

**NATIONAL SCIENCE FOUNDATION**  
**OFFICE OF POLAR PROGRAMS**  
4201 WILSON BOULEVARD, SUITE 755-S  
ARLINGTON, VA 22230

**ELECTRONIC SUBMISSION OF MEDICAL FORMS**

**Notice to all participants in the US Antarctic Program**

**PLEASE DO NOT SUBMIT YOUR COMPLETED MEDICAL FORMS OR OTHER DOCUMENTS THAT CONTAIN PERSONALLY IDENTIFIABLE INFORMATION BY EMAIL. YOU MUST PRINT THE FORMS, MANUALLY SIGN THEM AND MAIL OR FAX THEM TO RAYTHEON POLAR SERVICES COMPANY.**

Explanation:

The NSF is bound by the requirements of the Privacy Act of 1974 and its amendments. All information collected for the purpose of determining your physical qualifications for deploying to Antarctica, is considered confidential. The NSF and its contractors that are in receipt of your medical and personal information are required to maintain your confidentiality and secure your information.

For your convenience, the NSF has made the medical forms interactive so that you may, if you choose, fill them out electronically and save a copy on your computer for your personal use. However, the NSF currently has no way to secure the data as it is electronically transmitted and therefore cannot protect your confidentiality if you transmit the data over unsecured lines.

In order to ensure that we do not violate the Privacy Act or any other federal law pertaining to confidential or personally identifiable information, Raytheon Polar Services Company has been instructed not to accept any electronically submitted medical forms. **Any medical forms received by email will be disposed of without action.**

If you have any questions regarding NSF privacy rules or procedures, please contact the NSF Office of the General Counsel at 703-292-8060.

## MEDICAL AND DENTAL - INSTRUCTION GUIDE – Long Form

	DESCRIPTION OF FORM	ACTION
Checklist Form ME-DT-D-112	Completed by RPSC Medical for each candidate, based upon age, gender, family history (if available), previous deployment history, and seasonal deployment needs. <b>Additional tests/exams may be required based on information received.</b>	Call your Doctor/Dentist: request appointment to include any/all tests indicated on checklist. Take the checklist with you to appointments, along with the "Dear Doctor" letter (ME-DT-D-102).  <b><i>Falsifying and/or non-disclosure of information may result in permanent disqualification from the United States Antarctic Program.</i></b>
Release Form NSF Form 1421	"Medical Risks for NSF-Sponsored Personnel Traveling to Antarctica" release.	Read, sign and date. Return to RPSC Medical. Participants <b>WILL NOT</b> be cleared for deployment until RPSC Medical receives this form.
Medical History NSF Form 1422	Eight page medical history (long form).	Long form - Complete and take with you to your Doctor's appointment. Return to RPSC Medical.
Polar Physical Examination NSF Form 1423	Two page examination form.	This is for your Doctor to complete during your appointment. This completes the medical history form. Return to RPSC Medical.
Lab Work Required <b>Raytheon and NANA Employees Only</b>  LabCorp Requisition or LabCorp Lab Kit	LabCorp is a nationwide chain that will send the results to, and direct-bill, the RPSC Medical Department. For LabCorp locations in New York and California, you may be asked to provide full or partial payment at time of service. You will be reimbursed.  Please follow the instructions on your checklist.  If you do not have a LabCorp location near you, please notify RPSC Medical and we will mail you a LabCorp Lab Kit.	Visit <a href="http://www.labcorp.com">www.labcorp.com</a> to find the closest LabCorp patient draw site to your location. Bring with you the <b>LabCorp Requisition</b> sent to you via email from the RPSC Medical Department.  If a LabCorp is not available, contact RPSC Medical and request a LabCorp Lab Kit be mailed to your attention. Your doctor's office or other laboratory facility can follow the Lab Kit instructions. It is your responsibility to make sure that the laboratory specimens are mailed on the day they were collected.  Lab results will be directly faxed to the RPSC Medical Department.  <b>Labs must be done within 6 months of deployment. You must fast for 10-12 hours prior to the blood draw.</b>
Lab Work Required <b>Non-Raytheon Participants</b>  Required Labs Form ME-DT-A-109	Provides a list of required laboratory tests.  Please follow the instructions on your checklist.	Take this form with you to your doctor's appointment.  All lab results should be faxed to the RPSC Medical Department.  <b>Labs must be done within 6 months of deployment. You must fast for 10-12 hours prior to the blood draw.</b>
HIV Consent NSF Form 1424	Explains the walking blood bank procedure and the need for HIV testing.	Read, sign and date this form. Take it with you to your Doctor's appointment and have it returned with the medical forms.
Dental NSF Form 1425	Radiographs become the property of USAP and will not be returned to you or your Dentist. Instructions for digital radiographs can be found in the "Dear Dentist" letter (ME-DT-D-106).	Complete the top portion of the Dental Examination form BEFORE your appointment. Take the "Dear Dentist" letter to your Dentist. The exam form and ORIGINAL radiographs are to be sent to RPSC Medical.
Reimbursement Form ME-A-103	Form used by Raytheon employees for out-of-pocket reimbursable fees only. Use this form only if you are not currently working for RPSC.	Read and follow instructions on the Reimbursement form. Mail to RPSC Medical.
Eyewear Policy for Antarctica Form ME-A-119	Sunglasses are a requirement in Antarctica. This form details all requirements.	RPSC employees are eligible to be reimbursed every other year for one (1) pair of prescription sunglasses. Additionally, if required of your job position, reimbursement for one (1) pair of prescription safety glasses. You will be reimbursed up to \$175.00 for each pair. <b>You must be Physically Qualified to obtain reimbursement.</b>
Medications Form ME-A-121	<b>Participants taking prescription or over-the-counter medications are required to bring an adequate supply for the deployment duration.</b> USAP does not provide motion sickness medication.	If you need physician-prescribed medications of any kind during your deployment, please consult your physician. <b>You will need to obtain a prescription for the length of your deployment.</b> Be sure to bring enough medication to allow for travel and extended time on Ice. See letter included in packet.
Immunizations	Current Tetanus immunization -USAP required. Influenza Vaccination – USAP required. Hepatitis A & B vaccines are strongly recommended for certain positions. See checklist.	Consult the Centers for Disease Control and Prevention International Traveler's Hotline re: immunization for international travel at <a href="http://wwwn.cdc.gov/travel/default.aspx">http://wwwn.cdc.gov/travel/default.aspx</a>
Psychological Screening - Winter Over Participants	Required for candidates deploying to either McMurdo or the South Pole during the austral winter (March-October).	Call RPSC Medical at 800-688-8606, option 3, to arrange an appointment. Nicoletti-Flater Associates are located in Denver, CO, and will perform all psychological evaluations in Colorado.

## **Influenza Vaccination – Important Notice**

Effective 14 July 2008, every deploying USAP participant is required to receive an influenza vaccination prior to deployment. The National Science Foundation concluded that influenza resulted in a significant impact to operations and therefore all deploying personnel must receive a flu shot.

### **Please Review The Attached Documents:**

**\*\* Requires Signature and Return\*\*** The Read, Sign, Return - Influenza Vaccination form requires your signature and return to RPSC Medical prior to purchase of deployment airline tickets. *Sign and return the document immediately.*

For Your Information:

The Centers for Disease Control (CD) “What You Need To Know” Influenza Vaccine Guide: Inactivated Vaccine.

The Centers for Disease Control (CD) “What You Need To Know” Influenza Vaccine Guide: Live Vaccine.

### **Obtaining Flu Shots:**

1) Participants will be given flu shots in Denver at orientation, in Christchurch prior to departing for Antarctica, or upon arrival at Palmer Station.

OR

2) Participants may obtain a flu shot from their medical provider during the PQ process and submit the supporting documentation to RPSC Medical.

Below you will find Frequently Asked Questions (FAQs) regarding the Influenza Vaccination program. Once you have reviewed all the information, please contact your hiring manager or the Human Resources department for questions relating to your employment. For medical-based inquiries, please contact the Medical department at 1.800.688.8606 ext 3.

### **FAQs**

Q: Why do we have to take the flu shot to go to Antarctica?

A: A panel of medical consultants to the National Science Foundation recently reviewed health care in Antarctica. The report included the summary of two outbreaks of influenza at McMurdo during the 2007-2008 summer season. There was very significant impact on productivity and health care costs. The medical experts recommended that the vaccine should be given in order to prevent the likelihood of similar outbreaks in the future. The NSF accepted the recommendation and issued a directive making the immunizations mandatory.

Q: Will having the shot prevent me from getting the flu?

A: Not always. The vaccine is made up of three strains of influenza virus. There are many strains of “flu” viruses. Reports from all over the world are studied each year to predict the strains most likely to cause flu epidemics across different regions. The vaccine is 90% effective in protecting healthy young adults from illness when the vaccine strain is similar to the infecting strain. It is important for everyone to keep their immune systems healthy through regular exercise and good nutrition because the vaccine is less effective in preventing illness in older people and those that have diseases that reduce immunity. The “PQ” examinations are intended to prevent deployment of unhealthy people.

Q: How will I get the shot?

A: Ideally, you would get the shot from your personal physician as part of the “PQ” exam. However, the vaccine may not be available in the United States until late September, after many are on their way to Antarctica. The vaccine will also be given at the Denver HQ during deployment orientation, if available. The vaccine will be given in Christchurch if it is not available in the U.S. before deployment. It will be available at McMurdo, and given to the winter-over employees there. There is a one–two week period after getting the shot before full protection has developed, so the earlier in the deployment cycle it can be given, the better for you and your contacts.

Q: What if I’m allergic? Will I have a localized reaction?

A: If you have had a severe reaction to a flu shot in the past (severe reaction is throat, mouth or airway swelling, difficulty breathing, rash or hives), then bring documentation from the treating physician or emergency room. If you have a proven severe reaction to egg protein (same symptoms as above), then bring the report from your physician or allergist. People with previous severe reactions to the shot or to egg protein should not receive the shot. With proper documentation, you will be excused from the requirement. Localized reactions associated with the flu shot may include mild problems such as soreness, redness or swelling where the shot was given. These reactions have occurred less often as vaccine preparation has improved. They are generally not serious and do not justify exemption from the annual requirement for receiving the immunization.

Q: How can I learn more about the shots?

A: A Vaccine Information Statement (VIS) will be given to every employee prior to the shot. The VIS will explain in great detail the reasons for immunization, more about the vaccine, related benefits, risks, precautions and web sites for even greater information.

Remember to sign and return the attached Consent Form.

Thank you.

Emmett B. Ferguson MD, MPH – Medical Director  
RPSC Medical Department

## **READ, SIGN, RETURN**

### **Influenza Vaccination**

Every deploying USAP participant is required to receive an influenza vaccination prior to deployment, effective 14 July 2008.

The National Science Foundation concluded that 'the flu' has significantly impacted participants and operations.

You will receive the flu shot in Denver at orientation, in Christchurch prior to departing for Antarctica, or upon arrival at Palmer Station. Alternatively, you may obtain the flu shot from your medical provider during the PQ process and submit the supporting documentation to RPSC Medical.

Receiving the vaccination is a condition of your deployment. Exemptions based on medical reasons will be considered on an individual basis.

**This sheet must be signed and returned to the RPSC Medical department prior to the purchase of deployment airline tickets.**

Please sign, date and return this completed form to:

Raytheon Polar Services  
Medical Department  
7400 S. Tucson Way  
Centennial, CO 80112

Or, fax to RPSC Medical at 303.649.9275

***My signature below indicates that I am aware of this new requirement and agree to receive an influenza vaccine for the 2008-2009 season.***

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Printed Name

---

Signature

Date

# INACTIVATED INFLUENZA VACCINE

## WHAT YOU NEED TO KNOW 2007-08

### 1 Why get vaccinated?

**Influenza (“flu”) is a contagious disease.**

It is caused by the influenza virus, which spreads from infected persons to the nose or throat of others.

Other illnesses can have the same symptoms and are often mistaken for influenza. But only an illness caused by the influenza virus is really influenza.

Anyone can get influenza, but rates of infection are highest among children. For most people, it lasts only a few days. It can cause:

- fever
- sore throat
- chills
- fatigue
- cough
- headache
- muscle aches

Some people get much sicker. Influenza can lead to pneumonia and can be dangerous for people with heart or breathing conditions. It can cause high fever and seizures in children. On average, 226,000 people are hospitalized every year because of influenza and 36,000 die – mostly elderly.

**Influenza vaccine can prevent influenza.**

### 2 Inactivated Influenza vaccine

There are two types of influenza vaccine:

**Inactivated** (killed) vaccine, or the “flu shot” is given by injection into the muscle.

**Live, attenuated** (weakened) influenza vaccine, called LAIV, is sprayed into the nostrils. *This vaccine is described in a separate Vaccine Information Statement.*

For most people influenza vaccine prevents serious influenza-related illness. But it will *not* prevent “influenza-like” illnesses caused by other viruses.

Influenza viruses are always changing. Because of this, influenza vaccines are updated every year, and an annual vaccination is recommended. Protection lasts up to a year.

It takes up to 2 weeks for protection to develop after the vaccination.

Some inactivated influenza vaccine contains thimerosal, a preservative that contains mercury. Some people believe thimerosal may be related to developmental problems in children. In 2004 the Institute of Medicine published a report concluding that, based on scientific studies, there is no evidence of such a relationship. If you are concerned about thimerosal, ask your doctor about thimerosal-free influenza vaccine.

### 3 Who should get inactivated influenza vaccine?

People 6 months of age and older can receive inactivated influenza vaccine. It is recommended for **anyone who is at risk of complications from influenza or more likely to require medical care:**

- **All children** from 6 months up to 5 years of age.
- Anyone **50 years of age or older.**
- Anyone 6 months to 18 years of age on **long-term aspirin treatment** (they could develop Reye Syndrome if they got influenza).
- Women who will be **pregnant** during influenza season.
- Anyone with **long-term health problems** with:
  - heart disease
  - kidney disease
  - lung disease
  - metabolic disease, such as diabetes
  - asthma
  - anemia, and other blood disorders
- Anyone with a **weakened immune system** due to:
  - HIV/AIDS or other diseases affecting the immune system
  - long-term treatment with drugs such as steroids
  - cancer treatment with x-rays or drugs
- Anyone with certain **muscle or nerve disorders** (such as seizure disorders or severe cerebral palsy) that can lead to breathing or swallowing problems.
- **Residents of nursing homes and other chronic-care facilities.**

**Influenza vaccine is also recommended for anyone who lives with or cares for people at high risk for influenza-related complications:**

- **Health care providers.**
- **Household contacts and caregivers of children** from birth up to 5 years of age.
- **Household contacts and caregivers** of people 50 years and older, and those with medical conditions that put them at higher risk for severe complications from influenza.

A yearly influenza vaccination should be *considered* for:

- People who provide **essential community services.**
- People living in **dormitories** or under other crowded conditions, to prevent outbreaks.
- People at high risk of influenza complications who **travel** to the Southern hemisphere between April and September, or to the tropics or in organized tourist groups at any time.

Influenza vaccine is also recommended for anyone who wants to **reduce the likelihood of becoming ill** with influenza or **spreading influenza to others.**

## 4

### When should I get influenza vaccine?

Plan to get influenza vaccine in October or November if you can. But getting vaccinated in December, or even later, will still be beneficial in most years. You can get the vaccine as soon as it is available, and for as long as illness is occurring. Influenza illness can occur any time from November through May. Most cases usually occur in January or February.

Most people need one dose of influenza vaccine each year. **Children younger than 9 years of age getting influenza vaccine for the first time** should get 2 doses. For inactivated vaccine, these doses should be given at least 4 weeks apart.

Influenza vaccine may be given at the same time as other vaccines, including pneumococcal vaccine.

## 5

### Some people should talk with a doctor before getting influenza vaccine

Some people should not get inactivated influenza vaccine or should wait before getting it.

- Tell your doctor if you have any **severe** (life-threatening) allergies. Allergic reactions to influenza vaccine are rare.
  - Influenza vaccine virus is grown in eggs. People with a severe egg allergy should not get the vaccine.
  - A severe allergy to any vaccine component is also a reason to not get the vaccine.
  - If you have had a severe reaction after a previous dose of influenza vaccine, tell your doctor.
- Tell your doctor if you ever had Guillain-Barré Syndrome (a severe paralytic illness, also called GBS). You may be able to get the vaccine, but your doctor should help you make the decision.
- People who are moderately or severely ill should usually wait until they recover before getting flu vaccine. If you are ill, talk to your doctor or nurse about whether to reschedule the vaccination. People with a **mild illness** can usually get the vaccine.

## 6

### What are the risks from inactivated influenza vaccine?

A vaccine, like any medicine, could possibly cause serious problems, such as severe allergic reactions. The risk of a vaccine causing serious harm, or death, is extremely small.

Serious problems from influenza vaccine are very rare. The viruses in inactivated influenza vaccine have been killed, so you cannot get influenza from the vaccine.

#### Mild problems:

- soreness, redness, or swelling where the shot was given
- fever
- aches

If these problems occur, they usually begin soon after the shot and last 1-2 days.

#### Severe problems:

- Life-threatening allergic reactions from vaccines are very rare. If they do occur, it is usually within a few minutes to a few hours after the shot.
- In 1976, a certain type of influenza (swine flu) vaccine was associated with Guillain-Barré Syndrome (GBS). Since then, flu vaccines have not been clearly linked to GBS. However, if there is a risk of GBS from current flu vaccines, it would be no more than 1 or 2 cases per million people vaccinated. This is much lower than the risk of severe influenza, which can be prevented by vaccination.

## 7

### What if there is a severe reaction?

#### What should I look for?

Any unusual condition, such as a high fever or behavior changes. Signs of a serious allergic reaction can include difficulty breathing, hoarseness or wheezing, hives, paleness, weakness, a fast heart beat or dizziness.

#### What should I do?

**Call** a doctor, or get the person to a doctor right away.

- **Tell** your doctor what happened, the date and time it happened, and when the vaccination was given.
- **Ask** your doctor, nurse, or health department to report the reaction by filing a Vaccine Adverse Event Reporting System (VAERS) form.

Or you can file this report through the VAERS web site at [www.vaers.hhs.gov](http://www.vaers.hhs.gov), or by calling 1-800-822-7967.

*VAERS does not provide medical advice.*

## 8

### The National Vaccine Injury Compensation Program

In the event that you or your child has a serious reaction to a vaccine, a federal program has been created to help pay for the care of those who have been harmed.

For details about the National Vaccine Injury Compensation Program, call 1-800-338-2382 or visit their website at [www.hrsa.gov/vaccinecompensation](http://www.hrsa.gov/vaccinecompensation).

## 9

### How can I learn more?

- Ask your immunization provider. They can give you the vaccine package insert or suggest other sources of information.
- Call your local or state health department.
- Contact the Centers for Disease Control and Prevention (CDC):
  - Call 1-800-232-4636 (1-800-CDC-INFO)
  - Visit CDC's website at [www.cdc.gov/flu](http://www.cdc.gov/flu)



DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR DISEASE CONTROL AND PREVENTION

# LIVE, INTRANASAL INFLUENZA VACCINE

## WHAT YOU NEED TO KNOW 2007-08

### 1 Why get vaccinated?

Influenza (“flu”) is a contagious disease.

It is caused by the influenza virus, which spreads from infected persons to the nose or throat of others.

Other illnesses can have the same symptoms and are often mistaken for influenza. But only an illness caused by the influenza virus is really influenza.

Anyone can get influenza, but rates of infection are highest among children. For most people, it lasts only a few days. It can cause:

- fever
- sore throat
- chills
- fatigue
- cough
- headache
- muscle aches

Some people get much sicker. Influenza can lead to pneumonia and can be dangerous for people with heart or breathing conditions. It can cause high fever and seizures in children. On average, 226,000 people are hospitalized every year because of influenza and 36,000 die – mostly elderly.

Influenza vaccine can prevent influenza.

### 2 Live, attenuated influenza vaccine (nasal spray)

There are two types of influenza vaccine:

**Live, attenuated** influenza vaccine (LAIV) contains live but attenuated (weakened) influenza virus. It is sprayed into the nostrils rather than injected into the muscle.

**Inactivated** influenza vaccine, sometimes called the “flu shot,” is given by injection. *This vaccine is described in a separate Vaccine Information Statement.*

For most people influenza vaccine prevents serious influenza-related illness. But it will *not* prevent “influenza-like” illnesses caused by other viruses.

Influenza viruses are always changing. Because of this, influenza vaccines are updated every year, and an annual vaccination is recommended. Protection lasts up to a year.

It takes up to 2 weeks for protection to develop after vaccination.

LAIV does not contain thimerosal or other preservatives.

### 3 Who can get LAIV?

Live, intranasal influenza vaccine is approved for **healthy people from 2 through 49 years of age**, who are not pregnant. This includes people who can spread influenza to others at high risk, such as:

- **Household contacts and out-of-home caregivers** of children from birth up to 5 years of age.
- Physicians and nurses, and family members or any one else in **close contact with people at risk** of serious influenza.

Influenza vaccine should be given to anyone who wants to **reduce the likelihood of becoming ill** with influenza or **spreading influenza to others**.

LAIV may be considered for:

- People who provide **essential community services**.
- People living in **dormitories** or under other crowded conditions, to prevent outbreaks.

### 4 Some people should *not* get LAIV

LAIV is not licensed for everyone. The following people should check with their provider. They may be advised to get the **inactivated** vaccine (flu shot).

- **Adults 50 years of age and older** or **children 6 months up to 2 years of age**. (Children younger than 6 months cannot get *either* influenza vaccine.)
- Children younger than 5 with recurrent **wheezing**.
- People who have **long-term health problems** with:
  - heart disease
  - kidney disease
  - lung disease
  - metabolic disease, such as diabetes
  - asthma
  - anemia, and other blood disorders
- Anyone with a **weakened immune system**.
- Children or adolescents on **long-term aspirin treatment**.
- **Pregnant women**.
- Anyone with a history of **Guillain-Barré syndrome** (a severe paralytic illness, also called GBS).

Inactivated influenza vaccine is the preferred vaccine for people (including health-care workers, and family members) coming in **close contact with anyone who has a severely weakened immune system** (that is, anyone who requires care in a protected environment).



Some people should talk with a doctor before getting *either* influenza vaccine:

- Anyone who has ever had a **serious** allergic reaction to **eggs** or another vaccine component, or to a **previous dose** of influenza vaccine.
- People who are moderately or severely ill should usually wait until they recover before getting flu vaccine. If you are ill, talk to your doctor or nurse about whether to reschedule the vaccination. People with a **mild illness** can usually get the vaccine.

## 5 When should I get influenza vaccine?

Plan to get influenza vaccine in October or November if you can. But getting vaccinated in December, or even later, will still be beneficial in most years. You can get the vaccine as soon as it is available, and for as long as illness is occurring. Influenza illness can occur any time from November through May. Most cases usually occur in January or February.

Most people need one dose of influenza vaccine each year. **Children younger than 9 years of age getting influenza vaccine for the first time** should get 2 doses. These doses should be given at least 4 weeks apart.

LAIV may be given at the same time as other vaccines.

## 6 What are the risks from LAIV?

A vaccine, like any medicine, could possibly cause serious problems, such as severe allergic reactions. However, the risk of a vaccine causing serious harm, or death, is extremely small.

Live influenza vaccine viruses rarely spread from person to person. Even if they do, they are not likely to cause illness.

LAIV is made from weakened virus and does not cause influenza. The vaccine *can* cause mild symptoms in people who get it (see below).

### Mild problems:

Some children and adolescents 2-17 years of age have reported mild reactions, including:

- runny nose, nasal congestion or cough
- fever
- headache and muscle aches
- wheezing
- abdominal pain or occasional vomiting or diarrhea

Some adults 18-49 years of age have reported:

- runny nose or nasal congestion
- sore throat
- cough, chills, tiredness/weakness
- headache

These symptoms did not last long and went away on their own. Although they can occur after vaccination, they may not have been caused by the vaccine.

### Severe problems:

- Life-threatening allergic reactions from vaccines are very rare. If they do occur, it is usually within a few minutes to a few hours after the vaccination.

- If rare reactions occur with any product, they may not be identified until thousands, or millions, of people have used it. Over six million doses of LAIV have been distributed since it was licensed, and no serious problems have been identified. Like all vaccines, LAIV will continue to be monitored for unusual or severe problems.

## 7 What if there is a severe reaction?

### What should I look for?

- Any unusual condition, such as a high fever or behavior changes. Signs of a serious allergic reaction can include difficulty breathing, hoarseness or wheezing, hives, paleness, weakness, a fast heart beat or dizziness.

### What should I do?

- **Call** a doctor, or get the person to a doctor right away.
- **Tell** your doctor what happened, the date and time it happened, and when the vaccination was given.
- **Ask** your doctor, nurse, or health department to report the reaction by filing a Vaccine Adverse Event Reporting System (VAERS) form.

Or you can file this report through the VAERS website at [www.vaers.hhs.gov](http://www.vaers.hhs.gov), or by calling 1-800-822-7967.

*VAERS does not provide medical advice.*

## 8 The National Vaccine Injury Compensation Program

In the event that you or your child has a serious reaction to a vaccine, a federal program has been created to help pay for the care of those who have been harmed.

For details about the National Vaccine Injury Compensation Program, call 1-800-338-2382 or visit their website at [www.hrsa.gov/vaccinecompensation](http://www.hrsa.gov/vaccinecompensation).

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- Ask your immunization provider. They can give you the vaccine package insert or suggest other sources of information.
- Call your local or state health department.
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  - Call 1-800-232-4636 (1-800-CDC-INFO)
  - Visit CDC's website at [www.cdc.gov/flu](http://www.cdc.gov/flu)



DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR DISEASE CONTROL AND PREVENTION

Vaccine Information Statement  
Live, Attenuated Influenza Vaccine (10/4/07) 42 U.S.C. §300aa-26

# **NOTICE**

**You are required to report any changes in your health status occurring after your physical examination.**

**If you recently married or had a name change, please provide both of your names.**

**Report changes to:**

**RPSC Medical Screening  
7400 South Tucson Way  
Centennial, CO 80112**

**Fax (303) 649-9275**

**If you need medical care in New Zealand, please contact the RPSNZ Medical Coordinator, who will assist you with arranging medical/dental appointments. There will be a charge for your visit to the doctor/dentist.**

**If you require health care on your travel through Chile, contact the local AGUNSA office for assistance in making appointments. Be prepared to pay for services at your appointment.**

NATIONAL SCIENCE FOUNDATION - POLAR PHYSICAL EXAMINATION

MEDICAL HISTORY

Complete pages 1-8 in ink prior to Dr.'s exam

**Polar Medical Staff Use Only**

Date: \_\_\_\_\_  PQ  PQ Summer Only  NPQ

Medical Condition(s):

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Restrictions and Follow-up:

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Reason for NPQ:

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**Polar Medical Staff Use Only**

Reviewed by: \_\_\_\_\_

Date: \_\_\_\_\_

Name: last, first, middle (must match passport) Age: Birth date (YY/MM/DD): Sex  
 F  M

Nickname (aka) Maiden Name Previous Name or Other Legal Name:

Street City State Zip

Telephone (include area code):

Day: Evening: Mobile: E-Mail:

Emergency Point of Contact (Name, Address and Phone Number):

**Job Title:** Current Deployment Dates: Previous Polar (Arctic or Antarctic) Deployment?  
 From \_\_\_\_\_ to \_\_\_\_\_  
 Dates: \_\_\_\_\_  
 Location: \_\_\_\_\_

**Affiliation:**  NSF  
 Science Event # \_\_\_\_\_  
 Technical Event # \_\_\_\_\_  
 RPSC  
 VECO  
 Other: \_\_\_\_\_

**Proposed Antarctic Season and Worksite:**  
 Summer (Sep-Feb)  
 Winter (Mar-Oct)  
 Winfly \_\_\_\_\_ (dates)  
 McMurdo Station  
 South Pole Station  
 Palmer Station  
 RV/NB Palmer  
 RV/LM Gould  
 Field Camp \_\_\_\_\_  
 Other: \_\_\_\_\_

**Proposed Arctic Season and Worksite:**  
 Summer (Mar-Sep)  
 Winter (Oct-Feb)  
 Summit  
 Alaska \_\_\_\_\_  
 USCGC Healy  
 Field Camp \_\_\_\_\_  
 Other: \_\_\_\_\_

<b>FAMILY MEDICAL HISTORY****DO NOT USE FOR YOUR OWN HEALTH HISTORY****</b>									
Relationship	Status of Health and Age, if living			Age and Cause of Death					
Father									
Mother									
Spouse									
Brothers/Sisters/Children (list below):									
<b>Family History:</b> Check box, If yes, who? (Explain.):				Relationship	<b>Family History:</b> Check box, If yes, who? (Explain.):				Relationship
Diabetes?	<input type="checkbox"/> YES	<input type="checkbox"/> NO			Kidney Disease? Describe:	<input type="checkbox"/> YES	<input type="checkbox"/> NO		
Insulin Required?	<input type="checkbox"/> YES	<input type="checkbox"/> NO							
Heart Attack?	<input type="checkbox"/> YES	<input type="checkbox"/> NO			Cancer?	<input type="checkbox"/> YES	<input type="checkbox"/> NO		
Age? _____					Type?				
Stroke?	<input type="checkbox"/> YES	<input type="checkbox"/> NO			Treatment?				
Age? _____									
Bleeding Disorder? Describe: (Hemophilia, Clotting Factor Deficiency)	<input type="checkbox"/> YES	<input type="checkbox"/> NO			Stomach/GI Disease?	<input type="checkbox"/> YES	<input type="checkbox"/> NO		
_____					Type?				
_____					_____				
Autoimmune Disorder? Describe: (Rheumatoid Arthritis, Lupus, Other)	<input type="checkbox"/> YES	<input type="checkbox"/> NO			Mental Health Disorders? Describe: (i.e., Depression, Bipolar, Suicide, Schizophrenia)	<input type="checkbox"/> YES	<input type="checkbox"/> NO		
_____					_____				
_____					_____				
Hemoglobin disorder? Describe: (Sickle Cell, Thalassemia, etc.)	<input type="checkbox"/> YES	<input type="checkbox"/> NO							
_____									

**PERSONAL MEDICAL HISTORY (ANSWER THE FOLLOWING QUESTIONS REGARDING YOUR PRESENT OR PAST MEDICAL HISTORY)**

Do you have any allergies to medications?  YES  NO If yes, which ones?

Do you have any other known allergies?  YES  NO If yes, describe (including your reaction).

Medications: List all you take, including Over-the-Counter Medications and Vitamins:

Name of Medication	Dose	How Often Taken - daily, twice daily, as needed, etc.

**Surgeries/Hospitalizations** - List all surgeries and dates (include any outpatient surgery): If more space is needed, use back or add a sheet.

**ANSWER THE FOLLOWING QUESTIONS REGARDING YOUR PRESENT OR PAST MEDICAL HISTORY**

**ADDITIONAL COMMENTS**

- 1 Neurological Disorder?**
- a. Multiple Sclerosis  YES  NO
  - b. Fibromyalgia  YES  NO
  - c. Other Nerve/Muscle Disorders? (Describe.)  YES  NO
  - \_\_\_\_\_
  - d. Seizure disorder?  YES  NO  
Date of Last Seizure: \_\_\_\_\_
  - e. Head Injury?  YES  NO  
Loss of Consciousness - Date \_\_\_\_\_  
How Long \_\_\_\_\_

- 2 Headaches?**  YES  NO  
**Migraines ?**  YES  NO  
 Date Diagnosed \_\_\_\_\_  
 Date of last Migraine \_\_\_\_\_

- 3 Do you have diabetes?**  YES  NO  
 Date diagnosed: \_\_\_\_\_  
 Controlled by:  Insulin  Oral medication  Diet  
 Last Emergency Room visit: \_\_\_\_\_

- 4 Do you have Cholesterol disorders?**  YES  NO  
 Date diagnosed: \_\_\_\_\_  
 Controlled by:  Oral medication  Diet

- 5 Do you have Thyroid Disease?**  YES  NO  
**Explain, if Yes - include medication**
- Surgery required?**  YES  NO  
**When?** \_\_\_\_\_

**PERSONAL MEDICAL HISTORY (continued)**

ANSWER THE FOLLOWING QUESTIONS REGARDING YOUR PRESENT OR PAST MEDICAL HISTORY		ADDITIONAL COMMENTS
<p>6 <b>Vision:</b> Do you wear glasses? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p style="padding-left: 40px;">contacts? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p style="padding-left: 40px;">Do you have unequal pupils? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p style="padding-left: 40px;">Do you have blindness in one or both eyes? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p style="padding-left: 40px;">Do you have Glaucoma? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p style="padding-left: 40px;">Do you have Cataracts <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p style="padding-left: 40px;">Do you have Double Vision? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p style="padding-left: 40px;">Do you have other vision problems? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p style="padding-left: 40px;">Describe: _____</p>		
<p>7 <b>Dizziness/Fainting</b> <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p style="padding-left: 40px;">Reason: _____</p> <p style="padding-left: 40px;">Date of occurrence: _____</p>		
<p>8 <b>Do you have ear, nose, or throat problems?</b> <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p style="padding-left: 40px;">Describe: _____</p> <p style="padding-left: 40px;"><b>Hearing Impairment?</b> <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p style="padding-left: 40px;"><b>Hayfever?</b> <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p style="padding-left: 40px;">Are you currently taking allergy shots? <input type="checkbox"/> YES <input type="checkbox"/> NO</p>		
<p>9 <b>Do you have any Pulmonary Disease?</b> <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p style="padding-left: 40px;"><b>Chronic Obstructive Pulmonary Disease (COPD)?</b> <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p style="padding-left: 40px;"><b>Pulmonary Embolism/Blood Clots?</b> <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p style="padding-left: 40px;"><b>Sleep Apnea?</b> <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p style="padding-left: 40px;"><b>Asthma?</b> <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p style="padding-left: 80px;">Date of last attack _____</p> <p style="padding-left: 80px;">Number of attacks in past year _____ <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p style="padding-left: 40px;">Hospitalizations? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p style="padding-left: 40px;">Nebulizer treatment in the past year? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p style="padding-left: 40px;">How often? _____</p> <p style="padding-left: 40px;"><b>Emphysema or chronic Bronchitis or Bronchiectasis?</b> <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p style="padding-left: 40px;"><b>Shortness of Breath or Difficult Breathing?</b> <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p style="padding-left: 80px;">Explain: _____</p> <p style="padding-left: 40px;"><b>Tuberculosis</b> <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p style="padding-left: 80px;">History of positive TB skin test</p> <p style="padding-left: 80px;">Have you ever received BCG?</p> <p style="padding-left: 40px;"><b>Have you ever experienced altitude sickness?</b> <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p style="padding-left: 80px;">At what altitude _____</p> <p style="padding-left: 40px;">Describe treatment: _____</p>		

**PERSONAL MEDICAL HISTORY (continued)**

ANSWER THE FOLLOWING QUESTIONS REGARDING YOUR PRESENT OR PAST MEDICAL HISTORY		ADDITIONAL COMMENTS
10	<p><b>Do you have Heart Problems/Disease?</b> <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p><b>Previous Heart Attack?</b> <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p><b>Angina/Chest Pain?</b> <input type="checkbox"/> YES <input type="checkbox"/> NO Describe (include frequency, precipitating factors, and treatments): _____ _____ _____</p> <p><b>Congestive Heart Failure (CHF)?</b> <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p><b>Supraventricular Tachycardia (SVT)?</b> <input type="checkbox"/> YES <input type="checkbox"/> NO Date diagnosed _____ Frequency and treatment: _____ _____</p> <p><b>Atrial Fibrillation?</b> <input type="checkbox"/> YES <input type="checkbox"/> NO Date diagnosed _____</p> <p><b>Heart Murmur/Valvular Heart Disease?</b> <input type="checkbox"/> YES <input type="checkbox"/> NO Date diagnosed _____ Limitations: _____</p> <p><input type="checkbox"/> Angiogram <input type="checkbox"/> Angioplasty <input type="checkbox"/> Stent <input type="checkbox"/> Cardiac Bypass Surgery Date _____</p> <p><b>Pacemaker?</b> <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p><b>Hypertension?</b> <input type="checkbox"/> YES <input type="checkbox"/> NO Date diagnosed _____</p> <p><b>TIA/Stroke?</b> <input type="checkbox"/> YES <input type="checkbox"/> NO Date _____</p> <p><b>History of Deep Vein Thrombosis (DVT)/Blood Clots?</b> <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p><b>History of Abdominal or Cerebral Aneurysm?</b> <input type="checkbox"/> YES <input type="checkbox"/> NO</p>	
11	<p><b>Arthritis?</b> <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>Type: _____ <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>Permanent disability? <input type="checkbox"/> YES <input type="checkbox"/> NO</p>	
12	<p><b>Do you have Gout?</b> <input type="checkbox"/> YES <input type="checkbox"/> NO If so, describe your treatment plan _____</p>	
13	<p><b>Have you ever used tobacco/tobacco products?</b> <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>Do you currently use tobacco/tobacco products? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>Type of use <input type="checkbox"/> cigarettes <input type="checkbox"/> cigar <input type="checkbox"/> pipe <input type="checkbox"/> chew</p> <p>Packs per week? _____</p> <p>If you've quit, last year of use _____</p> <p>Number of years of tobacco use in past _____</p>	

**PERSONAL MEDICAL HISTORY (continued)**

ANSWER THE FOLLOWING QUESTIONS REGARDING YOUR PRESENT OR PAST MEDICAL HISTORY	ADDITIONAL COMMENTS
<p>14 <b>Have you had an Exercise Stress Test/Treadmill?</b> <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>If yes, when? _____</p>	
<p>15 <b>Do you have a regular exercise program?</b> <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>Describe: _____</p>	
<p>16 <b>Have you had Stomach/Bowel Problems?</b> <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>Anemia <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>Black tarry stools <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>Blood in stools <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>Frequent or persistent diarrhea <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>Gallbladder Problems/Stones <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>Heartburn <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>Hemorrhoids <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>Inflammatory bowel disease (Crohns/Ulcerative Colitis) <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>Ulcers <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>Date of last flare up _____</p>	
<p>17 <b>Have you been diagnosed with liver problems?</b> <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p><b>Hepatitis?</b> <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>Type <input type="checkbox"/>A <input type="checkbox"/>B <input type="checkbox"/>C <input type="checkbox"/>Other _____</p> <p><b>Hepatitis vaccine</b> <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>Dates: _____</p> <p>(first) (second) (third)</p>	
<p>18 <b>Do you have Kidney problems?</b> <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>History of Kidney Stones? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>Polycystic Kidney Disease? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>Frequent Urinary Tract Infections? <input type="checkbox"/> YES <input type="checkbox"/> NO</p>	
<p>19 <b>Do you have a history of Hernias?</b> <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>Date _____</p> <p>Location _____</p>	
<p>20 <b>Have you had any sexually transmitted diseases?</b> <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>When? _____</p> <p>Type: <input type="checkbox"/>Herpes <input type="checkbox"/>Chlamydia <input type="checkbox"/>Gonorrhea</p> <p><input type="checkbox"/>Syphilis <input type="checkbox"/>Other Specify) _____</p> <p>Treated? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>When? _____</p> <p>Describe: _____</p>	
<p>21 <b>Cancer or leukemia?</b> <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>Type/Location: _____</p> <p>Date diagnosed _____</p> <p>Surgery <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>Chemotherapy <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>Radiation Therapy <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>Other Treatment: _____ <input type="checkbox"/> YES <input type="checkbox"/> NO</p>	
<p>22 <b>Skin rash/Disease?</b> <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>Describe (include duration and treatment): _____</p>	



**PERSONAL MEDICAL HISTORY (continued)**

ANSWER THE FOLLOWING QUESTIONS REGARDING YOUR PRESENT OR PAST MEDICAL HISTORY	ADDITIONAL COMMENTS
<p>23 <b>Broken bones?</b> For any "YES" answers, list date, area affected and treatment: <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>Orthopedic Pins/Plates? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>Dislocations? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>Back injuries? <input type="checkbox"/> YES <input type="checkbox"/> NO For any "YES" answers, list date, area affected and treatment:</p> <p>Chronic Pain? Describe. <input type="checkbox"/> YES <input type="checkbox"/> NO</p>	
<p>24 <b>Have you ever been or are you currently treated for?</b> <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p><input type="checkbox"/>Schizophrenia <input type="checkbox"/>Depression <input type="checkbox"/>Bipolar <input type="checkbox"/> Panic Attacks  <input type="checkbox"/>Anxiety Attacks <input type="checkbox"/>Obsessive/Compulsive Disorder  <input type="checkbox"/>Suicide Attempt/Thoughts <input type="checkbox"/>Eating Disorders  <input type="checkbox"/>Addiction <input type="checkbox"/>Other:_____</p> <p><input type="checkbox"/>Post Traumatic Stress Syndrome?</p> <p><b>Have you ever been hospitalized for psychiatric treatment?</b> <input type="checkbox"/> YES <input type="checkbox"/> NO Describe with length and dates:</p>	
<p>25 <b>Do you drink alcohol?</b> <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p><b>Quantity per day</b>_____ <b>Total per week</b>_____ <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p><b>Have you ever felt you should decrease your drinking?</b> Explain: <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p><b>Have you ever received a DUI or court ordered treatment?</b> Describe circumstances: <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p><b>Have you ever been diagnosed as an alcoholic?</b> If now sober, length of sobriety_____</p>	
<p>26 <b>For Men:</b> <input type="checkbox"/> YES <input type="checkbox"/> NO History of Prostate disease including prostatitis or prostate stones? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>When? Describe treatment:</p> <p>Surgery required? <input type="checkbox"/> YES <input type="checkbox"/> NO Date_____</p>	

**PERSONAL MEDICAL HISTORY (continued)**

**27 For Women:**

Date of last period: \_\_\_\_\_

Date of last PAP Smear: \_\_\_\_\_

Results:  Normal  Other (describe):

Are you currently taking Oral contraceptives?  YES  NO

History of severe Menstrual Cramps/PMS?  YES  NO

Endometriosis?  YES  NO

Ovarian Cysts?  YES  NO

Describe treatment:

**I certify that the information contained herein is complete and accurate to the best of my knowledge. I will inform the contractor's medical staff of ALL medical/health changes that occur after submitting this form. I understand that failure to provide any or all of the requested information may result in a denial of my application for assignment to the Polar Regions. I also understand that willfully providing false statements to a Federal agency or its representatives is a criminal offense.**

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

# Raytheon Polar Services Company

7400 S Tucson Way Centennial, CO 80112-3938  
Local (303) 790-8606 ~Toll free (800) 688-8606 ~ Fax (303) 649-9275

RPSC has contracted with the following physicians, dentists, and eyewear distributors to provide services for RPSC employees and individuals deploying to Antarctica under the United States Antarctic Program (USAP). These contractors are located in the Denver Metro/Boulder area. Before making an appointment, please call the Medical Office to ask that your checklist be faxed to the Doctor or Dentist. **If you currently carry insurance you are REQUIRED to give your insurance information at the time of your appointment.** Your co-pay and any costs that are not covered/are rejected by your insurance provider will be direct billed to RPSC. **Please bring your insurance card with you to your appointment.**

**\*\*\*\*\* NOTE: This direct bill option only applies to the Doctors and Dentists listed below \*\*\*\*\***

You are free to go to the doctor or dentist of your choice; however, you are responsible for paying all fees associated with the visit. If you do not use one of the below contracted services, please submit the Medical/Dental Expense Reimbursement Form in your packet along with the itemized bill from your doctor and/or dentist. If you are currently a RPSC employee you must file online using WebTE.

**NOTE: There is no provision for reimbursement of dental work that may be required for deployment.**

## PHYSICIANS:

### Dr. Gerald Katz, M.D.

Dana Coutts, P.A.

HealthMark

4700 East Iliff Avenue

Denver, CO 80222

Phone (303) 584-5850 ~ appt scheduling ~ Jennifer Robertson

### Dr. John Harris, M.D.

12150 E Briarwood Ave. Ste. 105

Englewood, CO 80112

Phone (303) 790-1999

## Image One (Radiology)

8101 E. Lowry Blvd Ste 120

Denver, CO 80230

Phone (303) 340-8439

## DENTISTS:

### Dr. Roger Anderson, D.D.S

Dr. Wellman, D.D.S

Dr. York, D.D.S

14000 E Arapahoe Rd, Ste. 200

Englewood, CO 80112

Phone (303) 632-3638

## PRESCRIPTION SUN GLASSES:

### Opticus Inc.

760 E. Heartstrong

Superior, CO 80027

Phone (800) 870-5557 or (303) 499-0111

Fax (303) 499-0119

Website: [www.opticus.com](http://www.opticus.com)

(Prescription Sun Glasses)

# Raytheon Polar Services Company

7400 S. Tucson Way, Centennial, CO 80112-3938  
(303) 790-8606 (800) 688-8606 FAX (303) 649-9275

Dear Doctor:

This person is applying for a position with the United States Antarctic Program (USAP). Due to the remoteness of the area, medical facilities have limited diagnostic and therapeutic modalities. The clinics in Antarctica can comfortably manage primary care problems. Emergency situations requiring hospitalization or sophisticated diagnostic procedures require evacuation to New Zealand or the South American continent. Under optimal conditions, medical evacuation can be performed in no less than twelve hours. At Palmer Station evacuation is only available by sea and may take several days. At McMurdo and the South Pole Stations, weather conditions can delay flights in and out of Antarctica for several days in the summer. Winter evacuations are virtually impossible. Consequently, common clinical situations in urban communities such as evaluating atypical chest pain, acute abdominal pain or treating renal calculi can present a major dilemma.

Antarctica is the highest, driest and coldest continent on earth. Temperatures at McMurdo Station are frequently well below freezing in the summer. South Pole temperatures on average are -30F degrees in the summer with wind chills commonly -60F degrees. Employees live in a confined space during the unrelenting six-month summer daylight or winter darkness. The South Pole is at a physiological altitude greater than 10,000 feet and has virtually no humidity. Altitude sickness is very common and must be differentiated from other serious causes of dyspnea, dizziness and chest pain. Accordingly, it is vitally important to thoroughly screen individuals to identify risk factors for cardiopulmonary and psychological conditions. Your comments on the overall health of the applicant are valuable in contributing to the success of the Program and the safety of the participant. The USAP has medical examination requirements for summer and winter deployment as discussed below:

## **Summer Deployment (August-February)**

Medical Examination/Testing:

All tests and labs to be performed on this candidate can be found on the "**Medical/Dental Checklist for Deployment Clearance to Antarctica.**" Additional tests and exams may be required based on this information. Please review the candidate's checklist, eight-page Medical History Form, and perform a physical examination. **A comment on all positive findings in the history and examination is required to help in expediting the medical clearance process. All sections of the medical exam must be performed.** The lab testing must be done within 6 months of deployment.

**Blood typing** is required for all applicants. Personnel are requested to contribute to the USAP's walking blood bank. You may ask the participant if they are able to contribute blood. If the candidate indicates his/her willingness, please note the answer next to the blood type on the Physical Examination Form. This is not a requirement of you or the candidate and will not affect deployment clearance. **If the applicant does not wish to be a participant of the walking blood bank, please identify in the COMMENTS section of the exam – otherwise consent is implied.**

# Raytheon Polar Services Company

7400 S. Tucson Way, Centennial, CO 80112-3938  
(303) 790-8606 (800) 688-8606 FAX (303) 649-9275

## **Summer Deployment (October to February)**

All tests required for summer deployment – see Medical and Dental checklist

## **Winter Deployment (February to October)**

All tests required for summer deployment, plus the following:

- TSH
- HIV Testing
- Chest X-ray – send report only
- Psychological testing for McMurdo and South Pole stations

## **Administrative Information**

### **1. Lab Results: Labs to be completed no earlier than 6 months prior to deployment.**

Please follow the instructions in the Deployment E-mail and Deployment Packet.

For RPSC and NANA Employees: Visit [www.labcorp.com](http://www.labcorp.com) for the nearest patient service center to your location; bring with you the individualized LabCorp requisition sent to you via email. If a LabCorp center is not near your location, contact RPSC Medical; a LabCorp lab kit will be mailed to your attention. Your personal physician or other lab facility can follow the instructions for collecting the samples and forwarding them to LabCorp in Colorado for processing. Please ensure the lab kit instructions are closely followed.

For Non-RPSC Participants: Please refer to form ME-DT-A-109 in the Deployment Packet. Lab results are to be forwarded to RPSC Medical.

**2. Return of Examination/Tests:** Please send the original medical history and physical examination, including requested tests, to RPSC Medical.

**3. Other Requirements:** Prescription medications (type and quantity) are limited at all Antarctic medical facilities. Candidates are required to bring a sufficient supply of their own medication for the duration of their deployment. Please refer to form ME-A-121 or ME-A-121a in the deployment packet. RPSC Medical can assist candidates in obtaining sufficient medications if their prescription plans limit the quantity allowed at each refill.

**Payment for this Examination: The candidate is responsible for payment! This includes insurance deductible(s), payment of all charges incurred by this exam if no insurance is available, or insurance payment is denied. RPSC WILL NOT REIMBURSE HEALTH CARE PROVIDERS.**

**THANK YOU FOR YOUR COOPERATION WITH THIS  
MEDICAL EXAMINATION.**

**POLAR PHYSICAL EXAMINATION**

NAME: \_\_\_\_\_

DOB: \_\_\_\_\_

**BLOOD TYPE:** \_\_\_\_\_

COMPLETE ALL SECTIONS USING CODES WHERE APPROPRIATE

VITAL SIGNS		VISION			
		WITHOUT CORRECTION		WITH CORRECTION	
HEIGHT: _____	WEIGHT: _____	DIST	NEAR	DIST	NEAR
BP: _____/_____	HEART RATE: _____	R _____	_____	R _____	_____
RESPIRATIONS: _____	TEMPERATURE: _____	L _____	_____	L _____	_____

CODES: O – Within Limits  
 I – Significantly Abnormal  
 X – Not Examined

Code      Remarks (discuss abnormal findings in detail)

1. General Appearance.....		
2. Head and neck.....		
3. Eyes.....		
4. Ears.....		
5. Nose.....		
6. Mouth.....		
7. Thyroid.....		
8. Lymph nodes.....		
9. Chest, Lungs, Breasts.....		
10. Heart.....		
11. Abdomen.....		
12. Inguinal, include hernia.....		
13. Genitalia.....		
14. Anal and Rectum.....		
15. Spine.....		
Forward Bend, Fingers Miss Floor ____ Inches		
16. Upper Extremities.....		
17. Lower Extremities.....		
Varicosities.....		
18. Skin, Lymphadenopathy.....		
Identify Body Marks, Scars, Tattoos.....		
19. Peripheral Vascular.....		
20. Neurologic Status (include Reflexes)....		
21. Emotional Status.....		
22. Pelvic Exam.....		
23. Men > Age 40: Prostate Exam.....		

**Physical Examination**

Guiac Test (Required annually for age 50 and up)  _____ Results                      Date	Tetanus Immunization Date (Update every 10 years)  _____ Date	TB Skin Test (Required Annually)  _____ Results                      Date
---	---	--

**Examiner's Diagnoses and Comments:**

(Please ask the candidate if there is any other medical information not already obtained which should be known prior to deployment.)

I have thoroughly examined this candidate for travel to the Polar Regions. I have reviewed the participant's history with him/her, including ALL positive responses, and commented appropriately. I have performed all diagnostic tests as requested.

\_\_\_\_\_  
 Examiner's Name (Type or Print):

\_\_\_\_\_  
 Examiner's Signature                      DATE

\_\_\_\_\_  
 ADDRESS

\_\_\_\_\_  
 CITY                      STATE                      ZIP

I have been informed regarding the medical examination findings herein (signature optional).

PHONE #: \_\_\_\_\_

\_\_\_\_\_  
 PATIENT'S SIGNATURE                      DATE

Return the completed examination form and results of the requested tests to (return envelope enclosed):

**Raytheon Polar Services Company**  
 Attention: **MEDICAL**  
 7400 S. Tucson Way  
 Centennial, CO 80112-3839  
 1-800-688-8606 ext 32287 Fax: 303-649-9275

## **IMPORTANT NOTICE TO THOSE SIGNING THE MEDICAL SCREENING FOR BLOOD BORNE PATHOGENS/HIV CONSENT FORM**

Please be advised that a signature on the medical screening form, Blood Borne Pathogens/NSF Form 1424, does not ensure that an HIV test will be done. **You must specify on the lab requisition by marking the HIV box if you want the test done.**

If you are a Grantee and have chosen to use an outside laboratory, please note that you must request to have this test drawn.

If you choose to have this test, please sign the consent form and return it with your medical paperwork.

Screening for HIV is a requirement for participants who are wintering or who would like to participate in the walking blood bank.

If you have any questions, please contact RPSC Medical at 1-800-688-8606 option 3.



NATIONAL SCIENCE FOUNDATION  
4201 WILSON BOULEVARD  
ARLINGTON, VIRGINIA 22230

**OFFICE OF POLAR PROGRAMS**

**Medical Screening for Blood-borne Pathogens**

United States Antarctic Program (USAP) medical clinics at the three U.S. research stations do not maintain supplies of frozen blood. NSF research stations in the Arctic do not have readily available blood supplies. In the event of the need for a transfusion, other individuals at the research station with matching blood types would be asked to donate fresh whole blood for the patient. In order to maintain a viable donor pool, the National Science Foundation requests that USAP and Arctic participants during the austral summer season voluntarily submit to testing for Human Immunodeficiency Virus (HIV) along with the required Hepatitis virus B and C as part of their medical screening process. Please note that HIV testing is required for candidates intending to spend the winter in Antarctica or in the Arctic.

**Consent for HIV Antibody Blood Test**

I have been informed that my blood will be tested for Human Immunodeficiency Virus (HIV) antibodies, the causative agent of Acquired Immune Deficiency Syndrome (AIDS). I understand that the testing involves the withdrawal of a small amount of my blood by venipuncture and subsequent testing of that blood sample via ELISA and Western Blot methods.

I understand that if I have any questions regarding the testing procedure or interpretation of results, I should discuss them with my health care provider. I understand that my examining physician will receive a copy of these test results and may be required, under State law, to report positive test results to State Health Department authorities and I consent to these disclosures.

I understand that the results of this blood test will be incorporated into my USAP medical file. All information in that file is maintained in accordance with the Privacy Act (5 USC 552a) and protected against unauthorized release, as described in the appended Privacy Notice.

Having read and understood the above statements, I hereby give my consent to the collection and testing of my blood to determine the presence of HIV antibodies.

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Signature and Date

**NATIONAL SCIENCE FOUNDATION**  
4201 WILSON BOULEVARD  
ARLINGTON, VIRGINIA 22230

**PRIVACY NOTICE**

**Medical Examination Records for Service in Polar Regions**

The National Science Foundation's Office of Polar Programs is responsible for ensuring that all personnel traveling to Antarctica under the auspices of the United States Antarctic Program (USAP) meet certain medical standards, as outlined in 45 Code of Federal Regulations Section 675 (62 Fed. Reg. 31521 (June 10, 1997)). This medical screening process requires that certain medical records be generated on each individual participating in the USAP.

The information requested on USAP provided forms is solicited under the authority of the National Science Foundation Act of 1950, as amended, 42 U.S.C. 1870 et seq. It will be used by NSF and its contractors and subcontractors in the medical screening process to determine whether an applicant is qualified for deployment to Antarctica. An individual medical file will include information collected to determine whether one is qualified for Antarctic assignment, as well as clinical files that may be generated if one receives medical treatment in any of the USAP medical clinics in Antarctica or any off-ice treatment facilities arranged by the USAP.

The records are used for three primary purposes: (1) to determine the individual's fitness for Antarctic assignment, including individual waiver requests; (2) to assist in determining an appropriate course of medical/dental treatment should the individual seek medical care with any medical care provider while in Antarctica; and (3) to provide documentation for addressing quality of care issues associated with these medical functions.

Records contained within this system may be released to individuals involved in those three functions. Such individuals include, in addition to designated NSF employees as needed for assigned duties: (a) designated medical care practitioners and their administrative support personnel involved in determining an individual's fitness for Antarctic assignment, including individual waiver requests; (b) medical care providers in NSF-supported stations and field camps in the polar regions where the individual is assigned; and (c) medical experts advising the NSF on quality of medical care issues associated with NSF's polar research programs. In addition to these purposes, information in the medical records may be released to the individual's personal or examining physician or the individual's designated emergency point of contact when disclosure is necessary to determine initial medical clearance or to review treatment options if the individual requires medical attention while on assignment in the Polar Regions. The determination of whether the individual is physically qualified/not physically qualified (PQ/NPQ) may be released to representatives of the individual's sponsoring organization including academic institutions, and investigators on a grant to inform them whether an individual is approved for deployment or not.

If necessary, information may be released to Federal, state, or local agencies, or foreign governments when disclosure is necessary to obtain records in connection with an investigation by or for the NSF; and to another Federal agency, a court, or a party in litigation before a court or in an administrative proceeding if the government is a party, or when NSF determines that the litigation or anticipated litigation or proceeding is likely to affect the Agency.

Submission of the information requested is voluntary. However, if you fail to provide any of the requested information, NSF or its contractor may be unable to process or to approve your application for polar deployment through the USAP.

More detail about how and where these records are maintained in accordance with the Privacy Act, 5 U.S.C. 552a, is contained in the National Science Foundation's System of Records Notice, Medical Examination Records for Service in the Polar Regions, available upon request from the NSF<sup>1</sup>. No disclosure of information contained in your medical file will be made except as described by the NSF's System Notice or as otherwise authorized by law. You may request a copy of your records for review.

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<sup>1</sup> For a copy of the System Notice, please contact the OPP Safety and Occupational Health Manager at NSF at (703) 292-7438, or write to Safety and Occupational Health Manager, Office of Polar Programs, National Science Foundation, 4201 Wilson Blvd., Suite 755, Arlington, VA 22230.

NATIONAL SCIENCE FOUNDATION  
4201 WILSON BOULEVARD  
ARLINGTON, VIRGINIA 22230  
**OFFICE OF POLAR PROGRAMS**

**Medical Risks for NSF-Sponsored Personnel Traveling to Antarctica**

Travel to Antarctica imparts certain risks to the traveler, because of harsh environmental conditions encountered, limitations in the medical care available in Antarctica, and difficulties, in emergencies, of providing timely evacuation to tertiary medical care facilities in New Zealand, South America, or in the United States. United States Antarctic Program (USAP) participants should consider these risks before deciding to deploy to Antarctica.

With no indigenous support infrastructure in Antarctica, virtually all medical care to USAP participants is provided through the USAP medical care system. This includes medical clinic operations at all three year-round stations (McMurdo, South Pole, and Palmer Stations), dispensary operations on the two oceanographic research vessels, and first-aid/first responder support in the larger seasonal remote field camps. The three clinics are comparable to a small community hospital emergency room and ambulatory care facility, but without secondary or tertiary care facilities nearby for patient referral or specialist support. Radiography (X-rays) and selected laboratory tests are available in the clinics, but more sophisticated imaging procedures and diagnostic tests are not. Typical operating room surgical suites are not available at the stations, although each clinic has a triage/trauma room. The USAP does not maintain a frozen blood supply at each station, relying instead on a "walking blood bank" concept (where individual donors could provide fresh blood if transfusions were needed and blood types matched). The evacuation of critically ill or injured patients from Antarctic sites to sophisticated medical care off the continent (to New Zealand, South America, or the United States) is difficult during the austral summer and may be impossible during the austral winter (February through August).

It is important that USAP participants recognize these limitations in medical care while they are in Antarctica. It is, in part, because of these limitations, that the NSF requires medical and dental screening of personnel prior to deployment to Antarctica. These medical screening examinations are necessary to determine the presence of medical conditions that could threaten the health or safety of the individual while in Antarctica. They are also necessary to determine whether medical conditions exist that cannot be effectively treated while the individual is in Antarctica. Persons who fail to meet these medical/dental screening criteria will be notified of the specific reason(s) for their disqualification. Disqualified individuals may request reconsideration by completing a waiver request package (obtained from the NSF's support contractor).

Pre-deployment screening can identify existing medical conditions that may be difficult or impossible to treat effectively in Antarctica. USAP participants should realize that serious accidents or injuries might challenge the medical care system in Antarctica as well. Therefore, individuals should recognize the limitations in the medical care system in Antarctica before they engage in any risk-taking behaviors (whether on-the-job or during recreational pursuits) that may result in accidents or injuries.

Data collected as a result of this medical screening requirement are maintained in accordance with the Privacy Act (5 USC 552a) and protected against unauthorized release, as described in the appended Privacy Notice. The collection of this information must display a currently valid OMB control number. You are not required to respond to the collection of this information unless it displays a currently valid OMB control number.

I have read and understand this information sheet.

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Print Name

---

Signature and Date

# Raytheon Polar Services Company

7400 S. Tucson Way, Centennial, CO 80112-3938  
(303) 790-8606 (800) 688-8606 FAX (303) 649-9275

Dear Dentist:

This person is being considered for participation in the United States Antarctic Program (USAP). Antarctica is isolated and lacks dental facilities, therefore the state of the dental health of the candidates is important and **all preventive and corrective procedures must be completed before deployment.**

All participants must be free of dental disease and all treatment must be completed three weeks prior to deployment. This means there must be no caries, active periodontal disease, potential endodontic disease, prosthetic deficiencies, potentially symptomatic wisdom teeth or any uncompleted treatment. Additional treatment or procedures may be required before this person can deploy to Antarctica. All dental work must be completed, documented and sent to RPSC Medical for review in order for the candidate to be dentally qualified for deployment.

**All Candidates are required to:**

## **I. DOCUMENTATION OF DENTAL EXAMINATION**

Please chart all existing restorations, missing teeth and endodontically treated teeth only on the Dental Examination Form. The treating Dentist must sign the Dental Examination Form and document all completed work.

## **II. THIRD MOLARS**

To qualify for deployment to Antarctica with the USAP, treatment must be completed three weeks prior to deployment in order for the dental condition to stabilize before deployment.

Third molars must be extracted if they are symptomatic or any of the following are present:

1. Periodontal probe can contact the crown of an erupted third molar;
2. Bleeding or poor hygiene is evident in the third molar area;
3. Pseudo pockets, bony pockets are present;
4. Soft tissue extends onto the occlusal surface of the third molar;

## **III. RADIOGRAPHS**

**ORIGINAL MOUNTED RADIOGRAPHS** must be included with the Dental Examination Form. **Copies or poor quality radiographs will not be accepted.** Digital radiographs can be sent in high-resolution JPEG format or printed in high resolution on glossy photographic paper. Radiographs become a part of the candidate's USAP record and **WILL NOT BE RETURNED** to you or the candidate, so you may wish to use a double film pack to retain original radiographs for yourself. Necessary radiographs include:

1. Set of four **ORIGINAL** bitewing x-rays **mounted** - showing crestal bone and all posterior teeth and **contacts clearly**. These films must be taken within 6 months of the deployment date and must accompany the completed examination form.
2. Panoramic and/or mounted full mouth survey - Must have been taken within 5 years of deployment date and updated every five years.
3. A periapical (PA) film of all endodontic work, crowns, and extensive restorations.

# Raytheon Polar Services Company

7400 S. Tucson Way, Centennial, CO 80112-3938  
(303) 790-8606 (800) 688-8606 FAX (303) 649-9275

## **IV. ORTHODONTICS**

Candidates with fixed orthodontic appliances or undergoing any active treatment may be considered for short deployments, only with written approval from the attending provider and approval from the RPSC Dental Reviewer.

1. Unrestricted Clearance – Fixed or removable orthodontic retainer only, with no active appliance.
2. Restricted Clearance for deployments up to six months – Candidates undergoing orthodontic treatment who do not require treatment for the period of deployment and who have not had active treatment for two months prior to deployment.

In view of the fact that there will be no orthodontic care, and in most cases, no dental care available, consideration should be given to placing the candidate in passive appliances or passive retention for the period of deployment.

## **V. SUBMISSION OF DENTAL FORM AND RADIOGRAPHS**

Send the signed, completed examination form, documentation of treatment, and ORIGINAL radiographs or digital files to RPSC Medical. (Digital files may be sent to [medical@usap.gov](mailto:medical@usap.gov))

## **VI. PAYMENT**

Insurance submission and payment of out-of-pocket fees/deductibles for all dental work, including exam, radiographs, and any necessary treatment **IS THE RESPONSIBILITY OF THE CANDIDATE.**

**THANK YOU FOR YOUR COOPERATION WITH THIS  
DENTAL EXAMINATION.**

NATIONAL SCIENCE FOUNDATION  
**POLAR DENTAL EXAMINATION**

NAME: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_ AGE: \_\_\_\_\_

DAY TELEPHONE#: \_\_\_\_\_ EMAIL ADDRESS: \_\_\_\_\_

YEAR OF PREVIOUS DEPLOYMENT: \_\_\_\_\_ CURRENT DEPLOYMENT DATES: FROM \_\_\_\_\_ TO \_\_\_\_\_

**AFFILIATION:**  
 NSF  S-Event or Group # \_\_\_\_\_  RPSC  VECO  Other \_\_\_\_\_

**ANTARCTIC DEPLOYMENT STATION:**  
 McMurdo  South Pole  Palmer  
 Field Camp \_\_\_\_\_  
 RVIB NB Palmer  RVIB LM Gould

**ARCTIC DEPLOYMENT STATION:**  
 Summit  Alaska  Thule  
 Other : \_\_\_\_\_

**Chart existing restorations, missing teeth and endodontically treated teeth only:**

**PERIODONTAL EVALUATION**  
 PROBINGS > 5 mm  YES  NO  
 ACTIVE DISEASE NOTED  YES  NO

**THIRD MOLAR EVALUATION**  
 3<sup>rd</sup> MOLARS PRESENT  YES  NO  
 POTENTIALLY SYMPTOMATIC  YES  NO

**ALLERGIES:**  
 \_\_\_\_\_

**Documentation of all treatment identified and rendered and original radiographs must accompany this form.**

DATES	DIAGNOSES and TREATMENTS

Attach the following **ORIGINALS** to this exam:  
 PANO OR FULL MOUTH SERIES  
 (Required first deployment and every 5 years after)  
 \*Date of last Pano or Full Mouth Series: \_\_\_\_\_

BITEWING X-RAYS, SET OF 4 MOUNTED SHOWING ALL POSTERIOR TEETH  
 (Required annually – within six months of deployment)

I have thoroughly examined this candidate for travel to the Polar Regions. All necessary treatment has been performed; all evaluations completed; and the appropriate diagnostic radiographs will accompany this completed form as requested by the "Dear Dentist" letter.

\_\_\_\_\_  
**DENTIST'S NAME (PRINT)**

\_\_\_\_\_  
**DENTIST'S SIGNATURE**

\_\_\_\_\_  
**DATE**

\_\_\_\_\_  
**TELEPHONE NUMBER** (include area code)

\_\_\_\_\_  
**ADDRESS**

\_\_\_\_\_  
**CITY**

\_\_\_\_\_  
**STATE**

\_\_\_\_\_  
**ZIP**

**ATTENTION EXAMINING DENTIST:**  
 Please forward completed form, all documentation of treatment and all **ORIGINAL X-rays** to:  
**RAYTHEON POLAR SERVICES COMPANY**  
**ATTN: Medical**  
**7400 S. Tucson Way**  
**Centennial, CO 80112-3839**  
**1-800-688-8606 ext 32287**

**MEDICAL STAFF USE ONLY:**

PQ  WINTER REVIEW

NPQ

**PERSONAL INFORMATION**

NAME (Last, First, Middle)	SEX <input type="checkbox"/> M <input type="checkbox"/> F	TELEPHONE NUMBERS (include area code)
PERMANENT ADDRESS (Street, City, State, Zip Code, Country)		RESIDENCE: _____  WORK: _____

**PARENT ORGANIZATION**

NSF     OFFICIAL VISITOR EVENT NUMBER \_\_\_\_\_     RPSC-FULL-TIME     RPSC-CONTRACTOR

SCIENCE GROUP MEMBER EVENT NUMBER \_\_\_\_\_     TECHNICAL EVENT NUMBER \_\_\_\_\_

Principal Investigator \_\_\_\_\_    Company Name \_\_\_\_\_

OTHER \_\_\_\_\_    JOB TITLE \_\_\_\_\_

(All participants complete for appropriate gear)

DATE OF BIRTH (month, day, year)	PLACE OF BIRTH (city, state, country)
----------------------------------	---------------------------------------

U. S. CITIZEN <input type="checkbox"/> YES <input type="checkbox"/> NO	NATIONALITY (if not a U.S. Citizen)	
---	-------------------------------------	--

NAME OF PERSON TO BE NOTIFIED IN CASE OF ACCIDENT/DEATH	RELATIONSHIP
---	--------------

ADDRESS	TELEPHONE NUMBER(S)
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**TRAVEL INFORMATION**

U.S. Departure Date (Estimated) \_\_\_\_\_

Dates in Antarctica (Estimated) FROM: \_\_\_\_\_ TO: \_\_\_\_\_

SEASON:     WINFLY (August deployment)     SUMMER (Sep thru Feb)     WINTER (March thru August)

<p align="center"><b>CLOTHING INFORMATION</b></p> <p>HEIGHT: _____    WEIGHT: _____</p> <p>COAT SIZE: _____    CHEST SIZE: _____</p> <p>SHIRT SIZE (check one):</p> <p><input type="checkbox"/> SMALL    <input type="checkbox"/> MEDIUM    <input type="checkbox"/> LARGE    <input type="checkbox"/> EXTRA-LARGE</p> <p>WAIST: _____    HIP: _____ (women)</p> <p>INSEAM: _____ (men)    SHOE SIZE: _____</p> <p>HAT SIZE: _____    GLOVE SIZE: _____</p> <p>Additional Requirements:</p>	<p align="center"><b>WORK SITE INFORMATION</b></p> <p>Check all that apply. For multiple sites, note dates next to site.</p> <p>CONTINENTAL SYSTEM</p> <p><input type="checkbox"/> MCMURDO STATION</p> <p><input type="checkbox"/> DRY VALLEYS</p> <p><input type="checkbox"/> SOUTH POLE</p> <p><input type="checkbox"/> OTHER _____</p> <p>PENINSULA SYSTEM</p> <p><input type="checkbox"/> PALMER STATION</p> <p><input type="checkbox"/> R/V NATHANIEL B. PALMER</p> <p><input type="checkbox"/> R/V L.M. GOULD</p> <p><input type="checkbox"/> OTHER (describe) _____</p> <hr/> <p>Have you previously deployed to Antarctica?    <input type="checkbox"/> Yes    <input type="checkbox"/> No</p> <p>Most recent year: _____</p>
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NATIONAL SCIENCE FOUNDATION  
4201 WILSON BOULEVARD  
ARLINGTON, VIRGINIA 22230

**PRIVACY NOTICE**

**PERSONAL INFORMATION FOR DEPLOYMENT TO AND FROM ANTARCTICA**

The National Science Foundation's Office of Polar Programs provides transport and logistical support for individuals traveling to and working in Antarctica under the auspices of the United States Antarctic Program (USAP). The NSF and its contractors and subcontractors will use the information collected on this form to facilitate deployment or redeployment of individuals participating in the USAP.

The information requested is solicited under the authority of the National Science Foundation Act of 1950, as amended, 42 U.S.C. 1870; 16 U.S.C. § 3101. It may be disclosed to Office of Polar Programs civilian contractors and their subcontractors in connection with their responsibilities for coordinating the administrative processing and tracking of persons deploying to Antarctica. These responsibilities include proper outfitting for deployment, facilitating medical clearances, coordinating cargo handling and tracking, and maintaining emergency contacts. It may also be disclosed to: Air National Guard medical personnel to track medical clearances; family members, or other persons designated by the deploying or deployed individual, in instances of emergency; other Federal agencies providing transport, search and rescue, and other logistical assistance to and from Antarctica, including manifest information for pilots or crew transporting individuals to and from Antarctica; other Federal agencies and academic or other organizations when the records are relevant to an agency decision with regard to disciplinary or other administrative actions concerning an employee; another Federal agency, a court, or a party, or when NSF determines that the litigation or anticipated litigation or proceeding is likely to affect the Agency; Federal, state, or local agencies, or foreign governments, when disclosure is necessary to obtain records in connection with an investigation by or for the NSF; and representatives of the New Zealand government or other foreign governments when deployment involves travel through, or use of, New Zealand or other foreign government facilities, and the information is necessary to ensure safe and efficient deployment, including compliance with immigration requirements.

Submission of the information requested is voluntary. However, if you fail to provide any of the requested information, NSF or its contractor may be unable to process or to approve your application for deployment through the USAP.

Public reporting burden for this collection of information is estimated to average less than one-quarter hour per response. Send comments regarding this burden estimate and any other aspect of this collection of information, including suggestions for reducing this burden to: Ms. Suzanne Plimpton, Reports Clearance Officer, Division of Administrative Services, National Science Foundation, Arlington, VA 22230.



NATIONAL SCIENCE FOUNDATION  
4201 WILSON BOULEVARD  
ARLINGTON, VIRGINIA 22230

**OFFICE OF POLAR PROGRAMS**

**IMPORTANT NOTICE FOR PARTICIPANTS IN THE UNITED STATES ANTARCTIC PROGRAM**

Participants in the United States Antarctic Program are expected to present themselves in such a manner that their activities and demeanor reflect credit on themselves and their sponsoring organizations. The special circumstances and conditions prevailing in Antarctica require some high standards of conduct.

The potential for mishap in Antarctica is a constant threat. Your ability to deal effectively with a mishap is reduced if you are under the influence of alcohol or other drugs. The National Science Foundation will not condone abuse of alcohol or controlled substances in Antarctica. Unauthorized use or use in excess of such substances will not be tolerated.

The laws of the United States prohibit the possession, shipping or mailing of illegal drugs. In addition, governments in New Zealand and South American countries have strict laws forbidding the possession or transportation through their country of firearms, knives, pornographic materials, marijuana or nonprescription dangerous drugs. These laws are strictly enforced and penalties for violation are severe. For example, in New Zealand the importation of illegal drugs, including marijuana, is punishable by up to fourteen years imprisonment. Letter mail, parcels, and cargo being sent to Antarctica are subject to examination and opening by United States and foreign authorities. For example, all incoming and outgoing mail for McMurdo station transits New Zealand and is subject to interdiction by New Zealand Customs Service through the use of narcotics detection dogs and other direct inspection procedures. Like any traveler, you must abide by local foreign law. If you are found in violation thereof, you are subject to prosecution in the courts of that country. Association with the United States Antarctic Program affords neither preferential treatment nor immunity from prosecution. The New Zealand and Chilean Governments have expressly stated their intention to vigorously prosecute violators.

Conviction for any criminal action under the laws of the United States, or foreign countries may result in your removal from the United States Antarctic Program.

I have read and understand this information sheet.

---

Print Name

---

Signature and Date

# Raytheon Polar Services Company

7400 S. Tucson Way, Centennial, CO 80112-3938  
(303) 790-8606 (800) 688-8606 fax (303) 649-9275

## REQUIRED LABS

Please follow the instructions in your Deployment E-mail and Deployment Packet.

**RPSC and NANA Employees:** Follow instructions for utilizing LabCorp. If there is no LabCorp patient service center near you, contact RPSC Medical Department to request a LabCorp Lab Kit.

**Non-RPSC Participants:** Present this list of required labs to your medical provider.

Please complete the following tests and send results to the RPSC Medical Department.

### **Labs to be done no earlier than 6 months prior to deployment**

**You must fast for 10-12 hours prior to the blood draw.**

#### Lipid Panel

- Triglycerides
- Cholesterol, Total
- HDL – cholesterol
- LDL – cholesterol
- CHOL/HDLC ratio

#### Biochem

- Alkaline Phosphatase
- Bilirubin, Total
- Calcium
- Chloride
- Creatinine
- Glucose, Serum
- Potassium
- Aspartate Transaminase - AST (SGOT)
- Alanine Transaminase - ALT (SGPT)
- Sodium
- Uric Acid
- HgA1c required for all Diabetics

#### Iron, Total

#### Iron Binding Capacity

#### % Saturation

#### CBC with differential/platelet

#### Urinalysis, reflex

#### Hepatitis B core AB total

#### Hepatitis C Antibody

#### RPR/VDRL (monitor)

#### ABO Group & RH type

PSA: For ages 40-49 with family history of prostate cancer; all males aged 50 and up

HIV: Recommended, but optional. Mandatory for winter-over in Antarctica (February – October) and for participants in the walking blood bank

TSH: Mandatory for Participants with a Thyroid Disorder or winter-over in Antarctica (February-October)

# Need a Copy of Your Medical/Dental/Lab Results?

Please send this form back with your medical packet or fax to the Medical Department  
Fax: (303) 649-9275

**(Please allow up to 30 days to process request)**

Name: \_\_\_\_\_  
Last First MI      DOB: \_\_\_\_\_

What information do you require? Please check applicable boxes.

Lab results    Medical records    Dental records   (Note: X-rays cannot be reproduced)

Year(s) Requested: \_\_\_\_\_

How do you want the records sent to you? Please choose one option.

Direct       Handed directly to participant

Fax       Fax Number: \_\_\_\_\_

U.S. Mail       Address: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I hereby authorize Raytheon Polar Services Medical Department to release copies of my records as indicated above.

\_\_\_\_\_  
Participant Signature

\_\_\_\_\_  
Date



Technical Services Company LLC  
Polar Services

7400 S Tucson Way  
Centennial, Colorado  
80112-3938 USA  
303.790.8606

To USAP Participants: **(Personal Prescription Medications)**

It is the responsibility of all participants to obtain a supply of their regular prescription medications to cover the time that they will be deployed. **The Stations do not have prescriptions available to support maintenance medications – our medication stock is limited to support emergent requirements, in accordance with NSF requirements.** Additionally, **if any changes to your medical well-being occur after PQ, you are required to let us know so we can ensure your continued good health while deployed.** Participants will not be allowed to winter-over unless they have enough of their regular medications to last through the winter season. The New Zealand custom laws, however, only allow for three months of prescription medications and one month of controlled prescription medications to be hand carried through New Zealand. Therefore, if you will be deployed for a longer period of time, you must make arrangements for additional medication to be mailed to the Station Medical Clinic through the APO mail system. The medications will need to be in properly labeled pharmacy containers to be passed through the APO system. It is important that you hand carry the initial three months of medication (one month for controlled medications) in order to provide enough time for the mail to reach you in Antarctica. When you get your prescription medications filled, ask the pharmacist to put three months of medication (or one month of controlled medications) in one labeled container and the remainder in a separately labeled container. If you are not sure if your medication is controlled (Class II or III), ask the pharmacist when you get the prescription filled. Mail the containers with the remainder of the medication to the Medical Clinic at the Station where you will be deployed. **If you are a Raytheon employee** and are having difficulty in getting the amount that you need for your deployment, contact Medical at RPSC for assistance. We can coordinate with your health plan to help you obtain the sufficient quantity of your prescription to last your deployment. Most health plans only allow one month of medication to be dispensed at a time.

Mail the medication to the APO address listed below. Packages destined for summer participants should be mailed after Labor Day or they will be returned. The addresses for the Medical Clinics are:

**McMurdo Station – RPSC**

Medical Clinic, RPSC  
McMurdo Station  
PSC 469 Box 700  
APO AP 96599-1035

**South Pole Station -- RPSC**

Medical Clinic  
South Pole Station  
PSC 468 Box 400  
APO AP 96598

The Medical Clinic will open the packages upon receipt at the Station and maintain an Excel spreadsheet listing the name of the participant, the name and amount of the medication, date received, the date that the medication was dispensed to the participant and the signature of the person dispensing the medication. The Medical Clinic will notify the participant when the medication is received. The participant will go to the Clinic to sign the medication spreadsheet and obtain their medication.

Chilean customs laws do not restrict the amount of personal medications hand-carried through Chile and participants that are deploying through Chile can hand carry the amount of medication that they need for their deployment.

Remember that you will have to clear customs in New Zealand to reenter the country on redeployment and the same restrictions on the quantity of medications will apply. If you have an excess amount on redeployment, mail the excess amount to yourself at home before leaving Antarctica.

If you have any questions about the procedure for transporting your prescription medications to Antarctica, contact the Medical Department at RPSC, 1.800.688.8606, option 3 on the menu.

**RAYTHEON TECHNICAL SERVICES COMPANY LLC  
POLAR SERVICES**

## Will You be Visiting South Pole Station?

In the upcoming season, you will be traveling to not only one of the coldest climates on earth, but also to a high altitude environment. When traveling to Antarctica, we prepare physically and mentally for the physical impacts of extreme cold. Below, we hope to stress the equal importance of preparing for the effects of high altitude on your body, and the efforts you can make in your first week at altitude to prevent altitude related illnesses.

**What is considered “high altitude”?** “High altitude” is defined as altitudes exceeding 6,000 to 8,000 feet. Above these levels, changes in the pressures of gases we breathe, and of oxygen in particular, result in a number of chemical changes in our bodies – some of which can be unpleasant.

**How do we adapt to high altitude?** We begin to adapt to these changes, or acclimatize, within hours of our exposure to altitude. Significant adaptations occur within the first four days at altitude. It may take a month or more to completely adapt. Individuals with certain medical conditions – most of which we screen for in your PQ process – may never properly adapt to high altitude environments, and therefore may not qualify for South Pole employment. South Pole residents are challenged in their acclimatization because they are not able to gradually ascend to altitude, as one might on a gradual climb to a mountain peak; instead, residents are flown directly from sea level to approximately 11,000 feet of altitude. This requires vigilance to prevent overexertion in the first days at altitude, as overexertion can significantly increase the risk of developing an altitude-related illness.

**What are the physical problems (Altitude Related Illnesses) I might experience with my initial arrival at altitude?**

- **Periodic Breathing of Altitude:** This irregular breathing pattern, part of normal acclimatization, presents as multiple breaths followed by pauses in breathing. Most evident at night, this breathing pattern can cause repeated awakenings, leading to poor or disrupted sleep and subsequent daytime fatigue. In some individuals, blood oxygen levels will drop significantly with breathing pauses, putting them at risk for further altitude related illnesses. Chemicals which suppress the drive to breathe – such as alcohol and sleeping medications – can worsen the effects of periodic breathing, and are therefore not recommended while acclimatizing. **Treatment:** Periodic breathing can be reduced through the use of acetazolamide (Diamox) 125mg at bedtime in the first three to four days at altitude.
- **Acute Mountain Sickness (AMS):** AMS, a syndrome of headache, nausea, loss of appetite, dizziness, and worsened periodic breathing, impacts approximately 30% of people traveling to high altitude. It normally presents in day one to three at altitude. **Anyone can get AMS – even people who have lived and worked at high altitude in the past without any problem.** Excessive exertion and dehydration in one’s first days at altitude, and possibly a high salt diet, increase the risk for getting AMS. Remaining well hydrated – at least four liters of water per day, practicing a low salt diet, and doing no heavy physical exertion for the first two to four days at altitude will reduce one’s risk of getting AMS. **Treatment:** Diamox (250mg) twice a day, started the day before ascent, and continued for the first three to four days at altitude, will reduce the risk of getting AMS. (This dosing will also treat Periodic Breathing, mentioned above.) Gingko, previously thought to be of benefit at altitude, has recently been found to be ineffective at preventing AMS. Using supplemental oxygen, especially at night, can also help reduce symptoms.

- **High Altitude Pulmonary Edema (HAPE):** HAPE occurs when leaky tissues and blood vessel spasms in the lung cause the lungs to backflow with fluid, including blood. Three percent of people going to altitude are expected to develop HAPE, which normally presents on day two to three at altitude. Symptoms initially include shortness of breath at rest and with lying flat; they can progress to dry, wet, pink-frothy or bloody cough, associated with an inability to catch one's breath. This is a serious and progressive condition, which if untreated can lead to death. Risk for HAPE can be reduced by avoiding heavy exertion in one's first three to four days at altitude, taking Diamox to reduce periodic breathing and pauses, and keeping warm – to include breathing through a neck gaiter outside to prevent cold-induced spasm of blood vessels of the lungs. **Treatment:** Diamox (250mg) twice a day, possible blood vessel dilators like nifedepine or Viagra, inhalers such as albuterol, dexamethasone, oxygen and possible descent from altitude. The medical providers at McMurdo and Pole Stations can best assist you on the advisability of any of the other medications beside or in addition to Diamox.
- **High Altitude Cerebral Edema (HACE):** HACE is brain swelling, resulting from the low oxygen environment, and the body's chemical reactions thereunto. HACE is rare at South Pole's altitude, but can be seen when oxygenation is worsened by the presence of HAPE. Therefore, HACE and HAPE are commonly seen together. HACE presents with severe headache, dizziness and ataxia (falling over due to lack of balance), extreme nausea/vomiting, altered levels of consciousness including unconsciousness, and seizures. Without treatment, HACE can be fatal. **Treatment:** Diamox (250mg) twice a day, dexamethasone to reduce brain swelling, oxygen and descent from altitude.

**What if I've never had an altitude related illness before, and I've been to altitude many times?** You are still at risk for getting altitude illness. If you've gone to altitude 99 times, you may get altitude illness on your hundredth ascent. If you live at altitude, your time in New Zealand and McMurdo is sufficient to allow you to lose your previous altitude acclimatization. The only predictor that you will get sick is that you've been sick before. Therefore, **everyone** must take seriously the above precautions and strongly consider taking medicine to prevent altitude illness.

**Where do I get Acetazolamide (Diamox)?** You can get Diamox at McMurdo Medical before you go to Pole at any time during the season. If you are going to Pole directly, you will be met by a member of the McMurdo medical team upon your arrival to Antarctica, given a briefing about altitude illness, and offered Diamox before your Pole flight. If you forget to get your Diamox in McMurdo, it is also available from the South Pole Clinic.

**What if I have other questions about Altitude Related Illnesses?** Feel free to stop by in the medical clinics at McMurdo or South Pole, or speak to your regular doctor before you deploy. A good website to read more about altitude illnesses is: [www.basecampmd.com](http://www.basecampmd.com).

## **EYEWEAR POLICY FOR ANTARCTICA**

Everyone in Antarctica is required to wear sunglasses! You are traveling to a part of the world where scientists have documented increased ultraviolet radiation due to depletion in the ozone layer. Snow and ice reflect 85% of Ultraviolet Radiation (UVR) and can cause a serious, painful and disabling condition known as snow blindness. Sunglasses are especially important on windy days to protect against volcanic ash particles and blowing snow in the eyes.

***The type of sunglasses you wear while you are in Antarctica is very important.*** Sunglasses must block 100% of the sun's Ultraviolet Rays. Some dark glasses do not block UVR and cause the iris to widen and admit more light that can cause damage to the eye. Frames must be non-metal to avoid injury to the skin from the cold. Retaining straps are mandatory. Side protectors are recommended, but not required.

### **Prescription Eyewear:**

If you wear prescription eyewear and choose to wear prescription sunglasses during your deployment, the sunglasses must meet the above criteria. Please obtain a current prescription from your ophthalmologist/optometrist (including pupillary distance) and bring it with you when you deploy. Eyeglass prescriptions are good for two years.

Contact lenses can be worn in Antarctica. At the South Pole, however, the dry climate can cause difficulties. It is suggested that you carry your lenses on your person to avoid possible damage and/or freezing. Limited lens cleaning supplies are available at the McMurdo, Palmer, and South Pole stores (heat-type is NOT available.)

RPSC will reimburse deploying employees up to \$175.00 for one pair of prescription sunglasses (frames and lenses combined) every other year. RPSC will also reimburse employees up to \$175.00 for one pair of prescription safety glasses if required for your job. RPSC will NOT reimburse you for the eye exam. You must be both medically and dentally qualified before you are eligible to be reimbursed. Once you are notified by the Medical Department that you are Physically Qualified, please submit your expenses on the RPSC Medical/Dental Expense Reimbursement Form (ME-A-103). If you are within 30 days of deploying or are currently an active employee, you must submit your expense report online via WebTE.

**Please bring two pair of glasses, prescription or non-prescription, in case of damage or loss.**

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**MEDICAL/DENTAL EXPENSE REIMBURSEMENT FORM**

RPSC will reimburse **Raytheon employees** for out-of-pocket fees for approved medical and dental costs incurred while obtaining clearance for deployment to Antarctica. If an insurance carrier has been billed, the reimbursement amount will be the amount of the cost minus any insurance payment. All candidates are responsible for submitting the proper claims to their insurance carrier and for paying any fees/deductibles associated with the medical and dental clearances directly to their provider. You must pay bills in full and show a zero balance before you can be reimbursed. RPSC will reimburse for dental exams and x-rays, but **will not reimburse for cleanings (prophylaxis) or work done on teeth.** RPSC will reimburse employees up to \$175.00 for one pair of prescription sunglasses and also up to \$175 for one pair of prescription safety glasses (if required for job duties) (frames and lens combined) **every other year.** RPSC will not reimburse for eye exams or non-prescription sunglasses. RPSC will only reimburse employees for their prescription sunglasses/safety glasses after they are medically and dentally cleared for deployment and itemized receipts are attached.

**Falsifying and/or fraudulent claims may result in penalties and disqualification from the United States Antarctic Program.**

**Do NOT have Doctor or Dentist bill RPSC!**

RPSC employees should complete and submit this form along with **ITEMIZED BILLS** showing full payment from the doctor/dentist/optometrist and any corresponding insurance provider information. **EXPENSE REIMBURSEMENTS MUST BE SUBMITTED BY MARCH 1<sup>st</sup> OF THE FOLLOWING CALENDAR YEAR.**

Medical	Amount	Dental	Amount
Physical Exam (Including EKG – 12 Lead)		Dental Examination	
Labs		Bitewing X-rays	
Tetanus Immunization Tuberculin Skin Test		Panographic or Full Mouth X-rays	
Exercise Stress Test/Echo		Periodontal Probing	
HIV Test		PA X-ray(s)	
Chest X-ray		Dental Misc. (list):	
Mammogram			
Gyn Exam (w/ Pap Smear)			
Drug Screen		<b>DENTAL TOTAL</b>	
Gallbladder U.S.			
EKG			
Medical Misc. (list):			
<b>MEDICAL TOTAL</b>			
<b>Rx Sunglasses</b>	<b>R-PS80-210A40I03BD</b>	<b>Rx Safety Glasses</b>	
Frames		Frames	
Lenses		Lenses	
<b>SUNGLASS TOTAL</b>		<b>SAFETY GLASS TOTAL</b>	

Mailing address to send check: \_\_\_\_\_

SIGNATURE (Required): \_\_\_\_\_

For RPSC use only:	Amount	Approver	Date
<b>Total Reimbursement Due to Participant:</b>			
<b>Charge Codes: R-PS80-210A40I03BA</b>		<b>Employee #:</b> _____	<b>GL#: 521099</b>

## MEDICAL/DENTAL AND PSYCHOLOGICAL EMPLOYEE EXPENSE REPORTS

While going through the rigorous physical qualification process to deploy to Antarctica, candidates often incur expenses that can be reimbursed in accordance with government, contract and company guidelines. In October of 2005 RPSC installed a new expense reporting system entitled WebTE to process employee reimbursements. WebTE is a web based expense report system that must be used by all current employees of RPSC. If you are a participant pending employment you have two options for reimbursement: 1) if you incur expenses and you can submit them at least 30 days prior to your first day of employment, you may still use the manual paper expense report form ME-A-103 or 2) you can retain your receipts and itemized bills and file from Antarctica via WebTE. WebTE reimbursements are direct deposited. No direct deposit is available for manual expense statements and reimbursement takes 4-5 weeks.

### IMPORTANT TIPS FOR SUBMITTING YOUR PQ REIMBURSEMENT EXPENSES:

1. When submitting for your Medical/Dental PQ expenses you will need to submit the itemized bills for all items. Receipts must reflect payment in full. **An invoice alone, showing the balance due with no indication of payment, does not satisfy the contract or audit requirement. All loose receipts should be taped to an 8 ½ x 11 piece of paper. Be sure the amounts you have listed are able to be clearly identified on the supporting medical statements and receipts.**
2. **If you currently carry insurance you are required to give your insurance information at the time of your appointment. Your co-pay and any costs that are not covered, or are rejected by your insurance, are eligible for reimbursement from RPSC. Please wait to submit your reimbursement until you have the final claims from your insurance showing the balance due.**
3. Dental exams and dental x-rays are covered. Dental work done (including Prophylaxis or cleaning) will NOT be reimbursed. Mileage to and from medical and dental appointments as well as postage will not be reimbursed.
4. When traveling to Denver for your Psychological Test, you will be reimbursed for employee meals (actuals) up to the government per diem rate. The per diem is limited to 75% for the first and last day of travel. Per Diem's are on your Itinerary and [www.gsa.gov](http://www.gsa.gov). Meals and incidentals are reimbursed for the actual amounts expended UP TO the per diem amount allowed. We recommend that you keep a log of your expenses and maintain the receipts. These receipts may be required for reimbursement. Do not highlight receipts or tape over the printing on the receipt as this may make it difficult or impossible to read. Be sure the receipts are clear and dark enough to be faxed or scanned. Keep all receipts until you are reimbursed.
5. If you are currently an employee or contract employee with Raytheon, you must complete your expense report on WebTE.
6. The complete WebTE expense report procedure can be found on the "I" drive, PERM, Procedures folder, Master List, Finance tab, Procedure 558. If you would like to have this procedure e-mailed to you, please contact us via e-mail at [expense.reports@usap.gov](mailto:expense.reports@usap.gov).
7. You will need a charge number (WBS) for your expense report. This number typically starts with R-PS and ends with a two letter suffix. Without this number you will not be able to complete your expense report. There is a different WBS number for Medical/Dental Reimbursement vs. Psychological Travel Reimbursement. Refer to the WBS on your Itinerary for Psychological Travel. Please refer to form ME-A-103 for the Medical/Dental reimbursement WBS or contact the Medical Department at [medical@usap.gov](mailto:medical@usap.gov).
8. Do not incur expenses that are not authorized on your Itinerary as these may not be reimbursed.

### Basic Steps in using WebTE:

1. Establish your Raytheon directory service password by calling 1-877-844-4712.
2. Convert all expenses to US dollars using [www.oanda.com](http://www.oanda.com).
3. Access WebTE at: <https://webte.raytheon.com/webte>.
4. Be sure you know your employee number; do not use the TS prefix.
5. Complete your WebTE profile (see Finance Procedure 558 for details).
6. Click on "Home" or "Start My Statement" to begin an expense report.
7. In the Comments Section, identify **"POLAR SERVICES Required Pre-Deployment Medical Testing for deployment to Antarctica in support of the National Science Foundation"**
8. Once your expense report is complete, you may be requested to fax in selected receipts. Be sure to print and use the fax cover page provided, along with the receipt.
9. You can view faxed documents and check on the status of your statement at the WebTE website.