

HEALTH SERVICES QUESTIONNAIRE

Application for Medical Qualification to Embark a NOAA Ship

Section I: Applicant Information					
Applicant Name (Last, First Middle)				Year of Birth	Today's Date
Office, Laboratory or Institution Name				Work Phone	<input type="checkbox"/>
Work Address				Cell Phone	<input type="checkbox"/>
City		State	Zip Code	Home Phone	<input type="checkbox"/>
E-mail Address				(Check one preferred contact phone number above)	
Emergency Contact Name			Relationship	Cell Phone	
Address		City	State	Zip Code	Home Phone
Project Dates	Start		End		
Project Ship(s)					
Position	<input type="checkbox"/> Scientist		<input type="checkbox"/> Contractor		<input type="checkbox"/> Other (specify below)
	<input type="checkbox"/> Teacher at Sea		<input type="checkbox"/> Volunteer		_____

Section II: Current Health Information – (provide additional information on page 4 if needed)					
List all health problems / medical conditions which regularly require a physician's attention.					
<input type="checkbox"/> None	1. _____				
	2. _____				
	3. _____				
	4. _____				
List all medications (prescription and non-prescription) you currently take.					
<input type="checkbox"/> None	1. _____		5. _____		
	2. _____		6. _____		
	3. _____		7. _____		
	4. _____		8. _____		
List all health problems / medical conditions which do not require a physician's attention or medication.					
<input type="checkbox"/> None	1. _____				
	2. _____				
	3. _____				
	4. _____				
List major surgeries, hospitalizations, and emergency room visits.					
<input type="checkbox"/> None	1. _____				
	2. _____				
	3. _____				
	4. _____				
List all known allergies and subsequent reactions.					
<input type="checkbox"/> None	Allergy		Reaction		
	1. _____		1. _____		
	2. _____		2. _____		
	3. _____		3. _____		

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Section III: General Screening

Indicate any medical condition experienced during adulthood.

Yes	No		Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy / Seizures
<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	Impaired Mobility
<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Severe Hearing Loss
<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	Severe Visual Impairment
<input type="checkbox"/>	<input type="checkbox"/>	Chronic Cough	<input type="checkbox"/>	<input type="checkbox"/>	Severe Motion Sickness
<input type="checkbox"/>	<input type="checkbox"/>	Severe Depression	<input type="checkbox"/>	<input type="checkbox"/>	Fainting / Loss of Consciousness
<input type="checkbox"/>	<input type="checkbox"/>	Untreated Dental Issues	<input type="checkbox"/>	<input type="checkbox"/>	Recent unexplained weight gain > 20 lbs
<input type="checkbox"/>	<input type="checkbox"/>	Currently Pregnant	<input type="checkbox"/>	<input type="checkbox"/>	Recent unexplained weight loss > 20 lbs

Explain any positive response(s) below.

Section IV: Cardiac Screening

Indicate any cardiac condition experienced during adulthood and the applicable test result.

Yes	No		Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	Abnormal EKG	<input type="checkbox"/>	<input type="checkbox"/>	Hypertension
<input type="checkbox"/>	<input type="checkbox"/>	Heart Attack	_____	_____	Recent Blood Pressure Reading
<input type="checkbox"/>	<input type="checkbox"/>	Shortness of Breath	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes
<input type="checkbox"/>	<input type="checkbox"/>	Chest Pain	_____	_____	Recent HbA1c Reading

Explain any positive response(s) below.

Section V: Immunization Screening

Indicate the applicable test result and the dates for the following screening and immunization;

1. Tuberculosis (TB) – A or B is required within the 12 months preceding the project end date.

A. Purified Protein Derivative-(PPD)	Result in mm _____	Date _____
B. QuantiFERON-TB	<input type="checkbox"/> Negative <input type="checkbox"/> Indeterminate <input type="checkbox"/> Positive	Date _____
2. Tetanus booster Date _____

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Section VI: Functional Abilities Screening

Indicate the ability to perform the following tasks.

Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	Step over a 24 inch high door sill
<input type="checkbox"/>	<input type="checkbox"/>	Walk on a steel deck for 4-8 hours per day
<input type="checkbox"/>	<input type="checkbox"/>	Stand on a steel deck for 4-8 hours per day
<input type="checkbox"/>	<input type="checkbox"/>	Walk on slippery or uneven walking surfaces
<input type="checkbox"/>	<input type="checkbox"/>	Climb stairs
<input type="checkbox"/>	<input type="checkbox"/>	Carry 15 lbs
<input type="checkbox"/>	<input type="checkbox"/>	Don a survival suit in less than one (1) minute
<input type="checkbox"/>	<input type="checkbox"/>	Ascend a rope ladder with rigid rungs
<input type="checkbox"/>	<input type="checkbox"/>	Descend a rope ladder with rigid rungs
<input type="checkbox"/>	<input type="checkbox"/>	Hear a ship's general alarm (hearing aid permitted)

Explain any negative response(s) below and indicate any medical condition or physical limitation which may adversely affect qualification for sea duty.

Section VII: Applicant Certification

I certify the information provided is true, accurate, and complete to the best of my knowledge. I acknowledge that falsification of any information on this government document is punishable by fine, imprisonment, or both.

Applicant Signature

Date

For assistance completing this form, contact;

- | | | |
|---|-----------------------|---------------------|
| 1. MOC-A Health Services in Norfolk, VA | Phone: (757) 441-6320 | Fax: (757) 441-3760 |
| 2. MOC-P Health Services in Newport, OR | Phone: (541) 867-8820 | Fax: (541) 867-8856 |

MOC Health Services Use Only

- Applicant is medically cleared for sea duty aboard a NOAA ship by history.
- Applicant is medically disqualified for sea duty aboard a NOAA ship by history.
- Additional information is needed to determine medical clearance for sea duty.

MOC Health Services Medical Officer Signature

Date

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Continuation Page

Use the space provided below to further explain any medical condition indicated on the previous pages.

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INSTRUCTIONS

The Health Services Questionnaire must be submitted to MOC Health Services 30 days in advance of the project start date. The form must be legible and complete. Unreadable or incomplete forms will be returned to the applicant. Late submissions may result in delayed qualification of sea duty past the project start date.

All positive responses in the General Screening and Cardiac Screening sections require a detailed explanation in the space provided. The Continuation Page may be used if more space is needed. An indication of hypertension requires the most recent blood pressure reading. An indication of diabetes requires the most recent glycosylated hemoglobin (HbA1c) reading.

All persons embarked aboard a NOAA ship must have a test for tuberculosis (TB) within the 12 months preceding the project end date. MOC Health Services accepts two tests to detect exposure to the TB bacteria; the Purified Protein Derivative (PPD or TB skin test) and the QuantiFERON-TB test (QFT or TB blood test). PPD results must be recorded in millimeters (mm) and not documented as positive or negative. QuantiFERON-TB results must be indicated as negative, positive, or indeterminate.

All persons embarked on a NOAA ship must be able to perform normal work functions and minimal personal emergency response functions while the ship is underway. During an abandon ship event, personnel may have to don a survival suit and/or descend a rope ladder to a life raft or rescue craft. Personnel deploying in small boats for operations may have to ascend and descend a rope ladder. A rope ladder (as pictured to the right) is a heavy duty ladder with rigid rungs that hangs over the side of the ship used for underway embarkation and disembarkation of personnel. A survival suit (as pictured to the right) is a full-body single-piece coverall designed to provide thermal protection to personnel immersed in water. A person at sea should be able to don a survival suit in one minute while fully clothed and without having to remove shoes. All negative responses in the Functional Abilities Screening section require additional explanation on the Continuation Page.



Sign and date the form in Section VII. Do not write in the "MOC Health Services Use Only" section. Use the Continuation Page to provide any additional information. Direct all questions regarding the information required on this form to the MOC Health Services Medical Officer at MOC-Atlantic (757) 441-6320 or MOC-Pacific (541) 867-8820.