This document's purpose is solely to aid the medical provider in evaluating an arduous duty fire personnel medically in regards to what they are likely to be exposed to in the fire environment.

ESSENTIAL FUNCTIONS AND WORK CONDITIONS OF A WILDLAND FIREFIGHTER

May Include:

Time/Work Volume	*Physical Requirements*	*Environment*	*Physical Exposures*
• 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 for 3 miles in 45 minutes, approximating an oxygen consumption (VO2 max) of 45 mL/kg-minute • typically 14 day assignments, ***BUT,*** *may extend up to 21 day assignments* **• *for smokejumpers* - ability to meet the minimum Smokejumper Fitness Test which includes 1 1/2 mile run in 11 minutes or less, 25 push-ups, 7 pull-ups, 45 sit-ups, and carry 110 lbs for 3 miles in 90 minutes or less**	• *use shovel, Pulaski, and other hand tools to construct fire lines* • *lift and carry more than 50 lbs* • *lifting or loading boxes and equipment* • *drive or ride for many hours* • fly in helicopters and fixed wing aircraft • work independently, and on small or 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 • use of a fire shelter **• *for smokejumpers* - lift and carry more than 100 lbs, perform parachute jumps, and perform parachute landings on uneven terrain**	• *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**	• *light (bright sunshine, UV exposure)* • *burning materials* • *extreme heat* • *airborne particulates* • *fumes, gases* • *falling rocks and trees* • *allergens* • *loud noises* • snakes • insects/ticks/spiders • poisonous plants • trucks and other large equipment • close quarters, large numbers of other workers • limited/disturbed sleep • hunger/irregular meals • dehydration

USFS Wildland Firefighter Medical Qualifications Program Physical Exam
Arduous Duty

Privacy Act Statement

Solicitation of this information is authorized by Section 552a of Title 5, United States Code, regarding records maintained on individuals: Section 3301 or Title 5, United State Code, regarding determination as to an individual's fitness for employment with regard to age, health, character, knowledge, and ability; and Section 3312 of Title 5, United States Code, regarding waiver of physical qualifications for preference eligibles. This form is used to collect medical information about individuals who are incumbents of positions in the Federal Government which require physical fitness testing and medical examinations, or individuals who have been selected for such a position contingent upon successful completion of physical fitness testing and medical examinations as a condition of their employment. The primary use of this information will be to determine the nature of a medical or physical condition that may affect safe and efficient performance of the work described, and whether an individual being considered for wildland firefighting can carry out those duties in a manner that will not place the candidate unduly at risk due to inadequate physical fitness and health. Additional potential routine uses of this information include using it to ensure fair and consistent treatment of employees and job applicants, to adjudicate requests to pass over preference eligibles, or to adjudicate claims of discrimination under the Rehabilitation Act of 1973, as amended. Completion of this form is voluntary; however, failure to complete the form may result in no further consideration of an applicant, or a determination that an employee is no longer qualified for his or her position. Its collection and use are covered under Privacy Act System of Records OPM/Govt-10 and are consistent with the provisions of 5 USC 552a (Privacy Act of 1974).

WARNING: The information you have given constitutes an official statement. Incomplete, misleading, or untruthful information provided on the form may result in delays in processing the form for employment, termination of employment, or criminal sanction. Federal law provides severe penalties (up to 5 years confinement or a $10,000 fine or both), to anyone making a false statement.

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995, an agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is OMB 0596-0164. The time required to complete this information collection is estimated to average 2 to 3 hours per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. The U.S. Department of Agriculture (USDA) prohibits discrimination in all its programs and activities on the basis of race, color, national origin, gender, religion, age, disability, political beliefs, sexual orientation, and marital or family status. (Not all prohibited bases apply to all programs) Persons with disabilities who require alternative means for communication of program information (Braille, large print, audiotape, etc.) should contact USDA's TARGET Center at 202-720-2600 (voice and TDD). To file a complaint of discrimination, write USDA, Director, Office of Civil Rights, 1400 Independence Avenue, SW, Washington, DC 20250-9410 or call (800) 975-3272 (voice) or (202) 720-6382 (TDD). USDA is an equal opportunity provider and employer.

Instructions

There are four parts in this form:

Part A - To be completed by the applicant or employee. Signature of the applicant or employee certifies that the information provided is complete and accurate; and that the applicant or employee consents to the release of the examination results to the employing agency.

Part B - To be completed by the applicant or employee prior to the medical examination. The responses will be used to identify medical conditions that may have bearing on the final qualification determination.

Part C - To be completed by the examining medical provider (M.D., D.O., N.P., or P.A. certified under a State Board of Medicine) after reviewing Part B with the examinee. *Please discuss any concerns found on exam with the examinee, with recommendations for follow up with a medical provider as appropriate.* NO ADDITIONAL TESTING TO BE DONE OTHER THAN WHAT IS ON THE PHYSICAL FORM. For a complete list of the "Interagency Wildland Firefighter Medical Qualification Standards" visit: http://www.fs.fed.us/fire/safety/wct/fs_version_ms.pdf

Part D - **To be completed by Agency officials.** Qualification determination made by the reviewing medical officer of the employing agency. Options are "Medically Qualified, Medically Qualified Temporary Restrictions, Medically Qualified Conditional, Medically Qualified with waiver/s, Not Medically Qualified, or Not Medically Qualified Information Needed."

Part A. TO BE COMPLETED BY APPLICANT OR EMPLOYEE		
1. Name (Last, First and Middle)		
2. Federal Employee Number	3. Sex □ Male □ Female	4. Birth Date (mm/dd/yyyy)
5. Address (including City, State, Zip Code)		
6. E-mail Address	7. Telephone Number (with area code)	8. Do you need a DOT physical as well? Please notify your supervisor.
9. Applicant or Employee Consent and Certification		
I certify that all of the information I have provided on this form is complete and accurate to the best of my knowledge, and that submitting information that is incomplete, misleading, or untruthful may result in termination, criminal sanctions, or delays in processing this form for employment. Furthermore, consistent with the Privacy Act Statement, I authorize the release to my employing agency of all information contained on this examination form and all other forms generated as a direct result of my examination.		
10. Signature		11. Date (mm/dd/yyyy)
Exercise		
12. **Physical Activity** Intensity: □ Low (walking, etc.) □ Moderate (jogging, cycling, etc.) □ High (strenuous exercise such as running, etc.) Duration in Minutes per Session_____ Frequency in Days per Week_____		
Firefighting Experience		
13. This information is needed in the event you do not meet a medical standard(s) and will be used to determine eligibility for a routine/initial waiver. What is your position title?_____ Does your official position description require you to maintain arduous duty firefighter qualifications? □ Yes □ No □ I don't know How many years and months have you performed the duties of an arduous fire position? _____ years and _____months List your three (3) highest arduous ICS qualifications, the year attained and the last year you performed this arduous ICS work:		
ICS Qualification	**Year Attained**	**Last Performed in:**
Home Unit and Forest Name:		
Home Unit Address:		

MEDICAL HISTORY

Part B. **TO BE COMPLETED BY APPLICANT OR EMPLOYEE**

If more space is needed to answer questions, please use the space at the end of this section.

Questions	Details	Yes	No
1. Have you undergone treatment by doctors, healers, or other practitioners for any problem or illness within the past year?	Reason, date, current status:	☐	☐
2. Have you ever been a patient in any type of hospital, except for your birth?	Reason, date, current status:	☐	☐
3. Have you had or have you been advised to have any operation?	Reason, date, current status:	☐	☐
4. Have you ever been treated with an organ transplant, prosthetic device (e.g. artificial hip), or an implanted pump (e.g. insulin) or electrical device (e.g. cardiac defibrillator or pacemaker)?	What, why, date:	☐	☐
5. Have you been rejected for or discharged from military service because of physical, mental, or other reasons?	Date and reason:	☐	☐
6. Have you ever received, is there pending, or have you applied for a pension or compensation for a disability?	Date, explain, current status, VA% disability (if applicable):	☐	☐

Medications and Allergies			
Questions	**Details**	**Yes**	**No**
7. Do you have any allergies, environmental or medication or food?	To what and the reaction:	☐	☐
8. Do you currently take or should you be taking any medications (prescribed and/or over-the-counter, including herbal preparations)?	Name:	☐	☐
9. Are you allergic to bee/wasp/hornet/fire ant/yellow jacket stings?	Check all that apply: ☐ Bees ☐ Wasps ☐ Hornets ☐ Fire Ants ☐ Yellow Jackets ☐ Don't know Check any of the reactions you have had: ☐ swelling or itching at site of sting only ☐ swelling or itching at site(s) other than site of sting, i.e. if stung on arm, swelling or itching has occurred somewhere other than on arm ☐ hives ☐ anaphylactic shock (had to be treated in the ER) ☐ blood pressure problems ☐ difficulty breathing Please explain in detail any positive responses marked above: _____ _____ _____ _____ _____ _____ _____	☐	☐

10. Have you ever been advised by a physician to carry an Epipen for yourself?	Do you carry an Epipen for yourself? ☐Yes ☐No	☐	☐
Mental Health			
Questions	**Details**	**Yes**	**No**
11. Have you ever been treated for a mental or emotional condition (e.g. depression, anxiety, panic attacks, claustrophobia, anger management, etc.)	Diagnosis, date, details of current treatment and status:	☐	☐
12. Have you ever had a history of, with or without being diagnosed with or treated for, alcoholism, alcohol dependence, illegal drug dependency or abuse, or prescription drug dependency or abuse?	What, date, current status, any rehab (when and where):	☐	☐
Vision			
Questions	**Details**	**Yes**	**No**
13. Have you ever had any history of eye disease or condition requiring surgery and/or medical treatment (e.g. LASIK, PRK, cataracts, glaucoma, detached retina, macular degeneration, etc.)?	Diagnosis and/or surgery, date, current status:	☐	☐
14. Do you suffer from any permanent or temporary loss of vision, blind spots, sensitivity to light, eye pain or any other visual disturbances not otherwise addressed in this section?	Problem, date, current status:	☐	☐
15. Are you colorblind?	Details:	☐	☐
16. Do you have a problem or difficulty with depth perception? Do you have difficulty with sensing the distance of objects you are looking at either stationary or moving?	Details:	☐	☐
17. Have you been told you have a lazy eye, strabismus, amblyopia, or an optic nerve issue in the past or present?	Details:	☐	☐

18. Do you have visual problems in one eye that you don't have in the other eye?	Details:	☐	☐
19. Do you wear corrective lenses for any reason?	For: ☐ near vision ☐ far vision ☐ both Use: ☐ contacts ☐ glasses ☐ both	☐	☐
Hearing			
Questions	**Details**	**Yes**	**No**
20. Do you have a history of any ear disease or hearing loss?	Diagnosis and date:	☐	☐
21. Have you had any type of ear surgery?	Type, date, current status:	☐	☐
22. Have you had a cold or ear infection in the last 2 weeks?	Details:	☐	☐
23. Have you had any exposure to any loud, constant noise or music in the last 12 hours? Do you ever get any ringing in your ears?	Details:	☐	☐
24. Do you wear hearing aid(s)?		☐	☐
25. Have you ever had a perforated/ruptured eardrum?	Date and details:	☐	☐
26. Do you use any protective hearing equipment when working around loud noise?	Type: ☐ foam ☐ pre-mold/plugs ☐ ear muffs	☐	☐
Head and Mouth			
Questions	**Details**	**Yes**	**No**
27. Do you have any deformity to the skull that causes problems wearing hats or anything form fitted on the head?	Details:	☐	☐
28. Do you have any jaw pain or tooth pain?	Details:	☐	☐

29. Do you have any deformity or growth of the tongue or mouth that interferes with speech?	Details:	☐	☐
Skin			
Questions	**Details**	**Yes**	**No**
30. Do you have any skin conditions that require medical treatment?	Details:	☐	☐
31. Any history of sun sensitivity that requires any prescription or over-the-counter medicines?	Details:	☐	☐
32. Any history of melanoma, or other skin cancer?	Details:	☐	☐
33. Any skin allergies to latex or rubber?	Type of reaction:	☐	☐
Vascular			
Questions	**Details**	**Yes**	**No**
34. Do you have any vascular (blood vessel) disease or conditions (e.g. aneurysm, varicose veins, peripheral vascular disease, etc)?	Diagnosis, current status:	☐	☐
35. Have you ever had a blood clot in the arm, leg, or lungs?	Location of clot, date, treatment, current status:	☐	☐
36. Do you have anemia currently or ever been told you have any issues with low blood counts?	Type, treatment, and current status:	☐	☐

37. Have you been seen for poor circulation or swelling in the hands or feet? Have you been told you have any blood disorders?	Diagnosis, date and treatment:	☐	☐
38. Do you get white fingers with exposure to the cold or vibration?	Details:	☐	☐
Heart			
Questions	**Details**	**Yes**	**No**
39. Do you have a history of high blood pressure or high cholesterol?	Current status:	☐	☐
40. Have you ever had chest pain with physical exertion or at rest, or been diagnosed with angina?	Date, diagnosis, tests, treatment:	☐	☐
41. Have you ever had an irregular heartbeat, skipped beats, palpitations, passed out, fainted, felt short of breath for no known reason, or lost consciousness?	Date, frequency, diagnosis, tests, treatment:	☐	☐
42. Have you ever had a heart attack, angioplasty or heart bypass surgery?	What and date:	☐	☐

43. Have you ever had a heart murmur?	Diagnosis and status:	☐	☐
44. Do you now, or have you ever had, any type of heart problem not mentioned above (heart valve problem, heart block, pacemaker, implanted defibrillator, Wolf-Parkinson-White Syndrome, other heart surgery, etc)?	Diagnosis, date, current status:	☐	☐
Chest and Lungs			
Questions	**Details**	**Yes**	**No**
46. Have you ever been diagnosed with asthma? How often are you put on oral steroids for your asthma?	Date diagnosed, date of last flare:	☐	☐
47. Do you or have you ever used an inhaler?	Name of inhaler and how often it is used:	☐	☐
48. Have you ever been to the hospital/ER or seen a medical provider because of an asthma flare/attack?	Dates in last 2 years:	☐	☐
49. Does smoke, dust, or exercise trigger your asthma?		☐	☐
50. Do you have any other type of lung disease or shortness of breath episodes other than asthma (reactive airway disease, COPD, emphysema, bronchitis, chronic cough, collapsed lung, etc)?	Diagnosis, date if applicable, and current status:	☐	☐

51. Any history of scoliosis that restricts your breathing or trachea (wind pipe), or lung surgery?	Details (date, diagnosis, etc):	☐	☐
52. Have you ever had a positive PPD (TB) skin test, received a BCG vaccination, or had a history of tuberculosis? Any unexplained fever or night sweats and a cough?	Date, diagnosis, tests (chest Xray?), treatment (for how long):	☐	☐
53. Have you ever been diagnosed with sleep apnea, wake up from sleep to catch your breath, or snore loudly?	Date diagnosed, treatment, current status:	☐	☐
Endocrine			
Questions	**Details**	**Yes**	**No**
54. Do you have a history of diabetes?	Treatment, average blood sugar reading, most recent Hgb A1c and date; any heart, kidney, eye or nerve damage due to diabetes:	☐	☐
55. Do you have any thyroid disease/problems?	Diagnosis, treatment, current status:	☐	☐
56. Do you have any other endocrine problems (adrenal, pituitary, etc)?	Diagnosis, treatment, current status:	☐	☐
57. Females, are you currently pregnant?	Due date:	☐	☐
Nervous System			
Questions	**Details**	**Yes**	**No**
58. Do you have any history of a stroke, transient ischemic attack (TIA), or cerebrovascular accident (CVA)?	Date, treatment, and residual problems:	☐	☐

59. Do you have any other neurologic disease?	Diagnosis, treatment, current status:	☐	☐
60. Have you had a spinal cord injury?	Date, diagnosis, current status:	☐	☐
61. Have you had any head or spine surgery?	Diagnosis, date, current status:	☐	☐
62. Do you have a tremor or shakiness?	Details:	☐	☐
Nervous System (cotinuted)			
Questions	**Details**	**Yes**	**No**
63. Do you have a history of head trauma/concussion?	Dates, any persistent headache or problems:	☐	☐
64. Do you have any history of brain tumor?	Diagnosis, date, current status:	☐	☐
65. Do you have any problems with dizziness, balance or coordination?	Details:	☐	☐
66. Do you have any loss of memory?	Details:	☐	☐

67. Do you have any numbness or tingling in your hands or feet?	Details:	☐	☐
68. Do you have chronic recurring headaches, migraines, cluster headaches, severe headaches?	Diagnosis, treatment, frequency of headaches:	☐	☐
69. Do you have insomnia problems	Frequency and treatment:	☐	☐
70. Have you ever had a seizure?	Dates in last 2 years, type of seizure, treatment:	☐	☐
Muscle and Bone			
Questions	**Details**	**Yes**	**No**
71. Do you have a history of arthritis, joint pain or swelling, tendonitis, recurrent shin splints?	Diagnosis, which joints, treatment, current status:	☐	☐
72. Do you have any amputations or absence of any fingers/toes or limbs or unable to use an arm, leg, finger/hand, or toe/foot?	Diagnosis, use of any assistive device (walker, prosthesis, etc):	☐	☐
73. Do you have any muscle loss, weakness/loss of strength?	Diagnosis,	☐	☐
74. Do you have any history of back or neck pain that you saw a medical provider for?	Diagnosis, treatment, frequency, location of pain, current status:	☐	☐
Stomach/Gut			
Questions	**Details**	**Yes**	**No**

75. Have you had hepatitis or other liver disease?	Date, type/diagnosis, treatment, current status:	☐	☐
76. Have you had any stomach, intestinal, spleen, pancreas, or gall bladder issues or disease?	Date, diagnosis, treatment, current status:	☐	☐
77. Do you currently have a hernia or have had recent surgery for a hernia?	Type/where, is surgery planned, date:	☐	☐
78. Do you have a colostomy or require any additional equipment or mediation in order to produce and eliminate stool in a safe and sanitary manner?	Details:	☐	☐
79. Have you ever had any blood in the stool or vomited blood?	Date, diagnosis, treatment, current status:	☐	☐
Kidney, Bladder, and Male/Female			
Questions	**Details**	**Yes**	**No**
80. Do you have any history of kidney, bladder, prostate, testicle, or ovary disease (kidney failure, pain, infection, stones, enlargement, blood in the urine, varicocele, hydrocele, cancer, cysts, torsion, etc)?	Date, diagnosis, frequency, treatment, current status:	☐	☐
81. Do you have any difficulty with urination or require any type of assistive equipment or medication to urinate, ie. catheterization?	Details:	☐	☐
82. Have you ever had or still require dialysis?	Details:	☐	☐
Other			
Questions	**Details**	**Yes**	**No**

83. a. Do you have any other medical condition, disease, or concern that is not listed elsewhere on this questionnaire? b. Have you ever had heat exhaustion or heat stroke?	Explain/details:	a. ☐ b. ☐	a. ☐ b. ☐
Wellness Profile			
Questions	**Details**	**Yes**	**No**
84. Do you smoke currently or have you smoked in the past?	Preferred method (cigarette, cigar, pipe), number per day, for how many years, when did you quit:	☐	☐
85. Do or did you use chewing tobacco or snuff/dip?	Number of bags or cans, for how many years, when did you quit:	☐	☐
86. Do you drink alcohol?	What is your average number of drinks per day/week/month? (1 drink = 12 oz. beer, 6 oz. of wine, 1.5 oz. of liquor)	☐	☐

Extra Space

MEDICAL HISTORY

Part C. **TO BE COMPLETED BY THE MEDICAL PROVIDER (MD, DO, NP, PA).**

Review Part B for any yes answers and provide any further comments or information received to identify the medical condition and its status. If any concern for active Tuberculosis, refer to PCP or health dept for further evaluation ASAP.

Staff may complete: (Forest Service Wildland Firefighter Medical Standards at: http://www.fs.fed.us/fire/safety/wct/fs_version_ms.pdf)

Vital Signs:

Height: _____ inches Weight: _____ pounds BMI: _____

BP: _____/_____ _____/_____ _____/_____

(If first reading is greater than 130/80 mm Hg, repeat in 10 minute intervals for a total of 3 readings)

Pulse: _____ beats per minute _____ beats per minute
(If first reading is greater than 100 bpm, repeat in 10 minutes. If first reading is less than 60 bpm, the examinee must run in place for 1 minute and then repeat reading)

Respirations: _____breaths per minute Temperature: _____ F / C

Vision:
Uncorrected Distant – Vision must be done on all examinees **except** soft contact wearers.
Corrected Distant – Vision must be done on **all** examinees who wear corrective lenses.

	Right:	Left:	Both:
Uncorrected Distant Vision:	20/_____	20/_____	20/_____
Corrected Distant Vision:	20/_____	20/_____	20/_____

Near Vision: Can read **on a dollar bill,** "This note is legal tender for all debts, public and private" (size 5 font) or similar size printed font? (with or without corrective lenses) ☐ Corrected ☐ Yes ☐ No

Color Vision: Can see red/green/yellow or passes Ishihara? ☐ Yes ☐ No

Peripheral Vision: (temporal) Right: _____ degrees Left: _____ degrees

Urinalysis:

Glucose:_____ Ketones:_____
SpGr:_____ Blood:_____
pH:_____ Protein:_____
Nitrites:_____ Leuks:_____

Hearing test: (do best test that's available)

a) Whisper test:

(No hearing aids to be used)

(The examinee is to be at least 5 feet from the examiner with the ear being tested facing the examiner. The other ear is covered. Using the breath that remains after a normal exhalation, the examiner whispers words or random numbers (eg. 66, 18, 23, 41) that the examinee has to repeat or asks a question they have to answer. The opposite ear should be tested the same way using different words, numbers, or question. If the individual fails this test in either ear, they will require an audiometer test. (Record in feet)

Right:_____ feet Left:_____ feet

b) Handheld Audiometer test:

(No hearing aids to be used)

(Record lowest number decibel, dB, that can be heard for that frequency)

Frequency	500 Hz	1000 Hz	2000 Hz	3000 Hz
Right ear				
Left ear				

c) Audiogram: _____ (check if performed)

If audiogram is done, please give a copy of report to employee to fax in.

Peak Flow: Please demonstrate to examinee first. Make sure the examinee is standing up straight and looking forward to perform the test.

1._____ 2._____ 3._____ (check)_____ normal for age and height

Medical provider completes:	(please explain all abnormal findings)	
1. General Appearance	◻ Normal	◻ Abnormal
2. Mental Status/Psychologic	◻ Normal	◻ Abnormal
3. Head and Neck		
a. Scalp, Skull, Face (no conflict with hard hat use)	◻ Normal	◻ Abnormal
b. Eyelids, Ocular Mobility	◻ Normal	◻ Abnormal
c. Pupils, Cornea, Conjunctiva, Retina	◻ Normal	◻ Abnormal
d. External Ear, Canal	◻ Normal	◻ Abnormal
e. Tympanic Membrane	◻ Normal	◻ Abnormal
f. Nose, Mouth/Throat/Teeth	◻ Normal	◻ Abnormal
g. Speech	◻ Normal	◻ Abnormal
h. Neck, Thyroid, Lymph Nodes	◻ Normal	◻ Abnormal
4. Lungs and Chest (CXR if abnormal lung exam/hx - send copy of report)	◻ Normal	◻ Abnormal
5. Cardiac (murmur, rhythm, etc.) (EKG and/or CXR if abnormal exam/hx) (please send copy of EKG reading or XR report)	◻ Normal	◻ Abnormal
6. Peripheral Blood Vessels	◻ Normal	◻ Abnormal
7. Abdomen	◻ Normal	◻ Abnormal
8. a. Hernia	◻ None	◻ Present Where:_____ Reducible_____ Incarcerated_____
b. Testicular exam	◻ Normal	◻ Abnormal
9. Skin	◻ Normal	◻ Abnormal
10. Upper Extremities		
a. Visual Observation/Palpation	◻ Normal	◻ Abnormal
b. Strength	◻ Normal	◻ Abnormal
c. Range of Motion	◻ Normal	◻ Abnormal
d. Hands/Fingers	◻ Normal	◻ Abnormal
e. Sensation	◻ Normal	◻ Abnormal
11. Lower Extremities		
a. Visual Observation/Palpation	◻ Normal	◻ Abnormal
b. Strength	◻ Normal	◻ Abnormal
c. Range of Motion	◻ Normal	◻ Abnormal
d. Feet/Toes	◻ Normal	◻ Abnormal
e. Sensation	◻ Normal	◻ Abnormal
12. Spine/Back (scoliosis, range of motion, tenderness, etc)	◻ Normal	◻ Abnormal
13. Neurological		
a. Cranial Nerves I-XIII	◻ Normal	◻ Abnormal
b. DTR's	◻ Normal	◻ Abnormal
c. Romberg	◻ Normal	◻ Abnormal
d. Proprioception of Major Joints	◻ Normal	◻ Abnormal
e. Temperature Sensation of Hands and Feet	◻ Normal	◻ Abnormal
f. Heel to Toe Walk	◻ Normal	◻ Abnormal

g. Balance on Each Foot	◻ Normal	◻ Abnormal
14. Tetanus up-to-date (in last 10 yrs)	◻ Yes	◻ No If not, please offer to immunize. ◻ Updated today
15. Other findings	◻ Normal	◻ Abnormal
Diagnosis: (list all diagnoses found including self-limiting, such as: colds, sprain/strain, etc.; as well as tobacco use disorder)	◻ Well Exam	◻ Medical Condition:
Examining Medical Provider Printed Name:		Address (Street, City, State, ZIP):
Signature:		
Date:		
Telephone and Fax Numbers: T: F:		

FOR AGENCY USE ONLY

Part D.

Reviewing Medical Officer Qualification	
Medically Qualified	◻ ◻ Temporary Restrictions (explain) ◻ Conditional (explain) ◻ with Waiver(s) (explain)
Not Medically Qualified	◻ ◻ Information Needed (explain)
(If changing a recent qualification determination please explain)	

Explanation:

Agency Medical Officer's Name	Email
Address	Telephone Number
Signature of Agency Medical Officer	Date (mm/dd/yyyy)