University of Colorado
Anschutz Medical Campus

CU Polar Medicine
Mail Stop C328
12631 E. 17th Avenue | Aurora, CO 80045
FAX: 303-724-5649 | arcticsupport@cuanschutz.edu
coloradoWM.org

PQ Packet Checklist and Packet Order			
Ready Check	Packet Order	Medical Tests and Packet Order Items/Notes	Page in Packet
	1.	Physical Qualification (PQ) Overview (x1 signature)	Page 2
	2.	Electronic Health Record - Registration Form (for Epic entry)	Page 3
	3.	Authorization to Request Protected Health Information/Authorization to Release Information in the Event of a Medical Emergency (x3 signatures)	Page 4 – 11
	4.	Request for Individual Access to Records Protected under the Privacy Act	Page 12– 16
	5.	Health Information Exchange (HIE) Opt-In/Out Request (x1 signature)	Page 17
	6.	Acknowledgment of Receipt of UCHealth Notice of Privacy Practices (signature/date)	Page 18
	7.	Consent to Service	Page 19
	8.	Medical History Form	Page 20 – 24
	9.	Arctic Physical Examination a. If under 45 yrs. only every other year unless modified by medical/nursing direction for prior NPQ, medevac, MAM, or complicated medical history.	Page 27 & 28, bring Pages to Doctor appointment
	10.	Any MD Notes	
	11.	**Immunizations: REQUIRED immunizations that you must provide written documentation for:**	
		a. Seasonal Influenza (exception for Arctic participants deploying in late spring/summer)	
		b. Measles (if not immune)	
		c. COVID-19 (CDC up-to-date recommendations) – Must complete CDC up-to-date recommendations for vaccination at least 14 days prior to deployment.	
		d. TDaP (Tetanus, Diphtheria, and Pertussis)	
	12.	Lab Test Results (required for all participants)	
		a. Complete Blood Count with Differential	
		b. Blood Chemistries (Sodium, Potassium, Chloride, Glucose, Creatinine, GFR/BUN, Calcium)	
		c. Hepatic Panel (Alkaline Phosphatase, Total Bilirubin, AST (SGOT), ALT (SGPT))	
		d. Lipid Panel (Cholesterol, HDL, LDL, Triglycerides)	
		e. Hepatitis B core total antibody (Anti-HBc)	
		f. Hepatitis C antibody (Anti-HCV)	
		g. RPR (syphilis)	
		h. Blood Type (ABO and RH)- required annually per American Blood Bank policies	
		i. Quantiferon TB	
		j. MMR Titer	
		k. HgA1c: *If has history of diabetes or glucose greater than 100*	
		l. HIV: *Required if you elected YES for volunteering for the walking blood bank (United States Arctic Program Deployment Consent/Authorization Documents -pg. 32*	
		a. TSH: *History of hyper/hypothyroidism.*	
		b. Guaiac Stool test (*If age 50+)*	
	13.	Twelve-lead EKG tracing or rhythm strip *a. All new participants; then, age 40-49 every 5 yrs; then, age 50+ annually*	
	14.	Exercise Stress Test (Criteria as noted in Appendix 1) *a. Summer Participant: required only if FHR score greater than 20%.*	
	15.	Pulmonary Function Test, pre/post bronchodilator *a. History of asthma, emphysema, or COPD OR occupational PFT (spirometry for work)*	
	16.	Mammogram (females) (radiology) *a. Age 40+ every 2 years*	
	17.	Chest X-Ray *a. Per TB protocol for positive PPD/ Quantiferon; or symptomatic pulmonary disease* Submit report only, not actual films	
	18.	Low-dose CT (screening for lung cancer) a. Screen participants at high-risk for lung cancer: *Age 55-80, AND at least 30 pack-yr history, AND current smoker or quit less than 15 years ago*	
	19.	Arctic Dental Examination	Page 29 & 30
	20.	United States Arctic Program Deployment Consent/Authorization Documents	Page 31 & 32
	21.	Authorization for Treatment of Field-Team Member/Participant Under 18-Years of Age	Page 33

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Physical Qualification (PQ) Overview

University of Colorado (CU) Polar Medicine

Congratulations on your prospective candidacy to support NSF Arctic north programs for the 2024 season! Due to the unique conditions and remote location associated with deployment, the NSF requires candidates to complete a process to physically qualify (PQ) for that deployment. This is an annual medical screening that includes:

1) a visit to a lab to complete required screening studies including blood work
2) a visit to a medical provider (MD, DO, NP, PA) for a physical exam and history
3) a visit to a dentist to include x-rays
4) Submission of the completed packet with requested documentation attached

The CU Polar Medicine team will review the submitted materials to ensure all necessary documentation is included. A medical provider will review the medical information to assign a designation of "Physically Qualified" (PQ) indicating that deployment can proceed or "Not Physically Qualified" (NPQ) indicating that deployment will be rescinded. If a designation of NPQ is assigned, the NSF has a waiver process that may be considered.

Full Disclosure: In the interest of the health and well-being of both yourself and the other program members, please answer the questions honestly and completely on this health form. A "Yes" answer does not automatically cancel your qualification. If we have a question regarding your capacity to successfully participate, we will contact you to discuss it. Failure to disclose a health condition that becomes relevant while on your deployment may result in a costly evacuation, disruption to research and other arctic activities, or a fatal event.

I realize that failure to disclose information could result in serious harm to myself and fellow program members. I agree to inform CU Polar Medicine, Battelle-ARO, and the National Science Foundation should there be any change in my health status prior to the start of the deployment. Based on the deployment description, and what I know or suspect about my physical and psychological health, I am fully capable of participating in this arctic deployment.

By my signature, I confirm that the information provided on this form will be an accurate and complete representation of my health history.

Participant's Signature_____
Date _____

You are not approved to deploy until this health form has been reviewed and approved by CU Polar Medicine personnel.

Thank you for your careful attention to completion of ALL forms within this document and timely submission to the CU Polar Medicine. If you have any questions concerns, please contact the PQ team promptly at arcticsupport@cuanschutz.edu.

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Electronic Health Record- Registration Form

**Of note: Information on this form is required for the creation of your electronic health record and can be helpful for us to be able to assist you best if an emergency arises during deployment.

First Name:	Last Name:	MI:
Deployment Location:	Prospective Date of Deployment:	
Social Security Number:	Sex: ☐ **M**ale ☐ **F**emale	
Date of Birth:	Age:	
Preferred Pronouns:		

*** Social Security Number is used as a measure to ensure that medical staff has the correct medical record, but is not required. If you would prefer, please call our admin, Kellie Schiller, at 802-275-6367 and she can take down your SS# over the phone.

Address:	
City:	State:
Zip Code:	Phone Number:
Email Address:	

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Authorization to Request Protected Health Information

*** Note: This form gives consent for our Arctic PQ team to reach out to your providers to request additional information, such as, work-up, supporting medical records, a letter of support, or more insight from your provider regarding a medical condition, ONLY WHEN NEEDED. We ask all patients beforehand if we can contact their provider.

Patient Name:	Birth Date:
Address:	
City/State:	ZIP:
Phone Number:	

I authorized release:

FROM: Primary Care Clinic/Medical Facility	**TO the following Medical facility**
Name:	Name: CU Polar Medicine
Facility:	Facility: University of Colorado, Anschutz Medical Campus
Address:	Address: CU Polar Medicine Mail Stop C328 12631 E 17th Ave Aurora, CO 80045
Phone:	Phone: 802-275-6367
FAX:	FAX: 303-724-5649

Date of service range (month/year)* From: _____ To: _____

*** *(Put date range from date of doctors appointment to end of deployment)*

☐ Clinic/Progress notes	☐ Laboratory results
☒ Complete (All records, notes, meds, flowsheets, etc).	☐ **Mental health treatment****
☐ Discharge summary	☐ Operative note
☐ **Drug/Alcohol treatment****	☐ Radiology reports
☐ Emergency room report	☐ **Sickle cell information****
☐ Facesheet	☐ **STD/Communicable disease****
☐ **Genetic information****	☐ Immunization record
☐ History & Physical	☐ **HIV/AIDS information****
☐ Visit record (includes emergency room records, provider notes/reports, health date, medical history, medicine and allergy lists, test results; does not include images)	☐ Visit summary (includes provider notes/reports, test results; does not include images)
☐ Other: _____	

**** I hereby consent to disclose the above bolded specialized information.**

_____

Patient's signature required.

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1. I authorize the release of my medical record, including photographs.
2. **This authorization is voluntary**, and the disclosure is made at my request.
3. If the organization authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.
4. Multiple requests are authorized if the purpose of the request remains the same.
5. I have a right to revoke this authorization at any time, and if I revoke this authorization, I must do so in writing and present thewritten revocation to the department that I have authorized to release the information. Any revocation will not apply to information that has already been released in response to this authorization.
6. I need not sign this form to ensure health care treatment.
7. Potential for redisclosure: Your health information disclosed according to this authorization will no longer be protected by the federal privacy law (known as "HIPAA"), and the recipient of the information may potentially redisclose it.

I request this authorization to expire on_____or 180 days from the date signed below and **covers only treatment for the date(s) specified above.**

IMPORTANT WARNING: The documents accompanying this message are intended for the use of the person or entity to which this message is addressed. These documents may contain information that is privileged and confidential, the disclosure of which is governed by applicable law. Unauthorized re-disclosure or failure to maintain confidentiality could subject you to penalties described in federal and state law. If you are the employee or agent responsible to deliver this information to the intended recipient, you are hereby notified that any dissemination, distribution, or copying of this information is **STRICTLY PROHIBITED.**

_____ _____

Signature of patient or legal representative Date

Authorization to Release Information in the Event of a Medical Emergency

In the event of a medical emergency, I authorize my information to be released to the National Science Foundation and/or Battelle Arctic Research Operations teammates only for the purposes of facilitating urgent/emergent medical care and/or evacuation. Information released will be limited to the minimum data required to ensure emergent medical care or emergency medical evacuation and will be limited only to select teammates providing clinical care and/or those required to coordinate evacuation/emergency medical care. I reserve the right to revoke this permission at any time.

_____ _____

Signature of patient or legal representative Date

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Authorization to Request Protected Health Information

*** Note: This form gives consent for our Arctic PQ team to discuss/provide your medical information with your primary care provider. In the event of an emergency during deployment, this would allow us to update your primary care provider, if needed.

Patient Name:	Birth Date:
Address:	
City/State:	ZIP:
Phone Number:	

I authorized release:

FROM: Medical Facility	**TO: Primary Care Clinic/Medical Facility**
Name: CU Polar Medicine	Name:
Facility: University of Colorado, Anschutz Medical Campus	Facility:
Address: CU Polar Medicine Mail Stop C328 12631 E 17th Ave Aurora, CO 80045	Address:
Phone: 802-275-6367	Phone:
FAX: 303-724-5649	FAX:

Date of service range (month/year)* ** From: _____ To: _____

*** (Put date range from date of doctors appointment to end of deployment)*

☐ Clinic/Progress notes	☐ Laboratory results
☒ Complete (All records, notes, meds, flowsheets, etc).	☐ **Mental health treatment****
☐ Discharge summary	☐ Operative note
☐ **Drug/Alcohol treatment****	☐ Radiology reports
☐ Emergency room report	☐ **Sickle cell information****
☐ Facesheet	☐ **STD/Communicable disease****
☐ **Genetic information****	☐ Immunization record
☐ History & Physical	☐ **HIV/AIDS information****
☐ Visit record (includes emergency room records, provider notes/reports, health date, medical history, medicine and allergy lists, test results; does not include images)	☐ Visit summary (includes provider notes/reports, test results; does not include images)
☐ Other: _____	

**** I hereby consent to disclose the above bolded specialized information.**

_____

Patient's signature required.

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Authorization to Request Protected Health Information

*** Note: This form gives consent for CU Polar Medicine to share records to UTMB, such as in the case of PQ Transfers.

Patient Name:	Birth Date:
Address:	
City/State:	ZIP:
Phone Number:	

I authorized release:

FROM: Medical Facility	**TO the following Medical facility**
Name: CU Polar Medicine	Name: Center for Polar Medical Operations
Facility: University of Colorado, Anschutz Medical Campus	Facility: University of Texas Medical Branch
Address: CU Polar Medicine Mail Stop C328 12631 E 17th Ave Aurora, CO 80045	Address: Levin Hall 5th Floor 301 University Blvd Galveston, TX 77555-1004
Phone: 802-275-6367	Phone: (855) 300-9704
FAX: 303-724-5649	FAX:

Date of service range (month/year)* From: _____ To: _____

*** *(Put date range from date of last submitted PQ packet with CU (if applicable) or doctors appointment, to end of deployment)*

☐ Clinic/Progress notes	☐ Laboratory results
☒ Complete (All records, notes, meds, flowsheets, etc).	☐ **Mental health treatment****
☐ Discharge summary	☐ Operative note
☐ **Drug/Alcohol treatment****	☐ Radiology reports
☐ Emergency room report	☐ **Sickle cell information****
☐ Facesheet	☐ **STD/Communicable disease****
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☐ Visit record (includes emergency room records, provider notes/reports, health date, medical history, medicine and allergy lists, test results; does not include images)	☐ Visit summary (includes provider notes/reports, test results; does not include images)
☐ Other: _____	

**** I hereby consent to disclose the above bolded specialized information.**

_____

Patient's signature required.

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_____ _____

Signature of patient or legal representative Date

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Authorization to Request Protected Health Information

*** Note: This form gives consent for UTMB to share records to CU Polar Medicine, such as in the case of PQ Transfers.

Patient Name:	Birth Date:
Address:	
City/State:	ZIP:
Phone Number:	

I authorized release:

FROM: Medical Facility	**TO the following Medical facility**
Name: Center for Polar Medical Operations	Name: CU Polar Medicine
Facility: University of Texas Medical Branch	Facility: University of Colorado, Anschutz Medical Campus
Address: Levin Hall 5th Floor 301 University Blvd Galveston, TX 77555-1004	Address: CU Polar Medicine Mail Stop C328 12631 E 17th Ave Aurora, CO 80045
Phone: (855) 300-9704	Phone: 802-275-6367
FAX:	FAX: 303-724-5649

Date of service range (month/year) From: _____ To: _____

*** *(Put date range from date of last submitted PQ packet with UTMB (if applicable) or doctors appointment, to end of deployment)*

☐ Clinic/Progress notes	☐ Laboratory results
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☐ Other: _____	

**** I hereby consent to disclose the above bolded specialized information.**

_____

Patient's signature required.

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_____ _____

Signature of patient or legal representative Date

NATIONAL SCIENCE FOUNDATION
2415 EISENHOWER AVENUE
ALEXANDRIA, VIRGINIA 22314

INFORMATION FOR INDIVIDUALS MAKING REQUESTS TO THE OFFICE OF POLAR PROGRAMS FOR RECORDS UNDER THE PRIVACY ACT OF 1974

To request information collected in the course of NSF's medical screening or care provided while deployed to the polar regions, please complete the *Request for Individual Access to Records* to make an official records request verifying the identity of the requestor. **Due to the COVID-19 pandemic and the full-time telework posture of NSF, NSF is allowing submission of this form electronically via email as long as the identity of the requestor is consistent with the identity on the records being requested. Please send all requests password protected then in a separate email provide the password.** Upon receipt of the official request, NSF expects to respond within 20 business days. Please note that NSF cannot provide copies of X-ray films. Medical records are not kept indefinitely and some older records may not be available.

NOTE: If you are providing consent and authorizing the agency to disclose your records to another person or entity, the *Consent for Disclosure* form will need to be submitted. Please send all requests password protected then in a separate email provide the password.

INSTRUCTIONS

1) Enter the requestor's name, physical address, email and phone number.
2) Provide specific information detailing the records requested and the time period covered by the request.
3) Provide the record requestor's name, address, phone number and email. The phone number and email will only be used in the event that NSF has questions regarding the request.
4) Provide the physical address where NSF will send the records. Records cannot be sent to a Post Office (P.O.) box. If sending the records to a third party (e.g. a physician's office), provide the recipient's name and address. A specific person must be named to receive the documents.
5) Verify under penalty of perjury by signing the form at the bottom, or notarize the form provided, to ensure this is a true and correct request.

Point of Contact:
Elicia Liles
Office of Polar Programs
National Science Foundation
2415 Eisenhower Avenue
Alexandria, VA 22314

Email: eliles@nsf.gov
Phone: 571-215-4420

Requests may also be sent to NSF's Office of the General Counsel. More information is available on NSF's FOIA and Privacy Act website: https://www.nsf.gov/policies/foia.jsp.

NATIONAL SCIENCE FOUNDATION

Request for Individual Access to Records Protected under the Privacy Act

If you are seeking access to your records, please provide the information below. This form may also be used if you are the parent seeking access to the records of a minor or the legal guardian seeking access to the records of an incompetent.

Information Required for Identity-Proofing and Authentication

This information is required for the agency to verify your identity.

Full Name:

Address:

Email: Phone Number:

If Applicable: Information for Request by Parent or Legal Guardian

Name of Record Subject:

Relationship to Subject:

Additional Information Required to Locate the Record(s)

Record Type (select all that apply):

☑ Medical Treatment ☑ Physical Therapy ☑ Other

If other, please specify: Dental Records

Record dates beginning on: . ending on:

Contact Information

Physical Address for Receiving Records:
CU Polar Medicine, Mail Stop C328, 12631 E 17th Ave, Aurora, CO 80045

Phone Number: 802-275-6367 Email Address: arcticsupport@cuanschutz.edu

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In accordance with 28 U.S.C. § 1746, I elect to use the following statement in lieu of notarization:

I declare under penalty of perjury under the laws of the United States of America that the foregoing is true and correct, and that I am the person named above and requesting access to my records [, *or records that I am entitled to request as the parent of a minor or the legal guardian of an incompetent],* and I understand that any falsification of this statement is punishable under the provisions of 18 U.S.C. § 1001 by a fine, imprisonment of not more than five years, or both, and that requesting or obtaining any record(s) under false pretenses is punishable under the provisions of 5 U.S.C. § 552a(i)(3) by a fine of not more than $5,000.

Signature: Date:

Privacy Act Statement

In accordance with the National Science Foundation's Privacy Act implementation rules, personal information sufficient to identify the individuals requesting access to records under the Privacy Act of 1974, 5 U.S.C. § 552a, is required. The purpose of this solicitation is to ensure that the records of individuals who are the subject of the National Science Foundation systems of records are not wrongfully disclosed by the National Science Foundation. Requests will not be processed if this information is not furnished. False information on this form may subject the requester to criminal penalties under 18 U.S.C. § 1001 and/or 5 U.S.C. § 552a(i)(3).

NATIONAL SCIENCE FOUNDATION

Request for Individual Access to Records Protected under the Privacy Act

If you are seeking access to your records, please provide the information below. This form may also be used if you are the parent seeking access to the records of a minor or the legal guardian seeking access to the records of an incompetent.

Information Required for Identity-Proofing and Authentication

This information is required for the agency to verify your identity.

Full Name:

Address:

Email: Phone Number:

If Applicable: Information for Request by Parent or Legal Guardian

Name of Record Subject:

Relationship to Subject:

Additional Information Required to Locate the Record(s)

Record Type (select all that apply):

☑ Medical Treatment ☑ Physical Therapy ☑ Other

If other, please specify: Dental Records

Record dates beginning on: . ending on:

Contact Information

Physical Address for Receiving Records:
Center for Polar Medical Operations
University of Texas Medical Branch
Levin Hall 5th Floor, 301 University Blvd
Galveston, TX 77555-1004

Phone Number: 855-300-9704 Email Address: PolarMed@utmb.edu

In accordance with 28 U.S.C. § 1746, I elect to use the following statement in lieu of notarization:

I declare under penalty of perjury under the laws of the United States of America that the foregoing is true and correct, and that I am the person named above and requesting access to my records [, *or records that I am entitled to request as the parent of a minor or the legal guardian of an incompetent],* and I understand that any falsification of this statement is punishable under the provisions of 18 U.S.C. § 1001 by a fine, imprisonment of not more than five years, or both, and that requesting or obtaining any record(s) under false pretenses is punishable under the provisions of 5 U.S.C. § 552a(i)(3) by a fine of not more than $5,000.

Signature: Date:

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Please note that opting in or out of the Health Information Exchange (HIE) will not influence your PQ decision, nor will it delay your PQ decision. Opt-in allows your primary medical records to be reviewed electronically by the PQ team and allows your primary medical team to review your PQ paperwork, if your clinic participates in EPIC sharing.

Health Information Exchange (HIE) Opt-In/Out Request

UCHealth Clinics and aligned medical facilities participates in the electronic exchange of protected health information ("PHI") with other health care providers and health insurance plans through approved health information exchange organizations. Through UCHealth's participation, PHI may be accessed by other providers and health insurance plans or other permitted recipients of PHI, as permitted by law, for treatment, payment, and health care operations purposes. These health information exchanges maintain safeguards to protect the privacy of your PHI. You are able to opt-out of having your PHI accessed on these exchanges.

In Colorado, UCHealth clinics and aligned medical facilities participates in the Colorado Regional Health Information Organization (CORHIO).

I understand that by OPTING IN I am requesting that my health information is viewable through the health information exchange systems listed above.

- A separate form must be filled out for each family member requesting to opt back in to the HIE system.
- All fields are required for the form to be processed.

I understand that by OPTING OUT I am requesting that my health information is not viewable through the health information exchange systems listed above.

Select here if you want to Opt In or Opt Out:

☐ Opt In

☐ Opt Out

_____ _____

Signature of patient or legal representative Date

uchealth

Patient Identification Label
Name
MRN
DOB
Date of service

Acknowledgment of Receipt of UCHealth Notice of Privacy Practices

This consent applies to all hospitals, physician offices, and other facilities that are part of University of Colorado Health ("UCHealth"), including to UCHealth Broomfield Hospital, UCHealth Grandview Hospital, Longs Peak Hospital, Medical Center of the Rockies, Poudre Valley Hospital, UCH-MHS (Memorial Hospital), UCHealth Greeley Hospital, UCHealth Highlands Ranch Hospital, UCHealth Pikes Peak Regional Hospital, University of Colorado Hospital Authority, UCHealth Yampa Valley Medical Center, UCHealth Medical Group, UCHealth Imaging Services, LLC, UCHealth Partners (including UCHealth Emergency Rooms) and UCHealth Ambulatory Surgery Centers (each a "Facility"), including all health care providers at those facilities, some of whom are employed by the University of Colorado.

By signing this document, I acknowledge that I have received a copy of the Notice of Privacy Practices for UCHealth, which is included in your Arctic PQ Information document.

DO NOT SIGN UNLESS YOU HAVE READ AND THOROUGHLY UNDERSTAND THIS FORM.

Name of patient (printed)	N/A Name of witness (printed)
Signature of patient or legally authorized representative	N/A Signature of witness
Self Relationship to patient	N/A Date N/A Time
Date Time	

N/A (Initials) Directed by patient/legal representative to sign on his/her behalf after reading document to him/her.

Reason for directed signature N/A

Interpretation: Informed consent discussion interpreted for patient/representative by (name) N/A (date/time) N/A

Patient Identification Label
Name
MRN
DOB
Date of service

Additionally, some health care providers at the Facility are considered federal employees. Federal sovereign immunity generally bars claims against federal employees, however, in certain circumstances, the Federal Tort Claims Act (FTCA), which provides a limited waiver of sovereign immunity, may apply. Under the FTCA, an administrative claim must be filed with the appropriate military agency within two years of the incident.

By signing this agreement below, I acknowledge that:

- I have read this document and understand its contents.
- I agree to this Agreement
- I agree that I have provided correct and accurate information about the patient (including current address, telephone number, email address, insurance information, and medical history) for health care.
- I understand that I have the right to have a copy of this Agreement.
- The law of the State of Colorado will apply to this Agreement.
- In any legal action brought under this Agreement, I waive my right to trial by jury.
- I understand that no person working at Facility is allowed to change or erase any part of this document. Changes or anything that was added or deleted will not change the original (first) agreement, but that I've had an opportunity to ask questions about this Agreement and have received answers to such questions. I enter into this Agreement freely, knowingly, and voluntarily.

	N/A
Name of patient (printed)	Name of witness (printed)
	N/A
Signature of patient or legally authorized representative	Signature of witness
Self	N/A N/A
Relationship to patient (if applicable)	Date Time ☐ a.m. ☐ p.m.
Date Time ☐ a.m. ☐ p.m.	

N/A (Initial) Directed by Patient/Legal Representative to sign on patient's behalf, after reading document to him/her.

Reason for directed signature N/A

Discussion interpreted by:

Language N/A Operator # or Interpreter name N/A

MEDICAL HISTORY

The PARTICIPANT COMPLETES this Medical History form prior to any exam

Arctic 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 Arctic Season	Worksite	Dates
☐ Summer (Mar-Aug)	☐ Summit Station	
☐ Winter (Sept-Feb)	☐ Field Camp	
	☐ Vessel	
_____ (dates)		

☐ Other (specify):

MEDICAL HISTORY

CURRENT MEDICATIONS - (Check box if None) ☐

Name	Dose	Frequency	Name	Dose	Frequency

DRUG ALLERGIES - (Check box if None) ☐ **FOOD ALLERGIES - (Check box if None)** ☐

Name	Type of Reaction	Name	Type of Reaction

PAST HOSPITALIZATIONS - (Check box if None) ☐

Condition	Date (YYYY)	Condition	Date (YYYY)

PAST SURGERIES - (Check box if None) ☐

Condition	Date (YYYY)	Condition	Date (YYYY)

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

Most recent vaccination Date	(YYYY)		
Influenza (Current Deployment Season)		Bacillus - Calmette (BCG) Vaccine (Given in childhood in countries with high rates of TB)	Yes ☐ No ☐
DT/Tdap			
MMR			
Hepatitis A			
Hepatitis B			

LIFESTYLE

Tobacco	Yes	No	Describe: Packs/Day	Total yrs.	Year last
Do you currently use tobacco products?	☐	☐			
Have you used tobacco products in the past?	☐	☐			

Alcohol	Yes	No	If abstinent, please enter date of your last alcoholic beverage (or NONE): (YYYY or NONE)
Do you drink alcohol?	☐	☐	
Have you ever felt you should decrease your alcohol consumption?	☐	☐	**Describe frequency and type of alcohol:**
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 :**
Do you have a regular exercise program?	☐	☐	
Have you had a cardiovascular stress test?	☐	☐	**Date of last Exercise Stress Test:** (MM/YYYY)

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	Transientischemic 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 line number, age of onset, frequency of event, date of last episode, current medications, other therapies and current status of the condition.

GENERAL MEDICAL HISTORY

ANSWER THE FOLLOWING QUESTIONS REGARDING YOUR PRESENT OR PAST MEDICAL HISTORY

	Condition	*Yes*	*No*		*Condition*	*Yes*	*No*
4	**Rheumatologic & Autoimmune disease**			8I	Irritable bowel syndrome (IBS)	☐	☐
4A	Fibromyalgia	☐	☐	8J	Pancreatitis	☐	☐
4B	Osteoarthritis	☐	☐	8K	Peptic ulcer disease	☐	☐
4C	Rheumatoid arthritis	☐	☐	8L	Ulcerative colitis	☐	☐
4D	Systemic Lupus erythematosis	☐	☐	8M	Other gastrointestinal disease	☐	☐
4E	Other Rheumatologic/Autoimmune condition	☐	☐	**9**	**Dermatology**		
				9A	Dermatitis	☐	☐
5	**Ears, Nose and Throat**			9B	Melanoma	☐	☐
5A	Hearing impairment	☐	☐	9C	Psoriasis/Eczema	☐	☐
5B	Nosebleeds	☐	☐	9D	Skin cancer	☐	☐
5C	Seasonal Allergies	☐	☐	9E	Other skin condition	☐	☐
6	**Ophthamology**			**10**	**Orthopedic**		
6A	Glaucoma	☐	☐	10A	Cervical spine injury	☐	☐
6B	Visual impairment	☐	☐	10B	Chronic pain	☐	☐
6C	Other eye condition	☐	☐	10C	Dislocation	☐	☐
6D	Lasik/restorative surgery	☐	☐	10D	Fractures	☐	☐
7	**Pulmonary**			10E	Low back injury	☐	☐
7A	Altitude sickness	☐	☐	10F	Orthopedic pins/plates	☐	☐
7B	Asthma after 10 years of age	☐	☐	10G	Other orthopedic condition	☐	☐
7C	Chronic bronchitis/bronchiectasis	☐	☐	**11**	**Metabolic**		
7D	Chronic obstructive pulmonary disease	☐	☐	11A	Adrenal insufficiency	☐	☐
7E	Dyspnea (shortness of breath)	☐	☐	11B	Diabetes Type I	☐	☐
7F	Obstructive sleep apnea	☐	☐	11C	Diabetes Type II	☐	☐
7G	Pulmonary embolism	☐	☐	11D	Gout	☐	☐
7H	Positive TB Test/Treatment	☐	☐	11E	Hypercholesterolemia	☐	☐
7I	Chronic cough (greater than 3 weeks)	☐	☐	11F	Hyperthyroidism	☐	☐
7J	Night sweats	☐	☐	11G	Hypothyroidism	☐	☐
7K	Unexplained weight loss	☐	☐	11H	Pituitary insufficiency	☐	☐
7L	Exposed to anyone with known TB	☐	☐	11I	Other hormonal disorder	☐	☐
7M	Other pulmonary condition	☐	☐	**12**	**Gynecology-female**		
8	**Gastro intestinal disease**			12A	Menstrual period over 30 days ago?	☐	☐
8A	Black tarry stools/Blood in stool	☐	☐	12B	Date of last PAP smear		
8B	Cholelithiasis (gall stones)	☐	☐	12C	Premenstrual syndrome (PMS)	☐	☐
8C	Crohn's disease	☐	☐	12D	Endometriosis	☐	☐
8D	Frequent or persistent diarrhea	☐	☐	12E	Severe menstrual cramps	☐	☐
8E	Gastroesophageal reflux (GERD)	☐	☐	12F	Ovarian cysts	☐	☐
8F	Hemorrhoids	☐	☐	12G	Sexually transmitted disease	☐	☐
8G	Hepatitis (describe below)	☐	☐	12H	Other gynecological conditions	☐	☐
8H	Hernia	☐	☐	12I	HIV	☐	☐

For all "yes" answers provide details to include line number, age of onset, frequency of event, date of last episode, current medications, other therapies and current status of the condition.

GENERAL MEDICAL HISTORY							
ANSWER THE FOLLOWING QUESTIONS REGARDING YOUR PRESENT AND PAST MEDICAL HISTORY							
	Condition	*Yes*	*No*		*Condition*	*Yes*	*No*
13	**Psychiatric**			**15**	**Hematology/Oncology**		
13A	Addiction	☐	☐	15A	Anemia	☐	☐
13B	Anxiety/panic attacks	☐	☐	15B	Cancer (describe type below)	☐	☐
13C	Attention deficit disorder	☐	☐	15C	Leukemia	☐	☐
13D	Bipolar	☐	☐	15D	Lymphoma – Hodgkins	☐	☐
13E	Depression	☐	☐	15E	Lymphoma – non Hodgkins	☐	☐
13F	Eating disorder (bulimia/anorexia)	☐	☐	15F	Platelet disorder	☐	☐
13G	Hospitalization for psych condition	☐	☐	15G	Hemochromatosis	☐	☐
13H	Post-traumatic stress disorder	☐	☐	15I	Other Hematologic/Oncologic	☐	☐
13I	Schizophrenia	☐	☐	**16**	**Genitourinary - male**		
13J	Suicidal thoughts or attempts	☐	☐	16A	Prostate disease	☐	☐
13K	Other psychiatric condition	☐	☐	16B	Sexually transmitted disease	☐	☐
14	**Renal disease**			16C	Testicular abnormality	☐	☐
14A	Chronic Renal Disease	☐	☐	16D	Other genitourinary condition	☐	☐
14B	Frequent urinary tract infections	☐	☐	16E	HIV	☐	☐
14C	Hematuria (blood in urine)	☐	☐	**17**	**Diving**		
14D	Kidney stones	☐	☐	17A	Are you a diver for the USAP?	☐	☐
14E	Other kidney condition	☐	☐	17B	Have you had the bends? (describe)	☐	☐
				18	**Any other medical condition NOT listed above**	☐	☐

For all "yes" answers provide details to include line number, age of onset, frequency of event, date of last episode, current medications, other therapies and current status of the condition.

I certify that the information contained herein is complete and accurate to the best of my knowledge. I will inform the contractor's medical staff of ALL medical/health changes, including medications that occur after submitting this form. I understand that failure to provide any or all of the requested information may result in a denial of my application for assignment to the Arctic Regions. I also understand that willf ully providing false statements to a Federal agency or its representatives is a criminal offense.

Print Name _____ *Signature* _____ *Date* _____

ARCTIC PARTICIPANT NAME

John Lemery, M.D.
NPI #1184711269
Bill to LabCorp Account #05049790
Account Phone #: 802-275-6367
Fax #: 303-724-5649

DOB: Age: Gender:

If LabCorp is unable to find the Account # to bill to, have them search the Phone # or Fax #. This will bring up our Account and allow them to bill the labs to us.

Dear Lab Collection (LabCorp or Physician)

This person is being considered for participation in the National Science Foundation's Arctic program. Collect specimens for the indicated laboratory analyses: All results need to be translated to English.

Participant: Do not eat or drink for 8 hours before labs.

Required Arctic Panel

- ☑ Complete Blood Count with Differential **(LabCorpTest #005009)**
- ☑ Blood Chemistries **(LabCorp Test #322758)** (Sodium, Potassium, Chloride, Glucose, Creatinine, GFR/BUN, Calcium)
- ☑ Hepatic Panel **(LabCorp Test #322755)** (Alkaline phosphatase, Total Bilirubin, AST (SGOT) , ALT (SGPT))
- ☑ Lipid Panel **(LabCorp Test #303756)** (Cholesterol, HDL, LDL, Triglycerides)
- ☑ Hepatitis B Total Core Antibody (Anti-HBc) **(LabCorp Test #006718)**
- ☑ Hepatitis C Antibody (Anti-HCV) **(LabCorp Test #144050)**
- ☑ RPR (Syphilis) **(LabCorp Test #006072)**
- ☑ Blood Type (ABO and Rh) **(LabCorp Test #006049)**
- ☑ Quantiferon TB **(LabCorp Test #182879)**
- ☑ MMR Titer **(LabCorp Test #058495)**

Additional Labs

- ☐ HgA1c **(LabCorpTest #001453)** (Diabetes, or if glucose 100 or greater)
- ☐ HIV **(LabCorpTest #083935)** (Required if you elected YES for volunteering for the walking blood bank (United States Arctic Program Deployment Consent/ Authorization Documents -pg. 32)
- ☐ TSH **(LabCorpTest #004259)** (History of hyper/hypothyroidism)

Additional Information:

NOTE: Lab results ordered under our LabCorp Account # will not automatically be sent to a participant's physician. All participants are responsible for their results and following up/reporting results to their physician. In the event of any abnormal results, it is the participant's responsibility to follow-up with their provider to evaluate these and receive further management/care.

If our Medical Director's NPI # or account # was used to collect the lab work (CU) will be able to access these results directly from LabCorp. You can get a copy of your labs at http://patient.labcorp.com Please allow a few days to get your lab into their system. Once you have signed up it may take a few hours before you see your results.

If any other lab or Physician's office collects the lab work, even if they use Lab Corp, CU Polar Medicine will not receive the results! **You must submit these results with your PQ packet. FAX: 303-724-5649**

Dear Doctor:

DOB: Age: Gender:

This person is being considered for participation in the National Science Foundation's Arctic Program. Arctic 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 Arctic Regions may be harsh. Temperatures range from 100 degrees above to 65 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 qualification for deployment to the Arctic Regions.

Conduct the indicated tests and provide the results to the Participant in English.

Required Vaccinations:

- ☑ TDap (Pertussis): Participants should receive a tdap if you have not had one in the last 10 years.
- ☑ Seasonal Influenza: Yearly (exception for Arctic participants deploying in late spring/summer)
- ☑ Measles (if not immune)
- ☑ COVID-19 (CDC up-to-date recommendations) - Must complete CDC up-to-date recommendations for vaccination at least 14 days prior to deployment.

Testing:

- ☑ Medical History Forms (pages 20-24) (Signed, dated)
- ☑ Arctic Physical Examination (pages 27-28)
- ☐ EKG - 12 lead with tracing or rhythm strip (all new participants; then, age 40-49 every 5 yrs; then, age 50+ annually)
- ☐ Exercise Stress Test with MD Interpretation (Summer Participant: required only if FHR score greater than 20%) (Bruce Protocol - must complete 9 minutes, stage 3, 85% max heart rate)
- ☐ Pulmonary Function Test, Pre/Post Bronchodilator (history of asthma, emphysema, or COPD OR occupational PFT (spirometry for work))
- ☐ Guaiac Stool Test (Age 50+)
- ☐ Mammogram (females) (radiology) (Age 40+, every 2 years)
- ☐ Chest X-Ray (Per TB protocol for positive PPD/ Quantiferon; or symptomatic pulmonary disease) (Submit report only, not actual films).
- ☐ Low-dose CT of the chest (Age 55-80 AND at least 30 pack-yr history AND current smoker or quit less than 15 years ago)

All participants are responsible for their results and following up/reporting results to their physician. In the event of any abnormal results, it is the participant's responsibility to follow-up with their provider to evaluate these and receive further management/care.

Prescription medications (type and quantity) are limited at all Arctic 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 Arctic Physical Qualification Important Information attachment.

ARCTIC 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**			
		Without Correction		With Correction	
		DIST	NEAR	DIST	NEAR
Height: _____	Weight: _____	R_____	_____	R_____	_____
BP:_____/_____	Pulse: _____				
BMI: _____	Framingham Risk Score: _____	L_____	_____	L_____	_____

Finding	Normal	Abnormal	Finding	Normal	Abnormal
General appearance			Inguinal, include hernia		
Head and neck			Genitalia male/female (Not Deferrable)		
Eyes			Rectal male/female (Not Deferrable)		
Ears			Spine		
Nose			Upper extremities		
Mouth			Lower extremities		
Thyroid			Skin (include body)		
Lymph nodes			Vascular		
Chest and lungs			Neurologic		
Breasts male/female (Not Deferrable)			Emotional Status		
Heart			**Pelvic exam** (female, Not Deferrable)		
Abdomen			Prostate exam (male age 40 & over)		

Guaiac Test (annually, age 50 and over):

_____ _____

Result Date

Influenza Vaccination (annually; must be for the flu season that corresponds to deployment):

(Mandatory for deployment)

_____

Date

TDap Vaccination (every 10 years):

Must include lot number, expiration date, manufacturer, date of injection. Please attach CDC compliant proof of vaccination.

_____

Date

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 arctic deployment.

☐ **Overall fitness of the participant is good.**

☐ **Participant is able to participate and complete duties in a remote arctic environment.**

☐ **Participant will require further evaluation prior to clearance. (Comment or Recommendation)**

Examiner's Name (printed with credentials) Signature Date

This exam is void without credentials.

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.

Dear Dentist:

This person is being considered for participation in the National Science Foundation's Arctic program. The Arctic Regions are isolated and lack dental facilities. Participants must be free of dental disease. There must be no caries, active periodontal disease, potential endodontic disease, prosthetic deficiencies, potentially symptomatic wisdom teeth, or any uncompleted treatment. All dental work must be completed and documented.

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 unerupted 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	Digital radiographs can be e-mailed in **high-resolution JPEG format (preferred)** or printed and sent in **high resolution on glossy photographic paper**. Original mounted radiographs can be included with the Dental Exam Form. Copies or poor quality radiographs will not be accepted. Radiographs become a part of the participant's USAP record and **WILL NOT BE RETURNED**. 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 12 months of PQ packet submission and must accompany the completed examination form. 2. Panoramic and/or mounted full mouth survey – a one time requirement. 3. A periapical (PA) film of all endodontic work, crowns, and extensive restorations
IV. ORTHODONTICS	Orthodontic care is not available in the Arctic Regions; so, Participants 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.

After completion, please return a copy of results to the participant. Copies of the dental exam form can be faxed to **303-724-5649**.

E-mail x-ray JPEG's to: arcticsupport@cuanschutz.edu. Dental X-ray JPEGs CANNOT be faxed.

Mailing Address:

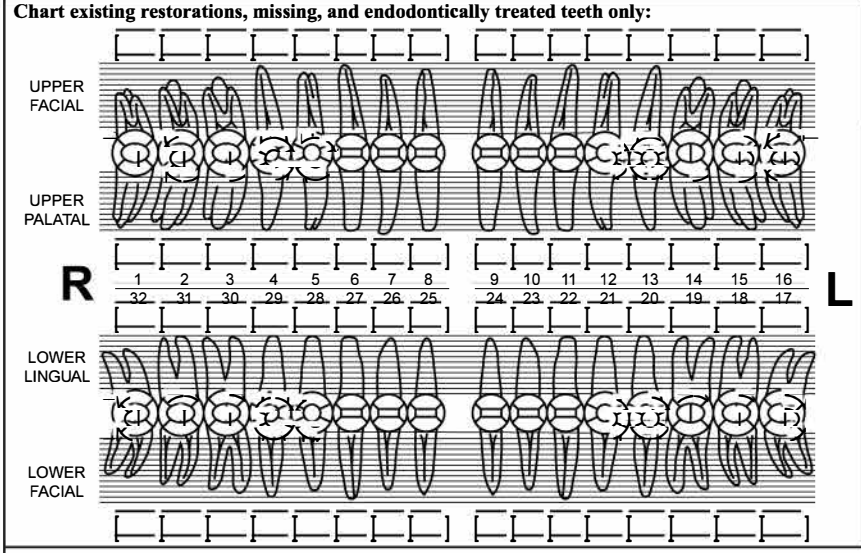
If shipping by **USPS** (*preferred mailing service*):
CU Polar Medicine
Attn: Kellie Schiller, Elaine Reno
Mail Stop C328
12631 E 17th Ave, Room 2509, Aurora, CO 80045

If shipping by **FedEx, UPS, DHL or any other mailing service**:
CU Polar Medicine/Kellie Schiller
Dept. of Emergency Medicine
12631 E 17th Ave, Aurora CO 80045
Academic Office One, Room 2509
802-275-6367

ARCTIC 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, and endodontically treated teeth only:



PERIODONTAL EVALUATION

Probings 5 mm or greater ☐ YES ☐ NO
Active Disease Noted ☐ YES ☐ NO

THIRD MOLAR EVALUATION

3rd Molars Present ☐ YES ☐ NO

List partially erupted _____
List impacted that can be probed _____
List fully impacted _____
List potentially symptomatic _____
List implants _____
List retained 1° teeth _____

Documentation of all treatment identified and rendered and original radiographs must accompany this form.

DATES	Diagnosis and treatment needed	DATES	List all treatment completed

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

Date taken: _____

X-Ray cannot be older than 12 months at the time of dental review by CU Polar Medicine.

I have thoroughly examined this candidate for travel to the Arctic 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)

_____
DENTIST'S SIGNATURE **DATE**

Date of Dental Exam: _____

ATTENTION EXAMINING DENTIST:

Return this completed form, all documentation of treatment and all **ORIGINAL X-rays** (digital preferred) to the Participant.

_____
TELEPHONE NUMBER (include area code):

_____
STREET ADDRESS

_____
CITY **STATE** **ZIP**

ARCTIC MEDICAL STAFF USE ONLY

☐ **PQ** ☐ **WINTER REVIEW** ☐ **NPQ**

UNITED STATES ARCTIC PROGRAM
DEPLOYMENT CONSENT/AUTHORIZATION DOCUMENTS

IMPORTANT NOTICE FOR PARTICIPANTS IN THE UNITED STATES ARCTIC PROGRAM

Participants in the United States Arctic 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 the Arctic require high standards of conduct.

The potential for mishap in the Arctic Regions 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 at its facilities. 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 Arctic countries have strict laws forbidding the possession or transportation through their countries of firearms, knives, pornographic materials, marijuana or non-prescription drugs. These laws are strictly enforced and penalties for violation are severe. 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 Arctic programs affords neither preferential treatment nor immunity from prosecution.

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

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

Initials

MEDICAL RISKS FOR NSF-SPONSORED PERSONNEL TRAVELING TO THE ARCTIC

Travel to the Arctic 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 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. Participants should consider these risks before deciding to deploy.

Arctic. A contracted paramedic is on staff at Summit Station on the Greenland Ice Cap. Facilities for emergency care are available (although rarely used) at Kangerlussuaq (western) and Thule Air Base (northern) in Greenland. Virtual or other emergency health care support may be made available for certain remote Arctic locations; e.g., medical kits and access to medical advice via satellite telephone. Researchers and support personnel at other Arctic locations, such as Alaska, Canada, Russia, etc., are typically able to avail themselves of locally available commercial care. Partly because of these limitations, NSF requires medical and dental screening of personnel prior to deployment. 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. They are also necessary to determine whether medical conditions exist that cannot be effectively managed while the individual is deployed. Persons who fail to meet these medical/dental screening criteria will be notified of the specific reason(s) for their disqualification.

Participants should realize that serious accidents or injuries might challenge the medical care system. Therefore, individuals should recognize 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 U.S. Code 552a) and protected against unauthorized release, as described in the appended Privacy Notice found in the Arctic Physical Qualification Important Information Packet. 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.

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

MEDICAL SCREENING FOR BLOOD-BORNE PATHOGENS

As described above, medical clinics at the NSF research stations in the Arctic do not have or maintain readily available supplies of frozen blood. 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, NSF requests that U.S. Arctic program participants during the respective austral summer seasons 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. [Whether you are voluntarily consenting to this testing (summer only) or required to do so (winter deployment), you should take this form with you to your laboratory appointment to ensure that the tests are 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 Arctic Physical Qualification Important 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 ☐

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

_____ 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 *United States Arctic Program Deployment Consent/Authorization Documents.*

_____
Signature

Participant Note: The Walking Blood Bank is for USAP only. Response is used if PQ is transferred from CU Polar Medicine to UTMB for Antarctica PQ.

PARTICIPANT NAME

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 Arctic Programs. Should any medical/dental care be required during his or her deployment to the Arctic, I hereby give my authorization and consent to the National Science Foundation's Division of Arctic 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 the Arctic.

_____

Name of Parent or Legal Guardian

_____

Street Address

_____

City State Zip Code

Telephone Numbers

Daytime: _____ Evening:_____

_____ _____ _____

Print Name Signature Date