The forms will not be accepted if these fields are blank.

PIPELINE # PARTICIPANT NAME:

**MEDICAL HISTORY**

*The PARTICIPANT COMPLETES this Medical History form prior to any exam.*

|  |  |  |  |  |  |  |  |  |  |  |  |
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| **Polar Medical Staff Use Only** *Date: Summer PQ Winter PQ NPQ Medical Condition(s):*  Reviewed by:  Date: *Restrictions and Follow-up:*  *Reason for NPQ:* | | | | | | | | | | | |
|  | | | | | | | | | | | |
| **CONTACT INFORMATION (INCLUDE AREA CODES):** | | | | | | | | | | | |
| **Name last, first, middle (must match official ID):** | | | | **Age:** | | | | **Birthdate: (MM/DD/YYYY)** | | | **Sex:**  F M |
| **Nickname:** | | | **Maiden Name:** | | | | | | **Previous Name or Other Legal Name:** | | |
| **Street Address:** | | | | | | | | | **E-Mail:** | | |
| **City:** | | **State:** | | | | **Zip:** | | | | **Country:** | |
| **Day Telephone:** | | **Evening Telephone:** | | | | **Mobile:** | | | | **Fax:** | |
|  | **EMERGENCY POINT OF CONTACT:** | | | | | | | | | | |
| **Name:** | | | | | **Address:** | | | | | | |
| **Phone Number:** | | | | |
|  | **DEPLOYMENT INFORMATION** | | | | | | | | | | |
| **Job Title:** | | **Estimated Deployment Dates:**  **(MM/YYYY)**  From: To: | | | | | **Prior Polar Deployment (Arctic or Antarctic)?**  **(MM/YYYY)**  Location: From: To: | | | | |
| **Affiliation:**  NSF Science Event Technical Event  Company Name Other | | | | | | | | | | | |
| **Proposed Antarctic Season Worksite Dates** Field Camp : Summer (Sep-Feb) McMurdo Station  Winter (Mar-Oct) South Pole Station  Other (specify): WinFly Palmer Station  Vessel  (dates) | | | | | | | | | | | |
| **Proposed Arctic Season Worksite Dates** Field Camp: Summer (Mar-Sep) Summit  Winter (Oct-Feb) Raven | | | | | | | | | | | |

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| **MEDICAL HISTORY** | | | | | | | | | | | | | | | | | | |
| **CURRENT MEDICATIONS - (Check box if None)** | | | | | | | | | | | | | | | | | | |
| **Name** | **Dose** | **Frequency** | | | | | | | | | | | | **Name** | **Dose** | **Frequency** | | |
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| **ALLERGIES - (Check box if None)** | | | | | | | | | | | | | | | | | | |
| **Name** | **Type of Reaction** | | | | | | | | | | | | | **Name** | **Type of Reaction** | | | |
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| **PAST HOSPITALIZATIONS - (Check box if None)** | | | | | | | | | | | |  |  | | | | | |
| **Condition** | | | | | **Date (YYYY)** | | | | | | | | | **Condition** | | | | **Date (YYYY)** |
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| **PAST SURGERIES - (Check box if None)** | | | | | | | | | | | | | | | | | | |
| **Condition** | | | | | **Date (YYYY)** | | | | | | | | | **Condition** | | | | **Date (YYYY)** |
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| **MEDICAL TESTING / PROCEDURES IN PREVIOUS 3 YEARS - (Check box if None)** | | | | | | | | | | | | | | | | | | |
| **Type (specify body location)** | | | **Date (YYYY) Describe reason for test procedure and result:** | | | | | | | | | | | | | | | |
| MRI | | |  | | | | | | | |  | | | | | | | |
| CT | | |  | | | | | | | |
| Ultrasound | | |  | | | | | | | |
| Angiogram | | |  | | | | | | | |
| Biopsy | | |  | | | | | | | |
| Other: | | |  | | | | | | | |
| **VACCINATION HISTORY - (Check box if None)** | | | | | | | | | | | | | | | | | | |
| **Most recent vaccination Date (YYYY)** | | | | | | | | | | | | | | **Most recent vaccination Date (YYYY)** | | | | |
| Influenza | | | |  | | | | | | | | | | Hepatitis A | | |  | |
| DT | | | |  | | | | | | | | | | Hepatitis B | | |  | |
| DPT | | | |  | | | | | | | | | | Other (specify): | | |  | |
| Pneumococcus | | | |  | | | | | | | | | |  | |
| Tetanus | | | |  | | | | | | | | | |  | |
| **LIFESTYLE** | | | | | | | | | | | | | | | | | | |
| **Tobacco** | | | | | | **Yes** | | | **No** | | | | **Describe: Packs/week Total yrs. Year last** | | | | | |
| Do you currently use tobacco products? | | | | | |  |  |  |  |  | |  |
| Have you used tobacco products in the past? | | | | | |  | | |  | | | |

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Alcohol** | | **Yes** | | **No** | If abstinent, please enter date of your last alcoholic beverage:  **(MM/DD/YYYY)** | | | | |
| Do you drink alcohol? | |  | |  | **(MM/DD/YYYY)** | | | | |
| Have you ever felt you should decrease your alcohol consumption? | |  | |  | **Describe frequency and type of alcohol: Describe “yes” answers to alcohol questions:** | | | | |
| Have you ever received a DUI, DWAI or court ordered treatment for alcohol? | |  | |  | **Describe “yes” answers to alcohol questions:** | | | | | |
| Have you been diagnosed as an alcoholic? | |  | |  |  | | | | | |
| **Exercise and conditioning** | | **Yes** | | **No** | **Describe frequency and type of exercise :**  **Date of last treadmill: (MM/YYYY)** | | | | | |
| Do you have a regular exercise program? | |  | |  |
| Have you had a cardiovascular stress test? | |  | |  |
| **GENERAL MEDICAL HISTORY** | | | | | | | | | | |
| New Government regulations require that you be informed of the following:  “The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. ‘Genetic information’ as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.”  Therefore, you should not forward any information related to your family’s medical history and only submit answers to these questions regarding your own personal/individual history. | | | | | | | | | | |
| **ANSWER THE FOLLOWING QUESTIONS REGARDING YOUR PRESENT OR PAST MEDICAL HISTORY** | | | | | | | | | | |
| *Condition* | | | *Yes* | | *No* | *Condition* | | *Yes* | *No* | |
| **1** | **Neurology** | |  | |  | 2D | Congestive heart failure |  |  | |
| 1A | Cerebrovascular accident (CVA) | |  | |  | 2E | Coronary angioplasty/stent/bypass |  |  | |
| 1B | Concussion | |  | |  | 2F | Coronary artery disease |  |  | |
| 1C | Dizziness/Loss of Consciousness | |  | |  | 2G | Heart murmur/valvular heart disease |  |  | |
| 1D | Headaches (Migraine) | |  | |  | 2H | Hypertension (high blood pressure) |  |  | |
| 1E | Headaches (Other) | |  | |  | 2I | Myocardial Infarction (MI) |  |  | |
| 1F | Multiple sclerosis | |  | |  | 2J | Supraventricular tachycardia (SVT) |  |  | |
| 1G | Peripheral neuropathy | |  | |  | 2K | Other cardiac condition |  |  | |
| 1H | Seizures | |  | |  | **3** | **Vascular disease** |  |  | |
| 1I | Transient Ischemic Attack (TIA) | |  | |  | 3A | Abdominal aneurysm |  |  | |
| 1J | Traumatic brain injury (TBI) | |  | |  | 3B | Arterial emboli |  |  | |
| 1K | Other neurological disorder | |  | |  | 3C | Cerebral aneurysm |  |  | |
| **2** | **Cardiology** | |  | |  | 3D | Deep venous thrombosis (DVT) |  |  | |
| 2A | Angina/chest pain | |  | |  | 3E | Venous stasis ulcers |  |  | |
| 2B | Atrial fibrillation | |  | |  | 3F | Other vascular condition |  |  | |
| 2C | Cardiac pacemaker/defibrillator | |  | |  |  |  |  |  | |
| *For all “yes” answers provide details to include age of onset, frequency of event, date of last episode, current medications, other therapies and current status of the condition.* | | | | | | | | | | |

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| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **GENERAL MEDICAL HISTORY** | | | | | | | | |
| **ANSWER THE FOLLOWING QUESTIONS REGARDING YOUR PRESENT OR PAST MEDICAL HISTORY** | | | | | | | | |
| *Condition* | | *Yes* | *No* | *Condition* | | | *Yes* | *No* |
| **4** | **Rheumatologic & Autoimmune disease** |  |  | 8H | | Hepatitis (describe below) |  |  |
| 4A | Fibromyalgia |  |  | 8I | | Hernia |  |  |
| 4B | Osteoarthritis |  |  | 8J | | Irritable bowel syndrome (IBS) |  |  |
| 4C | Rheumatoid arthritis |  |  | 8K | | Pancreatitis |  |  |
| 4D | Systemic Lupus erythematosus |  |  | 8L | | Peptic ulcer disease |  |  |
| 4E | Other Rheumatologic/Autoimmune  condition |  |  | 8M | | Ulcerative colitis |  |  |
| **5** | **Ears, Nose and Throat** |  |  | 8N | | Other gastrointestinal disease |  |  |
| 5A | Hearing impairment |  |  | **9** | | **Dermatology** |  |  |
| 5B | Nosebleeds |  |  | 9A | | Dermatitis |  |  |
| 5C | Seasonal allergies |  |  | 9B | | Melanoma |  |  |
| **6** | **Opthamology** |  |  | 9C | | Psoriasis/Eczema |  |  |
| 6A | Glaucoma |  |  | 9D | | Skin Cancer |  |  |
| 6B | Visual impairment |  |  | 9E | | Other skin condition |  |  |
| 6C | Other eye condition |  |  | **10** | | **Orthopedic** |  |  |
| **7** | **Pulmonary** |  |  | 10A | | Cervical spine injury |  |  |
| 7A | Altitude sickness |  |  | 10B | | Chronic pain |  |  |
| 7B | Asthma |  |  | 10C | | Dislocation |  |  |
| 7C | Chronic bronchitis/bronchiectasis |  |  | 10D | | Fractures |  |  |
| 7D | Chronic obstructive pulmonary disease |  |  | 10E | | Low back injury |  |  |
| 7E | Dyspnea (shortness of breath) |  |  | 10F | | Orthopedic pins/plates |  |  |
| 7F | Obstructive sleep apnea |  |  | 10G | | Other orthopedic condition |  |  |
| 7G | Pulmonary embolism |  |  | **11** | | **Metabolic** |  |  |
| 7H | BCG Vaccine or Positive TB Test |  |  | 11A | | Adrenal insufficiency |  |  |
| 7I | Chronic cough (>3 weeks) |  |  | 11B | | Diabetes Type I |  |  |
| 7J | Night sweats |  |  | 11C | | Diabetes Type II |  |  |
| 7K | Unexplained weight loss |  |  | 11D | | Gout |  |  |
| 7L | Exposed to anyone with known TB |  |  | 11E | | Hypercholesterolemia |  |  |
| 7M | Other pulmonary condition |  |  | 11F | | Hyperthyroidism |  |  |
| **8** | **Gastro intestinal disease** |  |  | 11G | | Hypothyroidism |  |  |
| 8A | Black tarry stools |  |  | 11H | | Pituitary insufficiency |  |  |
| 8B | Blood in stool |  |  | 11I | | Other hormonal disorder |  |  |
| 8C | Cholelithiasis (gall stones) |  |  | **12** | | **Gynecology-female** |  |  |
| 8D | Crohn’s disease |  |  | 12A | | Menstrual period over 30 days ago? |  |  |
| 8E | Frequent or persistent diarrhea |  |  | 12B | | Date of last PAP smear |  |  |
| 8F | Gastroesophageal reflux (GERD) |  |  | 12C | | Premenstrual syndrome (PMS) |  |  |
| 8G | Hemorrhoids |  |  | 12D | | Endometriosis |  |  |
| *For all “yes” answers provide details to include age of onset, frequency of event, date of last episode, current medications, other therapies and current status of the condition.*  *Page 4 of 19* | | | | | | | | |
| **GENERAL MEDICAL HISTORY** | | | | | | | | |
| **ANSWER THE FOLLOWING QUESTIONS REGARDING YOUR PRESENT OR PAST MEDICAL HISTORY** | | | | | | | | |
| *Condition* | | *Yes* | *No* | *Condition* | | | *Yes* | *No* |
| 12E | Severe menstrual cramps |  |  | 14E | Other kidney condition | |  |  |
| 12F | Ovarian cysts |  |  | **15** | **Hematology/Oncology** | |  |  |
| 12G | Sexually transmitted disease |  |  | 15A | Anemia | |  |  |
| 12H | Other gynecological conditions |  |  | 15B | Cancer (describe type) | |  |  |
| **13** | **Psychiatric** |  |  | 15C | Leukemia | |  |  |
| 13A | Addiction |  |  | 15D | Lymphoma – Hodgkins | |  |  |
| 13B | Anxiety/panic attacks |  |  | 15E | Lymphoma – non-Hodgkins | |  |  |
| 13C | Attention deficit disorder |  |  | 15F | Platelet disorder | |  |  |
| 13D | Bipolar |  |  | 15G | Other hematologic/oncologic | |  |  |
| 13E | Depression |  |  | **16** | **Genitourinary - male** | |  |  |
| 13F | Eating disorder (bulimia/anorexia) |  |  | 16A | Prostate disease | |  |  |
| 13G | Hospitalization for psych condition |  |  | 16B | Sexually transmitted disease | |  |  |
| 13H | Post-traumatic stress disorder |  |  | 16C | Testicular abnormality | |  |  |
| 13I | Schizophrenia |  |  | 16D | Other genitourinary condition | |  |  |
| 13J | Suicidal thoughts or attempts |  |  | **17** | **Diving** | |  |  |
| 13K | Other psychiatric condition |  |  | 17A | Are you a diver? | |  |  |
| **14** | **Renal disease** |  |  | 17B | Have you ever had the bends? If so, describe. | |  |  |
| 14A | Chronic renal disease |  |  | **18** | **Any other medical condition NOT listed above** | |  |  |
| 14B | Frequent urinary tract infection |  |  |  |  | |  |  |
| 14C | Hematuria (blood in urine) |  |  |  |  | |  |  |
| 14D | Kidney stones |  |  |  |  | |  |  |
| *For all “yes” answers provide details to include age of onset, frequency of event, date of last episode, current medications, other therapies and current status of the condition.* | | | | | | | | |

*Page 5 of 19*

**Dear Lab Collection (LabCorp or Physician),**

This Participant is being considered for participation in the NSF/GEO/PLR Arctic or Antarctic Program. Collect specimens for the following laboratory analyses:

**Standard Polar Panel (Blood work)**

Complete Blood Count with Differential

Blood Chemistries (Sodium, Potassium, Chloride, Glucose, Creatinine, GFR/BUN, Calcium) Hepatic Panel (Alkaline Phosphatase, Total Bilirubin, AST, ALT)

Uric Acid

Lipid Panel (Cholesterol, HDL, LDL, Triglycerides) Iron, Total

Total Iron Binding Capacity

Iron % Saturation

Hepatitis B core Antibody total

Hepatitis C Antibody

RPR (Syphilis)

Blood Type (ABO and Rh)

**Standard Polar Panel (Urine)**

Urinalysis with microscopy (and culture, if positive)

**Additional Labs**

PSA (men age 50 and over)

TSH (history of a thyroid disorder or wintering over)

HIV (recommended for all summer participants, required for all winter over and for participation in the walking blood bank.)

HgA1c (diabetics and recommended for those with a history of borderline glucose levels)

**Additional Information:**

If LabCorp is used to collect the lab work, UTMB will be able to access these results directly from LabCorp

If the physician collects the lab work, they need to return the results to the Participant so they can include them with this PQ packet.

For additional questions, please contact UTMB at [polmedpq@utmb.edu](mailto:polmedpq@utmb.edu) or 1-855-300-9704 (toll free). Thank you,

University of Texas Medical Branch – Center for Polar Medical Operations

*(medical processor for NSF/GEO/Polar sponsored contractors)*

*Page 6 of 19*

**Dear Doctor:**

This person is being considered for participation in the NSF Arctic or Antarctic Program. Polar medical facilities have limited diagnostic and therapeutic capabilities. In the event of a severe injury or medical emergency, transportation to a modern hospital or clinic may take several days or longer. Environmental conditions in the Polar Regions may be harsh. Temperatures range from 30 degrees above to 100 degrees below zero Fahrenheit. Physiologic altitude varies from 0 to over 10,000 feet above mean sea level. Participants may live in close quarters for extended periods of time in constant daylight or darkness. Your clinical assessment will be used to determine the person's physical qualifications for deployment to the Polar Regions.

Conduct the following tests and provide the results to the participant:

**Standard Panel**

Tuberculin Skin Test (PPD) Influenza vaccine

**Additional**

Tetanus Toxoid (good for 10 years)

Medical Self History (pages 1-5 of this form)

Polar Physical Examination (pages 8-9 of this form)

EKG (new participants; every five years if aged 40-49, and yearly if 50+) Exercise Stress Test with MD Interpretation

(must complete 9 minutes, stage 3, 85% max heart rate)

Pulmonary Function Test, Pre/Post Bronchodilator (with history of asthma or emphysema, or if job requires respiratory wear)

Guaiac Stool Test (age 50+)

Pap Smear Cytology Report with Endocervical Cell Reporting

(yearly for all women < 65)

Mammogram Radiology Report (Baseline for women at age 35, then every two years aged 40-49, then yearly if 50+)

Chest X-ray (every five years if Participant has a smoking history > 15 years; or if wintering over; or if there is a history of a positive PPD; or current symptoms of pulmonary disease)

Gallbladder Ultrasound (South Pole and McMurdo winter over Participants)

Psychological testing (South Pole and McMurdo winter over Participants)

Year: Year:

Year:

Year: Year:

Prescription medications (type and quantity) are limited at all Polar medical facilities. Participants are required to bring a sufficient supply of medications for the duration of their deployment or make the necessary arrangements for shipment of medication in accordance with provided guidelines found within the Polar Physical Qualification Important Information attachment.

After the examination, return the Medical History, Polar Physical Examination Form and ALL results to the Participant so they can include it with this packet. It’s the responsibility of the Participant to return all results to UTMB.

For additional questions, please contact UTMB at [polmedpq@utmb.edu](mailto:polmedpq@utmb.edu) or 1-855-300-9704 (toll free). Thank you,

University of Texas Medical Branch – Center for Polar Medical Operations

*(medical processor for NSF/GEO/Polar sponsored contractors)*

*Page 7 of 19*

**POLAR PHYSICAL EXAMINATION**

**MUST BE COMPLETED BY M.D., D.O., P.A., OR N.P.**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Name: | | | Date of Birth: | | | Blood Type: | |
| New Government regulations require that you be informed of the following:  “The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information.  ‘Genetic information’ as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.”  Therefore, you should not forward any information related to the patient’s family’s medical history and only submit answers to those questions regarding this patient’s personal/individual history. | | | | | | | |
| **VITAL SIGNS** | | | **VISION** | | | | |
| Height: Weight:  BP: / Pulse: BMI: | | | Without Correction  DIST NEAR  R  L | | | With Correction  DIST NEAR  R  L | |
| **Finding** | **Normal** | **Abnormal** | | **Finding** | **Normal** | | **Abnormal** |
| General appearance |  |  | | Inguinal, include hernia |  | |  |
| Head and neck |  |  | | Genitalia |  | |  |
| Eyes |  |  | | Rectal |  | |  |
| Ears |  |  | | Spine |  | |  |
| Nose |  |  | | Upper extremities |  | |  |
| Mouth |  |  | | Lower extremities |  | |  |
| Thyroid |  |  | | Skin (include body) |  | |  |
| Lymph nodes |  |  | | Vascular |  | |  |
| Chest and lungs |  |  | | Neurologic |  | |  |
| Breasts |  |  | | Emotional Status |  | |  |
| Heart |  |  | | Pelvic exam |  | |  |
| Abdomen |  |  | | Prostate exam (age > 40) |  | |  |
| **Guaiac Test** (annually, age > 50):  Result/Date | | | | **Influenza Vaccination** (annually):  **(Mandatory for Antarctic deployment)**  (Recommended for Arctic deployment) Date | | | |
| **TB Skin test** (annually):  Result/Date | | | | **Tetanus Vaccination** (every 10 years):  Date | | | |

*Page 8 of 19*

**Examiner** – Comment on all abnormal findings

**Examiner –** Comment on overall fitness and health conditions that might interfere with the Participant’s ability to participate in a remote polar deployment.

Examiner’s Name: Signature: Date: Examiner Street Address: City: State: Zip Code:

Office Phone: Office Fax:

**Return the completed examination form and results of the requested tests to the Participant.**

*Page 9 of 19* 1414114

**Dear Dentist:**

This Participant is being considered for participation in the NSF/GEO/Polar Programs). The Polar Regions are

isolated and lack dental facilities so the state of the candidate’s dental health is important. Participants must be free of dental disease and we recommend that all treatment be completed three weeks before deployment. There must be no caries, active periodontal disease, potential endodontic disease, prosthetic deficiencies, potentially symptomatic wisdom teeth, or any uncompleted treatment. Additional treatment or procedures may be required before this person can deploy to the Polar Regions. All dental work must be completed, documented and all results are to be given to the Participant so they can return the results to UTMB.

**Following the dental exam, the candidate should provide documentation of:**

|  |  |
| --- | --- |
| **I. DENTAL EXAM** | Chart all existing restorations, missing teeth, and endodontically treated teeth only on the **Dental Examination Form**. The treating dentist must sign the Dental Examination Form and document all completed work. |
| **II. THIRD MOLARS** | Treatment must be completed three weeks prior to deployment in order for the dental condition to stabilize before deployment. Third molars must be extracted **only** if they are symptomatic **or** any of the following are present:  1. Periodontal probe can contact the crown of an interrupted third molar  2. Bleeding or poor hygiene is evident in the third molar area  3. Pseudo pockets, bony pockets are present  4. Soft tissue extends onto the occlusal surface of the third molar |
| **III. RADIOGRAPHS** | **ORIGINAL MOUNTED RADIOGRAPHS** must be included with the Dental Examination Form. **Copies or poor quality radiographs will not be accepted**. Digital radiographs can be sent in high-resolution  JPEG format or **printed in high resolution on glossy photographic paper**. Radiographs become a part of the participant’s USAP record and **WILL NOT BE RETURNED** to you or the participant, so you may wish to use a double film pack to retain original radiographs for yourself. Necessary radiographs include:  **1.** Set of four **ORIGINAL** bitewing x-rays **mounted** – showing crestal bone and all posterior teeth and **contacts clearly**. These films must be taken within six months of the winter over deployment date and 12 months of the Summer deployment date and must accompany the completed examination form.  2. Panoramic and/or mounted full mouth survey – Must have been taken within five years of deployment date and updated every five years.  3. A periapical (PA) film of all endodontic work, crowns, and extensive restorations |
| **IV. ORTHODONTICS** | Candidates with fixed orthodontic appliances or undergoing any active treatment may be considered for short deployments, but only with written approval from the attending provider and approval from the ASC Dental Reviewer.  1. Unrestricted Clearance – Fixed or removable orthodontic retainer only, with no active appliance.  2. Restricted Clearance for deployments up to six months – Candidates undergoing orthodontic treatment who do not require treatment for the period of deployment and who have not had active treatment for two months prior to deployment.  In view of the fact that there will be no orthodontic care, and in most cases, no dental care available consideration should be given to placing the candidate in passive appliances or passive retention for the period of deployment. |

After the examination, return the Medical History, Polar Dental Examination Form, X-rays and ALL results to the Participant so they can include it with this packet. It’s the responsibility of the Participant to return all results to UTMB.

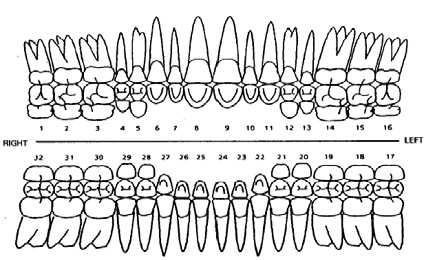
For additional questions, contact UTMB at [polmedpq@utmb.edu](mailto:polmedpq@utmb.edu) or 1-855-300-9704 (toll free).

Thank you,

University of Texas Medical Branch – Center for Polar Medical Operations

*(medical processor for NSF/GEO/Polar sponsored contractors)*

*Page 10 of 19*

**POLAR DENTAL EXAMINATION**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Name: | | Date of Birth: | | Age: |
| Day Telephone #: | | Email Address: | | |
| Last Deployment Dates:  From: To: | | Estimated Deployment Dates:  From: To: | | |
| **Chart existing restorations, missing teeth and endodontically treated teeth only:** | | **PERIODONTAL EVALUATION**  Probings > 5 mm YES NO Active Disease Noted YES NO | | |
| **THIRD MOLAR EVALUATION**  3rd Molars Present YES NO Potentially Symptomatic YES NO | | |
| **Documentation of all treatment identified and rendered and original radiographs must accompany this form.** | | | | |
| **DATES** | **DIAGNOSES and TREATMENTS** | | | |
|  |  | | | |
| Attach the following ORIGINALS to this exam: PANO OR FULL MOUTH SERIES **Required first deployment only.**  Date of last Pano or Full Mouth Series: | | | BITEWING X-RAYS, SET OF FOUR MOUNTED SHOWING ALL POSTERIOR TEETH  **Required annually within 12 months of Summer deployment and within 6 months of Winter Over.** | |
| I have thoroughly examined this candidate for travel to the Polar Regions. All necessary treatment has been performed; all evaluations completed; and the appropriate diagnostic radiographs will accompany this completed form as requested by the “Dear Dentist” letter. | | | | |
| **DENTIST’S NAME** (PLEASE PRINT)  **TELEPHONE NUMBER** (include area code):  **ATTENTION EXAMINING DENTIST**:  Return this completed form, all documentation of treatment and all  **ORIGINAL X-rays** (digital preferred) to the Participant. | | | **DENTIST’S SIGNATURE DATE**  **STREET ADDRESS**  **CITY STATE ZIP** | |
| **POLAR MEDICAL STAFF USE ONLY**  **PQ WINTER REVIEW NPQ** | |
|  | |

*Page 11 of 19*

**UNITED STATES ANTARCTIC PROGRAM DEPLOYMENT CONSENT/AUTHORIZATION DOCUMENTS**

**IMPORTANT NOTICE FOR PARTICIPANTS IN THE UNITED STATES ANTARCTIC PROGRAM**

Participants in the United States Antarctic Program (USAP) are expected to comport themselves in such a manner that their activities and demeanor reflect credit on themselves and their sponsoring organizations. The special circumstances and conditions prevailing in Antarctica require high standards of conduct.

The potential for mishap in Antarctica is a constant threat. Your ability to deal effectively with a mishap is reduced if you are under the influence of alcohol or other drugs. The National Science Foundation (NSF) will not condone abuse of alcohol or controlled substances in Antarctica. Unauthorized or excessive use of such substances will not be tolerated.

The laws of the United States prohibit the possession, shipping, or mailing of illegal drugs. In addition, governments in New Zealand and South American countries have strict laws forbidding the possession or transportation through their country of firearms, knives, pornographic materials, marijuana or non-prescription drugs. These laws are strictly enforced and penalties for violation are severe. For example, in New Zealand the importation of illegal drugs, including marijuana, is punishable by up to 14 years imprisonment. Letter mail, parcels, and cargo being sent to Antarctica are subject to examination and opening by United States and foreign authorities. All incoming and outgoing mail for McMurdo station transits New Zealand and is subject to interdiction by New Zealand Customs Service through the use of narcotics detection dogs and other direct- inspection procedures. Like any traveler, you must abide by applicable foreign law. If you are found in violation thereof, you are subject to prosecution in the courts of that country. Association with the USAP affords neither preferential treatment nor immunity from prosecution. The New Zealand and Chilean Governments have expressly stated their intention to vigorously prosecute violators.

Conviction for any criminal action under the laws of the United States or foreign countries may result in your removal from the USAP.

Initials

I have read and understand this *Important Notice for Participants in the United States Antarctic Program.*

**MEDICAL RISKS FOR NSF-SPONSORED PERSONNEL TRAVELING TO ANTARCTICA**

Travel to Antarctica imparts certain risks to the traveler, because of harsh environmental conditions encountered, limitations in the medical care available in Antarctica, and difficulties during emergencies with providing timely evacuation to tertiary medical care facilities in New Zealand, South America, or in the United States. USAP participants should consider these risks before deciding to deploy to Antarctica.

Virtually all medical care to USAP participants is provided through the USAP medical care system. Medical clinics operate at all three year-round stations (McMurdo, South Pole, and Palmer Stations). Emergency medical technicians and dispensary operations are available on the two oceanographic research vessels. First-aid/first responders support larger seasonal remote field camps. The three clinics are comparable to a small community hospital emergency room and ambulatory care facility, but without secondary or tertiary care facilities nearby for patient referral or specialist support. Radiography (X-rays) and selected laboratory tests are available in the clinics, but more sophisticated imaging procedures and diagnostic tests are not. Operating room surgical suites are not available at the stations, although each clinic has a triage/trauma room. The USAP does not maintain a frozen blood supply at each station, relying instead on a “walking blood bank” (where individual donors would provide fresh blood if transfusions were needed and blood types matched). The evacuation of critically ill or injured patients from Antarctic sites to sophisticated medical care off the continent (to New Zealand, South America, or the United States) is difficult during the austral summer and may be impossible during the austral winter (February through August). Partly because of these limitations, NSF requires medical and dental screening of personnel prior to deployment to Antarctica. These medical screening examinations are necessary to determine the presence of medical conditions that could threaten the health or safety of the individual while in Antarctica. They are also necessary to determine whether medical conditions exist that cannot be effectively managed while the individual is in Antarctica. Persons who fail to meet these medical/dental screening criteria will be notified of the specific reason(s) for their disqualification. Disqualified individuals may request reconsideration by completing a waiver request package (obtained from the University of Texas Medical Branch).

*Page 12 of 19*

Pre-deployment screening can identify existing medical conditions that may be difficult or impossible to treat effectively in Antarctica. USAP participants should realize that serious accidents or injuries might challenge the medical care system in Antarctica as well. Therefore, individuals should recognize the limitations in the medical care system in Antarctica before they engage in any risk-taking behaviors (whether on-the-job or during recreational pursuits) that may result in accidents or injuries.

Data collected as a result of this medical screening requirement are maintained in accordance with the Privacy Act (5

USC552a) and protected against unauthorized release, as described in the appended Privacy Notice found in the USAP PQ Important Information attachment. The collection of this information must display a currently valid OMB control number. You are not required to respond to the collection of this information unless it displays a currently valid OMB control number.

Initials

I have read and understand the *Medical Risks for NSF-Sponsored Personnel Traveling to Antarctica.*

**MEDICAL SCREENING FOR BLOOD-BORNE PATHOGENS**

As described above, USAP medical clinics at the three U.S. research stations do not maintain supplies of frozen blood. NSF research stations in the Arctic do not have readily available blood supplies. In the event of the need for a transfusion, other individuals at the research station with matching blood types would be asked to donate fresh whole blood for the patient. In order to maintain a viable donor pool, the NSF requests that USAP and Arctic participants during the austral summer season voluntarily submit to testing for Human Immunodeficiency Virus (HIV) along with the required Hepatitis virus B and C as part of their medical screening process. Please note that HIV testing is required for candidates intending to spend the winter in Antarctica or in the Arctic. In addition, consent to HIV testing does not guarantee that it will be performed.

**CONSENT FOR HIV ANTIBODY BLOOD TEST**

I have been informed that my blood will be tested for Human Immunodeficiency Virus (HIV) antibodies, the causative agent of Acquired Immune Deficiency Syndrome (AIDS). I understand that the testing involves the withdrawal of a small amount of my blood by venipuncture and subsequent testing of that blood sample via ELISA (Enzyme-Linked Immuno-Sorbent Assay) and Western Blot methods.

I understand that if I have any questions regarding the testing procedure or interpretation of results, I should discuss them with my health care provider. I understand that my examining physician will receive a copy of these test results and may be required, under State law, to report positive test results to state health department authorities, and I consent to these disclosures.

I understand that the results of this blood test will be incorporated into my USAP medical file. All information in that file is maintained in accordance with the Privacy Act (5 USC 552a) and protected against unauthorized release, as described in the appended Privacy Notice found in the Polar Physical Qualification Information Packet.

I volunteer for the Walking Blood Bank, should a medical emergency develop while I am on station that requires a blood

donation to help save a human life.

Yes No

Initials

I have read and understand the above *Medical Screening for Blood-Borne Pathogens information.*

Having read and understood the above statements, I hereby

GIVE DO NOT GIVE

my consent to the collection and testing of my blood to determine the presence of HIV antibodies if required. Initials

I have read and understand the

*NSF/GEO Polar Programs Deployment Consent/Authorization Documents.*

Signature

*Page 13 of 19*

**AUTHORIZATION FOR TREATMENT OF FIELD-TEAM MEMBER/PARTICIPANT UNDER 18 YEARS OF AGE**

I am the parent or legal guardian of , who is an underage participant in the National Science Foundation/Geosciences/Division of Polar Programs. Should any medical/dental care be required during his or her deployment to Antarctica or to the Arctic, I hereby give my authorization and consent to the NSF Polar Programs’ medical care provider(s) for any medical care, treatment or procedures that are deemed medically necessary while my son or daughter is deployed to either the Arctic or the Antarctic.

Name of Parent or Legal Guardian

Street Address

City State Zip Code

Telephone Numbers

Daytime: Evening:

Print Name Signature Date

*Page 14 of 19*

1. **Applicant Statement and Release of Liability**

**Applicant Statement**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, am a candidate for deployment to the Polar Regions under the auspices of the Geosciences

[name]

Division of Polar Programs as a \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **OR** under \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

[position/company] [grant number]

I was advised that I am not physically qualified for deployment to the Polar Regions.

I am aware that the Physical Qualification (PQ) process is designed to identify personnel who are physically qualified and, for Antarctic winter-over candidates, psychologically adapted for assignment in Antarctica. \_\_\_\_\_

[initial]

I understand that the PQ process is necessary to identify the presence of any physical or psychological condition that would threaten the health or safety of myself or of other Polar Programs participants, that could not be effectively treated by the limited medical care capabilities in the Polar Regions (in addition, transportation to Polar medical facilities or from the Arctic or Antarctic to higher level health care facilities may be limited), or that otherwise pose a risk that would jeopardize accomplishment of NSF Polar Programs objectives. \_\_\_\_\_

[initial]

I understand that also important during any season, summer or winter, are the costs of lost productivity and the diversion of limited resources that results when deployed personnel are unable to perform their assigned function.  \_\_\_\_\_

[initial]

I understand that medical care capabilities may be quite distant from work locations and research sites; that work may be required at terrestrial elevations as high as 12,000 feet (3,600 meters); that ambient temperatures may reach -123 degrees Fahrenheit (-86 degrees Celsius) or lower; that my assignment may involve complete isolation for up to nine months in groups of two to 200 people. \_\_\_\_\_

[initial]

I understand that I may be required to have further medical examinations or to furnish additional medical documentation in support of my Application for Reconsideration. \_\_\_\_\_

[initial]

I understand that I will not be reimbursed for the cost of any additional examinations or documentation. \_\_\_\_\_

[initial]

I understand that my employer has a responsibility to provide a physically qualified work force and therefore it may elect to hire an alternate at any time during this process. \_\_\_\_\_

[initial]

In the event that the National Science Foundation approves my application subject to certain limitations and restrictions, I agree that if I choose to deploy I will abide by any limitations and restrictions imposed by the National Science Foundation. \_\_\_\_\_

[initial]

I understand that the National Science Foundation’s decision on my Application for Waiver is final. \_\_\_\_\_

[initial]

*Page 15 of 19*

**Applicant Release of Liability**

For and in consideration of the National Science Foundation waiving the Medical Clearance Criteria as they pertain to a condition for which I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_[applicant], a candidate for employment in the Polar Regions with \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_[organization], was found to be “not physically qualified” and thereby authorizing my deployment under the auspices of the NSF/GEO Polar Programs, for and on behalf of myself, my personal representatives, heirs and assigns, hereby release and discharge the U.S., its agents, servants and employees, including but not limited to the National Science Foundation, the Department of Defense and its agencies, agents, servants or employees, whether military or civilian and, where applicable, the Lockheed Martin Antarctic Support Contractor, its subcontractors, agents, servants, and employees from any and all claims for property damage, personal illness or injury, or death resulting directly or indirectly from waiver of the Medical Clearance Criteria and authorization to deploy.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Printed Name Signature Date

State of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, County of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

On \_\_\_\_\_\_\_\_\_\_, before me personally appeared \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_,

[date] [applicant’s name]

who proved to me on the basis of satisfactory evidence to be the person named herein and who acknowledged to me that he/she executed this application in his/her authorized capacity, and that by his/her signature on the instrument the person executed the instrument.

I certify under PENALTY OF PERJURY under the laws of the State of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ that the foregoing is true and correct.

WITNESS my hand and official seal.

Notary Public Signature Notary Public Seal

*Page 16 of 19*

**2. Employer Endorsement and Release of Liability**

Employer Endorsement

Complete this form and obtain the signature of the Authorized Representative for your Organization as noted below.

Applicant’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Position: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |
| --- | --- |
| **Organization** | **Authorized Representative** |
| Lockheed Martin, Partners, Subcontractors | Project Director |
| NSF-Funded Research Grants | Authorized Organizational Representative |

The National Science Foundation, as manager of the U.S. Antarctic Program and lead federal agency for US Arctic Programs, requires all candidates for deployment to the Polar Regions under the auspices of National Science Foundation Division of Polar Programs to undergo and pass a Physical Qualification (PQ) process. The PQ process is designed to identify personnel that are physically qualified and, for Antarctic winter-over candidates only, psychologically adapted for assignment in Antarctica. The PQ process is necessary to identify the presence of any physical or psychological condition that would threaten the health or safety of the candidate or of other Polar Programs participants, that could not be effectively treated by the limited medical care capabilities in the Polar Regions (in addition, transportation to Polar medical facilities or from the Arctic or Antarctic to higher level health care facilities may be limited), or that otherwise pose a risk that would jeopardize accomplishment of NSF/GEO Polar Programs objectives. Also important during any season, summer or winter, are the costs of lost productivity and the diversion of limited resources that results when deployed personnel are unable to perform their assigned functions. For these reasons, all documentation is reviewed against a rigorous set of Medical Clearance Criteria that were established and are regularly reviewed by qualified medical personnel with extensive experience with conditions in the Polar Regions. The National Science Foundation’s physical qualification process is outlined at 45 CFR 675.

The above-named applicant has been found “not physically qualified” for deployment to the Polar Regions under the auspices of the NSF/GEO/Division of Polar Programs due to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

[insert condition]

The National Science Foundation provides a process whereby eligibility for deployment to the Arctic or Antarctic may be reconsidered. In order to be reconsidered, the applicant submits an application consisting of an Applicant Statement, an Applicant Release of Liability, an Employer Endorsement, and an Employer Release of Liability. The National Science Foundation’s subcontracted medical processor (UTMB Health Center for Polar Medical Operations) reviews the application, provides a medical recommendation, and submits the documentation to the National Science Foundation for reconsideration.

The reconsideration process takes approximately six to eight weeks to complete once the application has been submitted. Be advised that applicants may be required to have further medical examinations or to furnish additional medical documentation in support of their application. Costs incurred as a result of these requirements are not reimbursable by the National Science Foundation and must be borne by the applicant or his/her employing organization. In addition, the employer may find it necessary to hire an alternate at any time during this process in order to ensure it is able to perform its responsibilities in the Polar Regions.

If the National Science Foundation rules favorably on the application, the Medical Clearance Criteria as they pertain to the condition for which the applicant was found to be “not physically qualified” will be waived and the applicant will be authorized to deploy. The National Science Foundation may approve the application subject to certain limitations and restrictions. For example, the applicant could be restricted to certain operating locations or required to undergo monitoring of his/her condition by on-site medical providers. The National Science Foundation’s decision on the application is final.

As the Authorized Organizational Representative, you are asked to review the below Employer Endorsement in support of the above-named individual’s application. If you support the individual’s application and agree to the statements contained therein, initial as indicated and sign the Employer Endorsement and the Employer Release of Liability on behalf of your Organization.

*Page 17 of 19*

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, is a candidate for deployment to the Arctic or Antarctic under the auspices of the

[applicant’s name]

NSF/GEO/Division of Polar Programs as an employee of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

[organization]

We were advised that the applicant is “not physically qualified” for deployment to the Polar Regions. \_\_\_\_\_

[initial]

We are aware that the Physical Qualification (PQ) process is designed to identify personnel that are physically qualified and, for Antarctic winter-over candidates only, psychologically adapted for assignment in Antarctica. \_\_\_\_\_

[initial]

We understand that the PQ process is necessary to identify the presence of any physical or psychological condition that would threaten the health or safety of the applicant or of other Polar Programs participants, that could not be effectively treated by the limited medical care capabilities in the Polar Regions (in addition, transportation to Polar medical facilities or from the Arctic or Antarctic to higher level health care facilities may be limited), or that otherwise pose a risk that would jeopardize accomplishment

of NSF/GEO Polar Programs objectives. \_\_\_\_\_

[initial]

We understand that also important during any season, summer or winter, are the costs of lost productivity and the diversion of limited resources that results when deployed personnel are unable to perform their assigned function. \_\_\_\_\_

[initial]

We understand that medical care capabilities may be quite distant from work locations and research sites; that work may be required at terrestrial elevations as high as 12,000 feet (3,600 meters); that ambient temperatures may reach

-123 degrees Fahrenheit (-86 degrees Celsius) or lower; that his/her assignment may involve complete isolation for up to nine months in groups of two to 200 people. \_\_\_\_\_

[initial]

We understand that the applicant may be required to have further medical examinations or to furnish additional medical documentation in support of his/her application. \_\_\_\_\_

[initial]

We agree that we will not seek reimbursement of the costs of further medical examinations or additional medical documentation by the National Science Foundation through contracts, cooperative agreements, or grants funded by the National Science Foundation. \_\_\_\_\_

[initial]

We understand our responsibility to provide a physically qualified work force and therefore that we may elect to hire an alternate at any time during this process. \_\_\_\_\_

[initial]

We understand that the National Science Foundation may approve the application subject to certain limitations and restrictions which could affect the applicant’s ability to perform his/her duties. \_\_\_\_\_

[initial]

We are aware of the potential impacts that the applicant’s deployment may have on our organization, including the potential impact of the applicant being unable to perform his or her job while in the Arctic or Antarctic. \_\_\_\_\_

[initial]

*Page 18 of 19*

By my signature as the Authorized Organizational Representative, I acknowledge the risks associated with \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ deploying to the Polar Regions with his/her medical condition, and I support his/her

[applicant’s name]

Application for Waiver to the National Science Foundation on behalf of the Organization.

**Employer Release of Liability**

For and in consideration of the National Science Foundation waiving the Medical Clearance Criteria as they pertain to a condition for which \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_[applicant], a candidate for employment in the Polar Regions with \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_[organization], was found to be “not physically qualified” and thereby authorizing his/her deployment under the auspices of the NSF/GEO/Division of Polar Programs, for and on behalf of the Organization, we release and discharge the U.S., its agents, servants and employees, including but not limited to the National Science Foundation, the Department of Defense and its agencies, agents, servants or employees, whether military or civilian and, where applicable, the Antarctic Support Contractor, its subcontractors, agents, servants, and employees from any and all claims for property damage, personal illness or injury, or death resulting directly or indirectly from waiver of the Medical Clearance Criteria and authorization to deploy.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Organization Print Title, Authorized Organizational Representative

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print Name, Authorized Organizational Representative Authorized Organizational Representative Signature Date

*Page 19 of 19*

**DIVISION OF POLAR PROGRAMS ARCTIC PROGRAM**

**DEPLOYMENT CONSENT/AUTHORIZATION DOCUMENTS**

**Arctic Program Physical Qualification Important Information**

**IMPORTANT NOTICE FOR PARTICIPANTS IN THE NSF/GEOSCIENCES DIVISION OF POLAR PROGRAMS**

Participants in the Arctic Program under the auspices of the US National Science Foundation Geosciences Directorate Division of Polar Programs (herein after referred to as the NSF Polar Regions – North) are expected to comport themselves in such a manner that their activities and demeanor reflect credit on themselves and their sponsoring organizations. The special circumstances and conditions prevailing in the Arctic require high standards of conduct.

The potential for mishap in the Arctic is a constant threat. Your ability to deal effectively with a mishap is reduced if you are under the influence of alcohol or other drugs. The National Science Foundation (NSF) will not condone abuse of alcohol or controlled substances in its Arctic research stations. Unauthorized or excessive use of such substances will not be tolerated.

The laws of the United States prohibit the possession, shipping, or mailing of illegal drugs. In addition, governments in other Arctic countries have strict laws forbidding the possession or transportation through their country of firearms, knives, pornographic materials, marijuana or non-prescription drugs. These laws are strictly enforced and penalties for violation are severe.

Conviction for any criminal action under the laws of the United States or foreign countries may result in your removal from the Arctic Program.

\_\_\_\_\_

Initials

I have read and understand this Important Notice for Participants in the NSF Polar Regions – North.

**Medical Risks for Personnel Traveling to the NSF Polar Regions - North**

Travel to the NSF Polar Regions - North imparts certain risks to the traveler. You may experience extremely cold (subzero) temperatures, high altitude and other environmental conditions that put you at risk for cold-related injuries. The limitations in the medical care available and difficulties, in emergencies, of providing timely evacuation to tertiary medical care facilities in the U.S. or other countries in the Arctic increase your risk of serious complications from exposure or lack of immediate medical care. Extremes of daylight and darkness can impact sleep or other behaviors. Living in close quarters increases the likelihood of exposure to communicable diseases. United States polar programs participants should consider these risks before deciding to deploy to the NSF Polar Regions - North.

Therefore, it is imperative that each individual deploying to the NSF Polar Regions – North, recognize these limitations in medical care while they are deployed. It is, in part, because of these limitations, that the NSF requires medical and dental screening of personnel prior to deployment to the NSF Polar Regions - North. These medical screening examinations are necessary to determine the presence of medical conditions that could threaten the health or safety of the individual while deployed. Each person who fails to meet these medical/dental screening criteria will be notified of the specific reasons for the disqualification. Disqualified individuals may request reconsideration by completing a waiver request package (obtained from the designated NSF point of contact).

Prior to deploying, you should familiarize yourself with the conditions and available healthcare at the location to which you are traveling and ensure that you have medical evacuation insurance. Medevac insurance is an allowable grant cost.

Pre-deployment screening can identify existing medical conditions that may be difficult or impossible to treat effectively in the Polar Regions. Participants should realize that serious accidents or injuries might challenge the medical care system, as well. Therefore, individuals should understand the limitations in the medical care system before they engage in any risk-taking behaviors (whether on-the-job or during recreational pursuits) that may result in accidents or injuries.

Data collected as a result of this medical screening requirement are maintained in accordance with the Privacy Act (5 USC 552a) of 1974 and protected against unauthorized release, as described in the appended Privacy Notice.

I have read and understand this information sheet.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print Name Signature and Date