

<b>MEDICAL RECORD</b>		<b>REPORT OF MEDICAL EXAMINATION</b>		DATE OF EXAM
1. LAST NAME - FIRST NAME - MIDDLE NAME		2. IDENTIFICATION NUMBER	3. GRADE AND COMPONENT OR POSITION	
4. HOME ADDRESS (Number, street or RFD, city or town, state and ZIP Code)		5. EMERGENCY CONTACT (Name and address of contact)		
6. DATE OF BIRTH	7. AGE	8. SEX <input type="checkbox"/> FEMALE <input type="checkbox"/> MALE	9. RELATIONSHIP OF CONTACT	
10. PLACE OF BIRTH		11. RACE <input type="checkbox"/> WHITE <input type="checkbox"/> BLACK <input type="checkbox"/> AMERICAN INDIAN / ALASKA NATIVE <input type="checkbox"/> HISPANIC / WHITE <input type="checkbox"/> HISPANIC / BLACK <input type="checkbox"/> ASIAN / PACIFIC ISLANDER		
12a. AGENCY		12b. ORGANIZATION (U)		13. TOTAL YEARS GOVERNMENT SERVICE a. MILITARY _____ b. CIVILIAN _____
14. NAME OF EXAMINING FACILITY OR EXAMINER AND ADDRESS		15. RATING OR SPECIALTY OF EXAMINER		
		16. PURPOSE OF EXAMINATION		

**17. CLINICAL EVALUATION**

NOR-MAL	(Check each item in appropriate column, enter "NE" if not evaluated)	ABNOR-MAL	NOR-MAL	(Check each item in appropriate column, enter "NE" if not evaluated.)	ABNOR-MAL
	A. HEAD, FACE, NECK AND SCALP			O. PROSTATE (Over 40 or clinically indicated)	
	B. EARS - GENERAL (INTERNAL CANALS) (Auditory acuity under items 39 and 40)			P. TESTICULAR	
	C. DRUMS (Perforation)			Q. ANUS AND RECTUM (Hemorrhoids, Fistulae) (Hemocult Results)	
	D. NOSE			R. ENDOCRINE SYSTEM	
	E. SINUSES			S. G-U SYSTEM	
	F. MOUTH AND THROAT			T. UPPER EXTREMITIES (Strength, range of motion)	
	G. EYES - GENERAL (Visual acuity and refraction under items 28, 29, and 36)			U. FEET	
	H. OPHTHALMOSCOPIC			V. LOWER EXTREMITIES (Except feet) (Strength, range of motion)	
	I. PUPILS (Equality and reaction)			W. SPINE, OTHER MUSCULOSKELETAL	
	J. OCULAR MOTILITY (Associated parallel movements nystagmus)			X. IDENTIFYING BODY MARKS, SCARS, TATTOOS	
	K. LUNGS AND CHEST			Y. SKIN, LYMPHATICS	
	L. HEART (Thrust, size, rhythm, sounds)			Z. NEUROLOGIC (Equilibrium tests under item 41)	
	M. VASCULAR SYSTEM (Varicosities, etc.)			AA. PSYCHIATRIC (Specify any personality deviation)	
	N. ABDOMEN AND VISCERA (Include hernia)			BB. BREASTS	
				CC. PELVIS (Females only)	

NOTES: (Describe every abnormality in detail. Enter pertinent item number before each comment. Continue in item 42 and use additional sheets if necessary.)

<p>18. DENTAL (Place appropriate symbols, show in examples above or below number of upper and lower teeth)</p> <p>0 No. X X X (X)</p> <p>1 2 3 restorable 1 2 3 restorable 1 2 3 Missing 1 2 3 Replaced 1 2 3 Fixed</p> <p>32 31 30 Teeth 32 31 30 Teeth 32 31 30 Teeth 32 31 30 by 32 31 30 Partial</p> <p>0 // X X X Dentures ( X X )</p> <p>R _____</p> <p>I 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 E</p> <p>O 32 31 30 29 28 27 26 25 24 23 22 21 20 19 18 17 F</p> <p>H _____</p> <p>T _____</p>	<p>REMARKS AND ADDITIONAL DENTAL DEFECTS AND DISEASES</p>
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**19. TEST RESULTS (Copies of results are preferred as attachments)**

A. URINALYSIS: (1) SPECIFIC GRAVITY		B. CHEST X-RAY OR PPD (Place, date, film number and result) TB Tyne Test	
(2) URINE ALBUMIN	(4) MICROSCOPIC		
(3) URINE SUGER			
C. SYPHILIS SEROLOGY (Specify test used and results)	D. EKG	E. BLOOD TYPE AND RH FACTOR	F. OTHER TESTS



NOTE: This information is for official and medically-confidential use only and will not be released to unauthorized persons

1. NAME OF PATIENT (LAST, FIRST, MIDDLE)	2. DATE OF BIRTH	3. Are you
4. Division/Field Office Address	4a. Examining Facility	
4b. Division City	4c. Division State	4d. Zip Code

5. Purpose of Examination

**7. STATEMENT OF PATIENT'S PRESENT HEALTH AND MEDICATIONS CURRENTLY USED (Use additional pages if necessary)**

8. Present Health	8a. Current Medications /Dose and Frequency	8b. Allergies (include insect bites/stings and common foods)
9. Occupation		

**10. PAST/CURRENT MEDICAL HISTORY - Check Each Item; if "YES" Explain in Blank Space on Page 2. List explanation by condition item.**

Check each item	Yes	No	Don't know	Check each item	Yes	No	Don't know	Check each item	Yes	No	Don't know
Household contact with anyone with tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Eye surgery to correct vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Swollen or painful joints	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tuberculosis or positive TB test	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lack vision in either eye	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Frequent or severe headaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Blood in sputum or when coughing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Wear a hearing aid	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Dizziness or fainting spells	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Excessive bleeding after injury or dental work	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Wear a brace or back support	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Eye trouble	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Suicide attempt or plans	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Stutter or stammer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hearing loss	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sleepwalking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Scarlet Fever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Recurrent ear infections	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Wear corrective lenses	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic fever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Foot trouble	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Severe tooth or gum trouble	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Tumor, growth, cyst, cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Nerve injury	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sinusitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hernia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Paralysis (including infantile)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hay fever or allergic rhinitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hemorrhoids or rectal disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy or seizure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Head injury	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Frequent or painful urination	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Car, train, sea or air sickness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bed wetting since age 12	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Frequent trouble sleeping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Kidney stone or blood in urine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Depression or excessive worry	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pain or pressure in chest	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sugar or albumin in urine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Loss of memory or amnesia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chronic cough	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sexually transmitted diseases	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Nervous trouble of any sort	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Palpitation or pounding heart	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Recent gain or loss of weight	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Periods of unconsciousness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart trouble	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Eating disorder (anorexia, bulimia, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	X-ray or other radiation therapy for medical condition	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High or low blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis, Rheumatism, or Bursitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chemotherapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cramps in your legs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid trouble or goiter	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Asbestos or toxic chemical exposure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Frequent indigestion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sensitivity to chemicals, dust, sunlight	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Plate, pins or rod in any bone	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stomach, liver or intestinal trouble	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Inability to perform certain motions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Easy fatigability	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Gall bladder trouble or gallstones	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bone, joint or other deformity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Been told to cut down or criticized for alcohol use	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Jaundice or hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Loss of finger or toe	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Broken bones	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Painful or "trick" shoulder or elbow	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Used tobacco	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Adverse reaction to medication	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Recurrent back pain or any back injury	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Skin diseases	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	"Trick" or locked knee	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Inability to assume certain positions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chronic or frequent colds	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				

**Check Each Item, if "Yes" Explain in Blank Space Below. List explanation by item number**

Item	Yes	No
11. Have you been treated for a mental condition? If yes, specify when, where, and give details	<input type="checkbox"/>	<input type="checkbox"/>
12. Have you been denied life insurance? If yes, state reason and give details.	<input type="checkbox"/>	<input type="checkbox"/>
13. Have you had, or have been advised to have any operation? If yes, describe.	<input type="checkbox"/>	<input type="checkbox"/>
14. Have you been a patient in any type of hospital? If yes, specify when, where, why and name of doctor and complete address of hospital?	<input type="checkbox"/>	<input type="checkbox"/>
15. Have you consulted or been treated by clinics, physicians, healers, or other practitioners with the year, for other than minor illness?	<input type="checkbox"/>	<input type="checkbox"/>
16. Do you have a past or current medical history of any other condition not mentioned on this form?	<input type="checkbox"/>	<input type="checkbox"/>
17. Have you ever received, is there pending, or have you ever applied for pension or compensation for existing disability? If yes, specify what kind, granted by whom, and what amount, when, why.	<input type="checkbox"/>	<input type="checkbox"/>

**Explanation of all "Yes" findings**

18. Immunizations

**19. FEMALE ONLY**

Check each item	Yes	No	Don't know	Date of last menstrual period	Date of last Pap Smear	Date of Last Mammogram
Treated for a female disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Change in menstrual pattern	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			

20. I certify that I have reviewed the foregoing information supplied by me and that it is true and complete to the best of my knowledge. I authorize any of the doctors, hospitals, or clinics mentioned above to furnish the Government a complete transcript of my medical record for purpose of processing my application for this employment or service. I understand that falsification of information on Government forms is punishable by fine and/or imprisonment.

20a. Typed or Printed Name of Examinee -- OFFICIAL BUREAU NAME

<b>Note: HAND TO THE DOCTOR OR NURSE, OR IF MAILED MARK ENVELOPE "TO BE OPENED BY MEDICAL PERSONNEL ONLY"</b>	20b. Signature of Examinee	20c. Date
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**21. PHYSICIAN'S SUMMARY AND ELABORATION OF ALL PERTINENT DATA (PHYSICIAN SHALL COMMENT ON ALL POSITIVE ANSWERS IN ITEM 7 - 19. Physicians may develop by interview any additional medical history deemed important, and record any significant findings here.**

**Privacy Act Statement:** The collection of the information on this form, which is authorized by 5 U.S.C. § 301 and 5 U.S.C. § 3301, is relevant and necessary to provide appropriate medical care and to determine eligibility and/or fitness for duty. Completion of this form is voluntary; however, your failure to supply all the information requested on this form may impede or preclude agency action regarding medical care or continued employment. This information is maintained in your medical file in the FBI Central Records System, Justice/FBI-002, a description of which can be found at <http://home.fbinet.fbi/DO/OGC/LTB/PCLU/PrivacyCivil%20Liberties%20Library/Forms/FBI002.aspx>. This information may be disclosed in accordance with the routine uses referenced in this notice.

**GINA Notice: Do Not Provide Genetic Information, Including Family Medical History**

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. "Genetic information," as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services. See 29 C.F.R. § 1635.8(b)(1)(i)(B).

22. Typed or Printed Name of Physician or Health Care Professional	22a. Signature of Physician or HCP	22b. Date
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PLEASE USE ADDITIONAL PAGES IF NECESSARY

## Hazardous Devices School Physical Capacities Form

Applicant's Name: \_\_\_\_\_

Dear Doctor:

The above named individual is applying to attend a course at the Hazardous Devices School, which will certify him/her as a bomb technician. This training is physically demanding in that it requires students to wear protective suits while performing tasks. The bomb suit with helmet weighs up to 70 pounds and is quite restrictive. The combination chemical suit (level B) and WMD bomb suit (40-pound suit) also requires the wearing of a self-contained breathing apparatus (SCBA) with respirator. The microenvironment within this equipment can expose the wearer to temperatures in excess of 100 degrees Fahrenheit, and humidity of 100% for periods of up to 30 minutes. Tasks to be performed include carrying a portable x-ray (25 pounds) and disrupter (40 pounds) a distance of at least 600 feet. During these tasks the student must kneel, position the tools and get back up on their own. If they fall, they must be able to get back up without assistance. In order to be accepted to this HDS course, the applicant must not have any of the restrictions listed below.

Please check any of the following medical restrictions that may apply to the applicant:

- \_\_\_\_\_ Restricted from lifting more than 50 pounds.
- \_\_\_\_\_ Restricted from kneeling, bending or twisting.
- \_\_\_\_\_ Restricted from working in a respirator (including negative pressure or SCBA types) .
- \_\_\_\_\_ Overweight to the degree that wearing a 70-pound bomb suit while carrying equipment would present health risks.
- \_\_\_\_\_ Restricted from wearing protective chemical and/or bomb suits.

Comments: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

I have discussed the OSHA Respirator Medical Evaluation Questionnaire with the patient. (Questionnaire may be maintained by health care provider and need not be returned to the patient or the FBI.)

\_\_\_\_\_  
Physician's Printed Name

\_\_\_\_\_  
Physician's Signature

\_\_\_\_\_  
Date

**Maximum Weight by Height**  
From the *National Guidelines for Bomb Technicians*

Height (inches)	Male				Female			
	Age Group				Age Group			
	21-29	30-39	40-49	50+	21-29	30-39	40-49	50+
58					100	103	106	109
59					105	108	111	114
60	166	169	172	175	110	113	116	119
61	170	173	176	179	115	118	121	124
62	173	176	179	182	120	123	126	129
63	176	179	182	185	125	128	131	134
64	180	183	186	189	130	133	136	139
65	183	186	189	192	135	138	141	144
66	186	189	192	195	140	143	146	149
67	190	193	196	199	145	148	151	154
68	193	196	199	202	150	153	156	159
69	196	199	202	205	155	158	161	164
70	200	203	206	209	160	163	166	169
71	203	206	209	212	165	168	171	174
72	206	209	212	215	170	173	176	179
73	210	213	216	219	175	178	181	184
74	213	216	219	222	180	183	186	189
75	216	219	222	225	185	188	191	194
76	220	223	226	229	190	193	196	199
77	223	226	229	232	195	198	201	204
78	226	229	232	235	200	203	206	209
79	230	233	236	239	205	208	211	214
80	233	236	239	242	210	213	216	219

Alternative Body Fat Test	Age Group			
	21-27	28-39	40-49	50+
Maximum Body Fat (Male)	22%	24%	26%	28%
Maximum Body Fat (Female)	30%	32%	34%	36%

**OSHA 29CFR, Appendix C to Sec. 1910.134:  
OSHA Respirator Medical Evaluation Questionnaire (Mandatory)**

To the employer: Answers to questions in Section 1, and to question 9 in Section 2 of Part A, do not require a medical examination.

To the employee:

Can you read (circle one): Yes/No

Your employer must allow you to answer this questionnaire during normal working 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. Additionally, 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: \_\_\_\_\_ lbs.
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):
  - a. \_\_\_\_\_ N, R, or P disposable respirator (filter-mask, non-cartridge type only).
  - b. \_\_\_\_\_ 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): \_\_\_\_\_

**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 had 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've been told about: Yes/No
  
4. Do you *currently* have any of the following 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 with other people at an ordinary 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 (thick sputum): 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 that 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 had* 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've used a respirator, have you *ever had* any of the following problems? (If you've never used a respirator, check here • 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 below must be answered by every employee who has been selected to use either a full-facepiece 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 or vision problem: Yes/No
  
12. Have you *ever had* an 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 problem 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.

1. In your *present* job, are you working at high altitudes (over 5,000 feet) or in a place that has lower than normal amounts of oxygen: Yes/No  
If "yes," do you have feelings of dizziness, shortness of breath, pounding in your chest, or other symptoms when you're working under these conditions: 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., in sandblasting): 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
- j. Any other hazardous exposures: Yes/No

If "yes," describe these exposures: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

4. List any second jobs or side businesses you have: \_\_\_\_\_  
\_\_\_\_\_

5. List your previous occupations: \_\_\_\_\_  
\_\_\_\_\_

6. List your current and previous hobbies: \_\_\_\_\_  
\_\_\_\_\_

7. Have you been in the military services? Yes/No  
If "yes," were you exposed to biological or chemical agents (either in training or combat):  
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," name the medications if you know them: \_\_\_\_\_
10. Will you be using any of the following items with your respirator(s)?
- HEPA Filters: Yes/No
  - Canisters (for example, gas masks): Yes/No
  - Cartridges: Yes/No
11. How often are you expected to use the respirator(s) (circle "yes" or "no" for all answers that apply to you)?:
- Escape only (no rescue): Yes/No
  - Emergency rescue only: Yes/No
  - Less than 5 hours *per week*: Yes/No
  - Less than 2 hours *per day*: Yes/No
  - 2 to 4 hours *per day*: Yes/No
  - Over 4 hours *per day*: Yes/No
12. During the period you are using the respirator(s), is your work effort:
- Light** (less than 200 kcal per hour): Yes/No  
If "yes," how long does this period last during the average 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 (1-3 lbs.) or controlling machines.
  - Moderate** (200 to 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 nailing or filing; *driving* a truck or bus in urban traffic; *standing* while drilling, nailing, performing assembly work, or transferring a moderate load (about 35 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.
  - Heavy** (above 350 kcal per hour): Yes/No  
If "yes," how long does this period last during the average shift: \_\_\_\_\_ hrs. \_\_\_\_\_ mins.  
Examples 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

If "yes," describe this protective clothing and/or equipment: \_\_\_\_\_

\_\_\_\_\_

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

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

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

\_\_\_\_\_

\_\_\_\_\_

17. Describe any special or hazardous conditions you might encounter when you're using your respirator(s) (for example, confined spaces, 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):

## Hazardous Devices School Physical Examination Requirements for Students

The following physical examination forms and results are required for applications to the HDS Basic and Recertification Courses:

### 1. OSHA physical examination:

a. Standard physical exam that complies with OSHA 29CFR 1910.120. Complete the attached OSHA questionnaire and make this available to the physician.

b. If this OSHA related physical examination is more than 12 months prior to the date of graduation from training, a written certification must be provided prior to attendance of annual re-examination, or determination by the certifying physician that an examination on a bi-annual basis is acceptable. (See OSHA 29CFR 1910.120(f)). Instead of having students submit the actual results of this physical update, HDS will send an acceptance packet prior to attendance and include a letter to be signed by the department verifying this compliance.

c. Submit all written records related to the initial physical examination to HDS with the application.

d. The regulations concerning the requirement for an OSHA physical examination apply directly to employers. HDS has adopted this standard because the nature of the training has come to include not only bomb suits, but also chemical suits with respirators. Any references to "annual" requirements in the OSHA questionnaire, other than the update mentioned above, will not be monitored by HDS, and do not relate specifically to certification.

### 2. Additional forms required by HDS:

a. Standard Form 93 (completed by the candidate) along with the application.

b. Standard Form 88 (completed by the physician) along with the application. The Standard Form 88 in this Guide has been modified for HDS use only. If the doctor fails to fill in any of the required blocks, the application will be placed in a problem file and the applicant, applicant's bomb squad commander or the Training Technician will be notified to rectify the problem. The following sections must be completed on the SF88: 1, 5, 6, 7, 8, 9, 12a, 14, 17, 19 (B and D), 20, 21, 26A, 27A, 28, 30, 33 (Color Vision - Basic applicants only), 40, 42 - 44 (as required), 46, 48.

c. HDS Physical Capacities Form: Physician's indications that there are no medical restrictions related to HDS training.

### 3. Specific requirements for acceptance to HDS:

a. **Blood Pressure:** If the blood pressure is over 140/90, the physician's assessment of what is normal and safe for the individual must be included.

b. **Height/Weight Ratio:** Please refer to the attached height/weight chart that has been adopted by the National Bomb Squad Commanders Advisory Board as part of the National



Guidelines for Bomb Technicians. Recertification students who do not meet this requirement may complete the Performance Standard Test Form documented by their bomb squad commander. Basic students who do not meet this requirement must complete a body fat analysis test and provide the results to the HDS Registrar.

c. **Distant Vision:** Distant vision of at least 20/20 in one eye and 20/40 in the opposite eye, with or without corrective lenses, as measured by the 20-foot Snellen chart or equivalent.

d. **Near Vision:** Near vision of at least 20/40 in each eye, with or without correction, as measured by the Snellen chart or equivalent. Corrective lenses worn in protective suits must be safety glasses or inserts.

e. **Color Perception:** Color vision testing is required for Basic Course students only. Normal color perception as measured by Pseudoisochromatic Plates (PIP). Anyone who is not rated at the "Normal" level for the PIP color deficiency test, is allowed to take the Farnsworth Dichotomous (D-15) test.

f. **Hearing:** Average (mean) hearing level of 25dB at the four audiometer test frequencies 500, 1000, 2000, and 3000 Hz, with or without hearing aid.

g. **Seizure disorders:** Any history of seizure disorder is subject to review by HDS.

All physical examinations are subject to review by the FBI Health Care Programs Unit for determination as to the applicant's fitness for HDS training.