

**FEDERAL INTERAGENCY
MEDICAL HISTORY, EXAMINATION, and CLEARANCE FORM for Wildland Firefighters (Arduous Duty)**

WHEN COMPLETED, THIS DOCUMENT CONTAINS CONFIDENTIAL MEDICAL INFORMATION AND IS SUBJECT TO THE PROVISIONS OF THE PRIVACY ACT (5 USC 552a)

GENERAL INSTRUCTIONS: A medical history and physical examination are to be conducted and this form completed every 5 years until age 45, then every three years. In those years in which a physical examination is not scheduled, the Annual Medical History and Clearance Form Wildland Firefighters (Arduous Duty) is to be completed.

SPO or FMO: a) fill-in the firefighter’s name on the top left corner when this form is given/sent to the firefighter, b) on a computer generated label or typewriter, enter the Personnel Office’s name, street address, city, state, zip code, telephone number, and e-mail address, c) on a computer generated label or typewriter, enter the Fire Management Officer’s name, street address, city, state, zip code, telephone number, and e-mail address, d) check the appropriate box(es) on page 3 to indicate whether this is a baseline (initial)/exit exam, or a periodic exam, and e) request an appointment for the firefighter through the Central Medical Consultant’s secure webpage – <http://cas.chsmedical.com>.

Firefighter: Prior to your appointment, please complete ALL of the **SHADED PORTIONS** of the following pages of this form, and take the entire packet directly to the PHYSICIAN/CLINIC provided to you by the Comprehensive Health Services (CHS) on the day of your scheduled examination. All “Yes” answers in the medical history sections of the form must be explained, and may require further information from your personal physician. You should arrive for your examination in a fasting condition (i.e., no food or drink other than prescribed medications during the 12 hours prior to having your blood drawn at the exam site).

Examining Physician: Please review the functional requirements and work conditions of wildland firefighters on page 2, perform a history review and physical exam, and complete all of the double-lined portions of the following form, including the indication of individual clearances beginning on page 10. NOTE: To avoid delays in processing this clearance, ALL examination findings other than “NORMAL” are to be described or explained in the spaces provided or on the back of the sheets. Individual history or examination items should NOT be considered to be “PASS/FAIL;” they should be used to contribute to your assessment of the firefighter as meeting or not meeting the specified standards. Do NOT communicate to the examinee an opinion of qualification. Qualification decision will made by Agency’s Central Medical Consultant (CMC). When the exam is complete, please return the form and any associated forms/reports to the address provided by the Central Medical Consultant via an overnight courier (e.g. Fed Ex).

Overnight Courier Completed Form to the Central Medical Consultant

Central Medical Consultant
Comprehensive Health Services, Inc.
8229 Boone Blvd, Suite 700
Vienna, Virginia 22182
800-638-8083

Personnel Office

Name _____
Street Address _____
City, State, Zip _____
Telephone Number _____
E-Mail _____

Fire Management Officer

Name _____
Street Address _____
City, State, Zip _____
Telephone Number _____
E-Mail _____

PRIVACY ACT INFORMATION

The information contained in this form will be used to determine whether an individual considered for arduous level wildland firefighting can safely and efficiently perform those duties in a manner that will not unduly risk aggravation, acceleration, exaggeration, or permanently worsening a pre-existing medical condition. Its collection and use are consistent with the provisions of the 5 CFR 339 (Medical Qualification Determinations), 5 USC 552a (Privacy Act of 1974), 5 USC 3301 (Examination, Certification, and Appointment), and Executive Orders 12107 (Merit Systems Protection Board) and 12564 (Drug Free Federal Workplace). The information will be placed in your official Employee Medical File and is to be used only for official purposes as explained and published annually in the Federal Register under OPM/GOVT-10, the OPM system of records notice.

**ESSENTIAL FUNCTIONS AND WORK CONDITIONS OF A
WILDLAND FIREFIGHTER**

Time/Work Volume	Physical Requirements	Environment	Physical Exposures
<i>May include:</i>			
<ul style="list-style-type: none"> • 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 3 miles in 45 minutes, approximating an oxygen consumption (VO₂ max) of 45 mL/kg-minute • typically 14-day assignments <i>but may extend up to 21-day assignments</i> 	<ul style="list-style-type: none"> • 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 fire shelter 	<ul style="list-style-type: none"> • 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 	<ul style="list-style-type: none"> • 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

Federal Interagency Medical History, Examination, and Clearance Form for Wildland Firefighters (Arduous Duty)

Firefighter: PRINT ONLY. Complete ALL of the shaded medical history portions of this form prior to your examination appointment, and explain all “Yes” answers.

Name, address, and phone number (including fax) of physician/ health center performing examination:	Name, address, and phone number (including fax) of Firefighter’s personal physician:	New Applicants ONLY: Previous experience as firefighter? Yes <input type="checkbox"/> No <input type="checkbox"/> Your Current Occupation: Your Current Employer: Time in Current Position (in years/months):
Firefighter’s Name:	Signature:	Gender: Male <input type="checkbox"/> Female <input type="checkbox"/>
Name of Employing Agency:	Position/Job Title:	Date of Birth:
Home Address: (Street or PO Box) (City, State, Zip)	Work Phone: () Home Phone: ()	SSN: Date of Scheduled Exam:

Incomplete forms or missing information may result in a delay clearing you for firefighter duties and prevent you from taking the Pack Test. Submitting information that is misleading or untruthful may result in termination or failure to be cleared as a firefighter. This history form and review do not substitute for routine health care or a periodic health examination conducted by your physician. It is being conducted for occupational purposes only. I certify that all of the information I have provided on this form is complete and accurate to the best of my knowledge. I authorize release of information within this form to the Interagency Medical Standards Program Manager or their representatives for the purpose of medical clearance as an arduous duty wildland firefighter.

Firefighter’s Signature:	Current Date:
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EXAMINING PHYSICIAN (Please provide the following exam, as marked, and check off the services that have been completed)

<input type="checkbox"/> BASELINE (INITIAL) / EXIT EXAM	<input type="checkbox"/> PERIODIC EXAM
Required Services: (Check the services when completed) <ul style="list-style-type: none"> <input type="checkbox"/> Medical History review <input type="checkbox"/> Physical Examination <input type="checkbox"/> Vision Screening (Corrected AND Uncorrected Near AND Far Visual Acuity; Color Vision; Peripheral Vision; Depth Perception) <input type="checkbox"/> Audiometry <input type="checkbox"/> Spirometry <input type="checkbox"/> CBC/Blood Chemistry with Lipids <input type="checkbox"/> TB Skin Test (Mantoux) <input type="checkbox"/> Routine Urinalysis <input type="checkbox"/> Standards Review 	Required Services: (Check the services when completed) <ul style="list-style-type: none"> <input type="checkbox"/> Medical History review <input type="checkbox"/> Physical Examination <input type="checkbox"/> Vision Screening (Corrected AND Uncorrected Near AND Far Visual Acuity; Color Vision; Peripheral Vision; Depth Perception) <input type="checkbox"/> Audiometry <input type="checkbox"/> Spirometry <input type="checkbox"/> Electrocardiogram (One time only after 40 years of age) <input type="checkbox"/> CBC/Blood Chemistry with Lipids <input type="checkbox"/> Routine Urinalysis <input type="checkbox"/> Standards review and Summary Statement

MEDICAL HISTORY

Smoking History

This information is needed since smoking increases your risk for lung cancer and several other types of cancer, chronic bronchitis, emphysema, asbestos related lung diseases, coronary heart disease, high blood pressure, and stroke. Please check your smoking status and complete the associated section:

<input type="checkbox"/> Current Smoker	Number of cigarettes per day _____ Number of cigars per day _____ Number of pipe bowls per day _____ Total years you have smoked _____	<input type="checkbox"/> Former Smoker	Number of cigarettes per day _____ Number of cigars per day _____ Number of pipe bowls per day _____ Total years you smoked _____	<input type="checkbox"/> Never Smoked
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Describe Your Physical Activity or Exercise Program

Type of Activity or Exercise _____

Intensity: (Examples:	Low _____ <i>Walking</i>	Moderate _____ <i>Jogging, cycling</i>	High _____ <i>Sustained heavy breathing and perspiration</i>	Duration, in Minutes per Session _____
				Frequency, in Days per Week _____

Medications (List all medications you are currently taking, including those prescribed and over-the-counter.)

Date of last Tetanus (Td) shot:

Check each item "Yes" or "No". Every item checked "Yes" must be explained in the space provided or on the back of this form.

- | | | |
|--|------------------------------|-----------------------------|
| A. Have you ever been treated with an organ transplant, prosthetic device (e.g., artificial hip), or an implanted pump (e.g., for insulin) or electrical device (e.g., cardiac defibrillator)? (If Yes, please describe fully, and provide copies of pertinent medical records.) | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| B. Have you had, or have you been advised to have, any operation? (If Yes, please describe fully) | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| C. Have you ever been a patient in any type of hospital after childhood? (If Yes, please describe fully) | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| D. Have you consulted or been treated by clinics, physicians, healers, or other practitioners within the past year for other than minor illnesses? (If Yes, please describe fully) | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| E. Have you ever been rejected for military service, or discharged from service, because of physical, mental, or other reasons? (If Yes, give date and reason for rejection or discharge.) | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| F. Have you ever had or been treated for a mental or emotional condition? (If Yes, please describe fully) | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| G. Have you ever been diagnosed with or treated for alcoholism or alcohol dependence? (If Yes, please describe fully) | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| H. Have you ever been diagnosed as being dependent on illegal drugs, or treated for drug abuse? (If Yes, please describe fully) | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| I. Have you ever received, is there pending, or have you applied for a pension or compensation for a disability? (If Yes, please describe fully) | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| J. Do you have any allergies, such as to Poison Oak, latex, pollen, dust? (If Yes, please list and describe fully.) | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

Comments/Findings

MEDICAL HISTORY	DIAGNOSTIC AND PHYSICAL FINDINGS	
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VISION

	Yes	No
Any eye disease?	<input type="checkbox"/>	<input type="checkbox"/>
Do you wear eyeglasses?	<input type="checkbox"/>	<input type="checkbox"/>
Do you wear contact lenses? Hard or Soft (circle one)	<input type="checkbox"/>	<input type="checkbox"/>
Do you have a history of frequent headaches?	<input type="checkbox"/>	<input type="checkbox"/>
Blurred vision?	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty reading?	<input type="checkbox"/>	<input type="checkbox"/>
Glaucoma?	<input type="checkbox"/>	<input type="checkbox"/>
Cataracts?	<input type="checkbox"/>	<input type="checkbox"/>
Color blindness?	<input type="checkbox"/>	<input type="checkbox"/>

Head and Neck

	Normal	Abnormal	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Head, Face, Neck (thyroid), Scalp
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Nose/Sinuses/Eustachian tube
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Mouth/Throat
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Pupils equal/reactive
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Ocular Motility
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Ophthalmoscopic Findings
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Speech

Visual Acuity

Uncorrected vision (Snellen Units)

Both Near 20/____ Right Near 20/____ Left Near 20/____

Both Far 20/____ Right Far 20/____ Left Far 20/____

Corrected vision (Snellen Units)

Both Near 20/____ Right Near 20/____ Left Near 20/____

Both Far 20/____ Right Far 20/____ Left Far 20/____

Peripheral Vision

At least 85° laterally each eye Yes No

If "No", comment on decreased peripheral vision in the Physician Comments/Findings section below.

Color Vision

Normal Abnormal Number Correct:

 ____ of ____ tested Can see Red/Green/Yellow? Yes No

Type of test

Ishihara plate Function test (Yarn, wire, etc.) Other (specify _____)

Depth Perception

Type of test: _____

Normal Abnormal Number Correct: ____ of ____ tested

Interpretation: ____ Seconds of Arc

Physician Comments/Findings

HEARING

	Yes	No
Any ear disease?	<input type="checkbox"/>	<input type="checkbox"/>
Loud, constant noise or music in the last 14 hours?	<input type="checkbox"/>	<input type="checkbox"/>
Loud, impact noise in past 14 hours?	<input type="checkbox"/>	<input type="checkbox"/>
Ringing in the ears?	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty hearing?	<input type="checkbox"/>	<input type="checkbox"/>
Ear infections or cold in the last 2 weeks?	<input type="checkbox"/>	<input type="checkbox"/>
Dizziness or balance problems?	<input type="checkbox"/>	<input type="checkbox"/>
Eardrum perforation?	<input type="checkbox"/>	<input type="checkbox"/>
Use of a hearing aid?	<input type="checkbox"/>	<input type="checkbox"/>
Use of protective hearing equipment when working around loud noise?	<input type="checkbox"/>	<input type="checkbox"/>

If yes, type(s): foam pre-mold/plugs ear muffs

Ears

	Right		Left	
	Normal	Abnormal	Normal	Abnormal
<input type="checkbox"/>				
<input type="checkbox"/>				
<input type="checkbox"/>				
	TM	Canal	TM	Canal
	Pinna	Pinna	Pinna	Pinna

Comments/Findings

<p>HEARING (continued)</p> <p>Prior military service? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Prior ear surgery? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Recurrent ear infections? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>		<p>Hearing</p> <p>Audiogram: (Must be done <u>without</u> hearing aid, and must meet OSHA standard for testing [see 29 CFR 1910.95].)</p> <p>Calibration Method: <input type="checkbox"/> Oscar <input type="checkbox"/> Biological Date _____</p> <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:10%;">Frequency</td> <td style="width:10%;">500Hz</td> <td style="width:10%;">1000Hz</td> <td style="width:10%;">2000Hz</td> <td style="width:10%;">3000Hz</td> <td style="width:10%;">4000Hz</td> <td style="width:10%;">6000Hz</td> <td style="width:10%;">8000Hz</td> </tr> <tr> <td>Right Ear</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>Left Ear</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> </table>	Frequency	500Hz	1000Hz	2000Hz	3000Hz	4000Hz	6000Hz	8000Hz	Right Ear								Left Ear								
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Left Ear																											
<p>DERMATOLOGY</p> <p>Any skin disease? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Sun sensitivity? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>History of chronic dermatitis? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Active skin disease? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Moles that have changed in size or color? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>		<p>Skin</p> <p>Normal <input type="checkbox"/> Abnormal <input type="checkbox"/></p>	<p><u>Comments/Findings</u></p>																								
<p>VASCULAR</p> <p>Any vascular disease? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Enlarged superficial veins, phlebitis, or blood clots? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Anemia? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Hardening of the arteries? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>High Blood Pressure? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Stroke or Transient Ischemic Attack (TIA)? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Aneurysms (Dilated arteries)? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Poor circulation to hands and feet? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>White fingers when cold or with vibration? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>		<p>Vascular</p> <p>Normal <input type="checkbox"/> Abnormal <input type="checkbox"/></p> <p><input type="checkbox"/> Major blood vessels, including femoral pulses</p> <p><input type="checkbox"/> Peripheral blood vessels</p> <p>Cardiac</p> <p>Normal <input type="checkbox"/> Abnormal <input type="checkbox"/></p> <p><input type="checkbox"/> EKG (baseline) - Attach printout and interpretation</p> <p><input type="checkbox"/> Heart</p>	<p style="text-align: center;">Vital Signs</p> <p>Height _____ (inches) Weight _____ (pounds)</p> <p>Blood Pressure _____ / _____ mm/hg (Measure while sitting; if elevated, repeat in 15 min.)</p> <p>Pulse _____ /min</p> <p>Respirations _____ /min</p> <p>Temp(if indicated) _____ °F</p>																								
<p>HEART</p> <p>Any heart disease or heart murmurs? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Heart or chest pain (angina), with or without exertion? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Heart rhythm disturbance or palpitations (irregular beat)? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>History of Heart Attack? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Organic heart disease (including prosthetic heart valves, mitral stenosis, heart block, heart murmur, mitral valve prolapse, pacemakers, Wolf Parkinson White (WPW) Syndrome, etc.)? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Heart surgery? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Sudden loss of consciousness? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>		<p>Cardiac Risk Profile</p> <p>Chol _____ HDL _____ LDL _____ Trig _____</p> <p>Gluc _____</p> <p><u>Comments/Findings</u></p>	<p style="text-align: center;">Coronary Risk Factors*</p> <table style="width:100%;"> <tr> <td></td> <td style="text-align: center;">Yes</td> <td style="text-align: center;">No</td> </tr> <tr> <td>Blood Pressure ≥ 140/90</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Diabetes, or Fasting Glucose ≥ 126 mg/dl (Completed by CMC)</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Total Chol. > 200 mg/dl, or HDL < 35 mg/dl (Completed by CMC)</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Family history of CVD in males < 55</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Age (men > 45, women > 55)</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>No regular exercise program</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Current smoker</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> </table> <p><small>*ACSM Guidelines for Ex. Testing and Presc., 5th Ed., and National Institute of Diabetes and Digestive and Kidney Dis.</small></p>		Yes	No	Blood Pressure ≥ 140/90	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes, or Fasting Glucose ≥ 126 mg/dl (Completed by CMC)	<input type="checkbox"/>	<input type="checkbox"/>	Total Chol. > 200 mg/dl, or HDL < 35 mg/dl (Completed by CMC)	<input type="checkbox"/>	<input type="checkbox"/>	Family history of CVD in males < 55	<input type="checkbox"/>	<input type="checkbox"/>	Age (men > 45, women > 55)	<input type="checkbox"/>	<input type="checkbox"/>	No regular exercise program	<input type="checkbox"/>	<input type="checkbox"/>	Current smoker	<input type="checkbox"/>	<input type="checkbox"/>
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<p>RESPIRATORY</p> <p>Any respiratory disease? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Asthma(including exercise induced asthma)? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Use of inhalers? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Bronchitis or emphysema? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Shortness of breath with exertion? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Acute or chronic lung infections? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Excessive, unexplained fatigue? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Collapsed lung? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Scoliosis (curved spine)? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>History of Tuberculosis? Previous positive TB skin test? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Date: _____</p>	<p><u>Pulmonary Function Testing</u></p> <p>Calibration Date: (should be same day as test)</p> <p>Machine Brand: _____</p> <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:25%;">Actual FVC</td> <td style="width:25%;">Actual FEV1</td> <td style="width:25%;">Actual FEV1/FVC</td> <td style="width:25%;">Actual FEF 25-75</td> </tr> <tr> <td> </td> <td> </td> <td> </td> <td> </td> </tr> <tr> <td>%Predicted FVC</td> <td>%Predicted FEV1</td> <td>%Predicted FEV1/FVC</td> <td>%Predicted FEF 25-75</td> </tr> <tr> <td> </td> <td> </td> <td> </td> <td> </td> </tr> </table> <p><u>Respiratory</u></p> <p>Normal <input type="checkbox"/> Abnormal <input type="checkbox"/> Lungs/Chest</p>	Actual FVC	Actual FEV1	Actual FEV1/FVC	Actual FEF 25-75					%Predicted FVC	%Predicted FEV1	%Predicted FEV1/FVC	%Predicted FEF 25-75					<p>TB Mantoux (PPD) Date: _____</p> <p>mm Induration: _____</p> <p>_____ <u>Comments: Findings</u></p>
Actual FVC	Actual FEV1	Actual FEV1/FVC	Actual FEF 25-75															
%Predicted FVC	%Predicted FEV1	%Predicted FEV1/FVC	%Predicted FEF 25-75															
<p>ENDOCRINE</p> <p>Any endocrine disease? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Diabetes (insulin requiring; units per day _____)* Year diagnosed _____</p> <p>Diabetes (non-insulin requiring)* Year diagnosed _____</p> <p>Thyroid Disease? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Obesity? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Unexplained weight loss or gain? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><small>*Further information should be provided from your personal physician regarding adequacy of control (e.g., HbA1c results), and any complications (e.g., retinopathy).</small></p>	<p>OBSTETRIC Yes <input type="checkbox"/> No <input type="checkbox"/> Male/Not Applicable <input type="checkbox"/></p> <p>Are you pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Male/Not Applicable <input type="checkbox"/></p>	<p>_____ <u>Comments/Findings</u></p>																
<p>MUSCULOSKELETAL</p> <p>Any musculoskeletal disease? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Moderate to severe joint pain, arthritis, tendonitis? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Amputations? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Loss of use of arm, leg, fingers, or toes? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Loss of sensation? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Loss of strength? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Loss of coordination? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Chronic back pain? (back pain associated with neurological deficit or leg pain) <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Are you RIGHT <input type="checkbox"/> or LEFT <input type="checkbox"/> handed (check one)?</p>	<p><u>Musculoskeletal</u></p> <p>Normal <input type="checkbox"/> Abnormal <input type="checkbox"/></p> <p><input type="checkbox"/> Upper extremities (strength)</p> <p><input type="checkbox"/> Upper extremities (range of motion)</p> <p><input type="checkbox"/> Lower extremities (strength)</p> <p><input type="checkbox"/> Lower extremities (range of motion)</p> <p><input type="checkbox"/> Feet</p> <p><input type="checkbox"/> Hands</p> <p><input type="checkbox"/> Grip strength</p> <p><input type="checkbox"/> Spine, other musculoskeletal</p> <p><input type="checkbox"/> Flexibility of neck, back, spine, hips</p>	<p>_____ <u>Comments/Findings</u></p>																

<p>NEUROLOGICAL</p> <p>Any neurological disease? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Head/spine surgery? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Tremors, shakiness? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Seizures (current or previous)? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Spinal Cord Injury? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Numbness or tingling? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>History of head trauma with persistent problem? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Chronic recurring headaches (migraine)? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>History of brain tumor? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Loss of memory? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Insomnia (difficulty sleeping)? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>Neurological</p> <p>Normal <input type="checkbox"/> Abnormal <input type="checkbox"/></p> <p><input type="checkbox"/> Cranial Nerves (I - XII)</p> <p><input type="checkbox"/> Cerebellum</p> <p><input type="checkbox"/> Motor/Sensory (include vibratory and proprioception)</p> <p><input type="checkbox"/> Deep Tendon reflexes</p> <p><input type="checkbox"/> Mental Status Exam</p>	<p><u>Comments/Findings</u></p>
<p>GASTROINTESTINAL</p> <p>Any gastrointestinal disease? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Hernias? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Colostomy? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Persistent Stomach/Abdominal Pain? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Hepatitis, or other liver disease? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Active ulcer disease? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Irritable bowel syndrome? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Rectal bleeding? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Vomiting blood? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>Gastrointestinal</p> <p>Normal <input type="checkbox"/> Abnormal <input type="checkbox"/></p> <p><input type="checkbox"/> Auscultation</p> <p><input type="checkbox"/> Palpation</p> <p><input type="checkbox"/> Organo-megaly?</p> <p><input type="checkbox"/> Tenderness?</p> <p><input type="checkbox"/> Hernia?</p>	<p><u>Comments/Findings</u></p>
<p>GENTOURINARY</p> <p>Any genitourinary disease? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Blood in urine? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Kidney Stones? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Difficult or painful urination? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Infertility (difficulty having children)? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>Genitourinary</p> <p>Normal <input type="checkbox"/> Abnormal <input type="checkbox"/></p> <p><input type="checkbox"/> Urogenital exam (Note: this clearance exam <i>does not</i> require a pelvic exam or Pap smear for females, or a rectal or prostate exam for males)</p>	<p><u>Comments/Findings</u></p>

INDIVIDUAL STANDARDS, FOR EXAMINING PHYSICIAN REVIEW AND COMMENT

STANDARDS	Based upon the information available to you, does the examined firefighter appear to meet the:
<p><u>PSYCHIATRIC STANDARD</u> The applicant/incumbent must have judgement, mental functioning, and social interaction/behavior that will provide for the safe and efficient conduct of the requirements of the job. This may be demonstrated by:</p> <ul style="list-style-type: none"> • No evidence by physical examination and medical history of current psychiatric conditions (including alcohol or substance dependence or abuse) likely to present a safety risk or to worsen as a result of carrying out the essential functions of the job (see page 2). 	<p><u>PSYCHIATRIC STANDARD</u></p> <p><input type="checkbox"/> YES <input type="checkbox"/> NO (If "No", please fully explain)</p>
<p><u>PROSTHETICS, TRANSPLANTS, AND IMPLANTS STANDARD</u> The presence or history of organ transplantation or use of prosthetics or implants are not of themselves disqualifying. However, the applicant/incumbent must be able to safely and efficiently carry out the requirements of the job. This may be demonstrated by:</p> <ul style="list-style-type: none"> • No evidence by physical examination and medical history that the transplant, the prosthesis, the implant, or the conditions that led to the need for these treatments are likely to present a safety risk or to worsen as a result of carrying out the essential functions of the job (see page 2). <p>Note: For individuals with transplants, prosthetics, or implanted pumps or electrical devices, the firefighter will have to provide <u>for agency review</u> documentation from his/her surgeon or physician that the individual (and, if applicable, his/her prosthetic or implanted device) is considered to be fully cleared for the specified functional requirements of wildland fire fighting.</p>	<p><u>PROSTHETICS, TRANSPLANTS, AND IMPLANTS STANDARD</u></p> <p><input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> Not Applicable (If "No", please fully explain)</p>
<p><u>IMMUNE SYSTEM/ALLERGIC DISORDERS STANDARD</u> The applicant/incumbent must be free of communicable diseases, have a healthy immune system, and be free of significant allergic conditions in order to safely and efficiently carry out the requirements of the job. This may be demonstrated by:</p> <ul style="list-style-type: none"> • A general physical exam of all major body systems that is within the range of normal variation, including: <ul style="list-style-type: none"> no evidence of current communicable disease that would be expected to interfere with the safe and effective performance of the requirements of the job; and no evidence of current communicable disease that would be expected to pose a threat to the health of any co-workers or the public; and • Normal complete blood count, including white blood count and differential; and • Current vaccination status for tetanus; and • No evidence by physical examination and medical history of infectious disease, immune system, or allergy conditions likely to present a safety risk or to worsen as a result of carrying out the essential functions of the job (see page 2). 	<p><u>IMMUNE SYSTEM/ALLERGIC DISORDERS STANDARD</u></p> <p><input type="checkbox"/> YES <input type="checkbox"/> NO (If "No", please fully explain)</p>

<p><u>MEDICATION STANDARD</u> The need for and use of prescribed or over-the-counter medications are not of themselves disqualifying. However, there must be no evidence by physical examination, laboratory tests, or medical history of any impairment of body function or mental function and attention due to medications that are likely to present a safety risk or to worsen as a result of carrying out the specified functional requirements. Each of the following points should be considered:</p> <ol style="list-style-type: none"> 1. Medication(s) (type and dosage requirements) 2. Potential drug side effects 3. Drug-drug interactions 4. Adverse drug reactions 5. Drug toxicity or medical complications from long-term use 6. Drug-environmental interactions 7. Drug-food interactions 8. History of patient compliance 	<p><u>MEDICATION STANDARD</u></p> <p><input type="checkbox"/> YES <input type="checkbox"/> NO (If “No”, please fully explain)</p>
<p><u>VISION STANDARD</u> The applicant/incumbent must be able to see well enough to safely and efficiently carry out the requirements of the job. This requires binocular vision, far visual acuity, depth perception, peripheral vision, and color vision, which may be demonstrated by:</p> <ul style="list-style-type: none"> • Far visual acuity uncorrected of at least 20/100 in each eye for wearers of hard contacts or spectacles; and • Far visual acuity of at least 20/40 in each eye corrected (if necessary) with contact lenses or spectacles; and • Color vision sufficient to distinguish at least red, green, and amber (yellow); and • Peripheral vision of at least 85° laterally in each eye; and • Normal depth perception; and • No ophthalmologic condition that would increase ophthalmic sensitivity to bright light, fumes, or airborne particulates, or susceptibility to sudden incapacitation. <p>Note: Contact lenses and spectacles are acceptable for correction of visual acuity, but the user must be able to demonstrate that the corrective device(s) can be worn safely and for extended periods of time without significant maintenance, as well as being worn with any necessary personal protective equipment. Successful users of long-wear soft contact lenses are not required to meet the “uncorrected” vision guideline.</p>	<p><u>VISION STANDARD</u></p> <p><input type="checkbox"/> YES <input type="checkbox"/> NO (If “No”, please fully explain)</p>
<p><u>HEAD, NOSE, MOUTH, THROAT AND NECK STANDARD</u> The applicant/incumbent must have structures and functions of the head, nose, mouth, throat, and neck that are sufficient for the firefighter to safely and efficiently carry out the requirements of the job. This may be demonstrated by:</p> <ul style="list-style-type: none"> • A physical exam of the head, nose, mouth, throat, and neck that is within the range of normal variation, including: <ul style="list-style-type: none"> normal flexion, extension, and rotation of the neck; and open nasal and oral airways; and unobstructed Eustachian tubes; and no structural abnormalities that would prevent the normal use of a hard hat and protective eyewear; and • Normal conversational speech; and • No evidence by physical examination and medical history of head, nose, mouth, throat, or neck conditions likely to present a safety risk or to worsen as a result of carrying out the essential functions of the job (see page 2). 	<p><u>HEAD, NOSE, MOUTH, THROAT AND NECK STANDARD</u></p> <p><input type="checkbox"/> YES <input type="checkbox"/> NO (If “No”, please fully explain)</p>

<p><u>HEARING STANDARD</u> The applicant/incumbent must be able to hear well enough to safely and efficiently carry out the requirements of the job. This requires binaural hearing (to localize sounds) and auditory acuity, which may be demonstrated by:</p> <ul style="list-style-type: none"> • A current pure tone, air conduction audiogram, using equipment and a test setting which meet the standards of the American National Standards Institute (see 29 CFR 1910.95); and • Documentation of hearing thresholds of no greater than 40 dB at 500, 1000, 2000, and 3000 Hz in each ear; and • No evidence by physical examination and medical history of ear conditions (external, middle, or internal) likely to present a safety risk or to worsen as a result of carrying out the essential functions of the job. <p>Note: The use of a hearing aid(s) to meet this standards is <i>not</i> permitted.</p>	<p><u>HEARING STANDARD</u></p> <p><input type="checkbox"/> YES <input type="checkbox"/> NO (If “No”, please fully explain)</p>
<p><u>DERMATOLOGY STANDARD</u> The applicant/incumbent must have skin that is sufficient for the firefighter to safely and efficiently carry out the requirements of the function. This may be demonstrated by:</p> <ul style="list-style-type: none"> • A physical exam of the skin that is within the range of normal variation; and • No evidence by physical examination and medical history of dermatologic conditions likely to present a safety risk or to worsen as a result of carrying out the essential functions of the job (see page 2). 	<p><u>DERMATOLOGY STANDARD</u></p> <p><input type="checkbox"/> YES <input type="checkbox"/> NO (If “No”, please fully explain)</p>
<p><u>VASCULAR SYSTEM STANDARD</u> The applicant/incumbent must have a vascular system that is sufficient for the firefighter to safely and efficiently carry out the requirements of the job. This may be demonstrated by:</p> <ul style="list-style-type: none"> • A physical exam of the vasculature of the upper and lower extremities that is within the range of normal variation, including: <ul style="list-style-type: none"> no evidence of phlebitis or thrombosis; and no evidence of venous stasis; and no evidence of arterial insufficiency; and • No evidence by physical examination and medical history of peripheral vasculature conditions likely to present a safety risk or to worsen as a result of carrying out the essential functions of the job (see page 2). 	<p><u>VASCULAR SYSTEM STANDARD</u></p> <p><input type="checkbox"/> YES <input type="checkbox"/> NO (If “No”, please fully explain)</p>
<p><u>CARDIAC STANDARD</u> The applicant/incumbent must have a cardiovascular system that is sufficient for the firefighter to safely and efficiently carry out the requirements of the job. This may be demonstrated by:</p> <ul style="list-style-type: none"> • A physical exam of the cardiovascular system that is within the range of normal variation, including: <ul style="list-style-type: none"> blood pressure of less than or equal to 140 mmHg systolic and 90 mmHg diastolic; and if taken, a normal baseline electrocardiogram (minor, asymptomatic arrhythmias may be acceptable); and no pitting edema in the lower extremities, and normal cardiac exam. • No evidence by physical examination and medical history of cardiovascular conditions likely to present a safety risk or to worsen as a result of carrying out the essential functions of the job (see page 2). 	<p><u>CARDIAC STANDARD</u></p> <p><input type="checkbox"/> YES <input type="checkbox"/> NO (If “No”, please fully explain)</p>

<p><u>CHEST AND RESPIRATORY SYSTEM STANDARD</u></p> <p>The applicant/incumbent must have a respiratory system that is sufficient for the firefighter to safely and efficiently carry out the requirements of the job. This may be demonstrated by:</p> <ul style="list-style-type: none"> • A physical exam of the respiratory system that is within the range of normal variation; and • A pulmonary function test (baseline exam) showing: <ul style="list-style-type: none"> forced vital capacity (FVC) of at least 70% of the predicted value; and forced expiratory volume at 1 second (FEV1) of at least 70% of the predicted value; and the ratio FEV1/FVC of at least 70% of the predicted value; and • No evidence by physical examination and medical history of respiratory conditions likely to present a safety risk or to worsen as a result of carrying out the essential functions of the job (see page 2). <p>Note: The requirement to use an inhaler (such as for asthma) requires agency review.</p>	<p><u>CHEST AND RESPIRATORY SYSTEM STANDARD</u></p> <p><input type="checkbox"/> YES <input type="checkbox"/> NO (If "No", please fully explain)</p>
<p><u>ENDOCRINE AND METABOLIC SYSTEMS STANDARD</u></p> <p>Any excess or deficiency in hormonal production can produce metabolic disturbances affecting weight, stress adaptation, energy production, and a variety of symptoms or pathology such as elevated blood pressure, weakness, fatigue and collapse. The applicant/incumbent must have endocrine and metabolic functions that are sufficient for the firefighter to safely and efficiently carry out the requirements of the job. This may be demonstrated by:</p> <ul style="list-style-type: none"> • A physical exam of the skin, thyroid, and eyes that is within the range of normal variation; and • Normal fasting blood sugar level; and • Normal blood chemistry results; and • No evidence by physical examination (including laboratory testing) and history of endocrine/metabolic conditions likely to present a safety risk or to worsen as a result of carrying out the essential functions of the job (see page 2). 	<p><u>ENDOCRINE AND METABOLIC SYSTEMS STANDARD</u></p> <p><input type="checkbox"/> YES <input type="checkbox"/> NO (If "No", please fully explain)</p>
<p><u>THE CONDITION OF PREGNANCY</u></p> <p>If a female applicant or incumbent raises the issue of pregnancy as the basis for a request for a special benefit, a change in duty status, or job restrictions, then justification and clarifying information for that request must be provided by the woman's obstetrician or primary care physician, along with the estimated time period the special conditions are expected to apply.</p>	
<p><u>HEMATOPOIETIC SYSTEM STANDARD</u></p> <p>The applicant/incumbent must have a hematopoietic (blood and blood-producing) system that is sufficient for the firefighter to safely and efficiently carry out the requirements of the job. This may be demonstrated by:</p> <ul style="list-style-type: none"> • A physical exam of the skin that is within the range of normal variation; and • A complete blood count (including hemoglobin, hematocrit, platelets, and white blood count, with differential) that is within the normal range; and • No evidence by physical examination (including laboratory testing) and medical history of hematopoietic conditions likely to present a safety risk or to worsen as a result of carrying out the essential functions of the job (see page 2). 	<p><u>HEMATOPOIETIC SYSTEM STANDARD</u></p> <p><input type="checkbox"/> YES <input type="checkbox"/> NO (If "No", please fully explain)</p>

<p><u>MUSCULOSKELETAL SYSTEM STANDARD</u> The applicant/incumbent must have a musculoskeletal system that is sufficient for the firefighter to safely and efficiently carry out the functional requirements of the job. This may be demonstrated by:</p> <ul style="list-style-type: none"> • A physical exam of the upper and lower extremities, neck, and back that is within the range of normal variation for strength, flexibility, range of motion, and joint stability; and • No evidence by physical examination and medical history of musculoskeletal conditions likely to present a safety risk or to worsen as a result of carrying out the essential functions of the job (see page 2). <p>Note: For individuals who require the use of a prosthetic device, the firefighter will have to provide <u>for agency review</u> documentation from his/her surgeon or physician that the individual (and, if applicable, his/her prosthetic device) is considered to be fully cleared for the essential functions of the job.</p>	<p><u>MUSCULOSKELETAL SYSTEM STANDARD</u></p> <p><input type="checkbox"/> YES <input type="checkbox"/> NO (If "No", please fully explain)</p>
<p><u>CENTRAL AND PERIPHERAL NERVOUS SYSTEM STANDARD, AND VESTIBULAR SYSTEM STANDARD</u> The applicant/incumbent must have a nervous system that is sufficient for the firefighter to safely and efficiently carry out the requirements of the job. This may be demonstrated by:</p> <ul style="list-style-type: none"> • A physical exam of the cranial and peripheral nerves and the vestibular and cerebellar system that is within the range of normal variation, including: <ul style="list-style-type: none"> intact cranial nerves, I-XII; and normal vibratory sense in the hands and feet; and normal proprioception of the major joints; and normal sensation of hot and cold in the hands and feet; and normal sense of touch in the hands and feet; and normal reflexes of the upper and lower extremities; and normal balance (e.g., heel-toe walk; Romberg; balance on one foot); and • Normal basic mental status evaluation (e.g., person, place, time, current events); and • No evidence by physical examination and medical history of nervous, cerebellar, or vestibular system conditions likely to present a safety risk or to worsen as a result of carrying out the essential functions of the job (see page 2). 	<p><u>CENTRAL AND PERIPHERAL NERVOUS SYSTEM STANDARD, AND VESTIBULAR SYSTEM STANDARD</u></p> <p><input type="checkbox"/> YES <input type="checkbox"/> NO (If "No", please fully explain)</p>
<p><u>GASTROINTESTINAL SYSTEM STANDARD</u> The applicant/incumbent must have a gastrointestinal tract that is sufficient for the firefighter to safely and efficiently carry out the requirements of the job. This may be demonstrated by:</p> <ul style="list-style-type: none"> • A physical exam and evaluation of the gastrointestinal tract that is within the range of normal variation; and • Normal liver function and blood chemistry laboratory tests; and • No evidence by physical examination (including laboratory testing) and medical history of gastrointestinal conditions likely to present a safety risk or to worsen as a result of carrying out the essential functions of the job (see page 2). 	<p><u>GASTROINTESTINAL SYSTEM STANDARDS</u></p> <p><input type="checkbox"/> YES <input type="checkbox"/> NO (If "No", please fully explain)</p>
<p><u>GENITOURINARY SYSTEM STANDARD</u> The applicant/incumbent must have a genitourinary system that is sufficient for the firefighter to safely and efficiently carry out the requirements of the job. This may be demonstrated by:</p> <ul style="list-style-type: none"> • A normal clean catch urinalysis; and • No evidence by physical examination and medical history of genitourinary conditions likely to present a safety risk or to worsen as a result of carrying out the essential functions of the job (see page 2). 	<p><u>GENITOURINARY SYSTEM STANDARDS</u></p> <p><input type="checkbox"/> YES <input type="checkbox"/> NO (If "No", please fully explain)</p>

Examining Physician's Signature: _____

Date: _____