WCT Level
___ Arduous
___ Moderate
___ Light

HEALTH SCREENING QUESTIONNAIRE (HSQ)

Assess your health needs by marking all true statements.

The purpose of the HSQ is to identify individuals who may be at risk while taking the Work Capacity Test (WCT) and recommend an exercise program and/or medical examination prior to taking the WCT.

Employees are required to answer the following questions which were designed to identify those individuals who may be at medical risk when taking a WCT. The HSQ is not a medical examination. Any medical concerns you have that may place you or your health at risk should be reviewed with your personal physician prior to participating in the WCT.

SECTION A

___ I have a past waiver from the Forest Service/DOI for: _____
___ I currently have a hernia
___ I have epilepsy or a seizure disorder
___ I have a history of past heat exhaustion/stroke that required medical care
___ I currently take heart or asthma medications
___ My blood cholesterol is greater than 200 mg/dL or my HDL is less than 40 mg/dL, or you take cholesterol medication

I have experienced in the **last 12 months:**
___ chest discomfort/pain with exertion
___ breathlessness more than others with exertion
___ dizziness, fainting, black-outs
___ muscle or bone/joint problems: spine, knees, back hips, shoulders, etc. (swelling or pain that interferes with the function of that body part or your ability to use it)

I have/had:
___ a heart attack
___ heart surgery
___ coronary (heart) angioplasty or stent placement
___ a pacemaker/implantable cardiac defibrillator
___ rhythm disturbance (abnormal heartbeat)
___ heart valve disease or a heart murmur (excluding murmurs as an infant that disappeared as a baby)
___ heart failure
___ heart transplantation
___ congenital (born with) heart disease
___ blood pressure greater than 139/89
___ diabetes (diet/exercise controlled or you take medication)
___ personal experience or a doctor's advice of any other physical reason that would prohibit you from carrying out or participating in strenuous activity

SECTION B

Cardiovascular risks:
___ I am physically inactive (I get less than 30 minutes of physical activity less than 3 days per week)
___ I have a body mass index (BMI) ≥ 30*
___ I smoke currently or in the past 6 months
___ I have not had my cholesterol level checked in the last 3 years
___ I have not had my blood pressure checked in the last year

*(to determine BMI, go to: National Heart, Lung and Blood Institute: Calculate Your Body Mass Index)

I understand that if I need to be evaluated by a physician, it will be based on the fitness requirements of the position(s) for which I am qualified.

I have read and understand the above and answered truthfully.

Signature:_____ Printed Name_____ Date_____

Unit:_____ City_____ State_____

HSQ Coordinator:_____

PAPERWORK REDUCTION ACT STATEMENT

According to the Paperwork Reduction Act of 1995, a Federal agency may not conduct or sponsor, and a person is not required to respond to, an information collection request unless it displays a valid Office of Management and Budget (OMB) control number. The valid OMB control number for this information collection request is 0596-0164. Response to this information collection request is required to obtain or retain benefits. The authority for this information collection request is 5 CFR Part 339 (Medical Qualification Determinations). The time required to complete this information collection request is estimated to average 10 minutes per response, including the time for reviewing instructions, searching existing data sources, collecting and maintaining the data needed, and completing and reviewing the information collection request. Send comments regarding this burden estimate or any other aspect of this information collection request, including suggestions for reducing the burden, to U.S. Forest Service Information Collections Officer, SM.FS.InfoCollect@usda.gov, with OMB control number 0596-0164 in the subject line.

PRIVACY ACT STATEMENT

Pursuant to 5 U.S.C. § 552a(e)(3), this Privacy Act statement serves to inform you of the following concerning the collection of the information on this form.

Purpose: The Privacy Act of 1974 requires that the Office of the Assistant Secretary for Civil Rights (OASCR) provide the following statements to individuals from whom it requests information.

Authority: Collection of this information solicited on this form is authorized by the regulations of the Equal Employment Opportunity Commission (EEOC), 29 C.F.R. Part 1614.

Routine Uses: The information collected will be used to determine whether your complaint is acceptable for investigation and in connection with any subsequent investigation and processing of your complaint. A copy of this complaint will be provided to the Civil Rights office of the agency against whom it is filed. This form may be shown to any individual who may be required by regulations, policies or procedures of the EEOC or OASCR to provide information in connection with this complaint. Other disclosures may be (a) to respond to a request from a Member of Congress regarding the status of the complaint or appeal; (b) to respond to a court subpoena or refer to a district court in connection with a civil suit; (c) to disclose information to authorized officials or personnel to adjudicate a complaint or appeal; or (d) to disclose information to another Federal agency or to a court or third party in litigation when the Government is party to a suit before court. A complete list of the routine uses can be found in the system of records notice associated with this form, [cite to SORN].

NONDISCRIMINATION STATEMENT

In accordance with Federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, religion, sex, gender identity (including gender expression), sexual orientation, disability, age, marital status, family/parental status, income derived from a public assistance program, political beliefs, or reprisal or retaliation for prior civil rights activity, in any program or activity conducted or funded by USDA (not all bases apply to all programs). Remedies and complaint filing deadlines vary by program or incident.

Persons with disabilities who require alternative means of communication for program information (e.g., Braille, large print, audiotape, American Sign Language, etc.) should contact the responsible agency or USDA's TARGET Center at (202) 720-2600 (voice and TYY) or contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English.

To file a program discrimination complaint, complete the USDA Program Discrimination Complaint Form, AD-3027, found online at How to File a Program Discrimination Complaint and at any USDA office or write a letter addressed to USDA and provide in the letter all the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit the completed form or letter to USDA by (1) mail: U.S. Department of Agriculture, Office of the Assistant Secretary for Civil Rights, 1400 Independence Avenue, SW, Washington, D.C. 20250-9410; (2) fax: (202) 690-7442; or (3) email: program.intake@usda.gov.