Department of the Interior

Wildland Firefighter Medical Standards Program

(DOI MSP)

Annual

Exam Packet

Examinee: If you are in Pending Further Evaluation or Not Cleared status, you are **NOT** authorized to take this exam. To verify a clearance statuses contact the DOI MSP at 1-888-286-2521.

PRIVACY ACT STATEMENT

Solicitation of this information is authorized by Section 552a of Title 5, United States Code, regarding records maintained on individuals; Section 3301 of Title 5, United States Code, regarding determination as to an individual's fitness for employment with regard to age, health, character, knowledge and ability; and Section 3312 of Title 5 United States Code, regarding waiver of physical qualifications for preference eligible. This form is used to collect medical information about individuals who are incumbents of positions in the Federal Government which require physical fitness testing and medical examinations, or individuals who have been selected for such a position contingent upon successful completion of physical fitness testing and medical examinations as a condition of their employment. The primary use of this information will be to determine the nature of a medical or physical condition that may affect safe and efficient performance of the work described. Additional potential routine uses of this information include using it to ensure fair and consistent treatment of employees and job applicants, to adjudicate requests to pass over preference eligible, or to adjudicate claims of discrimination under the Rehabilitation Act of 1973, as amended. Completion of this form is voluntary; however, failure to complete the form may result in no further consideration of an applicant, or a determination that an employee is no longer qualified for his or her position. In addition, incomplete, misleading, or untruthful information provided on the form may result in delays in processing the form for employment, termination of employment, or criminal sanction.

INSTRUCTIONS

Part A – Payment process to be completed by Agency Official requesting exam. The DOI MSP Government estimate for clinic review of part B and completion of part C is $180.

Part B – Medical History to be completed by Examinee – Complete Part B prior to the clinic medical examination. The examining clinician will use responses in this section to help identify medical conditions that may have bearing on the final clearance determination. In order to avoid potentially lengthy delays in the clearance process, the examinee should provide supporting medical documentation pertaining to any YES response in this section. Examinee should bring contact lenses or eyeglasses if applicable for the eye exam portion of exam. Hearing Aids are not permitted for use during the whisper test.

Part C – Medical Examination to be completed by the examining clinician. The required certification to review Part B – Medical History and complete Part C – Medical Examination is a Nurse Practitioner, Physician Assistant or Physician under a State Board of Medicine. NO ADDITIONAL MEDICAL DIAGONISTIC TESTING FOR PART C IS AUTHORIZED!

Part D – Clearance Determination – After part B and C of the exam are completed the clinician will make a determination on if the examinee meets the Federal Interagency Wildland Firefighter Standards based on the information provided. The examining clinician should use his or her clinical judgment whether items marked as YES in part B require further work up or clarification in lieu of any additional information provided or omitted. To further clarify, circumstances may exist so that additional medical information is not needed to make a reasonable medical determination that a condition is static and stable. In addition it should be reminded that not all ongoing medical conditions necessarily equate to failure to meet a specific standard. Signature of the examinee certifies that the information provided is complete and accurate; and that the examinee consents to the release of the exam to the reviewing Medical Review Official (MRO) and the employing agency.

<u>Cleared:</u> Based on the information provide in part B and C (and any additional medical information provided) of the Annual Exam the examinee meets the Federal Interagency Wildland Firefighter Standards and is cleared to perform the Essential Functions and Work Conditions of Arduous Wildland Firefighting duties.
<u>Not Cleared:</u> Based on the information provided in part B and C (and any additional medical information provided) the examinee does not meet one or more of the Federal Interagency Wildland Firefighter Standards and is Not Cleared to perform the Essential Functions and Work Conditions of Arduous Wildland Firefighting duties. If the Examinee does not provide sufficient pre-existing additional medical information at the time of examination the clinician should choose Not Cleared based on information provided. NO ADDITIONAL MEDICAL DIAGONISTIC TESTING IS AUTHORIZED!

Part A. PAYMENT PROCESS

The requesting Agency Official is responsible for negotiating the cost of the exam with the local clinic based on the government estimate and identifying one of the approved procurement processes below and advising the Examinee of the required actions. The DOI MSP is in no way responsible for the cost associated with the Annual Exam. Contact your local Wildland Fire Safety Program Manager (WFSPM) for charge code.

- ☐ SF 1164 Employee Reimbursement
- ☐ Examinee with Purchase Authority Government Credit Card
- ☐ Agency Official Purchase Authority Government Credit Card (Within prescribed annual limits)
- ☐ Blanket Purchase Authority (Contact your local contracting department)

The Examinee should not provide the clinic any information on their personal insurance to avoid clinics billing the Examinee.

Part B. MEDICAL HISTORY

Examinee complete Part B prior to the exam. If a YES answer is applicable to a question please provide supporting documentation to the clinician at the time of exam. For a complete list of the "Federal Interagency Wildland Firefighter Medical Standards" please visit; http://www.nifc.gov/medical_standards/Program/index.html

MENTAL HEALTH

Treatment for a mental or emotional condition? YES ☐ NO ☐

Diagnosis: _____
Date(s): _____
Is this a current problem? Details:_____
_____

Any history of drug or alcohol abuse or dependence? This includes any condition requiring or not requiring any formal evaluation or treatment.
YES ☐ NO ☐

Date(s): _____
Current status: _____
Have you ever been in rehabilitation? If yes, when? _____

VISION

Have you ever had any history of eye disease or eye conditions requiring surgery and or medical treatment?
YES ☐ NO ☐

Diagnosis: _____
Date(s): _____
Is this a current problem? Details:_____
_____

Do you suffer from any permanent or temporary loss of vision, blind spots, sensitivity to light, eye pain or any other visual disturbances not otherwise addressed in this section?
YES ☐ NO ☐

Diagnosis: _____
Date(s): _____
Is this a current problem? Details:_____
_____

Do you wear corrective lenses during firefighting?
YES ☐ NO ☐

Diagnosis: _____
Date(s): _____

I will carry a duplicate pair of glasses or contact lenses while firefighting;

Signature:_____

Are you colorblind?
YES ☐ NO ☐

Explain:_____
_____

DERMATOLOGY

Do you have any type of skin disease (other than acne)?
YES ☐ NO ☐

Diagnosis: _____
Is this a current problem? Details:_____

HEARING

Do you have any history of hearing loss, ringing in the ears or ear disease requiring medical treatment and or surgery?
YES ☐ NO ☐

Diagnosis: _____
Do you have difficulty hearing? Do you wear a hearing aid(s)?
Explain:_____
_____
_____

Have you ever had an eardrum perforation?

YES ☐ NO ☐

Explain:_____

_____

_____

VASCULAR

Do you have any history of vascular disease or had any conditions due to poor circulation or clots such as strokes, TIAs, blockages in the lung or heart, or other reasons to the hands or feet?

YES ☐ NO ☐

Diagnosis & Current status: _____

Date(s): _____

Details:_____

_____

_____

Do you have anemia or been told you have any issues with low blood counts?

YES ☐ NO ☐

Diagnosis what type of anemia? _____

Date(s): _____

Details Type of treatment:_____

Have you been diagnosed or been told you have high blood pressure?

YES ☐ NO ☐

Diagnosis: _____

Date(s): _____

Details: _____

CARDIAC

Have you ever had a heart attack, angioplasty or heart bypass surgery?

YES ☐ NO ☐

Diagnosis: _____

Date(s): _____

Details: _____

Do you have chest pain with physical exertion or at rest or have you ever been diagnosed with angina?

YES ☐ NO ☐

Date(s): _____

Diagnosis did you see a doctor? _____

What tests were done? (Give results) Treatment Details:_____

_____

Have you ever passed out, fainted, or lost consciousness?

YES ☐ NO ☐

Diagnosis: _____

Date(s): _____

Details: _____

Do you currently have or had problems in the past with an irregular heartbeat, palpitations, shortness of breath or been told you have a heart murmur or other cardiac condition not previously mentioned beforehand?

YES ☐ NO ☐

Diagnosis: _____

Date(s): _____

Is this a current problem? Details: _____

_____

_____

_____

MEDICATIONS & ALLERGIES

Do you currently take any medications (prescribed and/or over-the-counter, including herbal)?

YES ☐ NO ☐

List all medications, prescribed and over-the-counter, including herbal by name and reason for taking.

_____

_____

_____

Are you allergic to bee/wasp/hornet/fire ant/yellow jacket stings?

YES ☐ NO ☐

Diagnosis: _____
Date(s): _____
Please explain in detail any positive responses marked below: Swelling or itching at site of sting only, Swelling or itching at site(s) other than site, Hives, Anaphylactic shock, Blood pressure problems
_____
_____
Have you ever been advised by a physician to carry an EpiPen for yourself? _____

Do you have any other allergies?

YES ☐ NO ☐

List and describe reaction(s): _____

CHEST & RESPIRATORY

Have you ever had a positive PPD (TB) skin test or tuberculosis?

YES ☐ NO ☐

Positive PPD only? _____
Diagnosed with tuberculosis?_____
Did you receive any treatment? _____
Was a chest x-ray done? _____
Details:_____

Have you ever been diagnosed with sleep apnea?

YES ☐ NO ☐

Diagnosis & current status:_____
Date(s): _____
Have you ever been advised to use a CPAP machine or other treatments?
_____
_____

Have you ever had asthma?

YES ☐ NO ☐

Diagnosis: _____
Date(s) of last asthma attack: _____
Do you use an inhaler?
Details_____
Have you ever been hospitalized or been to the emergency room or doctor's office because of an asthma attack?
Details:_____
Does smoke, dust or exercise trigger your asthma?
Details:_____

Do you have any type of lung disease other than asthma (reactive airway disease, emphysema, COPD, collapsed lung, etc.)?

YES ☐ NO ☐

Diagnosis: _____
Date(s): _____
Have you used an inhaler within the past 2 years? Details give dates, name(s) of inhalers and frequency of use: _____
_____

ENDOCRINE

Do you have diabetes?

YES ☐ NO ☐

Diagnosis & Current status: _____
Diagnosis date: _____
Do you take insulin?_____Do you take pills for diabetes? _____
Average blood sugar reading: _____
Most recent Hgb A1c result and test date: _____
Any episodes of low blood sugar in the last 2 years?_____
Any heart disease, kidney disease, eye disease or neuropathy due to diabetes?_____

Do you have any thyroid disease?

YES ☐ NO ☐

Diagnosis & Current status: _____
Date(s): _____
Details:_____

Do you have any other endocrine disease?

YES ☐ NO ☐

Diagnosis & Current status: _____
Date(s): _____
Details:_____

KIDNEY/BLADDER

Do you have any type of kidney, bladder or prostate disease?

YES ☐ NO ☐

Diagnosis & Current status: _____
Date(s): _____
Details:_____

Do you have difficulty with urination or require any type of assistive equipment or medication to urinate such as catheterization? Have you ever or still require dialysis secondary to kidney disease?

YES ☐ NO ☐

Diagnosis & Current status: _____
Date(s): _____
Details:_____

MUSCULOSKELETAL

Do you have any history of arthritis, or other type of joint pain or swelling that has necessitated medical evaluation, rehabilitation or medication use or that has caused you to be physically limited in any way?

YES ☐ NO ☐

Diagnosis: _____
Date(s): _____
Details: _____

Do you have any history of muscle weakness, muscle loss, numbness or tingling in any limbs, or any muscular dysfunction related to congenital or accident induced conditions?

YES ☐ NO ☐

Date(s): _____
Diagnosis: (did you see a doctor?) _____
What tests were done? (Give results) Treatment Details:
_____
_____

Do you have any history of amputations or absence of any limbs, fingers or toes due to either accidents or congenital conditions? Do you have any condition requiring the use of any mechanical assistance device such as prosthesis, walkers, wheelchairs etc.?

YES ☐ NO ☐

Diagnosis: _____
Date(s): _____
Details:
_____
_____
_____
_____

Do you have any current or past history of neck or back pain that has necessitated a medical evaluation, rehabilitation or medication use or that has caused you to have a physical limitation in standing, bending, stooping, carrying or turning/moving your head or body in any way?

YES ☐ NO ☐

Diagnosis: _____
Date(s): _____
Details:_____
Location(s):_____
Severity (pain 1-10): _____
Frequency (daily, weekly, monthly)_____

Do you have any history or symptoms related to numbness, tingling, loss of sensation or strength, or pain in any of the extremities for any reason other than that which would be explained by the above.

YES ☐ NO ☐

Diagnosis: _____
Date(s): _____
Details: _____
_____
_____

GASTROINTESTINAL

Have you ever had any type of esophageal, stomach or intestinal disease?

YES ☐ NO ☐

Diagnosis & Current status: _____
Date(s): _____
Details: _____

Do you currently have a hernia or recent hernia repair?

YES ☐ NO ☐

Type of hernia? Inguinal (groin), Umbilical, Other _____
Is surgery planned or recommended? _____
Does your hernia cause pain or other symptoms? _____

Do you have hepatitis or have any other diagnosed liver disease?

YES ☐ NO ☐

Type of hepatitis: Type A Type B Type C
Other(explain) _____
_____
Date(s): _____
Current status (Details) _____

Do you have a colostomy or require any additional equipment or mediation in order to produce and eliminate stool in a safe and sanitary manner?

YES ☐ NO ☐

Diagnosis: _____
Date(s): _____
Details: _____
_____
_____

Have you ever had any blood in the stool or vomited blood?

YES ☐ NO ☐

Diagnosis & Current status: _____
Date(s): _____
Details: _____

OTHER

Do you have any medical condition not listed elsewhere on this questionnaire?

YES ☐ NO ☐

Diagnosis & Current status: _____
Date(s): _____
Details: _____

Part C. MEDICAL EXAM

Clinic Instructions

The Examinee will present this exam packet to your clinic Part A and B should be completed. If the Examinee answers YES to any question in Part B they should provide any supporting medical documentation. NO ADDITIONAL MEDICAL DIAGONISTIC TESTING FOR PART C IS AUTHORIZED! The examining clinician should review the responses to Part B, perform all elements of the Medical exam listed in Part C, and identify any abnormalities and consult the Federal Interagency Wildland Firefighter Medical Standards. For a complete list of standards please visit; http://www.nifc.gov/medical_standards/Program/index.html.

Clinic Checklist

- ✓ Review Part B for any YES answers and any supporting medical documentation provided by the examinee that would demonstrate a static and stable medical condition and provide comments.
- ✓ Complete Part C – Medical Exam NO ADDITIONAL MEDICAL DIAGONISTIC TESTING FOR PART C IS AUTHORIZED!
- ✓ Complete Part D – Clearance Determination Page
- ✓ Send the original Annual Exam Packet with the Examinee including Clearance Determination Page (all pages are required)

Clinic Frequently Asked Questions

Q. Are labs or diagnostic testing required with this examination?
A. No. No labs or diagnostic testing is conducted with this examination. Determination should be made by physical examination as well as any medical information provided by the patient.

Q. Why do the standards mention diagnostic testing if they are not necessary?
A. If the Examinee has a known medical condition that could affect their ability to perform arduous duty Wildland firefighting; they should bring in medical records from their primary clinician showing the current status of their medical condition(s). For example, if an examinee has diabetes they could bring in recent test results from their primary clinician showing their condition is static and stable.

Q. How does my clinic get paid for this examination?
A. Refer to Part A of the Annual Exam Packet. The following methods of payment are acceptable; SF 1164 Employee Reimbursement, Government Credit Card, and Blanket Purchase Authority (please contact local unit to arrange this). Do NOT bill the examinee's personal medical insurance.

Q. Where do we send the exam packet once completed?
A. The entire original exam packet should be sent with the Examinee, including the Clearance Determination Page. Do NOT fax or mail the exam packet back to the Department of the Interior Medical Standard Program.

Q. What if there isn't enough information to make a Clearance Determination?
A. If there isn't enough information to make a Clearance Determination based on Part B, C and additional information provided by the Examinee then the clinician should select the "Not Cleared" option.

Examination

Date of Exam:	Last Name:	First Name:
Weight:	Height:	Date of Birth:

Sex: M F	Pulse:	Blood Pressure (repeat if higher than 150/90):

Review Part B for any YES answers and any supporting medical documentation provided by the examinee that would demonstrate a stable and static medical condition and provide comments. Include all medications. Refer to the Federal Interagency Wildland Firefighter Medical Standards and the Essential Functions and Work Conditions of Arduous Duty Wildland Firefighter. Identify any medical condition(s) and standard(s) not met.

_____
_____
_____
_____
_____
_____
_____

General Appearance	Normal	Abnormal	Describe Abnormality
HEENT			
Eyes-general and retina			
Ears-tympanic membrane, patency			
Pupils-equality and reaction			
Nose and sinuses			
Mouth, throat and thyroid			
Teeth, dentures, temporary fillings			
General Structure-nose, jaw, mouth, ears			
CHEST & RESPIRATORY			
Observe- use of accessory muscles, rate			
Auscultation-rales, rhonchi, wheezes			
CARDIAC			
PMI			
Rate, rhythm, mummur			
GASTRONITESTINAL			
Abdominal wall			
Organs, pulsations, masses, sounds			
Scars			
MUSCULOSKELETAL			
Back/Neck-deformity, ROM, tenderness			
Joints- swelling, ROM, crepitus			
Muscle- tone, bulk, strength			

General Appearance	Normal	Abnormal	Describe Abnormality
NEUROLOGIC			
Cranial Nerves			
Peripheral- sensation, strength, reflex			
Coordination- FTN, rapid alternating move			
Gait, balance			
OTHER (Skin, Extremities & Mental Health)			
Integrity-rashes, bruises, scares, active lesion			
Hands, feet, arms, legs- swelling, color, pulses			
Memory, mood, suicidal, homicidal ideation			

Visual Acuity

Contact lenses and eyeglasses are acceptable for correction of visual acuity. Successful users of long-wear soft contact lenses are not required to meet the "uncorrected" vision standards. Far visual acuity uncorrected of at least 20/100 in each eye for wearers of hard contacts or eyeglasses; and far visual acuity of at least 20/40 in each eye corrected (if necessary) with contact lenses or eyeglasses.

Uncorrected vision (Snellen Units)	Corrected vision (Snellen Units)
Both Near 20/____ Right Near 20/____ Left Near 20/____	Both Near 20/____ Right Near 20/____ Left Near 20/____
Both Far 20/____ Right Far 20/____ Left Far 20/____	Both Far 20/____ Right Far 20/____ Left Far 20/____

Color Vision

Color vision sufficient to distinguish at least red, green, and amber (yellow)

Type of test

☐ Ishihara plate ☐ Function test (Yarn, wire, ect.) ☐ Other (Specify) _____

☐ Normal ☐ Abnormal Number of Correct: ____ of ____ tested

Can see Red/Green/Yellow? ☐ Yes ☐ No

Peripheral Vision

Peripheral vision of at least 85^{o} laterally in each eye

Left Nasal_____ degrees Temporal_____ degrees	Right Nasal_____ degrees Temporal_____ degrees

Depth Perception

Type of test

☐ Jaeger ☐ Shepard Fry ☐ Worth 4 Dot ☐ Stereo Other_____

Number of Correct: ____ of ____ tested ____ Seconds of Arc Interpretation: ☐ Normal ☐ Abnormal

Whisper Test for Hearing

The use of a hearing aid(s) to meet this standard is *not* permitted. Hearing standard is no greater than a 40 dB hearing loss. "*Test is performed in a quiet room with the examiner facing the ear to be tested. The other ear is blocked with the examiner's hand. A rough hearing test is then performed one foot from the patient's ear. If a patient cannot hear a whispered voice at one foot, he has at least a 30-decibel loss. This loss is 60 decibels if he cannot hear a spoken voice at one foot.*"

30 DBL Loss	60 DBL Loss
No ☐ Yes ☐	No ☐ Yes ☐

ADDITIONAL DOCUMENTATION

ESSENTIAL FUNCTIONS AND WORK CONDITIONS OF AN ARDUOUS DUTY WILDLAND FIREFIGHTER

Time/Work Volume	*Physical Requirements*	*Environment*	*Physical Exposures*
May include:			
• *long hours (minimum of 12 hour shifts)* • *irregular hours* • *shift work* • *time zone changes* • *multiple and consecutive assignments* • *pace of work typically set by emergency situations* • *ability to meet "arduous" level performance testing (the "Pack Test"), which includes carrying a 45 pound pack for 3 miles in 45 minutes, approximating an oxygen consumption (VO_2 max) of 45 mL/kg-minute* • *typically 14-day assignments* *But may extend up to 21-day assignments* • *for smokejumpers - ability to meet the minimum Smokejumper Fitness Test, which includes 1 ½ mile run in 11:00 minutes or less, 25 pushups, 7 pullups, 45 situps; and carry 110 lbs for 3 miles in 90 minutes or less.*	• *use shovel, Pulaski, and other hand tools to construct fire lines* • *lift and carry more than 50#* • *lifting or loading boxes and equipment* • *drive or ride for many hours* • *fly in helicopters and fixed wing airplanes* • *work independently, and on small and large teams* • *use PPE (includes hard hat, boots, eyewear, and other equipment)* • *arduous exertion* • *extensive walking, climbing* • *kneeling* • *stooping* • *pulling hoses* • *running* • *jumping* • *twisting* • *bending* • *rapid pull-out to safety zones* • *provide rescue or evacuation assistance* • *use of a fire shelter* • *for smokejumpers - lift and carry more than 100 lbs; perform parachute jumps, and perform parachute landings on uneven terrain*	• *very steep terrain* • *rocky, loose, or muddy ground surfaces* • *thick vegetation* • *down/standing trees* • *wet leaves/grasses* • *varied climates (cold/hot/wet/dry/humid/ snow/rain)* • *varied light conditions, including dim light or darkness* • *high altitudes* • *heights* • *holes and drop offs* • *very rough roads* • *open bodies of water* • *isolated/remote sites* • *no ready access to medical help*	• *light (bright sunshine, UV)* • *burning materials* • *extreme heat* • *airborne particulates* • *fumes, gases* • *falling rocks and trees* • *allergens* • *loud noises* • *snakes* • *insects/ticks* • *poisonous plants* • *trucks and other large equipment* • *close quarters, large numbers of other workers* • *limited/disrupted sleep* • *hunger/irregular meals* • *dehydration*

Part D. CLEARANCE DETERMINATION

Examinee Name: (Print Last, First, Middle Initial)_____
Address: (including City, State, Zip Code) _____
E-mail Address:_____
Telephone Number: (with Area Code) _____

I certify that all of the information I have provided during this exam and on this form is complete and accurate to the best of my knowledge, and that submitting information that is incomplete, misleading, or untruthful may result in termination, criminal sanctions, or delays in processing this form for employment. Furthermore, consistent with the Privacy Act Statement, I authorize the release to my employing agency of all information contained on this examination form, supporting documentation and forms generated as a direct result of my examination.

Examinee Signature: (Do not print) _____
Date: (month, day, and year) _____

Examining Clinician's Name and Title (Print):_____
The required certification to make a clearance determination is a Nurse Practitioner, Physician Assistant or Physician licensed under a State Board of Medicine.
Address (including City, State, Zip Code): _____
E-mail Address:_____
Telephone Numbers (with Area Code): _____

☐ **Cleared*** –Based on the information provide in part B,C and any additional medical information provided the examinee meets the Federal Interagency Wildland Firefighter Standards and is cleared to perform the Essential Functions and Work Conditions of Arduous Wildland Firefighting duties.

☐ **Not Cleared**** – Based on the information provided in part B, C and any additional medical information provided the examinee does not meet one or more of the Federal Interagency Wildland Firefighter Standards and is Not Cleared to perform the Essential Functions and Work Conditions of Arduous duties. Please list and describe the disqualifying medical condition(s):

Standard(s) Not Met: _____

Medical Condition(s):_____

*If the Examinee answers yes to any question in part B or has a exam finding outside of the listed standard criteria in part C Clinician MUST document in part C how examinee meets Federal Interagency Wildland Firefighter Medical Standards.

**If the Examinee checks yes to a question in part B and does not provide sufficient pre-existing additional medical information at the time of examination the clinician should choose Not Cleared based on information provided.

Examining Clinician's Signature (Do not print) _____
Date (month, day, and year): _____

All exams are subject to a Medical Review by the Department of Interior Medical Standards Program that could potentially change the Examinees clearance status.