DEPARTMENT OF DEFENSE
PENTAGON FORCE PROTECTION AGENCY
9000 DEFENSE PENTAGON
WASHINGTON, DC 20301-9000

OMB No. xxxx-xxxx
OMB approval expires XXXXX XX XXXX

The public reporting burden for this collection of information, xxxx-xxxx, is estimated to average 20 minutes 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. Send comments regarding the burden estimate or burden reduction suggestions to the Department of Defense, Washington Headquarters Services, at whs.mc.alex.esd.mbx.dd-dod-information-collections@mail.mil. Respondents should be aware that notwithstanding any other provision of law, no person shall be subject to any penalty for failing to comply with a collection of information if it does not display a current valid OMB control number.

Privacy Act Notice

Pentagon Force Protection Agency will not disclose information collected on this form to any source other than what has been authorized under the Privacy Act of 1974 or 5 U.S. Code 552a for routine uses (i.e., information verifying an applicant's employment may be disclosed to a prospective Agency that require information obtained in the completion of this form to help in the determination as to the individual's fitness for federal employment in the field of law enforcement) as identified in the system of records notice at OPM/GOVT-5 system of records at http://dpcld.defense.gov/Privacy/SORNsIndex/DOD-wide-SORN-Article- View/Article/570737/opmgovt-5/. Your obligation to respond is voluntary, but failure to provide requested information could impede processing.

Request information on the below listed applicant who is applying for a position with the Pentagon Force Protection Agency. We have been informed they applied with your agency for a law enforcement position. It would be beneficial to our investigation if you would complete and return this questionnaire. An "Authorization for Release of Information Form" is attached. If you have any questions, please contact the PFPA Recruitment Branch at **(703) 571-8000.**

1. Applicant	
a. Name:	b. Date:
2. Supplemetal History Questionnaire	
a. Are you requesting any special accommodations while on the job?	☐ YES ☐ NO Description:
b. Do you take nutritional supplements, homeopathic regimens, steriods / performance enhancing substances, diet aids, etc.?	☐ YES ☐ NO Description:
c. Do you have a prior medical disability determination (VA, Social Security, Worker's Comp)? If so, please provide details so the PFPA Medical Advisor can assess your ability to safely perform the essential tasks of the job without risk to youself or others.	☐ YES ☐ NO Description:
d. Please list and describe any surgical history you may have had in life (e.g., tonsillectomy, eardrum tubes, appendectomy, scope of a joint, graft, orthopedic hardware, etc.)	Surgery/Year:
2. Vaccination History	
a. Tetanus Booster (TD or TDAP)	Year:
b. MMR (Measles, Mumps, Rubella)	Year:
c. Have you had all 3 Hepititus B vaccinations?	Year of Last One:
d. If you had a Hep B titer (blood test to show you have immunity and don't need revaccination), provide year and result	Year/Result:
e. Do you have a history of a serious reaction to a vaccination?	☐ YES ☐ NO

f. Do you have a history of a POSITIVE Tuberculousis skin test? Did you receive treatment? When was your most recent Chest X-Ray?	☐ YES ☐ NO Year ☐ YES ☐ NO Year Date:
g. Have you had occupational exposure (without benefit of protective equipment)? Examples can include noise, chemicals, particulates, toxins, smoke, etc.	☐ YES ☐ NO Exposure: Year:
h. Do you have any medical or health condition that would prevent you? - From maintaining a shaved face? (males) - From wearing contacts if glasses are needed to meet the Distance Visual Acuity requirement (20/20)?	 ☐ YES ☐ NO Condition: ☐ YES ☐ NO Condition:
i. Have you been adivised to limit specific activities on a routine bases? Examples might include; heavy lifting, work above shoulder level or overhead, running, etc.	☐ YES ☐ NO Limitations Advised:

3. Review of Systems (ROS)

Have you had / do you have any of the following (*Circle Positives*):	**Please Describe Items Circled Under ROS**
SKIN: Eczema/Psoriasis/Dermatitis, Skin Reaction to Contact Items (Examples: latex, nickel, plants) Skin Reaction to Cold Items, Skin Cancer, Other Skin Conditions **HEENT:** Head Trauma, Concussion, LASIK/PRK, Other Lazy Eye Surgery, Color Blindness, Retinal Reattachment, Ruptured Eardrum(s), Nasal Polyps, Sleep Apnea, TMJ **NECK:** Procedures/Trauma, Spine Conditions/Injuries, Radiation Treatment **CARDIO – VASCULAR:** Arrhythmia, Heart Valve Condition, Angina or Heart Attack, Chronic Heart Condition, Heart Procedures (Cath, Angioplasty, Stent, Ablation) Blood Clot or DVT, Pulmonary Embolism, Vessel Stenosis, Varicose Veins, Pacemaker, Defibrillator **PULMONARY** Partially Collapsed Lung, Exercise-Induced Asthma COPD / Emphysema, Smoke Inhalation (no PPE), Black Lung, Sarcoidosis or Amyloidosis, Other **DIGESTIVE TRACT** Hiatal Hernia, Ulcer, Pancreatitis or Gall Bladder, Hepatitis or Cirrhosis, Spleen Removed, Ulcerative Colitis or Crohn's Disease, Belly Button or Groin Hernia	

GENITO-URINARY
Kidney Condition, Kidney Stones or Cysts,
Urinary Tract Condition [male],
Prostate Condition [male], Testicular Condition,
[female] GYN Condition

ORTHOPEDIC
Back/Spine Condition or Injury,
Shoulder/Elbow/Arm Wrist/Hand Condition,
Hip/Knee/Leg/Knee Ankle/Foot Condition,
Arthritis (osteo, rheumatoid, psoriatic, other),
Osteoporosis, Broken or Crushed Bones,
Partial Amputations, Muscle Diseases or Conditions

BRAIN/NERVES/PSYCHIATRIC
Alzheimer's, Delirium (vs. Dementia),
MS/ALS or other Neuro Diseases, Migraines,
Shunt or Bleed (brain) Seizures,
Brainstem or Spinal Cord Lesion,
Vertigo or Positional Dizziness, Pinched Nerves**,**
Carpal or Cubital Tunnel Syndrome,
Tarsal Tunnel Syndrome, Radiculopathy or Paralysis
Numbness or Pins-and-Needles Reflex Sympathetic
Dystrophy, Neuropathy or Chronic Pain (Diabetic,
Compression, Disease), Alcoholism,
Substance Abuse and/or Dependence (Rx or Street),
Psychiatric Diagnoses; Anxiety/Panic Disorder,
Depression or Mania Bipolar Disorder, PTSD,
Schizophrenia Neurosis or Psychosis Self-inflicted
Harm Compulsive Disorder, ADD/ADHD

IMMUNE SYSTEM
Exercise-Induced Anaphylaxis, Auto-Immune
Conditions (Lupus, Thyroiditis, Raynaud's,
Rheumatoid Arthritis, MS, etc.)
Taking Immune System Suppressing Medication, Low
CD4 and/or T Helper Cell Ct., Chronic Infectious
Disease Cancer or Organ Transplant

HEMATOPOIETIC SYSTEM
Anemia, Sickle Cell or Thalassemia (T/D) Low Platelet
Count, Bleeding Disorder, Lymph Node Disorder

ENDOCRINE SYSTEM
Diabetes (no Insulin; + Insulin), Pituitary Disorder
Thyroid/Parathyroid Disorder Adrenal Gland Disorder
Polycystic Ovarian Disorder

NOTICE: 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.