U.S. DEPARTMENT OF COMMERCE
NATIONAL OCEANIC AND ATMOSPHERIC ADMINISTRATION

HEALTH SERVICES QUESTIONNAIRE

Application for Medical Qualification to Embark a NOAA Ship

INSTRUCTIONS FOR NOAA TEACHER AT SEA PARTICIPANTS

DUE - Thursday, March 21, 2019

1. Be sure to fill out all necessary fields and sign and date the form. A doctor's signature is **only required on the TB (PPD) Screening Document**, which must be submitted along with a copy of the test results. The form must be legible and complete. Unreadable or incomplete forms will be returned to the applicant.
2. Once you have completed the forms, please **fax** them to 301-263-7699 . **DO NOT EMAIL DOCUMENT** as it contains private information that cannot be sent through email. Once we receive your form, we will send it to our medical officer who will determine if you are fit for sea duty. You will only hear back from us about your form if there is an issue. You will hear directly from the medical officer if they have a question.

   Important Note: If you have any changes to your health (after you submit your medical form) or work status, we ask that you contact us immediately, as these are important factors for participation in our program.

All positive responses in the General Screening and Cardiac Screening sections require a detailed explanation in the space provided. The Continuation Page may be used if more space is needed. An indication of hypertension requires the most recent blood pressure reading. An indication of diabetes requires the most recent glycated hemoglobin (HbA1c) reading.

All persons embarked aboard a NOAA ship must have a test for tuberculosis (TB) within the 12 months preceding the project end date. MOC Health Services accepts three tests to detect exposure to the TB bacteria; the Purified Protein Derivative (PPD or TB skin test), the QuantiFERON-TB test (QFT or TB blood test), and the T-spot blood test. PPD results must be recorded in millimeters (mm) and not documented as positive or negative. QuantiFERON-TB and the T-spot results must be indicated as negative, positive, or indeterminate. You must also include a **copy of the TB test from your doctor**.

All persons embarked on a NOAA ship must be able to perform normal work functions and minimal personal emergency response functions while the ship is underway. During an abandon ship event, personnel may have to don a survival suit and/or descend a rope ladder to a life raft or rescue craft. Personnel deploying in small boats for operations may have to ascend and descend a rope ladder. A rope ladder (as pictured to the right) is a heavy duty ladder with rigid rungs that hangs over the side of the ship used for underway embarkation and disembarkation of personnel. A survival suit (as pictured to the right) is a full-body single-piece coverall designed to provide thermal protection to personnel immersed in water. A person at sea should be able to don a survival suit in one minute while fully clothed and without having to remove shoes. All negative responses in the Functional Abilities Screening section require additional explanation on the Continuation Page.

Do not write in the "MOC Health Services Use Only" section. Use the Continuation Page to provide any additional information. Direct all questions regarding the information required on this form to the MOC Health Services Medical Officer at MOC-Atlantic (757) 441-6320.

HEALTH SERVICES QUESTIONNAIRE

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Section I: Applicant Information					
Applicant Name (Last, First Middle)				Year of Birth	Today's Date
Office, Laboratory or Institution Name				Work Phone ☐	
Work Address				Cell Phone ☐	
City		State	Zip Code	Home Phone ☐	
E-mail Address				(Check one preferred contact phone number above)	
Emergency Contact Name		Relationship		Cell Phone	
Address	City	State	Zip Code	Home Phone	
Project Dates	Start To be determined		End To be determind		
Project Ship(s)	Not yet assigned				
Position	☐ Scientist	☐ Contractor	☐ Other (specify below)		
	☑ Teacher at Sea	☐ Volunteer	_____		

Section II: Current Health Information – (provide additional information on page 4 if needed)		
List all health problems / medical conditions which regularly require a physician's attention.		
☐ None	1.	
	2.	
	3.	
	4.	
List all medications (prescription and non-prescription) you currently take.		
☐ None	1.	5.
	2.	6.
	3.	7.
	4.	8.
List all health problems / medical conditions which do not require a physician's attention or medication.		
☐ None	1.	
	2.	
	3.	
	4.	
List major surgeries, hospitalizations, and emergency room visits.		
☐ None	1.	
	2.	
	3.	
	4.	
List all known allergies and subsequent reactions.		
☐ None	Allergy	Reaction
	1.	1.
	2.	2.
	3.	3.

HEALTH SERVICES QUESTIONNAIRE

Application for Medical Qualification to Embark a NOAA Ship

Applicant Name (Last, First Middle)	Today's Date

Section III: General Screening

Indicate any medical condition experienced during adulthood.

Yes	No		Yes	No	
☐	☐	Cancer	☐	☐	Epilepsy / Seizures
☐	☐	Tuberculosis	☐	☐	Impaired Mobility
☐	☐	Asthma	☐	☐	Severe Hearing Loss
☐	☐	Hepatitis	☐	☐	Severe Visual Impairment
☐	☐	Chronic Cough	☐	☐	Severe Motion Sickness
☐	☐	Severe Depression	☐	☐	Fainting / Loss of Consciousness
☐	☐	Untreated Dental Issues	☐	☐	Recent unexplained weight gain > 20 lbs
☐	☐	Currently Pregnant	☐	☐	Recent unexplained weight loss > 20 lbs

Explain any positive response(s) below.

Section IV: Cardiac Screening

Indicate any cardiac condition experienced during adulthood and the applicable test result.

Yes	No		Yes	No	
☐	☐	Abnormal EKG	☐	☐	Hypertension
☐	☐	Heart Attack	_____		Recent Blood Pressure Reading
☐	☐	Shortness of Breath	☐	☐	Diabetes
☐	☐	Chest Pain	_____		Recent HbA1c Reading

Explain any positive response(s) below.

Section V: Immunization Screening

Indicate the applicable test result and the dates for the following screening and immunization;

1. Tuberculosis (TB): A tuberculosis skin test or TST (purified protein derivative, PPD), a QuantiFERON-TB blood test, or a T-Spot blood test is required within the 12 months preceding the project or cruise end date. **Results are documented on the "NF 57-10-02 - Tuberculosis Screening Document" and this document must be submitted with the NHSQ along with an actual copy of the test results for medical clearance to embark.**

2. Tetanus booster Date _____

HEALTH SERVICES QUESTIONNAIRE

Application for Medical Qualification to Embark a NOAA Ship

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Section VI: Functional Abilities Screening

Indicate the ability to perform the following tasks.

Yes	No	
☐	☐	Step over a 24 inch high door sill
☐	☐	Walk on a steel deck for 4-8 hours per day
☐	☐	Stand on a steel deck for 4-8 hours per day
☐	☐	Walk on slippery or uneven walking surfaces
☐	☐	Climb stairs
☐	☐	Carry 15 lbs
☐	☐	Don a survival suit in less than one (1) minute
☐	☐	Ascend a rope ladder with rigid rungs
☐	☐	Descend a rope ladder with rigid rungs
☐	☐	Hear a ship's general alarm (hearing aid permitted)

Explain any negative response(s) below and indicate any medical condition or physical limitation which may adversely affect qualification for sea duty.

Section VII: Applicant Certification

I certify the information provided is true, accurate, and complete to the best of my knowledge. I acknowledge that falsification of any information on this government document is punishable by fine, imprisonment, or both.

Applicant Signature _____ Date _____

For assistance completing this form, contact;

1. MOC-A Health Services in Norfolk, VA Phone:(757) 441-6320 Fax: (757) 441-3760

MOC Health Services Use Only

☐ Applicant is medically cleared for sea duty aboard a NOAA ship by history.

☐ Applicant is medically disqualified for sea duty aboard a NOAA ship by history.

☐ Additional information is needed to determine medical clearance for sea duty.

MOC Health Services Medical Officer Signature _____ Date _____

HEALTH SERVICES QUESTIONNAIRE

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Applicant Name (Last, First Middle)	Today's Date

Continuation Page

Use the space provided below to further explain any medical condition indicated on the previous pages.

RESET

TUBERCULOSIS SCREENING DOCUMENT

This form must be used to document the annual tuberculosis screening required by NOAA Policy 1008 of all persons seeking medical clearance by NOAA Health Services to sail on a NOAA ship.

NAME	YEAR OF BIRTH	DATE

SECTION 1: To be completed by the healthcare professional performing the tuberculosis testing.

TST TEST RESULTS			**QUANTIFERON GOLD OR T-SPOT RESULT** (COPY OF RESULTS MUST BE INCLUDED)		
DATE GIVEN	DATE READ		DATE TEST OBTAINED	TEST OBTAINED ☐ QFT-G ☐ T-SPOT	
RESULT _____ (mm induration)	INTERPRETATION ☐ POSITIVE ☐ NEGATIVE		TEST RESULT ☐ NEGATIVE ☐ POSITIVE ☐ INDETERMINATE/BORDERLINE		
PROVIDER NAME (PRINT)	PROVIDER SIGNATURE	DATE	PROVIDER NAME (PRINT	PROVIDER SIGNATURE	DATE

SECTION 2: To be completed **ONLY** if you had positive results in Section 1 or have a history of a positive TST test or positive/indeterminate Quantiferon Gold or T-Spot blood test.

Please consider the following questions: (mark the appropriate answer)

1. Have you ever had a positive TB skin Test? ☐ NO ☐ YES If yes, when _____
2. Date of your last chest x-ray (if applicable) _____
3. Date of BGG Vaccine (if applicable) _____
4. Date you completed your prescribed medications to treat your positive TB Test (if applicable) _____
5. Have you ever lived with or been in close contact with anyone who had TB disease? ☐ NO ☐ YES
6. Have you ever had a positive HIV test? ☐ NO ☐ YES
7. Have you ever used illegal intravenous drugs? ☐ NO ☐ YES
8. Are you currently taking steroids, chemotherapy, or cancer treating drugs? ☐ NO ☐ YES
9. Have you ever been incarcerated? ☐ NO ☐ YES
10. Have you ever been homeless? ☐ NO ☐ YES
11. Do you currently have any of the following symptoms? (check if YES)

    ☐ Fever ☐ Weight Loss ☐ Night Sweats ___ Chronic Cough ☐ Chronic Fatigue ☐ Coughing up blood

12. Consider the following list of high burden countries that account for 80% of new TB cases each year:

Afghanistan	*DR Congo*	*Mozambique*	*Brazil*	*Kenya*	*Philippines*	*UR Tanzania*
Myanmar	*South Africa*	*Zimbabwe*	*China*	*Vietnam*	*Bangladesh*	*Ethiopia*
Indonesia	*Pakistan*	*Uganda*	*India*	*Nigeria*	*Thailand*	*Cambodia*
						Russian Federation

- Were you born in one of the countries listed above? ☐ NO ☐ YES
- Have you ever stayed/lived in one of these countries for one month or longer? ☐ NO ☐ YES
- Have you ever lived or been in close contact with someone who stayed/lived in one of these countries for one month or longer? ☐ NO ☐ YES

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TUBERCULOSIS SCREENING DOCUMENT

I certify that I have reviewed the foregoing information supplied by me and that it is true and complete to the best of my knowledge. I authorize any of the doctors, hospitals, or clinics mentioned above to furnish the Government a complete transcript of my medical record for purposes of processing my application for this employment or service. I understand that falsification of information on Government forms is punishable by fine and/or imprisonment.

SIGNATURE	SIGNATURE DATE

NOAA policy requires that all persons with a recent or remote positive test for exposure to the tuberculosis bacteria must obtain an annual physical examination by a licensed medical provider (physician, nurse practitioner, or physician assistant) to determine if latent TB infection or active disease is present, and if persons with latent infection are at high risk for developing active disease. This annual examination must include interpretation of a chest x-ray less than 5 years old. Center for Disease Control and Prevention (CDC) Guidelines and NOAA Health Services policy require persons with latent infections who are at high risk of developing active disease to initiate prophylactic treatment before obtaining medical clearance from NOAA Health Services to sail on a NOAA ship.

I have examined this patient following the NOAA Medical Policy and determined this patient has:

☐ **Latent TB** infection with **low risk** of developing active disease.

☐ **Latent TB** infection with **high risk** of developing active disease.

Prophylactic Medication/s Prescribed: _____

Date Prophylactic Medication began _____ Date Prophylactic Medication will be completed _____

☐ **Active Tuberculosis.**

PROVIDER CONTACT INFORMATION (ADDRESS)	PROVIDER CONTACT TELEPHONE NUMBER
PROVIDER TITLE	DATE OF EXAMINATION
PROVIDER PRINTED NAME	PROVIDER SIGNATURE

SUPERSEDES NOAA Form 57-10-02 (4-12)

RESET