USFS Self-Certification Statement and Blood Pressure Check

Part A. Name:_____ DOB:

Questions	Yes	No
Has there been a new psychological diagnosis in the last year, e.g. depression, anxiety, bipolar disorder, ADD, etc.?		
Have you had an amputation or prosthesis, transplant or implant occur in the last year?		
Any new prescribed medications or over the counter medications that you take on a fairly regular basis in the last year?		
Any new immune or infectious problems or any new allergies in the last year?		
Any change in your vision or problems with your eyes or eyelids in the last year?		
Any new problems with your head or neck, ears, nose, mouth, or throat in the last year?		
Any new problems with hearing in the last year?		
Any new endocrine or metabolic issues your medical provider has evaluated you for in the last year, eg. thyroid, adrenal, pituitary, diabetes?		
Any new skin issues you have been treated for in the last year?		
Any new vein or artery problems in the last year?		
Any new heart problems or diagnosis of high blood pressure in the last year?		
Any new lung problems or diagnosis of sleep apnea in the last year?		
If you are female, are you pregnant?		
Any blood or spleen problems in the last year?		
Any muscle problems, spine problems, new herniated/bulging disc, pinched nerves, arthritis, arm or leg injury, compartment syndrome, or other problems in the last year?		
Any new neurologic problems e.g. headaches, dizziness, seizures, Parkinson's disease, stroke, problem staying awake routinely, problem with taste or smell or touch in the last year?		
Any stomach, liver, pancreas, intestinal/colon or hernia problems in the last year?		
Any kidney, bladder, ovary, testicle, prostate problems or severe menstrual cramp problems in the last year?		
Any new heat illness, heat exhaustion, heat stroke, or rhabdomyolysis in the last year?		

Signature

Home Unit and Forest Name:
Home Unit Address:

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Part B. Name:_____ DOB:

BP:

_____

signature of person taking BP

_____

printed name and title (N.P., P.A., EMT, RN, etc.) of person taking BP and phone number

Medical Review Officer to complete:
___Medically Qualified
___Need more information
___Not Medically Qualified
Sign_____Date_____

Privacy Act Statement

Solicitation of this information is authorized by Section 552a of Title 5, United States Code, regarding records maintained on individuals: Section 3301 or Title 5, United State Code, regarding determination as to an individual's fitness for employment with regard to age, health, character, knowledge, and ability; and Section 3312 of Title 5, United States Code, regarding waiver of physical qualifications for preference eligibles. This form is used to collect medical information about individuals who are incumbents of positions in the Federal Government which require physical fitness testing and medical examinations, or individuals who have been selected for such a position contingent upon successful completion of physical fitness testing and medical examinations as a condition of their employment. The primary use of this information will be to determine the nature of a medical or physical condition that may affect safe and efficient performance of the work described, and whether an individual being considered for wildland firefighting can carry out those duties in a manner that will not place the candidate unduly at risk due to inadequate physical fitness and health. Additional potential routine uses of this information include using it to ensure fair and consistent treatment of employees and job applicants, to adjudicate requests to pass over preference eligibles, or to adjudicate claims of discrimination under the Rehabilitation Act of 1973, as amended. Completion of this form is voluntary; however, failure to complete the form may result in no further consideration of an applicant, or a determination that an employee is no longer qualified for his or her position. Its collection and use are covered under Privacy Act System of Records OPM/Govt-10 and are consistent with the provisions of 5 USC 552a (Privacy Act of 1974). **WARNING: The information you have given constitutes an official statement. Incomplete, misleading, or untruthful information provided on the form may result in delays in processing the form for employment, termination of employment, or criminal sanction. Federal law provides severe penalties (up to 5 years confinement or a $10,000 fine or both), to anyone making a false statement.**

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995, an agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0596-0164. The time required to complete this information collection is estimated to average 10 minutes per response, including the time for reviewing instructions (if any), searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. The U.S. Department of Agriculture (USDA) prohibits discrimination in all its programs and activities on the basis of color, race, national origin, gender, religion, age, disability, political beliefs, sexual orientation, and marital or family status. (Not all prohibited bases apply to all programs.) Persons with disabilities who require alternative means for communication of program information (Braille, large print, audiotape, etc.) should contact USDA's TARGET Center at 202-720-2600 (voice and TDD). To file a complaint of discrimination, write USDA, Director, Office of Civil Rights, 1400 Independence Avenue, SW, Washington, DC 20250-9410 or call 800-975-3272 (voice) or 202-720-6382 (TDD). USDA is an equal opportunity provider and employer.