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 your 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.

NATIONAL SCIENCE FOUNDATION
4201 Wilson Boulevard
ARLINGTON, VIRGINIA 22230

OFFICE OF POLAR PROGRAMS

Dear Grantee,

The National Science Foundation's Office of Polar Programs (OPP) would like to take this opportunity to remind you of the importance of being prepared for all aspects of your field work. You will have received a lot of information from OPP and from its support contractor, Raytheon Polar Services Company, with respect to working in Antarctica, including a link to the USAP Participant Guide which provides you with practical knowledge about working in Antarctica.

You are responsible for yourself and for all members of your team, including graduate students and postdoctoral fellows. All research staff (paid or volunteer) should be affiliated in some manner with your organization(s), so any worker compensation issues arising from injuries sustained while deployed can be addressed by your organization. NSF does not provide insurance for grantee personnel and the cost of insurance is not an allowable expense on NSF grants. As such, persons traveling to Antarctica are expected to have insurance appropriate to their normal life situations so that any needed health care, compensation for property loss, worker's compensation, or survivor benefit will be provided for in the event of a health care emergency. Emergency medical care for U.S. Antarctic Program participants in Antarctica is provided in clinics at the year-round stations, and persons who need hospital care will be transported to health care facilities in New Zealand, South America, or the United States, at which point they or their sponsors will be responsible for medical costs. An often overlooked aspect of field work is time you and members of your team will spend in the gateway cities of Christchurch, New Zealand and Punta Arenas, Chile. Check your health and life insurance policies to be sure that flights aboard scheduled military aircraft are covered and also that health care received in foreign countries is covered.

Wishing you a safe and productive deployment.

Brian Stone
Division Director
Antarctic Infrastructure
and Logistics Division

Michael Montopoli
Head
Polar Environment,
Safety and Health

Scott Borg
Division Director
Antarctic Sciences Division

Karl A. Erb
Director
Office of Polar Programs

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. **Additional tests/exams may be required based on information received.**	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). ***Falsifying and/or non-disclosure of information may result in permanent disqualification from the United States Antarctic Program.***
Release Form NSF Form 1421	"Medical Risks for NSF-Sponsored Personnel Traveling to Antarctica" release.	Read, sign and date. Return to RPSC Medical. Participants **WILL NOT** 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 **Raytheon and NANA Employees Only** 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 www.labcorp.com to find the closest LabCorp patient draw site to your location. Bring with you the **LabCorp Requisition** 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. **Labs must be done within 6 months of deployment. You must fast for 10-12 hours prior to the blood draw.**
Lab Work Required **Non-Raytheon Participants** 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. **Labs must be done within 6 months of deployment. You must fast for 10-12 hours prior to the blood draw.**
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. **You must be Physically Qualified to obtain reimbursement.**
Medications Form ME-A-121	**Participants taking prescription or over-the-counter medications are required to bring an adequate supply for the deployment duration.** USAP does not provide motion sickness medication.	If you need physician-prescribed medications of any kind during your deployment, please consult your physician. **You will need to obtain a prescription for the length of your deployment.** 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 http://wwwn.cdc.gov/travel/default.aspx
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.

MEDICAL AND DENTAL - INSTRUCTION GUIDE (continued)

REQUIRED FORM COMPLETION with RETURN TO RPS MEDICAL

The following paperwork is **required** to be **returned to RPSC Medical.** Failure to return all required paperwork may delay determination of your physical qualification status and/or your deployment date.

Section A: Required Paperwork Medical Professionals Complete

FORM NAME	FORM# / INFO / PAGES	COMPLETED BY
1. Polar Physical Examination –Antarctic Present your checklist to doctor Present "dear doctor" letter to doctor Present polar physical exam form to doctor	NSF Form 1423-A / 2 pages	Your Doctor
2. Required Laboratory Tests		
For RPSC/NANA	LabCorp Requisition	LabCorp
For All Others	ME-DT-A-109 List of Labs	Your Doctor
3. Polar Dental Examination Present your checklist to dentist Present "dear dentist" letter to dentist Present dental exam form to dentist	NSF Form 1425-A / 1 page	Your Dentist
4. Dental X-rays – Originals High resolution JPEG dental images can be emailed to medical@usap.gov **or** Original x-ray films mailed to RPS medical	X-ray films - originals only! All films are the property of the NSF and cannot be returned	Your Dentist
5. Any Additional Testing per Checklist Present your checklist to medical provider Complete all testing requirements and forward results to RPSC Medical	See Checklist	Medical Providers

Section B: Required Paperwork You Complete

FORM NAME	FORM# / INFO / PAGES	COMPLETED BY
1. Medical History Complete all 8 pages and present to doctor Either you or your doctor return to RPS Medical	NSF Form 1422 / 8 Pages	You
2. Influenza Vaccination Read/Sign/Return	ME-DT-127 / 1 Page	You
3. Personal Information	NSF Form 1458 / 1 Page	You
4. Important Notice to Participants	NSF Form 1457 / 1 Page	You
5. Medical Screening for Blood-Borne Pathogens/Consent for HIV Blood Test Optional for summer deployment Required for participation in walking blood bank Required for winter over deployment	NSF Form 1424 / 1 Page	You
6. Medical Risks – Traveling to Antarctica	NSF Form 1421-A / 1 Page	You

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.

Print Form

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):

Restrictions and Follow-up:

Reason for NPQ:

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: From ____________ to ____________	Previous Polar (Arctic or Antarctic) Deployment? 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:_________________________________

MEDICAL HISTORY (continued) NAME________________________________ DOB ________________________

FAMILY MEDICAL HISTORY****DO NOT USE FOR YOUR OWN HEALTH HISTORY****

Relationship	Status of Health and Age, if living	Age and Cause of Death
Father		
Mother		
Spouse		
Brothers/Sisters/Children (list below):		

Family History: Check box, If yes, who? (Explain.):			Relationship	**Family History**: Check box, If yes, who? (Explain.):			Relationship
Diabetes? Insulin Required?	☐ YES ☐ YES	☐ NO ☐ NO		Kidney Disease? Describe:	☐ YES	☐ NO	
Heart Attack? Age? _____________	☐ YES	☐ NO		Cancer? Type? Treatment?	☐ YES	☐ NO	
Stroke? Age? _____________	☐ YES	☐ NO					
Bleeding Disorder? Describe: (Hemophilia, Clotting Factor Deficiency) ______________________	☐ YES	☐ NO		Stomach/GI Disease? Type? _____________________ _____________________	☐ YES	☐ NO	
Autoimmune Disorder? Describe: (Rheumatoid Arthritis, Lupus, Other) _______________	☐ YES	☐ NO		Mental Health Disorders? Describe: (i.e., Depression, Bipolar, Suicide, Schizophrenia) _____________________	☐ YES	☐ NO	
Hemoglobin disorder? Describe: (Sickle Cell, Thalassemia, etc.)	☐ YES	☐ NO					

MEDICAL HISTORY (continued) NAME________________________________ DOB ______________________

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? Date of Last Seizure:__________________	☐ YES	☐ NO	
e. Head Injury? Loss of Consciousness - Date________________ How Long__________________	☐ YES	☐ NO	
2 **Headaches**?	☐ YES	☐ NO	
Migraines ? Date Diagnosed__________________ Date of last Migraine______________	☐ YES	☐ NO	
3 **Do you have diabetes**? Date diagnosed:_______________ Controlled by: ☐Insulin ☐Oral medication ☐Diet Last Emergency Room visit:___________________	☐ YES	☐ NO	
4 **Do you have Cholesterol disorders? Date diagnosed:_______________ Controlled by: ☐Oral medication ☐Diet**	☐ YES	☐ NO	
5 **Do you have Thyroid Disease? Explain, if Yes - include medication**	☐ YES	☐ NO	
Surgery required? When?______________________	☐ YES	☐ NO	

NAME______________________________ DOB ______________________

PERSONAL MEDICAL HISTORY (continued)

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

NAME______________________________ DOB ______________________

PERSONAL MEDICAL HISTORY (continued)

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

NAME________________________________ DOB ________________________

PERSONAL MEDICAL HISTORY (continued)

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

NAME______________________________ DOB ______________________

PERSONAL MEDICAL HISTORY (continued)

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

NAME______________________________ DOB ______________________

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

OMB CONTROL NUMBER 3145-0177: Expires 01/2011

Raytheon Polar Services Company
Contracted Medical Provider List

7400 S Tucson Way Centennial, CO 80112-3938
Local (303) 790-8606 ext 3 ~Toll free (800) 688-8606 ext 3 ~ Fax (303) 649-9275

RPSC has contracted with the following physicians, dentists, eyewear and other medical providers for services to RPSC employees and individuals deploying to Antarctica under the United States Antarctic Program (USAP). These contractors are located in the Denver Metro/Boulder Colorado area.

Step 1 Before making an appointment with a contracted Doctor, Dentist, Radiology or Mammogram office, please call the RPSC Medical Office to request your checklist be faxed to the providers. The fax authorizes the scheduling of your appointments as part of your PQ process.
Step 2 Call contracted providers and schedule your appointments.
Step 3 At the time of your appointments **you are REQUIRED to present your current health insurance card and complete health insurance information.**

BILLING INFORMATION
The offices of Dr. Katz, Dr. Harris, Dr. Anderson, ImageOne and Rose Breast Center will direct bill RPSC for authorized services provided.

You are free to go to the doctor or dentist of your choice. Do not instruct your doctor or dentist to bill RPSC directly. **You are responsible for paying all fees at the time of your visits.** You will then file for reimbursement from RPSC by submitting the Medical/Dental Expense Reimbursement Form in your medical packet along with the itemized bill from your doctor and/or dentist and your receipt of payment. 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, MD
Dana Coutts, P.A.
HealthMark
4700 East Iliff Avenue
Denver, CO 80222
Phone (303) 584-5844
Melanie Panton ~ appt scheduling ~ leave message on her voice mail

Dr. John Harris, MD
12150 E Briarwood Ave Ste 105
Englewood, CO 80112
Phone (303) 790-1999

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

RADIOLOGY

Image One
8101 E. Lowry Blvd Ste 120
Denver, CO 80230
Phone (303) 340-8439

MAMMOGRAMS

Rose Breast Center – Founders Building
4700 East Hale Parkway Ste 450
Denver, CO 80220
Phone Central Scheduling (303) 320-2568

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 Medical Deployment E-mail and Medical Deployment Packet for completing laboratory requirements. Additionally, the requirements are listed on the individual medical/dental checklist.

Visit www.labcorp.com for the nearest patient service center to your location; bring with you the LabCorp requisition sent to you via email. If a LabCorp center is not near your location, contact RPSC Medical to request a LabCorp Lab Kit, which 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.

Should you be completing your laboratory requirements outside the United States, please refer to form ME-DT-A-109 (titled "Required Laboratory Tests") in the Medical Deployment Packet. Lab results are to be forwarded to RPSC Medical.

2. Return of Examination/Tests: Please send the completed original medical history and physical examination forms, including requested test results, 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 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.

NATIONAL SCIENCE FOUNDATION

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….........		

NAME________________________________ DOB ______________________

Physical Examination

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

PHONE #:_______________________________________

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

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.

If you would like the HIV test and it is not on the LabCorp Requisition, please call RPSC Medical at 1-800-688-8606 ext 3.

If you 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[1]. 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.

[1] 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.

______________________________ ______________________________

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.

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)

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:

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16

RIGHT LEFT

32 31 30 29 28 27 26 25 24 23 22 21 20 19 18 17

PERIODONTAL EVALUATION

PROBINGS > 5 mm ☐ YES ☐ NO

ACTIVE DISEASE NOTED ☐ YES ☐ NO

THIRD MOLAR EVALUATION

3rd 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 ☐

NATIONAL SCIENCE FOUNDATION
4201 Wilson Boulevard
ARLINGTON, VIRGINIA 22230

OFFICE OF POLAR PROGRAMS

August 20, 2008

Dear Grantee,

Due to rising costs, we have eliminated the LabCorp service for centralized lab work required for deployment medical exams. Consequently, you must have the required lab work done in conjunction with your medical exam.

If the required tests are not covered by your employer or by your personal health insurance, you may pay for them from the grant as part of the medical exam costs that awards for field work contain. Contact your program officer if a supplement is required.

For additional information, please refer to your deployment medical packet or contact the Raytheon Polar Services Company Medical Department.

Sincerely,

Scott Borg
Director, Division of Antarctic Sciences

Michael Montopoli, MD, MPH
Head, Office of Polar Environment, Health, and Safety
Chief Medical Officer, US Antarctic Program

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 T
- 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) A
BO 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: ____ DOB:_______________
Last First MI

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

RPSC Form ME-DT-125, Medical Department, Revision #0, 28 April, 2008, All Locations, Approved by Emmett Ferguson M.D.

Technical Services Company LLC
Polar Services

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

To RPSC 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 occurs 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. Most health plans only allow one month of medication to be dispensed at a time. If you have 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 entire deployment.

To receive special shipping, medications must be addressed to the station address as below. Medications mailed to your name, will be sent as regular mail and not directly to the station medical clinics. 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.

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 pupiliary 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 is authorized to reimburse qualified USAP participants for out-of-pocket fees or approved medical and dental costs incurred while obtaining clearance for deployment to Antarctica. 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. The reimbursement amount will be the amount of the cost minus any insurance payment or discount. Please wait to submit your reimbursement until you have the final claims from your insurance carrier showing the balance due. You must pay this balance due in full before you can be reimbursed. RPSC is authorized to reimburse for dental exams and x-rays, but is **not authorized to reimburse for cleanings (prophylaxis) or work done on teeth**. RPSC is authorized to reimburse 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 plus lenses) **every other year.** RPSC is not authorized to reimburse for eye exams or non-prescription sunglasses. RPSC is only authorized to reimburse for prescription sunglasses/safety glasses after you are medically and dentally cleared for deployment and detailed receipts are attached. **Falsifying and/or fraudulent claims may result in penalties and disqualification from the United States Antarctic Program.**

USAP participants should complete and submit this form along with *ITEMIZED BILLS* showing full payment from the doctor/dentist/optometrist and any corresponding insurance provider information.

Medical	Amount	Dental	Amount
Physical Exam (Including EKG – 12 Lead)		Dental Examination	
Labs (required)		Bitewing X-rays	
Immunizations (Tetanus, Flu, etc.)		Panographic or Full Mouth X-Rays	
Tuberculin Skin Test - PPD		PA X-ray(s)	
Exercise Stress Test & Read			
HIV Test		**DENTAL TOTAL**	
Chest X-ray			
Mammogram			
GYN Exam (w/ Pap Smear)		**Rx Sunglasses / Safety Glasses**	**Amount**
Drug Screen			
Gallbladder U.S.		Rx Sunglasses – Frames + Lenses	
EKG / ECG			
Audiology / Hearing Test		Rx Safety Glasses – Frames + Lenses	
Pulmonary Function Test (Spirometry)			
Medical Misc. (list):			
MEDICAL TOTAL		**Rx Sunglasses/Safety Glasses TOTAL**	

MAILING ADDRESS to send check: ______________________________

____

SIGNATURE (Required): ______________________________

For RPSC use only:	**Amount**	**Approver**	**Date**
Total Reimbursement Due to Participant:			

Distribution	**Amount**	**WBS Charge Code:**	**GLA:**
> Medical	**$**	**R-PS___0-210A40___03BA**	**521099**
> Dental	**$**	**R-PS___0-210A40___03BA**	**521099**
> Rx Sun/Safety Glasses	**$**	**R-PS___0-210A40___03BD**	**521099**

MEDICAL/DENTAL AND PSYCHOLOGICAL MANUAL 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. Fulltime and Active RPSC employees must use WebTE (a web-based expense reporting system) to process their reimbursements. If, however, you are a candidate pending employment you have two options for reimbursement: 1) you can submit the expenses you incur using the manual paper expense report form ME-A-103 at least 30 days prior to your first day of employment or 2) you can retain your receipts and itemized bills and file during your Deployment Orientation in Denver or from Antarctica via WebTE. WebTE reimbursements are direct deposited. No direct deposit is available for manual expense statements and reimbursement may take 4-5 weeks.

IMPORTANT TIPS FOR SUBMITTING YOUR PQ REIMBURSEMENT EXPENSES:

MEDICAL:

1. 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.
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.
3. Please wait to submit your reimbursement until you have the final claims from your insurance showing the balance due.
4. 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 after any insurance coverage. **An invoice alone, showing the balance due with no indication of payment, does not satisfy the contract or audit requirement.** Be sure the amounts you have listed are able to be clearly identified on the supporting medical statements and receipts.
5. 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.

PSYCHOLOCIAL EVALUATION:

1. When traveling to Denver for your Psychological Test, the candidate will be reimbursed for 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 . 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 which may be required for reimbursement. Be sure the receipts are clear and dark enough to be faxed or scanned. Keep all receipts until you are reimbursed.
2. You will need to complete and sign a Manual Travel Expense Report (FI-A-521a). Submit expense report and all supporting receipts to: 7400 So Tucson Way, Centennial, CO 80112 ATTN: RPSC Finance or FAX to 1-720–895-0424
3. If you are currently an employee or contract employee with Raytheon, you must complete your expense report on WebTE. 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 .
4. 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. 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 Finance Department at 1-800-688-8606 or ExpenseReports@usap.gov.

Basic Steps in using WebTE:

1. Establish your Raytheon Directory Services password by calling 1-877-844-4712.
2. Convert all expenses to US dollars using 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. Contact Finance with any questions: 1-800-688-8606 or ExpenseReports@usap.gov