

Firefighter Name: **Sally Firefighter**

**Federal Interagency
Medical History and Examination Form for Wildland Firefighters (Arduous Duty)**

SHRO or FMO:

1. If it is not already provided, fill in the firefighter's name in the top left corner of this sheet before giving/sending to firefighter.
2. Using computer-generated label or typewriter, supply the following information in the space provided:

Servicing Human Resources Officer:

Name: _____
 Street Address: _____
 City, State, Zip: _____
 Telephone: _____
 E-mail: _____

Fire Management Officer:

Name: _____
 Street Address: _____
 City, State, Zip: _____
 Telephone: _____
 E-mail: _____

3. Request an appointment for the firefighter through the Central Medical Consultant's secure web site: <http://cas.chsmedical.com>

FIREFIGHTER:

1. Complete ONLY THE SHADED PORTIONS of pages 2 through 8 (**Note: All "Yes" answers in the medical history sections must be explained, including dates, treatments, and current status.**) Take this form to your examination at the CHS network Examining Physician/Clinic.
2. Do not eat or drink anything except water for 6 hours prior to exam. You may take medications.
3. For best hearing test results, avoid exposure to loud noise for a minimum of 14 hours prior to exam. (May use ear muffs and/or foam ear plugs.)
4. If you wear contacts or glasses, bring your lenses and lens case with you because **vision must be tested corrected and uncorrected.**
5. **Your signature is required on page 2. Failure to sign will result in delay of rating determination.**

EXAMINING PHYSICIAN:

1. Please contact the CHS Client Service Administrator for the Wildland Firefighters at 800-638-8083 if you have any questions about the procedures.
2. Please review the functional requirements and work conditions of Wildland Firefighters on page 9 of this form.
3. Please complete all of the appropriate portions of the form - pages 2-8; provide full explanation for each "abnormal and/or significant" finding.
4. Forward specimens and laboratory requisition to Quest Laboratories using the enclosed Express Labpak on the day of the collection.
5. When exam is completed, place all pages and all associated test results in the return envelope. It is imperative that this information be sent to CHS via express overnight mail on the day exam is performed to the address below.
6. Do not invoice the examinee or his/her insurance for any procedures authorized by CHS.

**Comprehensive Health Services, Inc. - Central Medical Consultant - Wildland Firefighters
8229 Boone Blvd., Suite 700 - Vienna, VA 22182**

7. Do not communicate an opinion of qualification to the examinee. All significant, abnormal findings are to be discussed with the firefighter. Recommended additional testing will not be covered under this program, and must be paid for by the examinee. Qualification and further evaluation decisions will be made by the Agency's Central Medical Consultant (CMC) at Comprehensive Health Services, Inc.

PRIVACY ACT INFORMATION

The information contained in this form will be used to determine whether an individual considered for arduous level wildland firefighting can safely and efficiently perform those duties in a manner that will not unduly risk aggravation, acceleration, exaggeration, or permanently worsening a pre-existing medical condition. Its collection and use are consistent with the provisions of 5 USC 552a (Privacy Act of 1974), 5 USC 3301 (Examination, Certification, and Appointment), and Executive Orders 12107 (Merit Systems Protection Board) and 12564 (Drug Free Federal Workplace).

The information will be placed in your official Employee Medical File, and is to be used only for official purposes as explained and published annually in the Federal Register under OPM/GOVT-10, the Office of Personnel Management system of records notice.



Federal Interagency Medical History and Examination Form for Wildland Firefighters (Arduous Duty)

| | | | |
|--|--|--|---|
| Physician / Clinic performing exam: | | | |
| Name: | | | |
| Address | | | |
| Phone: | Fax: | | |
| Name of Employing Agency: Fish and Wildlife Service | | Gender: <input checked="" type="checkbox"/> Male <input checked="" type="checkbox"/> Female | |
| Firefighter Name: Sally Firefighter | Position/Job Title (incumbent): | | Appointment Date & Time: |
| Number of Years: | | | |
| Address: 123 Main Street Anytown, VA 12345 | Date of Birth: 02/20/70 | Age: 35 | Social Security Number: 000-00-0000 |
| Home Phone: 703-5551213 | | Work Phone: 703-5551212 | Mobile Phone: |

Incomplete forms or missing information may result in a delay clearing you for firefighter duties and prevent you from taking the Pack Test. Submitting information that is misleading or untruthful may result in termination, criminal sanctions, or failure to be cleared as a firefighter.

This history form and review do not substitute for routine health care or a periodic health examination conducted by your physician. It is being conducted for occupational purposes only. I certify that all of the information I have provided on this form is complete and accurate to the best of my knowledge. I authorize release of information within this form to the Interagency Medical Standards Program Manager or their representatives for the purpose of medical clearance as an arduous duty wildland firefighter.

| | |
|---|-------------------|
| Firefighter's Signature (REQUIRED) _____ | Date _____ |
| <input checked="" type="checkbox"/> EXIT | |
| Required Services (Check completed components) | |
| <input type="checkbox"/> Medical History Review | |
| <input type="checkbox"/> Physical Examination | |
| <input type="checkbox"/> Far Vision Only (corrected and uncorrected); Color; Peripheral; Depth Perception | |
| <input type="checkbox"/> Audiogram (500 Hz - 8000 Hz) | |
| <input type="checkbox"/> Spirometry (attach tracings) | |
| <input type="checkbox"/> PPD test (Mantoux) - PPD placement | |
| <input type="checkbox"/> PPD test (Mantoux) - PPD read and form faxed to CHS | |
| <input type="checkbox"/> Lab Collection (Chemistries, CBC, UA, Lipid) * | |
| <input type="checkbox"/> Physician must sign completed exam in space provided (page 9) | |
| * indicates laboratory test to be sent to CHS contracted lab - Results will be forwarded directly to CHS | |



MEDICAL HISTORY

Smoking History

This information is needed since tobacco use increases your risk for lung cancer and several other types of cancer, chronic bronchitis, emphysema, asbestos related lung diseases, coronary heart disease, high blood pressure, and stroke. Please check your tobacco use status and complete this section.

Current Smoker
 Yes No

Number of cigarettes per day _____
 Number of cigars per day _____
 Number of pipe bowls per day _____
 Amount of chewing tobacco per day _____
 Total years of tobacco use _____

Former Smoker
 Yes No

Year Quit _____

Number of cigarettes per day _____
 Number of cigars per day _____
 Number of pipe bowls per day _____
 Amount of chewing tobacco per day _____
 Total years of tobacco use _____

Never Smoked

Describe your Physical Activity or Exercise Program

Type of Activity or Exercise _____

Intensity: Low _____ Moderate _____ High _____ Duration in Minutes per Session _____
 Examples: Walking Jogging, cycling Sustained heavy breathing and perspiration Frequency, in Days per Week _____

List all **medications** you are currently taking, including those prescribed and over-the-counter (including herbal) as well as the reasons that you are taking them. (Use additional sheets as necessary.)

Date of last Tetanus (Td) shot:

Tetanus booster is recommended every 10 years. Should you elect to have this updated at the time of your exam, you are responsible for payment.

NOTE: FOR EVERY ITEM CHECKED "YES" PROVIDE DATES, TREATMENTS, AND CURRENT STATUS. USE THE BLANK SPACES BELOW.

- | | |
|--|---|
| A. Have you ever been treated with an organ transplant, prosthetic device (e.g., artificial hip), or an implanted pump (e.g., for insulin) or electrical device (e.g., cardiac defibrillator)? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| B. Have you had or have you been advised to have any operation? (If Yes, give date, details of problem and name of procedure) | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| C. Have you ever been a patient in any type of hospital? (If Yes, give date, details and length of hospitalization) | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |
| D. Have you consulted or been treated by clinics, physicians, healers, or other practitioners within the past year for other than minor illness? (If Yes, give date, details of problem, and whether resolved) | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| E. Have you been rejected for military service because of physical, mental, or other reasons? (If Yes, give date, reason, and type of discharge, whether honorable or other than honorable) | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| F. Have you ever been treated for a mental or emotional condition? (If yes, please describe fully and include dates) | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| G. Have you ever been diagnosed with or treated for alcoholism or alcohol dependence? (If Yes, please describe fully) | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| H. Have you ever been diagnosed as being dependent on illegal drugs, or treated for drug abuse? (If Yes, please describe fully) | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| I. Have you ever received, is there pending, or have you applied for a pension or compensation for a disability? (If Yes, please describe fully) | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| J. Do you have any allergies? (If Yes, please list and describe fully) | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| K. Are you allergic to any medications? (If Yes, please list and describe fully) | <input type="checkbox"/> Yes <input type="checkbox"/> No |

Examiner: Use this space to comment on positive history or findings on this page.



MEDICAL HISTORY (continued)

VISION Yes No

Any eye disease

Do you wear eyeglasses

far near both

Do you wear contact lenses

hard soft

Do you have a history of frequent headaches

Blurred vision

Difficulty reading

Glaucoma

Cataracts

Color blindness

Please explain any YES answers, including dates:

HEARING Yes No

Any ear disease

Loud, constant noise or music in the last 14 hours

Loud, impact noise in past 14 hours

Ringing in the ears

Difficulty hearing

Ear infections or cold in the last 2 weeks

Dizziness or balance problems

Eardrum perforation

Use of a hearing aid - left right both

Use of protective hearing equipment when working around loud noise

If yes, type(s): foam pre-mold/plugs ear muffs

Please explain any YES answers, including dates:

HEAD AND NECK

NL ABNL

Head, Face, Neck (thyroid), Scalp

Nose/Sinuses/Eustachian tube

Mouth/Throat

Pupils equal/reactive

Ocular motility

Ophthalmoscopic findings

Speech

OTOSCOPIC EXAM

| | | | | |
|--------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| | <u>Right</u> | | <u>Left</u> | |
| | NL | ABNL | NL | ABNL |
| Canal/External Ear | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Tympanic Membrane | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

AUDIOGRAM (Attach Printout)

Type of test: Baseline Periodic Exit

Calibration Method: Oscar Biological Date: _____

Hearing must be done **without hearing aid**, and must meet OSHA standard for testing [see 29CFR 1910.95]

| Frequency | 500 Hz | 1000Hz | 2000Hz | 3000Hz | 4000Hz | 6000Hz | 8000Hz |
|----------------------|--------|--------|--------|--------|--------|--------|--------|
| Right Ear dB @ | | | | | | | |
| Left Ear dB @ | | | | | | | |

Verify Audiogram if >40dB for .5k, 1k, 2k or 3k.

Audio verified

Examiner: Use this space to comment on positive history or findings on this page:

DIAGNOSTIC AND PHYSICAL FINDINGS

VISION (Must complete A and B)

COLOR VISION A:

Type of Ishihara plate (# of plates = _____)

OPTEC 2000 Vision Tester

Titmus Vision Tester

Farnsworth D-15

Other (specify) _____

Number Correct: _____ of _____ tested

COLOR VISION B: Red, Green, and Yellow (Ishihara does not test for yellow)

Able to see red/green/yellow? Yes No

Type of test: _____

Clinician, please use a qualitative testing method.

FAR VISION ACUITY: (Near vision not required)

Uncorrected

Right 20/____ Left 20/____ Both 20/____

Only soft contact lens wearers do not need uncorrected vision recorded.

Corrected contacts glasses

Right 20/____ Left 20/____ Both 20/____

PERIPHERAL VISION (temporal only):

Right _____ degrees Left _____ degrees

DEPTH PERCEPTION:

Type of test:

Stereo Numbers: Number Correct: _____ of _____ tested

Stereo Animals: _____ seconds of arc

_____% Shepard Frye

Other: type of test _____

Response: _____ seconds of arc

Testing method must measure down to 100 arc seconds or less.

Confrontation is not an acceptable type of testing.



MEDICAL HISTORY (continued)

DIAGNOSTIC AND PHYSICAL FINDINGS

Have you had any of the following:

VASCULAR

- | | | |
|---|--------------------------|--------------------------|
| | Yes | No |
| Any vascular disease | <input type="checkbox"/> | <input type="checkbox"/> |
| Enlarged superficial veins, phlebitis, or blood clots | <input type="checkbox"/> | <input type="checkbox"/> |
| Anemia | <input type="checkbox"/> | <input type="checkbox"/> |
| Hardening of the arteries | <input type="checkbox"/> | <input type="checkbox"/> |
| High Blood Pressure | <input type="checkbox"/> | <input type="checkbox"/> |
| Stroke or Transient Ischemic Attack (TIA) | <input type="checkbox"/> | <input type="checkbox"/> |
| Aneurysms (Dilated arteries) | <input type="checkbox"/> | <input type="checkbox"/> |
| Poor circulation to hands and feet | <input type="checkbox"/> | <input type="checkbox"/> |
| White fingers with cold/vibration | <input type="checkbox"/> | <input type="checkbox"/> |

RESPIRATORY

- | | | |
|---|-------------------------------------|--------------------------|
| | Yes | No |
| Any respiratory disease | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| Asthma (including exercise induced asthma) | <input type="checkbox"/> | <input type="checkbox"/> |
| Bronchitis or Emphysema | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| Excessive, unexplained fatigue | <input type="checkbox"/> | <input type="checkbox"/> |
| Use of inhalers | <input type="checkbox"/> | <input type="checkbox"/> |
| Acute or chronic lung infection | <input type="checkbox"/> | <input type="checkbox"/> |
| Collapsed lung | <input type="checkbox"/> | <input type="checkbox"/> |
| Scoliosis (curved spine) with breathing limitations | <input type="checkbox"/> | <input type="checkbox"/> |
| History of Tuberculosis (Date: _____) | <input type="checkbox"/> | <input type="checkbox"/> |

HEART

- | | | |
|--|--------------------------|--------------------------|
| | Yes | No |
| Any heart disease or heart murmurs | <input type="checkbox"/> | <input type="checkbox"/> |
| Heart or chest pain (angina) with or without exertion | <input type="checkbox"/> | <input type="checkbox"/> |
| Heart rhythm disturbance or palpitations (irregular beats) | <input type="checkbox"/> | <input type="checkbox"/> |
| History of Heart Attack | <input type="checkbox"/> | <input type="checkbox"/> |
| Organic heart disease (including prosthetic heart valves, mitral stenosis, heart block, heart murmur, mitral valve prolapse, pacemakers, implanted defibrillator, Wolf-Parkinson-White (WPW) Syndrome, etc.) | <input type="checkbox"/> | <input type="checkbox"/> |
| Heart surgery | <input type="checkbox"/> | <input type="checkbox"/> |
| Sudden loss of consciousness | <input type="checkbox"/> | <input type="checkbox"/> |

Please explain any YES answers, including date(s):

CARDIO/PULMONARY ASSESSMENT

- | | |
|--------------------------|--|
| NL | ABNL |
| <input type="checkbox"/> | <input type="checkbox"/> Lungs/Chest |
| <input type="checkbox"/> | <input type="checkbox"/> Heart (thrill, murmur) |
| <input type="checkbox"/> | <input type="checkbox"/> Major blood vessels, including femoral pulses |
| <input type="checkbox"/> | <input type="checkbox"/> Peripheral blood vessels |

Please explain any "ABNL" answers:

CORONARY RISK FACTORS

- | | | |
|--|-------------------------------------|-------------------------------------|
| | Yes | No |
| Blood Pressure >= 140/90 | <input type="checkbox"/> | <input type="checkbox"/> |
| Diabetes, or Fasting Glucose >= 126 mg/dl (Completed by CHS) | <input type="checkbox"/> | <input type="checkbox"/> |
| Total Cholesterol > 200 mg/dl, or HDL < 40 mg/dl (Completed by CHS) | <input type="checkbox"/> | <input type="checkbox"/> |
| Family history of CVD in males < 55 | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| Age (men > 45, women > 55) | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| No regular exercise program | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| Current Smoker | <input type="checkbox"/> | <input checked="" type="checkbox"/> |

Examiner: Use this space to comment on positive history or findings:

VITAL SIGNS

Height _____ (in.) Weight _____ (lbs)

Resp _____ /Min. Temp (if indicated) _____

Blood Pressure ____/____ mm/Hg (sitting)

Pulse ____/Min. ____ regular ____ irregular

If blood pressure is > 140/90 repeat after 10-15 min.
If pulse is <50 or >100 repeat after 5-10 min.
Document findings below if BP or Pules repeated.

Blood Pressure ____/____ mm/Hg (sitting)

Pulse ____/Min.

SPIROMETRY: 3 good attempts required.
Attach all 3 tracings.

Technician ID: _____

Calibration Date _____

Daily Calibration performed: Yes No

Machine Make/Model: _____

Examinee effort: Good Fair Poor

| | | | |
|----------------|-----------------|---------------------|----------------------|
| Actual FVC | Actual FEV1 | Actual FEV1/FVC | Actual FEF 25-75 |
| %Predicted FVC | %Predicted FEV1 | %Predicted FEV1/FVC | %Predicted FEF 25-75 |

Examiner: Use this space to comment on positive history or findings on this page:



ENDOCRINE Yes No

Any endocrine disease

Thyroid Disease

Obesity

Unexplained weight loss or gain

Diabetes insulin requiring

If yes, units per day _____, Year diagnosed: _____

Diabetes non-insulin requiring

Year diagnosed: _____

If you have diabetes
current medication(s) _____

last hemoglobin A1c _____ %, date performed _____

have you ever had a hypoglycemic episode

If yes, last date _____

have you ever been hospitalized for diabetes

If yes, dates _____

Examiner: Use this space to comment on positive history or findings:

GASTROINTESTINAL Yes No

Any gastrointestinal disease

Hernias

Colostomy

Persistent stomach/abdominal pain/active ulcer

Hepatitis, or other liver disease

Irritable bowel syndrome

Rectal bleeding

Vomiting

Please explain any YES answers, including date(s):

GASTROINTESTINAL

NL ABNL Yes No

Auscultation Organomegaly

Palpation Tenderness

Hernia

(Specify type: _____)

Please explain any "ABNL" or "Yes" answers:

Examiner: Use this space to comment on positive history or findings:

GENITOURINARY Yes No

Any genitourinary disease

Blood in urine

Kidney stones

Difficult or painful urination

Infertility (difficulty having children)

Please explain any YES answers, including date(s):

GENITOURINARY

NL ABNL

External genitalia Deferred

Note: this clearance exam **does not** require a pelvic exam or PAP smear for females, or a rectal or prostate exam for males)

Please explain any "ABNL" answers:

Examiner: Use this space to comment on positive history or findings:



MUSCULOSKELETAL

| | Yes | No |
|--|--------------------------|--------------------------|
| Any musculoskeletal disease | <input type="checkbox"/> | <input type="checkbox"/> |
| Moderate to severe joint pain, arthritis, tendonitis | <input type="checkbox"/> | <input type="checkbox"/> |
| Amputations | <input type="checkbox"/> | <input type="checkbox"/> |
| Loss of use of arm, leg, fingers, or toes | <input type="checkbox"/> | <input type="checkbox"/> |
| Loss of sensation | <input type="checkbox"/> | <input type="checkbox"/> |
| Loss of strength | <input type="checkbox"/> | <input type="checkbox"/> |
| Loss of coordination | <input type="checkbox"/> | <input type="checkbox"/> |
| Chronic back pain | <input type="checkbox"/> | <input type="checkbox"/> |
| Chronic back pain associated with leg numbness, weakness or pain | <input type="checkbox"/> | <input type="checkbox"/> |
| Back surgery within last 2 years | <input type="checkbox"/> | <input type="checkbox"/> |
| Are you right <input type="checkbox"/> handed left <input type="checkbox"/> handed | | |

Please explain any YES answers, including date(s):

NEUROLOGICAL

| | Yes | No |
|--|--------------------------|--------------------------|
| Any neurological disease | <input type="checkbox"/> | <input type="checkbox"/> |
| Tremors, shakiness | <input type="checkbox"/> | <input type="checkbox"/> |
| Seizures (current or previous) | <input type="checkbox"/> | <input type="checkbox"/> |
| Spinal cord injury | <input type="checkbox"/> | <input type="checkbox"/> |
| Numbness or tingling | <input type="checkbox"/> | <input type="checkbox"/> |
| Head/spine surgery | <input type="checkbox"/> | <input type="checkbox"/> |
| History of head trauma with persistent problem | <input type="checkbox"/> | <input type="checkbox"/> |
| Chronic or recurring headaches (migraines) | <input type="checkbox"/> | <input type="checkbox"/> |
| History of brain tumor | <input type="checkbox"/> | <input type="checkbox"/> |
| Loss of memory | <input type="checkbox"/> | <input type="checkbox"/> |
| Insomnia (difficulty sleeping) | <input type="checkbox"/> | <input type="checkbox"/> |

Please explain any YES answers, including date(s):

MUSCULOSKELETAL

| NL | ABNL |
|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> Upper extremities (strength) |
| <input type="checkbox"/> | <input type="checkbox"/> Upper extremities (range of motion) |
| <input type="checkbox"/> | <input type="checkbox"/> Lower extremities (strength) |
| <input type="checkbox"/> | <input type="checkbox"/> Lower extremities (range of motion) |
| <input type="checkbox"/> | <input type="checkbox"/> Feet |
| <input type="checkbox"/> | <input type="checkbox"/> Hands |
| <input type="checkbox"/> | <input type="checkbox"/> Spine, other musculoskeletal |
| <input type="checkbox"/> | <input type="checkbox"/> Flexibility of neck, back, spine, hips |

Please explain any "ABNL" answers:

NEUROLOGICAL

| NL | ABNL |
|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> Cranial nerves (I-XII) |
| <input type="checkbox"/> | <input type="checkbox"/> Cerebellum |
| <input type="checkbox"/> | <input type="checkbox"/> Motor/sensory (include vibratory and proprioception) |
| <input type="checkbox"/> | <input type="checkbox"/> Deep tendon reflexes |
| <input type="checkbox"/> | <input type="checkbox"/> Mental status exam |

Please explain any "ABNL" answers:

Examiner: Use this space to comment on positive history or findings on this page:



DERMATOLOGY

Yes No

Any skin disease

Sun Sensitivity

History of chronic dermatitis

Active skin disease

Moles that have changed in size or color

Please explain any YES answers, including date(s):

DERMATOLOGY

Skin

Normal

Abnormal

Please explain any "ABNL" answers:

Examiner: Use this space to comment on positive history or findings on this page:

Examiner: Use this space to make additional comments about this examination:

Examining Physician's Signature: _____

Date: _____

Examiner's Address: _____

City, State Zip: _____

Examining Physician's Printed Name: _____

Phone Number: _____



Sample Only - Do Not Copy

**ESSENTIAL FUNCTIONS AND WORK CONDITIONS OF A
WILDLAND FIREFIGHTER**

| Time/Work Volume | Physical Requirements | Environment | Physical Exposures |
|--|---|---|--|
| <i>May Include</i> | | | |
| <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 3 miles in 45 minutes, approximating an oxygen consumption (VO₂ max) of 45 mL/kg-minute • typically 14-day assignments <i>but may extend up to 21-day assignments</i> | <ul style="list-style-type: none"> • use shovel, Pulaski, and other hand tools to construct fire lines • lift and carry more than 50# • lifting or loading boxes and equipment • drive or ride for many hours • fly in helicopters and fixed wing airplanes • work independently, and on small and 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 fire shelter | <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 • no ready access to medical help | <ul style="list-style-type: none"> • light (bright sunshine/UV) • burning materials • extreme heat • airborne particulates • fumes, gases • falling rocks and trees • allergens • loud noises • snakes • insects/ticks • poisonous plants • trucks and other large equipment • close quarters, large numbers of other workers • limited/disrupted sleep • hunger/irregular meals • dehydration |



STANDARDS

MEDICAL STANDARDS

There must be no evidence by physical examination or medical history of any medical or physical conditions that is likely to present a safety risk or to worsen as a result of carrying out the essential functions of the job. (See page 9)

PSYCHIATRIC STANDARD

The applicant/incumbent must have judgment, mental functioning, and social interaction/behavior that will provide for the safe and efficient conduct of the requirements of the job.

PROSTHETICS, TRANSPLANTS, AND IMPLANTS STANDARD

The presence or history of organ transplantation or use of prosthetics or implants are not of themselves disqualifying. However, the applicant/incumbent must be able to safely and efficiently carry out the requirements of the job.

Note: For individuals with transplants, prosthetics, or implanted pumps or electrical devices, the firefighter will have to provide **for agency review** documentation from his/her surgeon or physician that the individual (and, if applicable, his/her prosthetic or implanted device) is considered to be fully cleared for the specified functional requirements of wildland firefighting.

IMMUNE SYSTEM/ALLERGIC DISORDERS STANDARD

The applicant/incumbent must be free of communicable diseases, have a healthy immune system, and be free of significant allergic conditions in order to safely and efficiently carry out the requirements of the job. This may be demonstrated by:

- A general physical exam of all major body systems that is within the range of normal variation, including:
 - no evidence of current communicable disease that would be expected to interfere with the safe and effective performance of the requirements of the job; and
 - no evidence of current communicable disease that would be expected to pose a threat to the health of any co-workers or the public; and
- Normal complete blood count, including white blood count and differential; and
- Current vaccination status for tetanus

MEDICATION STANDARD

The need for and use of prescribed or over-the-counter medications are not of themselves disqualifying. However, there must be no evidence by physical examination, laboratory tests, or medical history of any impairment of body function or mental function and attention due to medications that are likely to present a safety risk or to worsen as a result of carrying out the specified functional requirements. Each of the following points should be considered:

- | | |
|--|------------------------------------|
| 1. Medication(s) (type and dosage requirements) | 5. Potential drug side effects |
| 2. Drug-drug interactions | 6. Adverse drug reactions |
| 3. Drug toxicity or medical complications from long-term use | 7. Drug-environmental interactions |
| 4. Drug-food interactions | 8. History of patient compliance |

HEAD, NOSE, MOUTH, THROAT AND NECK STANDARD

The applicant/incumbent must have structures and functions of the head, nose, mouth, throat, and neck that are sufficient for the firefighter to safely and efficiently carry out the requirements of the job. This may be demonstrated by:

- A physical exam of the head, nose, mouth, throat, and neck that is within the range of normal variation, including:
 - normal flexion, extension, and rotation of the neck; and
 - open nasal and oral airways; and
 - unobstructed Eustachian tubes; and
 - no structural abnormalities that would prevent the normal use of a hard hat and protective eyewear; and
- Normal conversational speech



INDIVIDUAL STANDARDS FOR EXAMINING PHYSICIAN

VISION STANDARD

The applicant/incumbent must be able to see well enough to safely and efficiently carry out the requirements of the job. This requires binocular vision, far visual acuity, depth perception, peripheral vision, and color vision, which may be demonstrated by:

- Far visual acuity uncorrected of at least 20/100 in each eye for wearers of hard contacts or spectacles; and
- Far visual acuity of at least 20/40 in each eye corrected (if necessary) with contact lenses or spectacles; and
- Color vision sufficient to distinguish at least red, green, and yellow; and
- Peripheral vision of at least 85° laterally in each eye; and
- Normal depth perception; and
- No ophthalmologic condition that would increase ophthalmic sensitivity to bright light, fumes, or airborne particulates, or susceptibility to sudden incapacitation.

Note: Contact lenses and spectacles are acceptable for correction of visual acuity, but the user must be able to demonstrate that the corrective device(s) can be worn safely and for extended periods of time without significant maintenance, as well as being worn with any necessary personal protective equipment. Successful users of long-wear soft contact lenses are not required to meet the "uncorrected" vision guideline.

HEARING STANDARD

The applicant/incumbent must be able to hear well enough to safely and efficiently carry out the requirements of the job. This requires binaural hearing (to localize sounds) and auditory acuity, which may be demonstrated by:

- A current pure tone, air conduction audiogram, using equipment and a test setting which meet the standards of the American National Standards Institute (see 29 CFR 1910.95); and
- Documentation of hearing thresholds of no greater than 40 dB at 500, 1000, 2000, and 3000 Hz in each ear

Note: The use of a hearing aid(s) to meet this standards is *not* permitted.

VASCULAR SYSTEM STANDARD

The applicant/incumbent must have a vascular system that is sufficient for the firefighter to safely and efficiently carry out the requirements of the job. This may be demonstrated by:

- A physical exam of the vasculature of the upper and lower extremities that is within the range of normal variation, including:
 - no evidence of phlebitis or thrombosis; and
 - no evidence of venous stasis; and
 - no evidence of arterial insufficiency

CHEST AND RESPIRATORY SYSTEM STANDARD

The applicant/incumbent must have a respiratory system that is sufficient for the firefighter to safely and efficiently carry out the requirements of the job. This may be demonstrated by:

- A physical exam of the respiratory system that is within the range of normal variation; and
- A pulmonary function test (baseline exam) showing:
 - forced vital capacity (FVC) of at least 70% of the predicted value; and
 - forced expiratory volume at 1 second (FEV1) of at least 70% of the predicted value; and
 - the ratio FEV1/FVC of at least 70% of the predicted value

Note: The requirement to use an inhaler (such as for asthma) requires agency review.

CARDIAC STANDARD

The applicant/incumbent must have a cardiovascular system that is sufficient for the firefighter to safely and efficiently carry out the requirements of the job. This may be demonstrated by:

- A physical exam of the cardiovascular system that is within the range of normal variation, including:
 - blood pressure of less than or equal to 140 mmHg systolic and 90 mmHg diastolic; and
 - if taken, a normal baseline electrocardiogram (minor, asymptomatic arrhythmias may be acceptable); and
 - no pitting edema in the lower extremities, and normal cardiac exam.

ENDOCRINE AND METABOLIC SYSTEMS STANDARD

Any excess or deficiency in hormonal production can produce metabolic disturbances affecting weight, stress adaptation, energy production, and a variety of symptoms or pathology such as elevated blood pressure, weakness, fatigue and collapse. The applicant/incumbent must have endocrine and metabolic functions that are sufficient for the firefighter to safely and efficiently carry out the requirements of the job. This may be demonstrated by:

- A physical exam of the skin, thyroid, and eyes that is within the range of normal variation; and
- Normal fasting blood sugar level; and
- Normal blood chemistry results



INDIVIDUAL STANDARDS FOR EXAMINING PHYSICIAN

GASTROINTESTINAL SYSTEM STANDARD

The applicant/incumbent must have a gastrointestinal tract that is sufficient for the firefighter to safely and efficiently carry out the requirements of the job. This may be demonstrated by:

- A physical exam and evaluation of the gastrointestinal tract that is within the range of normal variation; and
- Normal liver function and blood chemistry laboratory tests

GENITOURINARY SYSTEM STANDARD

The applicant/incumbent must have a genitourinary system that is sufficient for the firefighter to safely and efficiently carry out the requirements of the job. This may be demonstrated by a normal clean catch urinalysis.

MUSCULOSKELETAL SYSTEM STANDARD

The applicant/incumbent must have a musculoskeletal system that is sufficient for the firefighter to safely and efficiently carry out the functional requirements of the job. This may be demonstrated by a physical exam of the upper and lower extremities, neck, and back that is within the range of normal variation for strength, flexibility, range of motion, and joint stability.

Note: For individuals who require the use of a prosthetic device, the firefighter will have to provide **for agency review** documentation from his/her surgeon or physician that the individual (and, if applicable, his/her prosthetic device) is considered to be fully cleared for the essential functions of the job.

CENTRAL AND PERIPHERAL NERVOUS SYSTEM STANDARD, AND VESTIBULAR SYSTEM STANDARD

The applicant/incumbent must have a nervous system that is sufficient for the firefighter to safely and efficiently carry out the requirements of the job. This may be demonstrated by:

- A physical exam of the cranial and peripheral nerves and the vestibular and cerebellar system that is within the range of normal variation, including:
 - intact cranial nerves, I-XII; and
 - normal vibratory sense in the hands and feet; and
 - normal proprioception of the major joints; and
 - normal sensation of hot and cold in the hands and feet; and
 - normal sense of touch in the hands and feet; and
 - normal reflexes of the upper and lower extremities; and
 - normal balance (e.g., heel-toe walk; Romberg; balance on one foot); and
- Normal basic mental status evaluation (e.g., person, place, time, current events)

DERMATOLOGY STANDARD

The applicant/incumbent must have skin that is sufficient for the firefighter to safely and efficiently carry out the requirements of the function. This may be demonstrated by a physical exam of the skin that is within the range of normal variation.

HEMATOPOIETIC SYSTEM STANDARD

The applicant/incumbent must have a hematopoietic (blood and blood-producing) system that is sufficient for the firefighter to safely and efficiently carry out the requirements of the job. This may be demonstrated by: *

- A physical exam of the skin that is within the range of normal variation; and
- A complete blood count (including hemoglobin, hematocrit, platelets, and white blood count, with differential) that is within the normal range *

* Lab to be reviewed by CHS

