

Arkansas Fire Training Academy

Enclosed you will find a medical clearance packet. The student needs to fill out the Medical Clearance and the Physician will need to review it. The Physician will also need to fill out the rest of the physical starting with the PPD Test.

If you have any questions, feel free to call at 870-574-1521.

Thanks,

Savannah Zakin

Administrative Specialist

870-574-4579

Arkansas Fire Training Academy

PHYSICIANS GUIDANCE REGARDING

MEDICAL CLEARANCE

Firefighting and emergency medical response remain the most dangerous occupations in the United States. Research has repeatedly shown the need for high levels of fitness to perform safely in the fire rescue service. The Individual's long hours, shift work, sporadic high intensity work, strong emotional involvement, and exposure to human suffering places the job among the most stressful occupations in the world. High levels of stress intense physical demands, and long term exposure to chemicals and infectious disease contribute to heart disease, lung disease, and cancer – the three leading causes of death and occupational disease disability.

This information is provided as a courtesy to physicians who may be asked to complete a physical for a potential volunteer firefighter or emergency medical technician. This information is based on the National Fire Protection Association (NFPA) Standard 1582: Standard on Comprehensive Occupational Medical Program for Fire Departments, 2007 Edition. The department will be happy to provide a complete copy of the Standard if requested. Please e-mail f&safety@pwcgov.org to request a complete copy of the NFPA 1582.

Essential Job Functions

5.1.1 The fire department shall evaluate the following 13 essential job tasks against the types and levels of emergency services provided to the local community by the fire department, the types of structures and occupancies comprising the community, and the configuration of the fire department to determine the essential job tasks of fire department members and candidates.

- (1) Performing fire-fighting tasks (e.g., hoseline operations, extensive crawling, lifting and carrying heavy objects, ventilating roofs or walls using power or hand tools, forcible entry), rescue operations, and other emergency response actions under stressful conditions while wearing personal protective ensembles and self – contained breathing apparatus (SCBA), including working in extremely hot or cold environments for prolonged time periods.
- (2) Wearing an SCBA which includes a demand value – type positive-pressure facepiece or HEPA filter masks, which requires the ability to tolerate increased respiratory workloads.
- (3) Exposure to toxic fumes, irritants, particulates, biological (infectious) and no biological hazards, and/or heated gases, despite the use of personal protective ensembles and SCBA.
- (4) Depending on the local jurisdiction, climbing six or more flights of stairs while wearing fire protective ensemble weighing at least 50 lb (22.6 kg) or more and carrying equipment/tools weighing an additional 20 to 40 lb (9 to 19 kg)
- (5) Wearing fire protective ensemble that is encapsulating and insulated, which will result in significant fluid loss that frequently progresses to clinical dehydration and can elevate core temperature to levels exceeding 102.2 F (39 C)
- (6) Searching, finding, and rescue-dragging or carrying victims ranging from newborns up to adults weighing over 200 lb (90 kg) to safely despite hazardous conditions and low visibility
- (7) Advancing water-filled hoselines up to 2 1/2 in. (65 mm) in diameter from fire apparatus to occupancy (approximately 150 ft (50 m), which can involve negotiating multiple flights of stairs, ladders, and other obstacles
- (8) Climbing ladders, operating from heights, walking or crawling in the dark along narrow and uneven surfaces, and operating in proximity to electrical power lines and/or other hazards
- (9) Unpredictable emergency requirements for prolonged periods of extreme physical exertion without benefit of warm-up, scheduled rest periods, meals, access to medication(s), or hydration
- (10) Operating fire apparatus or other vehicles in an emergency mode with emergency lights and sirens

- (11) Critical, time-sensitive, complex problem solving during physical exertion in stressful, hazardous environments, including hot, dark, tightly enclosed specs, that is further aggravated by fatigue, flashing lights, sirens, and other distractions.**
- (12) Ability to communicate (give and comprehend verbal orders) while wearing personal protective ensembles and SCBA under conditions of high background noise, poor visibility, and drenching from hoselines and/or fixed protection systems (sprinklers)**
- (13) Functioning as an integral component of a team, where sudden incapacitation of a member can result in mission failure or in risk of injury or death to civilians or other team members**

**OSHA Respirator Medical Evaluation Questionnaire
(Mandatory)**

Directions: Please read through and answer all questions to the best of your knowledge.

1. Can you read (circle one): Yes / No

Your employer must allow you to answer this questionnaire during normal hours, or at a time and place that is convenient to you. To maintain your confidentiality, your employer or supervisor must not look at or review your answers, and your employer must tell you how to deliver or send this questionnaire to the health care professional who will review it.

Part A. Section 1. (Mandatory) The following information must be provided by every employee who has been selected to use any type of respirator (please print).

1. Today's date: _____
2. Your name: _____
3. Your age (to nearest year): _____
4. Sex (circle One): Male / Female
5. Your height: _____ ft. _____ in.
6. Your weight: _____
7. Your job title: _____
8. A phone number where you can be reached by the health care professional who reviews this questionnaire (include the Area Code): _____
9. The best time to Phone you at this number: _____
10. Has your employer told you how to contact the health care professional who will review this questionnaire (circle one): Yes / No
11. Check the type of respirator you will use (you can check more than one category):
____ N, R, or P disposable respirator (filter-mask, non-cartridge type only)
____ Other type (for example, half or full face piece type, powered-air purifying, supplied-air, self-contained breathing apparatus)
12. Have you worn a respirator (circle one): Yes / No
If "yes" what type(s) _____

Medical Provider

Part A. Section 2 (Mandatory) Questions 1 through 9 below must be answered by every employee who has been selected to use any type of respirator (please circle "yes" or "no").

1. Do you currently smoke tobacco, or have you smoked tobacco in the last month: Yes / No
2. Have you ever has any of the following conditions?
 - a. Seizures (fits): Yes / No
 - b. Diabetes (sugar disease): Yes / No
 - c. Allergic reactions that interfere with your breathing: Yes / No
 - d. Claustrophobia (fear of closed – in places): Yes / No
 - e. Trouble smelling odors: Yes / No
3. Have you ever had any of the following pulmonary or lung problems?
 - a. Asbestosis: Yes / No
 - b. Asthma: Yes / No
 - c. Chronic bronchitis Yes / No
 - d. Emphysema: Yes / No
 - e. Pneumonia: Yes / No
 - f. Tuberculosis: Yes / No
 - g. Silicosis: Yes / No
 - h. Pneumothorax (collapsed lung) Yes / No
 - i. Lung cancer: Yes / No
 - j. Broken Ribs: Yes / No
 - k. Any chest injuries or surgeries: Yes / No
 - l. Any other Lung problem that you been told about: Yes / No
4. Do you currently have any of the symptoms of pulmonary or lung illness?
 - a. Shortness of breath: Yes / No
 - b. Shortness of breath when walking fast on level ground or walking up a slight hill or incline: Yes / No
 - c. Shortness of breath when walking at your own pace on level ground: Yes / No
 - d. Have to stop for breath when walking at your own pace on level ground: Yes / No
 - e. Shortness of breath when washing or dressing yourself: Yes / No
 - f. Shortness of breath that interferes with your job: Yes / No
 - g. Coughing that produces phlegm: Yes / No
 - h. Coughing that wakes you early in the morning; Yes / No
 - i. Coughing that occurs mostly when you are lying down: Yes / No
 - j. Coughing up blood in the last month: Yes / No
 - k. Wheezing: Yes / No
 - l. Wheezing the interferes with your job: Yes / No
 - m. Chest pain when you breathe deeply: Yes / No
 - n. Any other symptoms that you think may be related to lung problems: Yes / No
5. Have you ever had any of the following cardiovascular or heart problems?
 - a. Heart attack: Yes / No
 - b. Stroke: Yes / No
 - c. Angina: Yes / No
 - d. Heart failure: Yes / No
 - e. Swelling in your legs or feet (not caused by walking): Yes / No
 - f. Heart arrhythmia (heart beating irregularly): Yes / No

- g. High blood pressure: Yes / No
- h. Any other heart problem that you've been told about: Yes / No
- 6. Have you ever has any of the following cardiovascular or heart symptoms?
 - a. Frequent pain or tightness in your chest: Yes / No
 - b. Pain or tightness in your chest during physical activity: Yes / No
 - c. Pain or tightness in your chest that interferes with your job: Yes / No
 - d. In the past two years, have you noticed your heart skipping or missing a beat: Yes / No
 - e. Heartburn or indigestion that is not related to eating: Yes / No
 - f. Any other symptoms that you think may be related to heart or circulation problems: Yes / No
- 7. Do you currently take medication for any of the following problems?
 - a. Breathing or lung problems: Yes / No
 - b. Heart trouble: Yes / No
 - c. Blood Pressure: Yes / No
 - d. Seizures (fits): Yes / No
- 8. If you're used a respirator, have your ever had any of the following problems? (If you've never used a respirator, check the following space and go to question 9:)
- a. Eye irritation: Yes / No
 - b. Skin allergies or rashes: Yes / No
 - c. Anxiety: Yes / No
 - d. General weakness or fatigue: Yes / No
 - e. Any other problem that interferes with your use of a respirator: Yes / No
- 9. Would you like to talk to the health care professional who will review this questionnaire about your answers to this questionnaire: Yes / No

Questions 10 to 15 must be answered by every employee who has been selected to use either a full-face piece respirator or a self-contained breathing apparatus (SCBA). For employees who have been selected to use other types of respirators, answering these questions is voluntary.

- 10. Have you ever lost vision in either eye (temporarily or permanently): Yes / No
- 11. Do you currently have any of the following vision problems?
 - a. Wear contact lenses: Yes / No
 - b. Wear glasses: Yes / No
 - c. Color blind: Yes / No
 - d. Any other eye vision problems: Yes / No
- 12. Have you ever had and injury to your ears, including a broken ear drum: Yes / No
- 13. Do you currently have any of the following hearing problems?
 - a. Difficulty hearing: Yes / No
 - b. Wear a hearing aid: Yes / No
 - c. Any other hearing or ear problem: Yes / No
- 14. Have you ever had a back injury: Yes / No
- 15. Do you currently have any of the following musculoskeletal problems?
 - a. Weakness in any of your arms, hands, legs, or feet: Yes / No
 - b. Back pain: Yes / No
 - c. Difficulty fully moving your arms and legs: Yes / No
 - d. Pain or stiffness when you lean forward or backward at the waist: Yes / No
 - e. Difficulty fully moving your head up or down: Yes / No
 - f. Difficulty fully moving your head side to side: Yes / No

- g. Difficulty bending at your knees: Yes / No
- h. Difficulty squatting to the ground: Yes / No
- i. Climbing a flight of stairs or a ladder carrying more than 25 lbs: Yes / No
- j. Any other muscle or skeletal problems that interferes with using a respirator: Yes / No

Part B Any of the following questions, and other questions not listed, may be added to the questionnaire at the discretion of the health care professional who will review the questionnaire. If you cannot answer any specific questions please leave those questions blank.

1. In your present job, are you working at high altitudes (over 5,000 feet) or in a place that has lower than normal amount of oxygen: Yes / No
2. At work or at home, have you ever been exposed to hazardous solvents, hazardous airborne chemicals (e.g., gases, fumes, or dust), or have you come into skin contact with hazardous chemicals: Yes / No If "yes" name the chemicals if you know them: _____
3. Have you ever worked with any of the materials, or under any of the conditions, listed below:
 - a. Asbestos: Yes / No
 - b. Silica (e.g., grinding or welding this material): Yes / No
 - c. Tungsten/cobalt (e.g., grinding or welding this material): Yes / No
 - d. Beryllium: Yes / No
 - e. Aluminum: Yes / No
 - f. Coal (for example, mining): Yes / No
 - g. Iron: Yes / No
 - h. Tin: Yes / No
 - i. Dusty environments: Yes / No If "yes" describe the exposures: _____
4. List any second jobs or side business you have: _____
5. List your previous occupations: _____
6. List your current and previous hobbies: _____
7. Have you been in the military services? Yes / No
8. Have you ever worked on a HAZMAT team? Yes / No
9. Other than medications for breathing and lung problems, heart trouble, blood pressure, and seizures mentioned earlier in this questionnaire, are you taking any other medications for any reason (including over the counter medications): Yes / No
If "yes" then name the medications if you know them: _____
10. Will you be using any of the following items with your respirator?
 - a. HEPA Filters: Yes / No
 - b. Canisters (for example, gas masks): Yes / No
 - c. Cartridges: Yes / No
11. How often are you expected to use the respirator(s), is your work effort:
 - a. Escape only (no rescue): Yes / No
 - b. Emergency rescue only: Yes / No
 - c. Less than 5 hours per week: Yes / No
 - d. Less than 2 hours per day: Yes / No
 - e. 2 to 4 hours per day: Yes / No
 - f. Over 4 hours per day: Yes / No

12. During the period you are using the respirator (s), is your work effort:

a. Light (less than 200 kcal per hour): Yes / No

If "yes" how long does this period last during the regular shift _____ hrs. _____ mins.

Examples of a light work effort are sitting while writing, typing, drafting, or performing light assembly work; or standing while operating a drill press (1-2 lbs) or controlling machines.

b. Moderate (200 o 350 kcal per hour): Yes / No

If "yes", how long does this period last during the average shift: _____ hrs. _____ mins.

Examples of moderate work effort are sitting while mailing or filing; driving a truck or bus in urban traffic; standing while drilling, nailing, performing assemble work, or transferring a moderate load (about 25 lbs.) at trunk level: walking on a level surface about 2 mph or down a 5 - degree grade about 3 mph; or pushing a wheelbarrow with a heavy load (about 100 lbs.) on a level surface.

c. Heavy (above 350 kcal per hour): Yes / No

If "yes" how long does this period last during the average shift: _____ hrs. _____ mins.

Example of heavy work are lifting a heavy load (about 50 lbs) from the floor to your Waist or shoulder; working on a loading dock; shoveling; standing while bricklaying or chipping castings: walking up an 8 - degree grade about 2 mph; climbing stairs with a heavy load (about 50 lbs.)

13. Will you be wearing protective clothing and / or equipment (other than the respirator) when you're using your respirator: Yes / No

14. Will you be working under hot conditions (temperature exceeding 77 deg F) : Yes / No

15. Will you be working under humid conditions: Yes / No

16. Describe work you will be doing while you're using respirator(s):

17. Describe any special or hazardous conditions you might encounter when you're using your respirator(s) (for example, confines space, life-threatening gases):

18. Provide the following information, if you know it, for each toxic substance that you'll be exposed to when you're using your respirator (s):

Name of the first toxic substance: _____

Estimated maximum exposure level per shift: _____

Duration of exposure per shift: _____

Name of the second toxic substance: _____

Estimated maximum exposure level per shift: _____

Duration of exposure per shift: _____

Name of the third toxic substance: _____

Estimated maximum exposure level per shift: _____

Duration of exposure per shift: _____

The name of any other toxic substances that you'll be exposed to while using your respirator:

19. Describe any special responsibilities you'll have while using your respirator(s) that may affect the safety and well-being of others (for example, rescue, security):

**ARKANSAS FIRE TRAINING ACADEMY
PPD TEST**

PATIENT: _____

EMPLOYER: _____

PHYSICIAN: _____

DATE: _____ TIME: _____

PREVIOUS POSITIVE TEST? Yes / No

- Have you ever received the BCG Vaccine? Yes / No
- A chest x-ray may be required if history of positive results. Company request/approval

PPD Skin Test: Left Right (Forearm)

LOT NUMBER: _____

EXPIRATION DATE: _____

ADMINISTERED BY: _____

INTERPRETATION:

Positive _____ mm induration

Negative _____ mm induration

Interpreted by _____

Date _____ Time _____

Please fax results to: 870-574-0817

ARKANSAS FIRE TRAINING ACADEMY

HISTORY AND PHYSICAL EXAM FORM

Time In _____ Time Out _____ Date _____

Name _____ Date of Birth _____ Social Security # _____ Sex: M F
 Home Address _____ City _____
 State _____ Zip _____ Home Phone # _____
 Employer _____ Employer Phone # _____ Occupation _____
 Private MD _____ Reason for Exam: ___ Post Offer ___ Return to Work ___ Periodic ___ Other

PERSONAL HEALTH HISTORY

Have you ever had?

Any Illness or Injury in the past 5 year	___ Yes ___ No	Loss of Consciousness	___ Yes ___ No
Head/Brain Injuries, Disorders or Illnesses	___ Yes ___ No	Fainting, Dizziness	___ Yes ___ No
Seizures, Epilepsy (<i>list medication below</i>)	___ Yes ___ No	Sleep Disorders (<i>sleep apnea, Sleepiness, loud snoring</i>)	___ Yes ___ No
Ear Disorder or Loss of Hearing, Balance	___ Yes ___ No	Stroke or Paralysis	___ Yes ___ No
Heart Disease or Heart Attack (<i>list medication below</i>)	___ Yes ___ No	Missing or Impaired Hand, foot, leg, finger, toe	___ Yes ___ No
Heart Surgery	___ Yes ___ No	Spinal Injury or disease	___ Yes ___ No
High Blood Pressure (<i>list medication below</i>)	___ Yes ___ No	Chronic Back Pain	___ Yes ___ No
Muscular Disease	___ Yes ___ No	Regular, Frequent Alcohol Use	___ Yes ___ No
Shortness of Breath	___ Yes ___ No	Narcotic or Habit Forming Drug Use	___ Yes ___ No
Lung, Disease, Asthma, Emphysema, etc.	___ Yes ___ No	Cancer	___ Yes ___ No
Kidney Disease, Dialysis	___ Yes ___ No	Hernia or Rupture	___ Yes ___ No
Liver Disease	___ Yes ___ No	Tuberculosis or Positive TB test	___ Yes ___ No
Digestive Problems	___ Yes ___ No	Prostate Disease	___ Yes ___ No
Diabetes (<i>Controlled by diet or medication</i>)	___ Yes ___ No	Other Disease, Illness or Hospitalization	___ Yes ___ No
Nervous or Psychiatric Disorders (<i>list below</i>)	___ Yes ___ No	Give Detail Below	

Have you ever:

Been rejected for employment for health reasons? ___ Yes ___ No
 Been discharged or rejected for Military Service? ___ Yes ___ No
 Applied for or received Disability Compensation ___ Yes ___ No
 Had exposure to poisons, asbestos, or other hazardous materials ___ Yes ___ No
 Has a prior occupational illness or injury? ___ Yes ___ No
 Females only: Are you pregnant? ___ Yes ___ No
 Any other Gynecological/Obstetric Problems ___ Yes ___ No
 Are you allergic to any medications or dye? (If yes, list below) ___ Yes ___ No

Please list all your current medications, vitamins and herbal supplements, including over-the-counter medications: _____

For any YES answer, indicate onset date diagnosis, treating physician's name and address and current limitation.

When was your last Tetanus shot?

Do you smoke? ___Yes ___No If "yes how much?

Do you drink alcohol? ___Yes ___No If "yes" how much

Physicians Notes

I have read the above questions and answers, and to the best of my knowledge they are complete and correct. I consent that any physician or hospital who has treated me for any purpose may divulge to above employer and to Arkansas Fire Training Academy any information obtained by them. I also authorize Arkansas Fire Training academy to divulge to above names employer, any information regarding my medical history and physical findings.

Signature of Employee

Signature of Medical Examiner

PHYSICAL EXAMINATION FORM

Patient Name _____ Date of Birth _____
 Height _____ ft. _____ in. Weight _____ Pulse _____
 Blood Pressure _____ Temperature _____

EXAMINATION: Circle one for each category – explain abnormalities in comments.

1. Skin	N	ABN	NE	COMMENTS:
2. Eyes	N	ABN	NE	
3. Ears	N	ABN	NE	
4. Nose	N	ABN	NE	
5. Mouth and Throat	N	ABN	NE	
6. Chest	N	ABN	NE	
7. Lungs	N	ABN	NE	
8. Neck including thyroid	N	ABN	NE	
9. Heart	N	ABN	NE	
10. Abdomen	N	ABN	NE	
11. Genitalia/Hernia	N	ABN	NE	
12. Extremities	N	ABN	NE	
13. Prostate	N	ABN	NE	
14. Back	N	ABN	NE	
15. Neurologic	N	ABN	NE	
16. Scars, Deformities or Disabilities	N	ABN	NE	
17. Other (explain)	N	ABN	NE	

General State of Health

Vision: _____ Uncorrected

Far: R _____ L _____ Near: R _____ L _____

Vision: _____ Corrected

Far: R _____ L _____ Near: R _____ L _____

Color Test result: _____ Normal _____ Abnormal

Horizontal visual field (degrees) _____ Right _____ Left

Chest X-Ray	_____ Not Done	_____ Normal	_____ Other
EKG	_____ Not Done	_____ Normal	_____ Other
Cardiac Stress Test	_____ Not Done	_____ Normal	_____ Other
PFT	_____ Not Done	_____ Normal	_____ Other
Audio	_____ Not Done	_____ Normal	_____ Other
Urine	_____ Not Done	_____ Normal	_____ Other
Hemmo cult	_____ Not Done	_____ Normal	_____ Other
CBC/ACP/Other	_____ Not Done	_____ Normal	_____ Other

Findings

Recommendations

☐ **No active Medical Problem**

☐ **Deferred Pending Further Medical Evaluation**

☐ **Medical Problem Under Approved care**

☐ **Medical Problem Needs Attention**

This Individual has been advised of the findings of this examination.

Signature of Examining Physician

Date of Examination