Comprehensive Health Services, Inc.
Attn: WLFF Client Service Administrator
10701 Parkridge Blvd., Suite 200
Reston, VA 20191
Phone: (866) 416-5941 Fax: (703) 288-5482

Federal Interagency Periodic w/out EKG Medical History and Exam Form
Wildland Firefighters (Arduous Duty)

Servicing Human Resources Officer (SHRO) or Fire Management Officer (FMO) :

On a computer generated label or typewriter, enter the SHRO's and FMO's name, street address, city, state, zip code, telephone number, and e-mail address in the space provided below:

Servicing Human Resources Officer (SHRO):	**Fire Management Officer (FMO):**
Name: _____	Name: _____
Street Address: _____	Street Address: _____
City, State, Zip: _____	City, State, Zip: _____
Telephone Number: _____	Telephone Number: _____
E-mail: _____	E-mail: _____

Firefighter:

- Complete ALL of the medical history questions on pages 2 through 9 of this form and attend the medical exam appointment.
- All "Yes" answers in the medical history sections must be explained, including dates, treatments and current status.
- Your signature is required on page 2. Failure to sign will result in a delay of rating determination.
- Take this form to your examination at the CHS network examining physician/clinic.
- Do not eat or drink anything except water for 6 hours prior to exam. You may take medications.
- 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.)

Examining Physician:

- Please contact CHS Client Service Administrator for the Wildland Firefighters at 866-416-5941 if you have any questions about the procedures.
- Review the functional requirements and work conditions of Wildland Firefighters on the last 2 pages of this form.
- Review the firefighter's medical history responses on pages 2 through 9 and provide full explanations on page 9 regarding all "yes" answers. These comments should include dates and current status.
- Complete the "Vital Signs and Required Testing", "Physical Exam", and "Exam Summary" sections. Sign where indicated under the "Physical Exam" and "Exam Summary" sections.
- Forward specimens and laboratory requisition to Quest Laboratories using the enclosed Express Labpak on the day of the collection.
- When the 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 the exam is performed to the address above.
- Do not communicate an opinion of qualification to the examinee. All significant abnormal findings are to be brought to the attention of 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 permanent worsening of a pre-existing medical condition. Its collection and use are consistent with the provisions of the 5 CFR 339 (Medical Qualification Determinations), 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 OPM system of records notice.

Required Services (Check completed components)

- ☐ Medical History Review
- ☐ Physical Examination
- ☐ Far Vision Acuity (corrected and uncorrected);Color; Peripheral; Depth
- ☐ Audiogram (500 Hz - 8000 Hz)
- ☐ Spirometry (attach tracings)
- ☐ Lab collection (chemistries, CBC, Lipid and UA)*
- ☐ Physician must sign completed exam in space provided (pages 11 and 12)
- ☐ Physician must complete exam summary on page 12.

☐ Please fax completed exam form to CHS 703-288-5482

* indicates laboratory test to be sent to CHS contraced lab - Results will be forwarded directly to CHS

Federal Interagency Periodic w/out EKG Medical History and Exam Form
Wildland Firefighters (Arduous Duty)

Firefighter's Name:		**SSN:**
Name of Employing Agency:		**Date of Birth:**
Position/Job Title:		**Gender:** ☐ Male ☐ Female
Home Address: **City, State, Zip:**		**Date of Last Physical Exam:**
Home Phone:	**Work Phone:**	**Cell Phone:**

Incomplete forms or missing information will result in a delay clearing you for arduous firefighter duties. Submitting information that is misleading or untruthful may result in termination, criminal sanctions, or failure to be cleared as a firefighter.

I understand that this history form and review do not substitute for routine health care or a periodic health examination conducted by my physician and that 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: _____ Date signed: _____

Your signature is REQUIRED. Failure to sign will result in a delay of rating determination.

Answer all questions below. If you answer "yes" to any question(s), please provide ALL the requested information asked for in the "yes" box. Note: Missing information will result in a delay clearing you for arduous wildland firefighter duties.

MEDICAL HISTORY

1. Do you currently take any medications (prescribed and/or over-the-counter, including herbal)?	☐ No	☐ Yes (list all medications, prescribed and over-the-counter, including herbal) Name — Reason For Taking
2. Are you allergic to bee/wasp/hornet/ fire ant/yellow jacket stings?	☐ No	☐ Yes Check any of the reactions you have had: ☐ large amount of swelling at sting site only ☐ 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 ☐ hives ☐ anaphylactic shock ☐ blood pressure problems ☐ difficulty breathing Please explain in detail any positive responses marked above: _____ Have you ever been advised by a physician to carry an EpiPen for yourself? ☐ No ☐ Yes Do you carry an EpiPen for yourself? ☐ No ☐ Yes
3. Do you have any other allergies?	☐ No	☐ Yes List and describe reaction(s):

4. Have you undergone treatment by doctors, healers, or other practitioners for any problem or illness within the past year?	☐ No	☐ Yes Reason / Date / Current Status 1. 2. 3.
5. Have you ever been a patient in any type of hospital?	☐ No	☐ Yes Reason / Date / Current Status 1. 2. 3.
6. Have you had or have you been advised to have any operation?	☐ No	☐ Yes Reason / Date / Current Status 1. 2.
7. 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)?	☐ No	☐ Yes Explain: _____ Date(s): _____ Current status: _____
8. Have you been rejected for or discharged from military service because of physical, mental, or other reasons?	☐ No	☐ Yes Date: _____ Reason: _____ Details:
9. Have you ever received, is there pending, or have you applied for a pension or compensation for a disability?	☐ No	☐ Yes Date(s): _____ Explain: _____ Current status: _____ % VA disability (if applicable): _____ Details:
10. Treatment for a mental or emotional condition?	☐ No	☐ Yes Date(s): _____ Diagnosis: _____ Is this a current problem? ☐ No ☐ Yes Details:
11. Diagnosed with or treated for alcoholism or alcohol dependence?	☐ No	☐ Yes Date(s): _____ Current status: _____ Have you ever been in rehabilitation? ☐ No ☐ Yes If yes, when?: _____ Details:
12. Diagnosed as being dependent on illegal drugs or treated for drug abuse?	☐ No	☐ Yes Date(s): _____ Current status: _____ Have you ever been in rehabilitation? ☐ No ☐ Yes If yes, when?: _____ Details:
13. Have you ever had any type of eye surgery (LASIK, PRK, RK, cataract surgery, surgery for eye muscles, etc.)?	☐ No	☐ Yes Date(s): _____ Type of surgery: _____ Current status: _____

14. Have you ever had any type of eye disease (cataracts, glaucoma, retinopathy, macular degeneration, detached retina, etc)?	☐ No	☐ Yes Diagnosis: _____ Date(s): _____ Is this a current problem? ☐ No ☐ Yes Details:
15. Do you wear corrective lenses?	☐ No	☐ Yes Type used during firefighting: ☐ Glasses ☐ Soft Contacts ☐ Hard Contacts ☐ Other _____ Reason: ☐ For seeing far ☐ For seeing close up ☐ Both
16. Are you colorblind?	☐ No	☐ Yes Explain: _____
17. Do you have any type of ear disease or hearing loss?	☐ No	☐ Yes Diagnosis: _____ Do you have difficulty hearing? ☐ No ☐ Yes Do you wear a hearing aid(s)? ☐ No ☐ Yes
18. Have you ever had any type of ear surgery?	☐ No	☐ Yes Type of surgery: _____ Date(s): _____ Current status: _____
19. Have you been exposed to any loud, constant noises or music within the last 14 hours?	☐ No	☐ Yes Explain: _____
20. Have you had a cold or any ear infections in the last 2 weeks?	☐ No	☐ Yes Explain: _____
21. Do you get any ringing in the ears?	☐ No	☐ Yes Explain: _____
22. Have you ever had an eardrum perforation?	☐ No	☐ Yes Explain with date(s): _____
23. Do you use any protective hearing equipment when working around loud noise?	☐ No	☐ Yes What type? ☐ Foam ☐ Pre-mold/plugs ☐ Ear muffs
24. Do you have any type of skin disease (other than acne)?	☐ No	☐ Yes Diagnosis: _____ Details:
25. Do you have any vascular disease (aneurysm, peripheral vascular disease, etc.)?	☐ No	☐ Yes Diagnosis: _____ Current status: _____
26. Have you ever had a blood clot in a vein or in your lungs?	☐ No	☐ Yes Diagnosis and location of clot: _____ Date: _____
27. Do you currently have anemia?	☐ No	☐ Yes What type of anemia? _____ Any Treatment? ☐ No ☐ Yes Type of treatment: _____
28. Do you have high blood pressure?	☐ No	☐ Yes
29. Have you ever had a stroke or transient ischemic attack (TIA)?	☐ No	☐ Yes Date: _____

30. Have you ever seen a doctor for poor circulation in your hands or feet?	☐ No	☐ Yes Explain and give date(s): _____
31. Do you get white fingers with cold or vibration?	☐ No	☐ Yes Explain: _____
32. Have you ever had a heart attack, angioplasty, or heart bypass surgery?	☐ No	☐ Yes Which of the three have you had? _____ Date(s): _____
33. Have you had chest pain or angina?	☐ No	☐ Yes Date(s): _____ Did you see a doctor about the pain? ☐ No ☐ Yes What tests were done? (Give results) _____ Diagnosis: _____ Treatment: _____
34. Have you ever had an irregular heart beat, skipped beats, or palpitations?	☐ No	☐ Yes Date(s): _____ How many times over the past year has this occurred? _____ Have you seen a doctor about them? ☐ No ☐ Yes Type of palpitations: _____ Test(s) done: _____ Treatment: _____ Have you ever passed out or almost passed out due to an irregular heart beat? ☐ No ☐ Yes If yes, please explain with date(s): _____
35. Do you have a heart murmur?	☐ No	☐ Yes Date diagnosed: _____ Cause of the murmur: _____
36. Have you ever passed out, fainted, or lost consciousness?	☐ No	☐ Yes Date(s): _____ Details:
37. 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, heart surgery, etc.)?	☐ No	☐ Yes Diagnosis: _____ Date(s): _____ Is this a current problem? ☐ No ☐ Yes Details:
38. Do you have parents or siblings with a history of coronary artery disease (heart attack, angina, angioplasty, bypass surgery, etc.)?	☐ No	☐ Yes Which relative(s); what diagnosis; and age of relative(s) when first diagnosed: _____
39. Have you ever had asthma?	☐ No	☐ Yes Date diagnosed: _____ Date of last asthma attack: _____ Do you use an inhaler? ☐ No ☐ Yes (list name(s) of inhaler(s) AND how many times per week you use each inhaler): _____ _____ Have you ever been hospitalized or been to the emergency room or doctor's office because of an asthma attack? ☐ No ☐ Yes (give dates) _____ Does smoke, dust, or exercise trigger your asthma? ☐ No ☐ Yes (give dates) _____

40. Do you have any type of lung disease other than asthma (reactive airway disease, emphysema, COPD, collapsed lung, etc.)?	☐ No	☐ Yes Diagnosis: _____ Current status: _____ Have you used an inhaler within the past 2 years? ☐ No ☐ Yes (give dates, name(s) of inhalers and frequency of use) _____
41. Have you ever had a positive PPD (TB) skin test or tuberculosis?	☐ No	☐ Yes Specify: ☐ Positive PPD only ☐ Diagnosed with tuberculosis Date: _____ Did you receive any treatment? ☐ No ☐ Yes (list dates, duration of treatment, and type of treatment such as INH) _____ _____ Was a chest x-ray done? ☐ No ☐ Yes (give result and date) _____ Have you ever had a BCG vaccine (to prevent TB)? ☐ No ☐ Yes (date) _____
42. Have you ever been diagnosed with sleep apnea?	☐ No	☐ Yes Date diagnosed: _____ Have you ever been advised to use a CPAP machine? ☐ No ☐ Yes, but I do not use CPAP now ☐ Yes, and I do use CPAP now Other treatments: _____ Current status: _____
43. Do you have any neurological disease?	☐ No	☐ Yes Diagnosis: _____ Current status: _____ Does this disease limit or restrict your activities in any way? ☐ No ☐ Yes (explain) _____
44. Have you had any spinal cord injury?	☐ No	☐ Yes Diagnosis: _____ Date(s): _____ Current status: _____
45. Have you had any head or spine surgery?	☐ No	☐ Yes Diagnosis: _____ Date(s): _____ Current status: _____
46. Do you have a history of head trauma with persistent problems?	☐ No	☐ Yes Diagnosis: _____ Date(s): _____ Current status: _____

47. Do you have any history of brain tumor?	☐ No	☐ Yes Diagnosis: _____ Date(s): _____ Current status: _____
48. Do you have any problems with dizziness, balance, or coordination?	☐ No	☐ Yes Explain and give date(s): _____
49. Do you have any loss of memory?	☐ No	☐ Yes Explain and give date(s): _____
50. Do you have a tremor or shakiness?	☐ No	☐ Yes Explain and give date(s): _____
51. Do you have any numbness in your hands or feet?	☐ No	☐ Yes Explain and give date(s): _____
52. Do you have migraines or severe headaches?	☐ No	☐ Yes Diagnosis: _____ Number of headaches/migraines per month: _____ When you have a headache, does it limit your work activities? ☐ No ☐ Yes (explain) _____
53. Have you ever had a seizure?	☐ No	☐ Yes Type of seizure: _____ Date of last seizure: _____
54. Do you have diabetes?	☐ No	☐ Yes Do you take insulin? ☐ No ☐ Yes Do you take pills for diabetes? ☐ No ☐ Yes Average blood sugar reading: _____ Most recent Hgb A1c result and test date: _____ Any episodes of low blood sugar in the last 2 years? ☐ No ☐ Yes (explain with dates) _____ Any heart disease, kidney disease, eye disease, or neuropathy due to diabetes? ☐ No ☐ Yes (explain) _____ When was your diabetes diagnosed? _____
55. Do you have any thyroid diseases?	☐ No	☐ Yes Type of thyroid disease: _____ Current status: _____
56. Do you have any other endocrine disease?	☐ No	☐ Yes Diagnosis: _____ Date(s): _____ Current status: _____
57. Have you ever had any type of stomach or intestinal disease?	☐ No	☐ Yes Diagnosis: _____ Date(s): _____ Current status: _____

58. Do you currently have a hernia?	☐ No	☐ Yes Type of hernia: ☐ Inguinal (groin) ☐ Umbilical ☐ Other _____ Is surgery planned or recommended? ☐ No ☐ Yes Does your hernia cause pain or other symptoms? ☐ No ☐ Yes (explain) _____
59. Have you ever had hepatitis?	☐ No	☐ Yes Type of hepatitis: ☐ Type A ☐ Type B ☐ Type C ☐ Other (explain) _____ Date: _____ Current status: _____
60. Have you ever had any other type of liver disease?	☐ No	☐ Yes Diagnosis: _____ Date: _____ Current status: _____
61. Have you ever had any blood in the stool or vomited blood?	☐ No	☐ Yes Explain and give date(s): _____
62. Do you have any type of kidney, bladder, or prostate disease?	☐ No	☐ Yes Diagnosis: _____ Date: _____ Current status: _____
63. Do you get back or neck pain?	☐ No	☐ Yes Location: ☐ lower back ☐ upper back ☐ neck Number of episodes over the last year: _____ Date of last episode: _____ Current status: _____ Any numbness or weakness in legs or arms? ☐ No ☐ Yes (explain) _____ When you get pain, does it limit your work activities? ☐ No ☐ Yes (explain) _____
64. Do you get joint pain?	☐ No	☐ Yes Which joint(s)? _____ Diagnosis: _____ Frequency of pain: _____ Current status: _____ Does the pain limit your work activities? ☐ No ☐ Yes (explain) _____
65. Do you have any amputations or are you unable to use any arm, leg, finger or toe?	☐ No	☐ Yes Explain and give date: _____ Does this loss limit your work activities? ☐ No ☐ Yes (explain) _____
66. Do you have any loss of strength?	☐ No	☐ Yes Explain and give date(s): _____
67. Are you right-handed or left-handed?		☐ Right-handed ☐ Left-handed
68. Do you have any medical condition not listed elsewhere on this questionnaire?	☐ No	☐ Yes Explain with date(s) and current status:

69. Tobacco History: This information is needed since tobacco use increases your risk for many diseases including cancer, lung disease and heart disease. Please mark the appropriate box:

☐ Currently use tobacco:
cigarettes/day _____
other tobacco products/day _____
Total years of tobacco use _____

☐ Formerly used tobacco:
cigarettes/day _____
other tobacco products/day _____
Total years of tobacco use _____

☐ Never used tobacco

70. Physical Activity

Intensity: ☐ Low (walking, etc.) ☐ Moderate (jogging, cycling, etc.) ☐ High (strenuous exercise such as running, etc.)
Duration in Minutes per Session: _____ Frequency in Days per Week: _____

71. Date of Last Tetanus (Td) Booster: ☐ Within 10 Years ☐ More than 10 years ☐ I don't remember
(NOTE: Tetanus booster is recommended every 10 years. Should you elect to have this updated at the time of your exam, you are responsible for the payment.)

EXAMINER COMMENTS

EXAMINER MUST PROVIDE COMMENTS REGARDING ALL "YES" ANSWERS FOR MEDICAL HISTORY QUESTIONS 1-68.
Please be sure that date(s) and current status are documented.

(If additional space is needed, please add another page.)

Question #	Comments

VITAL SIGNS AND REQUIRED TESTING (To Be Completed By Exam Facility)

Vital Signs

1. Height: _____ inches Weight: _____ pounds
2. Blood Pressure: _____/_____
   Repeat after 5-10 minutes if first blood pressure is greater than 140/90: _____/_____
3. Pulse: _____ beats/minute ☐ Regular ☐ Irregular
   Repeat after 5-10 minutes if first pulse is greater than 100 or less than 50: _____beats/minute
4. Respirations: _____ breaths/minute 5. Temperature (if indicated): _____

Vision

1. Uncorrected Distance Vision (Must be done on all examinees except those who wear soft contacts.)

2. Corrected Distance Vision (Must be done on all examinees who wear glasses or contacts for distance vision.)

	Right:	Left:
Uncorrected distance vision	20/_____	20/_____
Corrected distance vision	20/_____	20/_____

3. Color Vision

Part I

Type of test: ☐ Ishihara ☐ Titmus ☐ Other _____

Number correct: _____ of _____ correct

Part II

Can see: Red/Green/Yellow ☐ Yes ☐ No Name of test: _____

4. Peripheral Vision (temporal only)

Right: _____ degrees Left: _____ degrees

5. Depth Perception (Must be recorded in arc seconds or % Shepard Frye):

_____ arc seconds OR _____ % Shepard Frye

(Please record: Name of test: _____ Number correct: ___ of ___)

1. Testing method must measure down to 100 arc seconds or less. 2. Confrontation is not an acceptable type of testing. 3. Check with corrective lenses if applicable.

Audiogram

Frequency	500 Hz	1000Hz	2000Hz	3000Hz	4000Hz	6000Hz	8000Hz
Right Ear							
Left Ear							

☐ If examinee wears hearing aids, check here to indicate that the audiogram was done without hearing aids

☐ Check here to indicate that audiogram printout is attached

1 Verify audiogram if > 40 dB for 500, 1000, 2000, or 3000 Hz.

2. Audiogram must meet OSHA standard for testing (see 29 CFR 1910.95)

3. Calibration method:
   ☐ Oscar
   ☐ Biological
   Date: _____

Spirometry

	Actual	% Predicted
FVC		
FEV1		
FVC/FEV1		

Examinee Effort: ☐ Good ☐ Fair ☐ Poor

☐ Check here to indicate that the tracings are attached to the exam form.

1. Perform up to 3 attempts to get a good tracing.

2. Calibration date: _____

3. Daily calibration performed?
   ☐ Yes ☐ No

4. Technician ID: _____

5. Machine Make/Model:
   _____

PHYSICAL EXAM (To Be Completed By Examiner)		
ALL ABNORMAL FINDINGS MUST BE EXPLAINED IN THE "ABNORMAL" BOX		
1. General Appearance	☐ Normal	☐ Abnormal
2. Mental Status	☐ Normal	☐ Abnormal
3. Head and Neck		
Head, face, neck (thyroid)	☐ Normal	☐ Abnormal
Mouth, nose, throat	☐ Normal	☐ Abnormal
Pupils	☐ Normal	☐ Abnormal
Ocular mobility	☐ Normal	☐ Abnormal
Canal/external ear	☐ Normal	☐ Abnormal
Tympanic membrane	☐ Normal	☐ Abnormal
Speech	☐ Normal	☐ Abnormal
4. Lungs/Chest	☐ Normal	☐ Abnormal
5. Cardiac (mumur, irregular beats)	☐ Normal	☐ Abnormal
6. Peripheral Blood Vessels	☐ Normal	☐ Abnormal
7. Abdomen	☐ Normal	☐ Abnormal
8. Hernia	☐ None present	☐ Hernia present Type and location: _____ Size: ☐ Small ☐ Medium ☐ Large
9. External Genitalia (Pelvic, rectal, and prostate exams are NOT required.)	☐ Normal ☐ Deferred	☐ Abnormal
10. Upper Extremities		
Strength	☐ Normal	☐ Abnormal
Range of motion	☐ Normal	☐ Abnormal
Hands/Fingers	☐ Normal	☐ Abnormal
11. Lower Extremities		
Strength	☐ Normal	☐ Abnormal
Range of motion	☐ Normal	☐ Abnormal
Feet/Toes	☐ Normal	☐ Abnormal
12. Spine	☐ Normal	☐ Abnormal
13. Neurological	☐ Normal	☐ Abnormal
14. Skin	☐ Normal	☐ Abnormal
15. Other Comments		

Physician Printed Name **Signature** **Date**

Note: Examiner must also complete Exam Summary on next page.

EXAM SUMMARY (This Must Be Completed By Examining Physician)

1. Have all medical history questions been answered and explained? ☐ YES ☐ NO
2. Has the examiner provided comments (including dates and current status) for all medical history questions which were answered "yes"? ☐ YES ☐ NO
3. Is an uncorrected visual acuity recorded for all examinees (except those who wear soft contacts)? ☐ YES ☐ NO
4. For those who wear contacts or glasses, is a corrected visual acuity recorded? ☐ YES ☐ NO
5. Is color vision recorded? ☐ YES ☐ NO
6. Is peripheral vision recorded? ☐ YES ☐ NO
7. Is depth perception recorded in sec of arc or % Shepard Frye? ☐ YES ☐ NO
8. Are the results of a complete audiogram recorded? ☐ YES ☐ NO
9. Are the spirometry results recorded and tracings attached? ☐ YES ☐ NO
10. Has the firefighter signed the exam form on page 2? ☐ YES ☐ NO
11. Has the examiner signed where indicated on the previous page and on this page? ☐ YES ☐ NO
12. Have the blood and urine specimens been collected? ☐ YES ☐ NO

Physician Printed Name	Signature	Date
Street Address (print)	**City, State, ZIP (print)**	**Telephone Number**

ESSENTIAL FUNCTIONS AND WORK CONDITIONS OF AN ARDUOUS DUTY WILDLAND FIREFIGHTER

Time/Work Volume	Physical Requirements	Environment	Physical Exposures
May Include			
❁ Long hours (minimum of 12-hour shifts)	❁ Use shovel, Pulaski and other hand tools to construct fire lines	❁ Very steep terrain	❁ Light (bright sunshine/UV)
❁ Irregular hours	❁ Lift and carry more than 50 pounds	❁ Rocky, loose, or muddy ground surfaces	❁ Burning materials
❁ Shift work	❁ Lifting or loading boxes and equipment	❁ Thick vegetation	❁ Extreme heat
❁ Time zone changes	❁ Drive or ride for many hours	❁ Down/standing trees	❁ Airborne particulates
❁ Multiple and consecutive assignments	❁ Fly in helicopters and fixed wing airplanes	❁ Wet leaves/grasses	❁ Fumes, gases
❁ Pace of work typically set by emergency situations	❁ Work independently, and on small and large teams	❁ Varied climates (cold/ hot/ wet/ dry/ humid/ snow/ rain)	❁ Falling rocks and trees
❁ Ability to meet "arduous" level performance testing (the Pack Test), which includes carrying a 45 lb pack 3 miles in 45 minutes, approximating an oxygen consumption (VO2 max) of 45 mL/kg-minute	❁ Use PPE (includes hard hat, boots, eyewear and other equipment)	❁ Varied light conditions, including dim light or darkness	❁ Allergens
	❁ Arduous exertion	❁ High altitudes	❁ Loud noises
	❁ Extensive walking, climbing, kneeling, stooping, pulling hoses, running, jumping, twisting, and bending	❁ Heights	❁ Snakes
❁ Typically 14-day assignments but may extend up to 21-day assignments	❁ Rapid pull-out to safety zones	❁ Holes and drop-offs	❁ Insects/ticks
	❁ Provide rescue or evacuation assistance	❁ Very rough roads	❁ Poisonous plants
	❁ Use of a fire shelter	❁ Open bodies of water	❁ Trucks and other large equipment
		❁ Isolated/ remote sites	❁ Close quarters, large number of other workers
		❁ No ready access to medical help	❁ Limited/disrupted sleep
			❁ Hunger/irregular meals
			❁ Dehydration

Medical Standards for Wildland Firefighter Arduous Duty

System	Standard
Psychiatric	Must have judgement, mental functioning, and social interaction that will provide for the safe and efficient conduct of the job requirements.
Vision	Uncorrected far visual acuity at least 20/100 in each eye for those who wear hard contacts or glasses; far visual acuity of at least 20/40 each eye corrected (if necessary) with contact lenses or glasses; peripheral vision of at least 85 degrees laterally in each eye; normal depth perception; color vision sufficient to distinguish red, green and amber (yellow); no ophthalmologic condition that would increase ophthalmic sensitivity to bright light, fumes, airborne particles, or susceptibility to sudden incapacitation. Note: Successful users of soft contact lenses are not required to meet the "uncorrected" vision guideline.
Hearing	Documentation of hearing thresholds of no greater than 40 dB at 500, 1000, 2000, and 3000 Hz in each ear. Current pure tone audiogram using equipment and a test setting which meets ANSI standards (C29CFR1910.95)
HEENT	Normal conversational speech. No evidence of head, nose, mouth, throat, or neck conditions likely to present a safety risk or to worsen as a result of carrying out the essential functions of the job.
Dermatology	No evidence of dermatologic conditions likely to present a safety risk or to worsen as a result of carrying out the essential functions of the job.
Vascular	No current evidence of phlebitis, thrombosis, venous stasis or arterial insufficiency. No evidence of peripheral vasculature conditions likely to present a safety risk or to worsen as a result of carrying out the essential functions of the job.
Cardiac	No evidence that the cardiovascular system is outside the range of normal. Blood pressure must be less than or equal to 140 mmHg systolic and 90 mmHg diastolic. If taken, a normal baseline EKG.
Gastrointestinal	No evidence of gastrointestinal conditions likely to present a safety risk or to worsen as a result of carrying out the essential functions of the job.
Genitourinary	No evidence of genitourinary conditions likely to present a safety risk or to worsen as a result of carrying out the essential functions of the job.
Endocrine	No evidence of endocrine conditions likely to present a safety risk or to worsen as a result of carrying out the essential functions of the job.
Nervous and Vestibular	Normal mental status. No evidence of nervous, cerebellar, or vestibular system conditions likely to present a safety risk or to worsen as a result of carrying out the essential functions of the job.
Chest/Respiratory	No evidence of respiratory conditions likely to present a safety risk or to worsen as a result of carrying out the essential functions of the job. Documentation of a pulmonary function test showing FEV1 and FVC of greater than or equal to 70% and FEV1/FVC greater than or equal to 80%. Note: The requirement to use an inhaler (such as for asthma) requires agency review.
Immune/Allergic	No evidence of infectious disease, immune system disorder, or allergic conditions likely to present a safety risk or to worsen as a result of carrying out the essential functions of the job.
Hematopoietic	No evidence of hematopoietic conditions likely to present a safety risk or to worsen as a result of carrying out the essential functions of the job.
Musculoskeletal	Normal strength, flexibility, range of motion, and joint stability. No musculoskeletal conditions likely to present a safety risk or to worsen as a result of carrying out the essential functions of the job.
Prosthetics; Transplants; Implants	No evidence that the transplant, prosthesis, implant, or conditions that led to the need for these treatments are likely to present a safety risk or to worsen as a result of carrying out the essential functions of the job. Note: For individuals with transplants, prosthetics or implanted pumps or electrical devices, the firefighter will need to provide documentation that the individual (and, if applicable, his/her prosthetic or implanted device) is considered fully cleared for the specified functional requirements of wildland firefighting.
Medication	The need for and use of prescribed or over-the-counter medications are not of themselves disqualifying. However, there must be no impairment of body function, mental function, or attention due to medications that is likely to present a safety risk or worsen as a result of carrying out the specified functional requirements.

Further information regarding the Medical Standards for Wildland Firefighter Arduous Duty can be found at:
http://www.nifc.gov/medical_standards/resources/medstand_review-criteria.pdf