

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
<ul style="list-style-type: none"> • 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, <i>BUT</i>, may extend up to 21 day assignments • <u>for smokejumpers</u> - 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 	<ul style="list-style-type: none"> • 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 • <u>for smokejumpers</u> - lift and carry more than 100 lbs, perform parachute jumps, and perform parachute landings on uneven terrain 	<ul style="list-style-type: none"> • 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 • <u>no ready access to medical help</u> 	<ul style="list-style-type: none"> • 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).

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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 <input type="checkbox"/> Male <input type="checkbox"/> 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: <input type="checkbox"/> Low (walking, etc.) <input type="checkbox"/> Moderate (jogging, cycling, etc.) <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> 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 <u>treatment</u> by doctors, healers, or other practitioners for any problem or illness within the past year?	<u>Reason, date, current status:</u>	<input type="checkbox"/>	<input type="checkbox"/>
2. Have you ever been a patient in any type of hospital, <u>except</u> for your birth?	<u>Reason, date, current status:</u>	<input type="checkbox"/>	<input type="checkbox"/>
3. Have you had or have you been advised to have any operation?	<u>Reason, date, current status:</u>	<input type="checkbox"/>	<input type="checkbox"/>
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)?	<u>What, why, date:</u>	<input type="checkbox"/>	<input type="checkbox"/>
5. Have you been rejected for or discharged from military service because of physical, mental, or other reasons?	<u>Date and reason:</u>	<input type="checkbox"/>	<input type="checkbox"/>
6. Have you ever received, is there pending, or have you applied for a pension or compensation for a disability?	<u>Date, explain, current status, VA% disability (if applicable):</u>	<input type="checkbox"/>	<input type="checkbox"/>

Medications and Allergies			
Questions	Details	Yes	No
7. Do you have any allergies, environmental or medication or food?	<u>To what and the reaction:</u>	<input type="checkbox"/>	<input type="checkbox"/>
8. Do you currently take or should you be taking any medications (prescribed and/or over-the-counter, including herbal preparations)?	<u>Name:</u>	<input type="checkbox"/>	<input type="checkbox"/>
9. Are you allergic to bee/wasp/hornet/fire ant/yellow jacket stings?	<p><u>Check all that apply:</u> <input type="checkbox"/> Bees <input type="checkbox"/> Wasps <input type="checkbox"/> Hornets <input type="checkbox"/> Fire Ants <input type="checkbox"/> Yellow Jackets <input type="checkbox"/> Don't know</p> <p><u>Check any of the reactions you have had:</u> <input type="checkbox"/> swelling or itching at site of sting only <input type="checkbox"/> 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 <input type="checkbox"/> hives <input type="checkbox"/> anaphylactic shock (had to be treated in the ER) <input type="checkbox"/> blood pressure problems <input type="checkbox"/> difficulty breathing</p> <p><u>Please explain in detail any positive responses marked above:</u></p> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/>	<input type="checkbox"/>	<input type="checkbox"/>

10. Have you ever been advised by a physician to carry an Epipen for yourself?	Do you carry an Epipen for yourself? <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/>
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.)	<u>Diagnosis, date, details of current treatment and status:</u>	<input type="checkbox"/>	<input type="checkbox"/>
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?	<u>What, date, current status, any rehab (when and where):</u>	<input type="checkbox"/>	<input type="checkbox"/>
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.)?	<u>Diagnosis and/or surgery, date, current status:</u>	<input type="checkbox"/>	<input type="checkbox"/>
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?	<u>Problem, date, current status:</u>	<input type="checkbox"/>	<input type="checkbox"/>
15. Are you colorblind?	<u>Details:</u>	<input type="checkbox"/>	<input type="checkbox"/>
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?	<u>Details:</u>	<input type="checkbox"/>	<input type="checkbox"/>
17. Have you been told you have a lazy eye, strabismus, amblyopia, or an optic nerve issue in the past or present?	<u>Details:</u>	<input type="checkbox"/>	<input type="checkbox"/>

18. Do you have visual problems in one eye that you don't have in the other eye?	<u>Details:</u>	<input type="checkbox"/>	<input type="checkbox"/>
19. Do you wear corrective lenses for any reason?	For: <input type="checkbox"/> near vision <input type="checkbox"/> far vision <input type="checkbox"/> both Use: <input type="checkbox"/> contacts <input type="checkbox"/> glasses <input type="checkbox"/> both	<input type="checkbox"/>	<input type="checkbox"/>
Hearing			
Questions	Details	Yes	No
20. Do you have a history of any ear disease or hearing loss?	<u>Diagnosis and date:</u>	<input type="checkbox"/>	<input type="checkbox"/>
21. Have you had any type of ear surgery?	<u>Type, date, current status:</u>	<input type="checkbox"/>	<input type="checkbox"/>
22. Have you had a cold or ear infection in the last 2 weeks?	<u>Details:</u>	<input type="checkbox"/>	<input type="checkbox"/>
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?	<u>Details:</u>	<input type="checkbox"/>	<input type="checkbox"/>
24. Do you wear hearing aid(s)?		<input type="checkbox"/>	<input type="checkbox"/>
25. Have you ever had a perforated/ruptured eardrum?	<u>Date and details:</u>	<input type="checkbox"/>	<input type="checkbox"/>
26. Do you use any protective hearing equipment when working around loud noise?	<u>Type:</u> <input type="checkbox"/> foam <input type="checkbox"/> pre-mold/plugs <input type="checkbox"/> ear muffs	<input type="checkbox"/>	<input type="checkbox"/>
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?	<u>Details:</u>	<input type="checkbox"/>	<input type="checkbox"/>
28. Do you have any jaw pain or tooth pain?	<u>Details:</u>	<input type="checkbox"/>	<input type="checkbox"/>

29. Do you have any deformity or growth of the tongue or mouth that interferes with speech?	<u>Details:</u>	<input type="checkbox"/>	<input type="checkbox"/>
Skin			
Questions	Details	Yes	No
30. Do you have any skin conditions that require medical treatment?	<u>Details:</u>	<input type="checkbox"/>	<input type="checkbox"/>
31. Any history of sun sensitivity that requires any prescription or over-the-counter medicines?	<u>Details:</u>	<input type="checkbox"/>	<input type="checkbox"/>
32. Any history of melanoma, or other skin cancer?	<u>Details:</u>	<input type="checkbox"/>	<input type="checkbox"/>
33. Any skin allergies to latex or rubber?	<u>Type of reaction:</u>	<input type="checkbox"/>	<input type="checkbox"/>
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)?	<u>Diagnosis, current status:</u>	<input type="checkbox"/>	<input type="checkbox"/>
35. Have you ever had a blood clot in the arm, leg, or lungs?	<u>Location of clot, date, treatment, current status:</u>	<input type="checkbox"/>	<input type="checkbox"/>
36. Do you have anemia currently or ever been told you have any issues with low blood counts?	<u>Type, treatment, and current status:</u>	<input type="checkbox"/>	<input type="checkbox"/>

37. Have you been seen for poor circulation or swelling in the hands or feet? Have you been told you have any blood disorders?	<u>Diagnosis, date and treatment:</u>	<input type="checkbox"/>	<input type="checkbox"/>
38. Do you get white fingers with exposure to the cold or vibration?	<u>Details:</u>	<input type="checkbox"/>	<input type="checkbox"/>
Heart			
Questions	Details	Yes	No
39. Do you have a history of high blood pressure or high cholesterol?	<u>Current status:</u>	<input type="checkbox"/>	<input type="checkbox"/>
40. Have you ever had chest pain with physical exertion or at rest, or been diagnosed with angina?	<u>Date, diagnosis, tests, treatment:</u>	<input type="checkbox"/>	<input type="checkbox"/>
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?	<u>Date, frequency, diagnosis, tests, treatment:</u>	<input type="checkbox"/>	<input type="checkbox"/>
42. Have you ever had a heart attack, angioplasty or heart bypass surgery?	<u>What and date:</u>	<input type="checkbox"/>	<input type="checkbox"/>

43. Have you ever had a heart murmur?	<u>Diagnosis and status:</u>	<input type="checkbox"/>	<input type="checkbox"/>
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)?	<u>Diagnosis, date, current status:</u>	<input type="checkbox"/>	<input type="checkbox"/>
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?	<u>Date diagnosed, date of last flare:</u>	<input type="checkbox"/>	<input type="checkbox"/>
47. Do you or have you ever used an inhaler?	<u>Name of inhaler and how often it is used:</u>	<input type="checkbox"/>	<input type="checkbox"/>
48. Have you ever been to the hospital/ER or seen a medical provider because of an asthma flare/attack?	<u>Dates in last 2 years:</u>	<input type="checkbox"/>	<input type="checkbox"/>
49. Does smoke, dust, or exercise trigger your asthma?		<input type="checkbox"/>	<input type="checkbox"/>
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)?	<u>Diagnosis, date if applicable, and current status:</u>	<input type="checkbox"/>	<input type="checkbox"/>

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

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

67. Do you have any numbness or tingling in your hands or feet?	<u>Details:</u>	<input type="checkbox"/>	<input type="checkbox"/>
68. Do you have chronic recurring headaches, migraines, cluster headaches, severe headaches?	<u>Diagnosis, treatment, frequency of headaches:</u>	<input type="checkbox"/>	<input type="checkbox"/>
69. Do you have insomnia problems	<u>Frequency and treatment:</u>	<input type="checkbox"/>	<input type="checkbox"/>
70. Have you ever had a seizure?	<u>Dates in last 2 years, type of seizure, treatment:</u>	<input type="checkbox"/>	<input type="checkbox"/>

Muscle and Bone

Questions	Details	Yes	No
71. Do you have a history of arthritis, joint pain or swelling, tendonitis, recurrent shin splints?	<u>Diagnosis, which joints, treatment, current status:</u>	<input type="checkbox"/>	<input type="checkbox"/>
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?	<u>Diagnosis, use of any assistive device (walker, prosthesis, etc):</u>	<input type="checkbox"/>	<input type="checkbox"/>
73. Do you have any muscle loss, weakness/loss of strength?	<u>Diagnosis,</u>	<input type="checkbox"/>	<input type="checkbox"/>
74. Do you have any history of back or neck pain that you saw a medical provider for?	<u>Diagnosis, treatment, frequency, location of pain, current status:</u>	<input type="checkbox"/>	<input type="checkbox"/>

Stomach/Gut

Questions	Details	Yes	No
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75. Have you had hepatitis or other liver disease?	<u>Date, type/diagnosis, treatment, current status:</u>	<input type="checkbox"/>	<input type="checkbox"/>
76. Have you had any stomach, intestinal, spleen, pancreas, or gall bladder issues or disease?	<u>Date, diagnosis, treatment, current status:</u>	<input type="checkbox"/>	<input type="checkbox"/>
77. Do you <u>currently</u> have a hernia or have had recent surgery for a hernia?	<u>Type/where, is surgery planned, date:</u>	<input type="checkbox"/>	<input type="checkbox"/>
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?	<u>Details:</u>	<input type="checkbox"/>	<input type="checkbox"/>
79. Have you ever had any blood in the stool or vomited blood?	<u>Date, diagnosis, treatment, current status:</u>	<input type="checkbox"/>	<input type="checkbox"/>
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)?	<u>Date, diagnosis, frequency, treatment, current status:</u>	<input type="checkbox"/>	<input type="checkbox"/>
81. Do you have any difficulty with urination or require any type of assistive equipment or medication to urinate, ie. catheterization?	<u>Details:</u>	<input type="checkbox"/>	<input type="checkbox"/>
82. Have you ever had or still require dialysis?	<u>Details:</u>	<input type="checkbox"/>	<input type="checkbox"/>
Other			
Questions	Details	Yes	No

(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) Yes No Corrected

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

g. Balance on Each Foot	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal
14. Tetanus up-to-date (in last 10 yrs)	<input type="checkbox"/> Yes	<input type="checkbox"/> No If not, please offer to immunize. <input type="checkbox"/> Updated today
15. Other findings	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal
Diagnosis: (list all diagnoses found including self-limiting, such as: colds, sprain/strain, etc.; as well as tobacco use disorder)	<input type="checkbox"/> Well Exam	<input type="checkbox"/> 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	<p style="text-align: center;">Medically Qualified</p> <input type="checkbox"/> <input type="checkbox"/> Temporary Restrictions (explain) <input type="checkbox"/> Conditional (explain) <input type="checkbox"/> with Waiver(s) (explain) <p style="text-align: center;">Not Medically Qualified</p> <input type="checkbox"/> <input type="checkbox"/> Information Needed (explain)	
<i>(If changing a recent qualification determination please explain)</i>		
Explanation:		

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