

Fax

To: K. Chase, MD & S. Scott, MD

From:



Fax: 202-223-6525

Pages:

Phone:

Date:

Re:

CC:

Comments

My completed Civil Emergency Medical Screening Packet and additional information, if necessary, is included in this fax.

After you have completed your review, please email the Physician Medical Clearance Memorandum to the DOI Emergency Operations Center: DOIEnglink@DO.USBR.gov

My home duty station is _____

My EOC can be reached by fax at 303-445-3961 or by telephone at 303-445-2775.

If you have any questions regarding the information provided, I can be contacted at _____

If you cannot locate me, please contact my supervisor _____ at _____

Thank you,

**[BEGIN] MEDICAL SCREENING QUESTIONNAIRE
Version 2.7 (September 2008)**

Through the lessons learned process, it has been determined medically screening deployees drastically decreases the number of medical emergencies during deployment. The Department of the Interior and the U.S. Corps of Engineers have made a decision to include the Department of Interior employees in the medical screening program. Throughout the process, you may read or hear of two types of deployment, office only and field. Due to the nature of your job, you are being requested to be deployed for field, because you will be expected to work long hours outside under less than desirable conditions. The work tasks usually include observing and accounting for contractors who are collecting and consolidating debris, installing blue roofs, or assessing the structure of or demolishing damaged structures. The medical data sheet identifies conditions that have in the past or in the opinion of the medical screening physician, could increase the likelihood of a medical emergency in the field. If after completing the data sheet you question your ability to deploy, please speak to your deployment center personnel for further clarification.

To deploy with the U.S. Army Corps of Engineers for a Civil Emergency response or recover effort, complete this Medical Data Sheet according to the attached instructions. Your civil emergency deployment status is dependent on the Medical Provider receiving ALL the required information. Double Check! It is important to complete this information to the best of your ability. Our primary goal is to ensure that you can perform the job tasks assigned while working long hours under stressful and sometimes physically demanding working conditions without jeopardizing your health.

Section I. Personal Identifiers

The following Personal Identifiable Information (PII) is required in order to process your Civil Emergency Medical Screening Packet. All data is subject to HIPAA and Privacy Act requirements and is stored in a secure, format. Any changes made to your auto-populated data on this form will *not* be reflected back to your Personal Data Sheet (PDS).

*1. Last Name:



*2. First Name:

*3. Middle Initial:

4. Social Security:

*5. Date of Birth (DD-Mon-YYYY):

6. Office Symbol:

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7. Supervisor Name:

8. Supervisor Phone:

9. Telephone Numbers

*9a. Telephone (Work):

9b. Telephone (Home):

9c. Telephone (Cellular):

9d. Telephone (Pager):

Section II. Duty Description

The qualifications for your chosen deployment will be determined by the information you supply in the proceeding sections.

Note: FIELD DEPLOYMENTS must be selected if you wish to deploy OCONUS.

*1. FIELD DEPLOYMENTS: Are you requesting a medical clearance for Field work?
Field work is primarily conducted outdoors at a CONUS or OCONUS disaster site such as that performed by a Debris Quality Assurance Inspector, Construction Representative, et. al.

Yes No

Section III. General Information

Please answer the following questions regarding prior deployment experience and general physical ability.

*1. Are you taking any medications or prescription drugs?

If Yes, you must describe in full.

Yes No

*2. Has your doctor restricted you from performing certain activities?

If Yes, you must describe in full.

Yes No

3. Do you have any condition that would...

*3a. Interfere with your ability to evacuate a site during an emergency?

If Yes, you must describe in full.

Yes No

*3b. Make you prone to sudden incapacitation?

If Yes, you must describe in full.

Yes No

*3c. Be aggravated by significant exertion?

If Yes, you must describe in full.

Yes No

*3d. Interfere in any way with the full performance of emergency duties?

If Yes, you must describe in full.

Yes No

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*4. Have you ever been denied deployment to emergency response operations due to medical condition?

If Yes, you must describe in full.

Yes No

*5. Have you ever been sent home from emergency response operations due to a medical condition? If Yes, you must describe in full.

Yes No

*6. Are you currently pregnant?

If Yes, you must include a medical release form from your obstetrician with this completed questionnaire to the USACE Medical Provider @ 202-223-6525 (Fax).

Yes No

Section IV. Medical History

Please answer the following questions related to your past medical history and current medical conditions, if applicable.

*7. Do you have an active case of a communicable disease e.g. tuberculosis, chicken pox? If Yes, you must describe in full.

Yes No

*8. Do you bleed excessively after injury or tooth extraction? If Yes, you must describe in full.

Yes No

*9. Do you wear a leg brace, back brace, back support, or any other type of brace? If Yes, you must describe in full.

Yes No

*10. Have you been told within the past year that you have an abnormal EKG? If Yes, you must describe in full.

Yes No

*11. Do you have swollen or painful joints? If Yes, you must describe in full.

Yes No

*12. Do you have dizziness or fainting spells? If Yes, you must describe in full.

Yes No

*13. Have you had an asthma attack within this past year? If Yes, you must describe in full.

Yes No

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*14. Have you ever been hospitalized for asthma?

If Yes, you must describe in full.

Yes No

*15. Do you have shortness of breath?

If Yes, you must describe in full.

Yes No

*16. Do you have pain or pressure in chest?

If Yes, you must describe in full.

Yes No

*17. Do you have palpitations (flutter or pounding heart beat)?

If Yes, you must describe in full.

Yes No

*18. Do you have high or low blood pressure?

If Yes, you must describe in full.

Yes No

19. If you do have high or low blood pressure, is it well controlled?

If Yes, you must describe in full.

Yes No

*20. Do you have a history of heart attack or stroke?

If Yes, you must describe in full.

Yes No

*21. Do you have cramps in your legs?

If Yes, you must describe in full.

Yes No

*22. Have you been told that you have a hernia?

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If Yes, you must describe in full.

Yes No

*23. Do you have any life-threatening allergic reaction e.g. bee sting, shellfish or medications?

If Yes, bring your Epi-pen with you on your deployment.

Yes No

*24. Are you currently being treated for depression?

If Yes, you must describe in full.

Yes No

*25. Are you currently suffering from depression or excessive worry?

If Yes, you must describe in full.

Yes No

*26. Are you currently being treated for any current illness?

If Yes, you must describe in full.

Yes No

*27. Have you been hospitalized or had surgery within the past year?

If Yes, you must describe in full.

Yes No

*28. Are you currently using any medications that may make you sleepy or reduce your level of attention during working hours?

If Yes, you must describe in full.

Yes No

*29. Are you currently using any medications that require refrigeration?

If Yes, you must describe in full.

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Yes No

*30. Are you diabetic?

If Yes, please answer questions #31 and #32.

Yes No

31. Do you take insulin?

If No, you must describe in full.

Yes No

32. Do you take medication by mouth for elevated blood sugar?

If No, you must describe in full.

Yes No

*33. Do you have any history of any seizure disorder?

If Yes, please answer question #34.

Yes No

34. Are your seizures controlled?

If No, you must describe in full.

Yes No

*35. Are you taking Anticoagulants (blood thinner)?

If Yes, you must describe in full.

Yes No

*36. Do you have migraines or severe headaches?

If Yes, you must describe in full.

Yes No

*37. Do you have any gastrointestinal disorder or disease?

If Yes, you must describe in full.

Yes No

Section V. Physical Capacity - FIELD Work

Complete this section only if you have selected to be cleared for Field deployments, which may include Office work. This section must be completed if you intend to deploy OCONUS.

*38. Do you have complete use of your arms and legs?

If No, you must describe in full.

Yes No

*39. Can you perform light lifting (under 15 pounds) on a regular basis without pain?

If No, you must describe in full.

Yes No

*40. Can you reach above your shoulders and work comfortably?

If No, you must describe in full.

Yes No

*41. Can you reach below your knees and work comfortably?

If No, you must describe in full.

Yes No

*42. Can you use your fingers on both hands comfortably?

If No, you must describe in full.

Yes No

*43. Can you walk/stand up to four (4) hours daily?

If No, you must describe in full.

Yes No

*44. Can you kneel without pain?

If No, you must describe in full.

Yes No

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*45. Can you use your legs only to climb (e.g. hills or steps) for up to 1 hour without pain? If **No**, you must describe in full.

Yes No

*46. Can you climb using your legs or arms to safely work on ladders or scaffolding? If **No**, you must describe in full.

Yes No

*47. Can you work at heights, below ground, or in confined spaces (tunnels/basements)? If **No**, you must describe in full.

Yes No

*48. Can you work in a noisy environment using hearing protection? If **No**, you must describe in full.

Yes No

*49. Can you work outside, exposed to the weather, nuisance dust and air pollutants? If **No**, you must describe in full.

Yes No

*50. Can you wear personal protective equipment such as respirators and protective clothing? If **No**, you must describe in full.

Yes No

*51. **With or without** corrective lenses, are you able to read a typewritten letter at arms length? If **No**, you must describe in full.

Yes No

*52. **With or without** the aid of corrective lens is your vision at least 20/20 in one eye and at least 20/40 in the other? If **No**, you must describe in full.

Yes No

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*53. With or without the use of hearing aid(s), can you hear normal conversational speech? If No, you must describe in full.

Yes No

*54. Can you tolerate excessive heat and humidity (typical Florida summer weather)? If No, you must describe in full.

Yes No

*55. Can you tolerate excessive cold (temperatures less than 4 degrees C / 40 degrees F)? If No, you must describe in full.

Yes No

*56. Can you perform your normal job duties without fatigue? If No, you must describe in full.

Yes No

*57. Are you able to work closely with others under stressful conditions? If No, you must describe in full.

Yes No

*58. Are you able to work alone and away from your normal routine? If No, you must describe in full.

Yes No

*59. Are you able to work protracted or irregular hours away from your home? If No, you must describe in full.

Yes No

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*60. Do you have a current valid driver's license?

If **No**, you must describe in full.

Yes No

*61. If **Yes** to # 60, does your license have any restrictions?

Yes No

SECTION VI. Employee Consent

PRIVACY ACT NOTICE: This information is provided in accordance with the requirements of the Privacy Act of 1974. (See AR 340-21.)

AUTHORITY: 5 USC 3301, 33 USC 701n, 42 USC 5121 et. Seq., E.O. 9397. System notices A0690-200TAPC, Army Civilian Personnel Systems; OPM Govt 1, General Personnel Records; OPM Govt 10, Employee Medical File System Records. Collection is also addressed in ER690-1-321, Staffing for Civilian Support to Emergency Operations. The purpose for collecting information in the Medical Data Sheet (MDS)is to allow the Medical provider to review your medical condition to ensure that you can perform the job tasks assigned while working long hours, under stressful and sometimes physically demanding conditions without jeopardizing your health. Emergency Managers will use the Medical provider clearance determination to assign tasks and manage staff during deployment to emergency events. Providing information in the MDS strictly voluntary. If you fail to provide the information the Medical provider will not be able to evaluate your medical condition and you may not be selected for deployment.

PURPOSE: The medical screening questionnaire, interviews, data obtained from tests, review of existing records and review by a medical professional is utilized to determine whether assigned or volunteer employees have any health problems that would prevent them from deployment to, or adversely impact their assigned duties at, emergency response sites. The medical information collected will be filed with other medical record information in the employee's medical file (EMF).

ROUTINE USE: Information may be shared with other Federal agencies such as OSHA and FEMA and state and local agencies for law enforcement, and occupational and/or public health purposes.

DISCLOSURE: Providing this information is voluntary. However, refusal to provide the information requested, including medical information and social security number, may result in the employee not being deployed to perform emergency response assignments at emergency response sites.

I certify that I have reviewed the information I have supplied, it is true and complete to the best of my knowledge, and that I have read the Privacy Act Notice assigned to the use of this information.

Write Name in Full

Sign Name in Full

Date

[END] MEDICAL SCREENING QUESTIONNAIRE