WCT Level
__ Arduous
__ Moderate
__ Light

HEALTH SCREENING QUESTIONNAIRE (HSQ)

Assess your health needs by marking all true statements.

The purpose is to identify individuals who may be at risk in taking the Work Capacity Test (WCT) and recommend an exercise program and/or medical examination prior to taking the WCT.

Individuals are required to answer the following questions. The questions were designed, in consultation with occupational health physicians, to identify individuals who may be at risk when taking a WCT. The HSQ is not a medical examination. Any medical concerns you have that place you or your health at risk should be reviewed with your personal physician prior to participating in the WCT.

Check 'Yes' or 'No' in response to the following questions:

[ ] Y [ ] N 1) During the past 12 months have you at any time (during physical activity or while resting) experienced pain, discomfort or pressure in your chest.

[ ] Y [ ] N 2) During the past 12 months have you experienced difficulty breathing or shortness of breath, dizziness, fainting, or blackout?

[ ] Y [ ] N 3) Do you have a blood pressure with systolic (top #) greater than 140 or diastolic (bottom #) greater than 90?

[ ] Y [ ] N 4) Have you ever been diagnosed or treated for any heart disease, heart murmur, chest pain (angina), palpitations (irregular beat), or heart attack?

[ ] Y [ ] N 5) Have you ever had heart surgery, angioplasty, or a pace maker, valve replacement, or heart transplant?

[ ] Y [ ] N 6) Do you have a resting pulse greater than 100 beats per minute?

[ ] Y [ ] N 7) Do you have any arthritis, back trouble, hip /knee/joint /pain, or any other bone or joint condition that could be aggravated or made worse by the Work Capacity Test?

[ ] Y [ ] N 8) Do you have personal experience or doctor's advice of any other medical or physical reason that would prohibit you from taking the Work Capacity Test?

[ ] Y [ ] N 9) Has your personal physician recommended against taking the Work Capacity Test because of asthma, diabetes, epilepsy or elevated cholesterol or a hernia?

Regardless whether you are taking the Work Capacity test at the Arduous, Moderate or Light duty level, a "Yes" answer requires a determination from your personal physician stating that you are able to participate.

I understand that if I need to be evaluated by a physician, it will be based on the fitness requirements of the position(s) for which I am qualified.

Signature:_____ Printed Name _____ Date _____

Unit: _____ City _____ State _____

REQUIRED FOR ALL WORK CAPACITY TEST PARTCIPANTS

Privacy Statement

The information obtained in the completion of this form is used to help determine whether an individual being considered for wildland firefighting can carry out those duties in a manner that will not place the candidate unduly at risk due to inadequate physical fitness and health.

Work Capacity Test: Informed Consent

- **Arduous** - The 3-mile test with a 45 pound pack in 45 minutes is strenuous, but no more so than the duties of wildland firefighting.
- **Moderate** - The 2-mile test with a 25 pound pack in 30 minutes is fairly strenuous, but no more so than the field duties.
- **Light** - The 1-mile walk in 16 minutes is moderately strenuous, but no more so than the duties assig.

Risks

- There is a slight risk of injury (blisters, sore legs, sprained ankles) especially for those who have not practiced the test. If you have been inactive and have not practiced or trained for the test, you should engage in several weeks of specific training before you take the test. Be certain to warm up and stretch before taking the test, and to cool down after the test. The risk of more serious consequences (such as respiratory or heart problems) is diminished by completing the **(HSQ)** physical activity readiness questionnaire.

☐ **I have read the information on this form, the brochure "Work Capacity Test" and understand the purpose, instructions, and risks of the job related to work capacity test.**

☐ **I have read the information, understood, and truthfully answered the HSQ.**

Test to be Taken (check one) Arduous ☐ **Moderate** ☐ **Light** ☐

Signature _____ Date _____

Printed Name _____

REQUIRED FOR ALL WORK CAPACITY TEST PARTCIPANTS

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To be given to the individual examined with a pre-addressed envelope marked "Confidential - Medical".

CERTIFICATE OF MEDICAL EXAMINATION

U.S. OFFICE OF PERSONNEL MANAGEMENT

Form Approved
OMB No. 3206 - 0250

PART B - CONTINUED - TO BE COMPLETED BEFORE EXAMINATION BY APPOINTING OFFICER

4. Check the box for each functional requirement in section 4a and each environmental factor in section 4b essential to the duties of this position. List any additional essential factors in the blank spaces. Also, if the position involves law enforcement, air traffic control, or fire fighting, attach the specific medical standards for the information of the examining physician.

4a. Functional Requirements

- [X] Heavy lifting, 45 pounds and over
- [ ] Moderate lifting, 15-44 pounds
- [ ] Light lifting, under 15 pounds
- [X] Heavy carrying, 45 pounds and over
- [ ] Moderate carrying, 15-44 pounds
- [ ] Light carrying, under 15 pounds
- [ ] Straight pulling (____ hours)
- [X] Pulling hand over hand (8 hours)
- [ ] Pushing (____ hours)
- [X] Reaching above shoulder
- [X] Use of fingers
- [X] Both hands required
- [X] Walking (16 hours)
- [X] Standing (16 hours)
- [ ] Crawling (____ hours)
- [ ] Kneeling (____ hours)
- [X] Repeated bending (8 hours)
- [X] Climbing, legs only (8 hours)
- [X] Climbing, use of legs and arms
- [X] Both legs required
- [X] Operation of crane, truck, tractor, or motor vehicle
- [X] Ability for rapid mental and muscular coordination simultaneously
- [ ] Ability to use and desirability of using firearms
- [ ] Near vision correctable at 13" to 16" to Jaeger 1 to 4
- [ ] Far vision correctable in one e... /20 and to 20/40 in the other
- [ ] Specific visual requiremen... specify)
- [ ] Both eyes required
- [ ] Depth perception
- [ ] Ability to distinguish basic colors
- [ ] Ability to distinguish shades of colors
- [ ] Hearing (aid permitted)
- [ ] H...ring without aid
- [ ] Specifi... requirements (specify)

Other (specify)

- [ ] ____
- [ ] ____
- [ ] ____
- [ ] ____
- [ ] ____
- [ ] ____
- [ ] ____
- [ ] ____

4b. Environmental Factors

- [ ] Outside
- [X] Outside and inside
- [X] Excessive heat
- [X] Excessive cold
- [ ] Excessive humidity
- [X] Excessive dampness or chill
- [X] Dry atmospheric conditions
- [X] Excessive noise, intermittent
- [X] Constant noise
- [X] Dust
- [ ] Silica, asbestos, etc.
- [X] Fumes, smoke, or gases
- [ ] Solvents (degreasing agents)
- [ ] Grease and oils
- [ ] Radiant energy
- [ ] Electrical en...
- [X] ...pery or un... walking surfaces
- [X] Wo... ...d machinery with moving parts
- [X] Working around moving objects or vehicles
- [ ] Working on ladders or scaffolding
- [ ] Working below ground
- [X] Unusual fatigue factors (specify)

(see entries on right)

- [X] Working with hands in water
- [ ] Explosives
- [ ] Vibration
- [X] Working closely with others
- [X] Working alone
- [X] Protracted or irregular hours of work

Other (specify)

- [X] travel in isolated areas
- [X] no days off for 14 days
- [ ] ____
- [X] fatigue factors: limited sleep
- [X] fatigue factors: long shifts
- [ ] ____
- [ ] ____
- [ ] ____
- [ ] ____

To be given to the individual examined with a pre-addressed envelope marked "Confidential - Medical".

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5. Conclusions: Summarize below any medical findings that in your opinion, would limit this person's ability to perform these job duties or make them a hazard to themselves or others. If none, so indicate.

☐ No limiting conditions for this job

☐ Limiting conditions as follows:

6. Examining Physician's Name	7. E-Mail Address
8. Address (Including Street, City, State and ZIP Code)	Telephone Number
10. Signature of Examining Physician	11. Date (Month, Day, Year)

IMPORTANT: After signing, return the entire form in the pre-addressed "Confidential-Medical" envelope which the person you examined gave you.

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PART B - CONTINUED (TO BE COMPLETED BEFORE EXAMINATION BY EXAMINING OFFICER)

4. Check the box for each functional requirement in section 4a and each environmental factor in section 4b essential to the duties of this position. List any additional essential factors in the blank spaces. Also, if the position involves law enforcement, air traffic control, or fire fighting, attach the specific medical standards for the information of the examining physician.

4a. Functional Requirements

- ☐ Heavy lifting, 45 pounds and over
- ☒ Moderate lifting, 15-44 pounds
- ☐ Light lifting, under 15 pounds
- ☐ Heavy carrying, 45 pounds and over
- ☒ Moderate carrying, 15-44 pounds
- ☐ Light carrying, under 15 pounds
- ☐ Straight pulling (_____ hours)
- ☐ Pulling hand over hand (_____ hours)
- ☐ Pushing (_____ hours)
- ☐ Reaching above shoulder
- ☐ Use of fingers
- ☐ Both hands required
- ☐ Walking (_____ hours)
- ☐ Standing (_____ hours)
- ☐ Crawling (_____ hours)
- ☐ Kneeling (_____ hours)
- ☐ Repeated bending (_____ hours)
- ☐ Climbing, legs only (_____ hours)
- ☐ Climbing, use of legs and arms
- ☒ Both legs required
- ☐ Operation of crane, truck, tractor, or motor vehicle
- ☐ Ability for rapid mental and muscular coordination simultaneously
- ☐ Ability to use and desirability of using firearms
- ☐ Near vision correctable at 13" to 16" to Jaeger 1 to 4
- ☐ Far vision correctable in one e[illegible] 20/20 and to 20/40 in the other
- ☒ Specific visual requirement (sp[illegible])

  Have sight
- ☐ Both eyes required
- ☐ Depth perception
- ☐ Ability to distinguish basic colors
- ☐ Ability to d[illegible]uish shades of colors
- ☐ Heari[illegible] (aid pe[illegible]tted)
- ☐ Hear[illegible] wit[illegible]t aid
- ☐ Specifi[illegible]aring re[illegible]rements (specify)
- ☐ [illegible]er (specify)
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____

4b. Environmental Factors

- ☐ Outside
- ☒ Outside and inside
- ☐ Excessive heat
- ☐ Excessive cold
- ☐ Excessive humidity
- ☐ Excessive dampness or chilling
- ☒ Dry atmospheri[illegible]ions
- ☐ Excessive noise, i[illegible]mitte
- ☐ Constant noise
- ☐ Dust
- ☐ Silica, asbestos, etc.
- ☐ Fumes, smoke, or gases
- ☐ Solvents (degreasing agents)
- ☐ Grease and oils
- ☐ Radiant energy
- ☐ Ele[illegible]cal energy
- ☒ [illegible]lippe[illegible]r uneven walking surfaces
- ☐ W[illegible]ng around machinery with moving parts
- ☐ Wor[illegible]g around moving objects or vehicles
- ☐ Wo[illegible]ng on ladders or scaffolding
- ☐ Working below ground
- ☒ Unusual fatigue factors (specify)

  (see entries on right)
- ☐ Working with hands in water
- ☐ Explosives
- ☐ Vibration
- ☐ Working closely with others
- ☐ Working alone
- ☐ Protracted or irregular hours of work

Other (specify)

- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☒ fatigue factors: Long shifts
- ☒ fatigue factors: Lack of sleep
- ☐ _____
- ☐ _____
- ☐ _____

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☐ No limiting conditions for this job

☐ Limiting conditions as follows:

6. Examining Physician's Name	E-Mail Address
8. Address (Including Street, City, State and ZIP Code)	Telephone Number
10. Signature of Examining Physician	11. Date (Month, Day, Year)

IMPORTANT: After signing, return the entire form in it in the pre-addressed "Confidential-Medical" envelope which the person you examined gave you.