ≥ 126 mg/dl	<input type="checkbox"/>	<input type="checkbox"/>	Total Cholesterol >200 mg/dl or HDL <40 mg/dl	<input type="checkbox"/>	<input type="checkbox"/>	Family History of CVD in males <55	<input type="checkbox"/>	<input type="checkbox"/>	Age (men >45 , women >55)	<input type="checkbox"/>	<input type="checkbox"/>	No regular exercise program	<input type="checkbox"/>	<input type="checkbox"/>	Current tobacco user	<input type="checkbox"/>	<input type="checkbox"/>
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Current tobacco user	<input type="checkbox"/>	<input type="checkbox"/>																											
11k. Physical Activity or Exercise Program																													
Type of Activity or Exercise: _____																													
Intensity: Low _____ Moderate _____ High _____																													
Example: Walking Jogging, Cycling Sustained heavy breathing																													
Duration in Minutes per Session _____ 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 <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor	Machine Make/Model	Calibration Date
---	--------------------	------------------

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.

<input type="checkbox"/> Hearing Loss	<input type="checkbox"/> High Pitch	<input type="checkbox"/> Hay Fever/Congestion Now	<input type="checkbox"/> Sinus Infection
<input type="checkbox"/> Ear Infection	<input type="checkbox"/> Ear wax build-up	<input type="checkbox"/> Dizziness/Vertigo	<input type="checkbox"/>

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; 3 rd 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, discectomy 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, lumbosacral vertebral fractures*; 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	<input type="checkbox"/> Yes	<input type="checkbox"/> No
29b	Chemical, Drugs & Medications	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Use Code : V – 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.			

<p>31. Recommendations</p> <p><input type="checkbox"/></p> <p><input type="checkbox"/></p> <p><input type="checkbox"/></p> <p><input type="checkbox"/></p>		<p>32. R.N. signature</p> <hr/> <p>33. Physician's signature</p> <hr/> <p>34. Patient's signature</p> <hr/>	
<p>35. Work Qualifications</p>	<p>36. Contact Person</p>	<p>37. Date</p>	<p>38. Initial</p>

PRIVACY ACT INFORMATION

The information contained in this form will be used to determine whether 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 USC 3301 (Examination, Certification and Appointment), and Executive Orders 12107 (Merit systems Protection Board) and 12564 (Drug Free Federal Workplace).



White Mountain Apache Fire & Rescue Department
 P.O. Box 1929,
 610 S. Chief Ave., Whiteriver, AZ 84941
 Ph: 928-338-4311 Fax: 928-338-4474

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.

<input type="checkbox"/> TIER 1: Fit for Duty	<input type="checkbox"/> TIER 2 – Fit for Duty: Some decline in health parameters.
<input type="checkbox"/> TIER 3 – Clear for Duty: mandatory wellness/fitness referral.	
METS Output: _____ Tiered Reason: _____	Mandatory Re-Check Date: _____ <input type="checkbox"/> Repeat Treadmill <input type="checkbox"/> Body Fat <input type="checkbox"/> Weight <input type="checkbox"/> Blood Pressure <input type="checkbox"/> Consult Only <input type="checkbox"/> Labs: _____
<u>Recommendations</u> <input type="checkbox"/> PFT support <input type="checkbox"/> Dietician support <input type="checkbox"/> PCP support <input type="checkbox"/> Other: _____	
<input type="checkbox"/> TIER 4 – Unfit for Duty: Requires immediate health response.	
METS Output: _____ Tiered Reason: _____	<input type="checkbox"/> Repeat Treadmill <input type="checkbox"/> Body Fat <input type="checkbox"/> Weight <input type="checkbox"/> Blood Pressure <input type="checkbox"/> Consult Only <input type="checkbox"/> Labs: _____
<u>Recommendations</u> <input type="checkbox"/> Removal from field operational assignment until sufficient progress is demonstrated. <input type="checkbox"/> Delayed removal from field operational assignment, provided mandatory regularly schedule requirements are met and sufficient progress is demonstrated. <input type="checkbox"/> Health Center Re-Checks <input type="checkbox"/> PFT support <input type="checkbox"/> Dietician support <input type="checkbox"/> Immediate referral to PCP and requires medical clearance return to duty. <input type="checkbox"/> 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 regimen.*

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		
_____	_____		
_____	_____		
_____	_____		
_____	_____		
Have you had any surgeries/operations:			
On your back, arm, leg or knee?	<input type="checkbox"/>	<input type="checkbox"/>	_____
To treat a hernia?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Varicose Veins	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other Operations?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Have you ever been hospitalized?	<input type="checkbox"/>	<input type="checkbox"/>	_____
	<input type="checkbox"/>	<input type="checkbox"/>	_____
Allergy – Have you ever had or do you currently have:			
Serious allergies?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Bad reaction to any medication?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Advised not to take any medication?	<input type="checkbox"/>	<input type="checkbox"/>	_____
	<input type="checkbox"/>	<input type="checkbox"/>	_____
Skin – Have you ever had or do you currently have:			
Hives/eczema or rash?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Chronic skin problems (cuts slow to heal)?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Excessive skin dryness?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Problems with "easy bruising"?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Chemical or jewelry rash/sensitivity?	<input type="checkbox"/>	<input type="checkbox"/>	_____
	<input type="checkbox"/>	<input type="checkbox"/>	_____
Neuro – Have you ever had or do you currently have:			
A psychiatric or emotional problem?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Numbness/weakness/paralysis?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Dizziness or fainting spells?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Severe/frequent or migraine headaches?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Head injury, concussions or skull fractures?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Neruological disorders?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Seizures or blackouts?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Stroke?	<input type="checkbox"/>	<input type="checkbox"/>	_____
	<input type="checkbox"/>	<input type="checkbox"/>	_____
Eyes/Ears – Have you ever had or do you currently have:			
Hearing loss?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Ringing in ears?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other ear problems?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Glaucoma or cataracts?	<input type="checkbox"/>	<input type="checkbox"/>	_____

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

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

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

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

HEALTH HISTORY	Yes	No	If "Yes", give details.
Chromates?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Chromic acid mist?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cutting oils?	<input type="checkbox"/>	<input type="checkbox"/>	_____
DDT?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Dieldrin?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Dioxin?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Dust, coal?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Dust, sandblasting?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Dust, other?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Ethyl dibromide?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Ethylene oxide?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Extreme heat or cold?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heptachlor?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hexachlorobenzene?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Isocyanates?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Loud or continuous noise?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Mercury?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Methylene chloride?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Microwaves, lasers?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Nickel?	<input type="checkbox"/>	<input type="checkbox"/>	_____
PCB's?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Pesticides, herbicides?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Phenois?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Phosgene?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Plastics?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Radioactive materials?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Roofing materials?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Rubber?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Silica?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Solvents/degreasers?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Soots and tars?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Spray painting?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Tri/Per chloroethylene?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Vinyl chloride?	<input type="checkbox"/>	<input type="checkbox"/>	_____
	<input type="checkbox"/>	<input type="checkbox"/>	_____
List any toxins/chemicals/biological hazards you might currently be expose to: _____			

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

<u>Date (Year to Year)</u>	<u>Company</u>	<u>Position</u>	<u>Any Work Hazards</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

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: _____

WHITE MOUNTAIN APACHE FIRE & RESCUE DEPARTMENT
ANNUAL MEDICAL HISTORY and CLEARANCE FORM
Structure/Wildland Firefighters
(Arduous Duty)

CAUTION

THIS DOCUMENT CONTAINS CONFIDENTIAL MEDICAL
INFORMATION AND IS SUBJECT TO THE PROVISIONS OF
THE PRIVACY ACT (5 USC 552A)

This medical history form is to be completed every year unless the firefighter receives a baseline or periodic examination. This form must be completed prior to participating in the arduous duty work capacity test ("Pack Test").

Firefighter: Complete ALL of pages 3 and 4 of this form, attend the medical screening appointment, and return the "Clearance Sheet" (page 6) to your fire department. If the fire department does not receive the "Arduous Duty Firefighter Clearance Form" you will not be allowed to take the Pack Test. All "Yes" answers in the medical history sections must explained and be may require further information from your personal physician(s).

Local Health Care Professional: Review the requirements for an arduous duty firefighter (page 2), review the firefighter's self-disclosure responses (page 3 and 4), and complete the "Medical Screening" (page 5) and the "Arduous Duty Firefighter Clearance Form" (page 6). Provide the completed "Arduous Duty Firefighter Clearance Form" to the firefighter (page 6), unless directed otherwise. All significant, abnormal findings are to be discussed with the firefighter.

White Mountain Apache Fire & Rescue
612 S. Chief Avenue
PO Box 1929
Whiteriver, AZ 85941
Tel: (928) 338-1701

PRIVACY ACT INFORMATION

The information contained in this form will be used to determine whether an individual considered for arduous level firefighting can safely and efficiently perform those duties in a manner that will not unduly risk aggravation, acceleration, exaggeration, or permanently worsening a pre-existing medical condition. Its collection and use are consistent with the provisions of the 5 CFR 339 (Medical Qualification Determinations), 5 USC 552a (Privacy Act of 1974), 5 USC 3301 (Examination, Certification, and Appointment), and Executive Orders 12107 (Merit Systems Protection Board) and 12564 (Drug Free Federal Workplace). The information will be placed in your official Employee Medical File, and is to be used only for official purposes as explained and published annually in the Federal Register under OPM/GOVT-10, the OPM system of records notice.

**ESSENTIAL FUNCTIONS AND WORK CONDITIONS OF AN ARDOUS DUTY
WILDLAND FIREFIGHTER**

Time/Work Volume	Physical Requirements	Environment	Physical Exposures
<i>May include:</i>			
<ul style="list-style-type: none"> • 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 (VO₂ max) of 45 mL/kg-minute <p><i>And up to:</i></p> <ul style="list-style-type: none"> • 14-day assignments 	<ul style="list-style-type: none"> • 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 	<ul style="list-style-type: none"> • 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 	<ul style="list-style-type: none"> • 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 <input type="checkbox"/> Female <input type="checkbox"/>
Home Address: (Street or PO Box)	Date of Last Physical Exam:
(City, State, Zip)	
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:
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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:

<input type="checkbox"/> Current Smoker	<input type="checkbox"/> Former Smoker	<input type="checkbox"/> Never Smoked
Number of cigarettes per day _____	Number of cigarettes per day _____	
Number of cigars per day _____	Number of cigars per day _____	
Number of pipe bowls per day _____	Number of pipe bowls per day _____	
Total years you have smoked _____	Total years you smoked _____	

Describe Your Physical Activity or Exercise Program

Type of Activity or Exercise _____

Intensity:	Low _____	Moderate _____	High _____	Duration, in Minutes per Session _____
(Examples:	Walking	Jogging, cycling	Sustained heavy breathing and perspiration)	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:

<p style="text-align: center;">MEDICAL HISTORY (continued)</p> <p>Do you have, or have you ever had:</p>	Yes	No	<p>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.</p>
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 <input type="checkbox"/> Left Whisper <input type="checkbox"/> Right Spoken <input type="checkbox"/> Left Spoken <input type="checkbox"/>	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 <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	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