

UNITED STATES  
DEPARTMENT OF THE INTERIOR  
BUREAU OF LAND MANAGEMENT

**CERTIFICATE OF PRE-APPOINTMENT MEDICAL EXAMINATION FOR  
FIREFIGHTER**

(Supplements SF-78 for arduous temporary and permanent positions)

**Part A. TO BE COMPLETED BEFORE EXAMINATION BY APPOINTING OFFICER**

**OFFICE CODE:**

**POSITION TITLE:**

**BRIEF DESCRIPTION OF WHAT POSITION REQUIRES EMPLOYEE TO DO**

<b>Wildland Firefighting Tasks</b>	<b>Energy cal/min</b>	<b>Cost ml/kg · min</b>
<b>Using a handtool</b> (for instance, digging or chopping with a Pulaski, combi-tool, McLeod, or brush hook)	7.5	22.5
<b>Lifting and carrying light loads</b> (examples are clearing loose brush or trees, deploying or repositioning hose, throwing dirt with a shovel, firing operations, or structure protection)	6.8	20.0
<b>Chain sawing</b> (felling, bucking, limbing)	6.2	18.0
<b>Packing heavy loads</b> (pumps, hose packs, 5-gallon water bags)	7.5 flat 10.0 hill	22.5 29.4
<b>Hiking with light loads</b> (field pack and tools)	6.5	19.0
<b>Performing under adverse conditions</b> (including long work shifts; rough, steep terrain; heat, cold, altitude, and smoke; insufficient food, fluid replacement, sleep)	6.5-10+	19-30
<b>Emergency responses</b> (fast pull-out to safety zone, rescue or evacuation assistance to others)	10.0+	29.4
<b>Chopping wood</b>	7.5	21.4
<b>Tree felling</b> (ax)	8.5	25.0
<b>Stacking wood</b>	5.8	17.0
<b>Shoveling</b>	6.8	20.0

Appendix B

<b>Part B. TO BE COMPLETED BY APPLICANT</b> (typewrite or print in ink)			
NAME (last, first, middle)	SOCIAL SECURITY NO.	SEX ____ MALE ____ FEMALE	DATE OF BIRTH
DO YOU HAVE ANY MEDICAL DISORDER OR PHYSICAL IMPAIRMENT WHICH WOULD INTERFERE IN ANY WAY WITH THE FULL PERFORMANCE OF THE DUTIES SHOWN ABOVE IN PART A?  ____ YES      ____ NO  (If your answer is "YES" explain to the physician performing the examination)		I CERTIFY THAT ALL THE INFORMATION GIVEN BY ME IN CONNECTION WITH THIS EXAMINATION IS CORRECT TO THE BEST OF MY KNOWLEDGE AND BELIEF    (Signature of Applicant)	

<b>Part C. TO BE COMPLETED BY EXAMINING PHYSICIAN.</b>						
(INSTRUCTIONS TO PHYSICIAN: The duties of firefighter positions require sustained, arduous physical exertion under rigorous conditions. Persons will be subject to extreme environmental conditions and to irregular and protracted hours of work. This form lists some specific physical requirements for these positions. Please review the physical condition of this individual on every item listed on this form. Record any comments you may have on conditions which may limit the applicant's ability to safely perform this job on the reverse side of this form. It is essential that you review your patient on every item listed and that we have all of the following information recorded here.)						
Weight: (lbs)	Height: (in)	Blood Pressure:	Pulse:	Uncorrected Distant Vision: R20/                  L20/	Corrected Distant Vision: R20/                  L20/	
DOES THE APPLICANT MEET THE REQUIREMENTS FOR THE FOLLOWING FUNCTIONS?					YES	NO
EYESIGHT: a) Uncorrected distant vision at least 20/100 Snellen in one eye and 20/200 in the other b) Corrected distant vision at least 20/30 Snellen in one eye and 20/40 in the other c) Evidence of acute or chronic eye disease ( <u>not time limited</u> ) d) Corrected near vision; can read typewritten materials e) Can distinguish basic colors f) Peripheral vision						
EARS: No evidence of acute or chronic disease of external, middle or internal ear. Without hearing aid, no loss greater than an average in either ear of more than 40 dB at 500, 1000, and 2000 Hz						
HEART & BLOOD VESSELS: (Based on medical history and in-office						

examination) No evidence of organic heart disease, valvular disease, coronary heart disease, cardiac enlargement, angina pectora, cardiac arrhythmia or irregularity other than sinus arrhythmia. Blood pressure, regulated or not, less than 160/90. Pulse rate at rest less than 100.		
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NAME OF APPLICANT: \_\_\_\_\_ DATE OF EXAM: \_\_\_\_\_

FOLLOWING FUNCTIONS ARE WITHIN NORMAL LIMITS YES NO

NOSE, MOUTH & THROAT: No evidence of acute or chronic disease or other nasopharyngeal conditions which interfere with distinct speech or free breathing.

TEETH: No evidence of gross dental problems that would be expected to affect the ability to carry out the work.

LUNGS: No evidence of acute or chronic lung disease which impairs physical functioning or might limit the applicant's ability to perform the functions of the position (45mL/kg VO<sub>2</sub> max)

ABDOMEN: No evidence of acute or chronic diseases; significant enlargement of the liver or spleen; hernia which would interfere with lifting, stretching or bending; or conditions that would otherwise affect the ability of the applicant to perform the requirements of the position.

GENITOURINARY/METABOLIC: (Based on macroscopic and microscopic urine analysis) No evidence of acute or chronic genitourinary disease which would affect work. Individuals with a diagnosis of diabetes require individual evaluation by the agency.

FOLLOWING FUNCTIONS ARE WITHIN NORMAL LIMITS YES NO

SPINE: No problems with the spine or back that would affect the ability of the applicant to perform the requirements of the position.

EXTREMITIES: No problems with the extremities that would be expected to affect work. No loss of limbs, hands, or feet.

NERVOUS SYSTEM: No evidence of neurological or psychiatric disorders likely to interfere with the performance of duties. A history of epilepsy or other seizure disorders requires an evaluation of pertinent treatment records by the agency MRO.

SKIN: No evidence of excessive scarring or debilitating acute or chronic skin disease which would interfere with performance.

OTHER DEFECTS: No evidence of diseases of defects not mentioned above which would interfere with performance of position.

CONCLUSIONS: Summarize below any medical findings which, in your opinion, would limit this person's physical ability to perform job duties and/or

Appendix B

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could create an imminent hazard to himself/herself or others. If none, so indicate.

No limiting conditions for this job

Potentially limiting conditions and recommended work restrictions.

Limiting conditions as follows:

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NAME OF APPLICANT:

EXAMINING PHYSICIAN'S NAME AND ADDRESS (Type or print and include ZIP code):

SIGNATURE OF EXAMINING PHYSICIAN

Signature

Date

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IMPORTANT: After signing, return the form to:

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**Part D. TO BE COMPLETED BY AGENCY PERSONNEL OFFICER**

ACTION TAKEN:  Hired or retained.  Non-selected for appointment, or eligibility objected to  
 Action taken to separate.

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AGENCY PERSONNEL OFFICER (type or print)	SIGNATURE	DATE