WESTON FIRE

To: All members of the Weston Volunteer Fire Department & Weston EMS

From: Marc Barenberg, Purchasing Agent

RE: Annual Physical Exams

Date: November 2018

All members of the WVFD must have an annual physical to remain active and compliant in the department.

The department recommends that all physicals include the following:

- NFPA compliant History and Complete Physical Exam
- Electrocardiogram Exam (EKG)
- Blood Draw/ CBC
- Complete Lipid Profile
- Urinalysis
- TB Screening (PPD)
- Visual Acuity and Peripheral Vision Testing
- Spirometry
- Audiometry

If the doctor presents you with any diagnosis that requires further tests or procedures, you (or your medical insurer) will be responsible for payment of those services. Be sure to consult your medical insurance provider in such circumstances.

The department offers the following two options to complete your annual physical requirement.

Option 1:

The department has partnered with the following facility to conduct standard physical:

*****AFC Urgent Care*****
607 Main Avenue
Norwalk, CT
(203) 845-9100
(call 24-hours in advance)

Please be sure to correctly identify yourselves as members of the Weston Volunteer Fire Department or Weston EMS. AFC will bill the department directly.

AFC Urgent Care is a walk-in urgent care clinic. We are listing them as a preferred provider, because of their location, easy access, and efficient operation. For those that require additional services (i.e. CDL, camp/school forms for the kids, x-rays, etc.), AFC Urgent Care has agreed to charge you the discounted corporate rate[s].

Option 2:

You may use your preferred physician to complete these tests/exams. In this case, we ask that you submit to your own insurance. In the event the above tests are not covered by your insurance, the department will reimburse you up to $330.00. **WVFD will reimburse members for any out-of-pocket expenses born from the above recommended tests that are not covered by insurance up to $330.00 (this includes blood draw and/or outside labs).** Any additional tests that are recommended and/or provided by your physician will be for your account.

For your own reference, the following are some of the tests and services that are **NOT** covered by WVFD as a part of the annual physical:

- Nutritional Consultation
- Fitness Assessment
- Cardiac Stress Test
- Chest X-Ray
- Prostatic-Specific Antigen (PSA)
- Stool Occult Blood
- Bone Density
- Colonoscopy
- Mammography

Upon completion of your physical, it is your responsibility to return copies of the signed forms to WVFD's Office Administrator.

- Medical Evaluation for Firefighters Certificate **[FIRE]**
- Respirator Medical Evaluation Questionnaire/Certificate **[FIRE]**

All other materials that may be included in this package (e.g SCBA Medical Package, Respirator Medical Evaluation) are for your review and discussion/disclosure with your appointed physician. WVFD does not require any of those items/documents be returned. Aside from the aforementioned compliance certificates, WVFD does not maintain records or health questionnaires of our members.

Feel free to contact me with any questions, mbarenberg@wvfd.com or 203-253-3317.

Sincerely,

Marc Barenberg
Purchasing Agent
Weston Fire Department

RETURN TO WVFD

Weston Volunteer Fire Department

Medical Evaluation for Firefighters

To: Chief, Weston Volunteer Fire Department

Re:_____
Name of Firefighter

I have been given a copy of NFPA 1582, Medical Requirements for Firefighters and I have evaluated the firefighter named above on the date shown below in accordance with those requirements. Base on my evaluation:

_____ I certify that the firefighter is fit for duty.

_____I certify that the firefighter is fit for restricted duty, subject to the following limitations.

_____

_____

_____The firefighter is not fit for duty.

Date of evaluation_____

_____ _____
Doctor's Signature Doctor's Name

_____
Address

_____

I have been evaluated/examined on the date, and by the physician shown above. I have been given the results of my evaluation/examination and have had the opportunity to discuss them with the doctor. I understand that the Weston Volunteer Fire Department does not have a copy of the evaluation/examination and that it is my responsibility to deliver a copy to the Chief if I want a copy on file in the event of an emergency. I also understand that any medical records delivered to the Chief will be kept confidential and not disclosed to any person without my express permission.

_____ _____
Firefighter Date

RETURN TO WVFD

Weston Volunteer Fire Department

Respirator Medical Evaluation Questionnaire

OSHA 1910.134-Appendix C

Report by Qualified Medical Professional

To: Chief, Weston Volunteer Fire Department

Re: _____ _____
Print-Name of Firefighter Date of Birth

_____
Firefighter's Address

I have reviewed the Respirator Medical Evaluation Questionnaire completed by the name firefighter and find:

Check One Box Below

_____The named firefighter is able to use a respirator in his/her firefighting activities without any restrictions.

The named firefighter may use a respirator in his/her firefighting duties subject to the following limitations: _____
_____

_____

_____The named firefighter is NOT ABLE to use a respirator in his/her firefighting duties.

I have received a copy of the Weston Volunteer Fire Department's Respirator Standard Operating Procedure and a copy of the OSHA standard.

_____ _____
Date Signature

_____
Print Name

_____
Address

_____

To: Medical Professional

From: Deputy Fire Chief, Terrence Blake

Re: Medical Evaluation-OSHA Respiratory Regulations

OSHA requires that each of our firefighters be evaluated to determine their ability to use certain respiratory protection. The OSHA regulations provide for a specific medical information questionnaire that may be used by you in making a medical determination concerning an individual's fitness to use respiratory protection.

The attached questionnaire is being submitted for your review and evaluation. We ask that based upon the information contained in that questionnaire that you complete the enclosed report and return it to the Department. You are asked, per OSHA regulations to send a copy of the report to the firefighter. The Department does not want to receive any clinical or diagnostic information concerning the firefighter.

In making your assessment, please be advised of the following factors:

- The respirator to be used will be a Self-Contained Breathing Apparatus (SCBA), which consists of an air tank, harness and full-face piece, which is carried on the person's back. The SCBA weighs approximately 25 pounds.

- The firefighter, while wearing the SCBA will also be wearing structural firefighting gear, which weighs approximately 25 pounds. Due to the nature of the gear, core body temperature will be raised.

- In addition to the above factors, the firefighter may often be performing strenuous exercise in a very hot environment when performing fire suppression activities.

- You may want to (a) conduct further examination or (b) obtain more detailed answers to the questions in the questionnaire. In either event, the Department's Office Manager can assist you in contacting the firefighter directly.

You have previously been provided with a copy of the Department's Standard Operation Plan covering respiratory protection, as well as a copy of the PSHA regulation. If you need another copy of either of these two documents, please contact me.

Please send all bills for your services to the Weston Volunteer Fire Department.

OSHA RESPIRATOR MEDICAL EVALUATION QUESTIONNAIRE

1910.134 Appendix C (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? ❑ 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, 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)

Date: ____/____/____ Employee Number: _____

Name: _____ Age: _____
Job Title: _____Firefighter_____ Height: _____ft. ____in.

Weight: _____lbs.

Phone number where you can be reached by the Health Care Professional who reviews this questionnaire (including Area Code): _____ Best time to reach you at this number: _____ days

Has your employer (Weston Fire Department) told you how to contact the health care professional who will review this questionnaire? ❑ Yes ❑ No

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) **N95**

☑ Other type (for example, half – or full-facepiece type, powered-air purifying, supplied-air, self-contained breathing apparatus

Have you ever worn a respirator? ❑ Yes ❑ No If yes, what type(s): Full face piece SCBA

Part A. Section 2. (Mandatory)

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	❑ 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 problems 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 in an ordinary place	❑ Yes	❑ No
d. Have to stop for breath when walking at your own pace on ground level	❑ 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 up 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 problem?		
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 problems 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 had used a respirator, check the following box ❑ 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 problems 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

10. Have you ever lost vision in either eye (permanently or temporarily)? ❑ 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 problem ❑ Yes ❑ No

12) 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

13) Have you ever had a back injury: ❑ Yes ❑ No

14) Do you have any of the following musculoskeletal problems:

a. Weakness in arms, hands, legs, or feet ❑ Yes ❑ No
b. Back Pain ❑ Yes ❑ No
c. Difficulty moving arms and legs ❑ Yes ❑ No
d. Pain or stiffness when you lean forward or backward at waist ❑ Yes ❑ No
e. Difficulty moving head up or down ❑ Yes ❑ No
f. Difficulty moving head side to side ❑ Yes ❑ No
g. Difficulty bending at knees ❑ Yes ❑ No
h. Difficulty squatting to the ground ❑ Yes ❑ No
i. Difficulty climbing a ladder or flight of stairs carrying more than 25lbs ❑ 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 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)?
    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) (circle "yes" or "no" for all answers that apply to you)?:
    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 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.

b. *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.

c. *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: Structural firefighter gear with SCBA tank

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

Fire suppression, rescue, working with hand and power tools

17. Describe any special or hazardous conditions you might encounter when you're using your respirator(s) (for example, confined spaces, life-threatening gases): toxic conditions and low oxygen

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): Unknown at this time

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): Fire suppression and rescue
_____