

Oswego Town Fire District
640 County Route 20
Oswego, New York 13126
315•343•2030
www.otvfd.com

Medical Evaluation Policy Instructions for Physicals

This packet **must** be used for any physical that will be used for the Oswego Town Fire District.

Page 2-3 information is for you, the firefighter

Page 4-5 information is for the PLHCP (doctor).

Page 6-14 (questionnaire) is for Interior/SCBA firefighters to fill out. You should complete this prior to your visit to the PLHCP (as long as the information is accurate and does not change prior to your visit). If you plan to do any type of training with SCBA you need to complete this section.

Page 15-19 (questionnaire) is for **NON**-Interior/SCBA firefighters to fill out. You should complete this prior to your visit to the PLHCP (as long as the information is accurate and does not change prior to your visit).

Questionnaire information is for the PLHCP only, not to be reviewed by any other Fire District officials. This information can stay in your personal file with you PLHCP.

Page 20, Medical Evaluation Form, must be completed by the PLHCP. **This part and this part only** need to be returned to the Fire District. (Chief or Captain).

If you have any questions, please contact the Fire Chief.

Fire District Doctor is:

Oswego Family Physicians

110 West Utica St (corner of West 9th)

Phone – 342-2024

Call for hours; they do have some early and some late days.

Lab opens at 7am on Tues and Thurs.

Medical Evaluation Policy for The Oswego Town Fire District

All active personnel shall successfully complete a medical evaluation every twelve months. The medical evaluation shall be completed by Oswego Family Physicians or other medical personnel approved by the fire district. Only those personnel that are deemed to be physically fit for certain roles in the department may serve in those capacities. The district shall create standards of physical fitness. Should a person not be able to safely fulfill those standards, such person shall not operate in that capacity. Any person that is not able to be certified to fulfill a desired role may re-test at a later date once the physical issues have been rectified.

The Oswego Town Fire District will covers the costs of the required physical and associated tests when completed at Oswego Family Physicians. If a female volunteer or prospective female volunteer chooses to use her own female PLHCP, the Oswego Town Fire District will reimburse for out of pocket cost up to the cost of current firefighter physical and testing.

The medical evaluation shall obtain the information requested by the questionnaire attached with this document. Members must release the results of their medical exam in the form of 'pass' or 'does not pass' to the fire district. No information other than this will be released from the exam.

It is the volunteer's responsibility to notify the Oswego Town Fire District if any of the medical conditions mentioned in Section 2 change during the period of time between annual physicals. The fire district will ensure a follow up medical examination to reevaluate the member's fire department status based on the current circumstances. The volunteer can be requested to have a re-examination at any time, as deemed necessary by the Chief of the department.

The fire chief shall be notified before any follow up examinations take place, unless delay shall cause possible harm to the volunteer, as determined by the PLHCP.

The Fire District Medical Director has determined that the following things will be included in the yearly physicals:

1. Complete routine physical exam
2. Pulmonary function test
3. EKG with printout
4. Baseline chemistry profile, CBC and cardiovascular risk.
 - a. If there are abnormalities in the blood work or elevated cholesterol, the member may be required to have a repeat blood work done.
5. Tetanus shot every 10 years.
6. Tuberculosis vaccine yearly.
7. Recommended flu vaccine annually.

If a female member chooses to have the physical done by a female doctor, a complete detailed record, including EKG and PFT results must be submitted to the district medical director for review. The Fire District Medical Director will make final determination of active status based on results of the above tests. It is the member's responsibility to deliver the information to Oswego Family Physicians for review.

If is highly suggested that all blood and urine samples/testing be taken at the lab inside of Oswego Family physicians. Alternatively the Lab at Oswego Hospital can be used.

If, during the course of the annual physical, the PLHCP finds any abnormalities in any of the tests being conducted he/she may require the member to see their personal physician for additional testing/procedures. The costs associated with any follow up appointments/procedures/testing will be the responsibility of the member.

***Information for PLHCP
Physician or Licensed Health Care Provider
related to evaluating individuals for any firefighting position.***

The Oswego Town Fire District has 4 levels of firefighting positions. All positions are voluntary and require different levels of expertise. They are detailed below:

Class 1 - Interior volunteer firefighter

Duties may include, but are not limited to the following:

1. Suppression and control of building and other fires by operating firefighting equipment in hazardous areas, confined spaces and high places such as ladders. Suppresses grass and brush fires using fire hose and equipment and wild land firefighting hand tools. Conduct rescue operations from smoke filled or confined areas that have been compromised by fire. Cleans up debris and does salvage work during and after firefighting.
2. Performs and/or assists with emergency medical treatment to ill and injured persons.
3. Performs technical rescues using ropes and associated rescue hardware, various power tools and hand tools and techniques for special rescue situations (mechanical entrapments, confined spaces, high angle, and trench rescues).
4. Responds to hazardous materials releases to safely isolate and deny entry, to make appropriate notifications, and perform mitigation tasks as appropriate.
5. Perform company level fire prevention inspections and hazard reduction activities.
6. Performs public relations and educational awareness actions by meeting and speaking to civic and school based groups.
7. Drives and maintains both large and small firefighting apparatus after appropriate training. Performs minor repair and inspection work. Makes necessary adjustments as needed.
8. Completes routine daily fire station janitorial and maintenance tasks.
9. Utilizes self-contained breathing apparatus (SCBA) to operate in hazardous environments.
10. Performs other related duties as required.

Class 2 - Exterior volunteer firefighter

This classification is the same as the interior firefighter listed above with the exception of the use of self contained breathing apparatus. This person will be doing the same tasks without making entry into any hazardous areas requiring SCBA.

Class 3 - Volunteer firefighter

Duties may include, but are not limited to the following:

1. Fire Police duties requiring firefighter to have to stand for long periods of time in various weather conditions.
2. Perform company level fire prevention inspections and hazard reduction activities.
3. Performs public relations and educational awareness actions by meeting and speaking to civic and school based groups.
4. Drives and maintains both large and small firefighting apparatus in both emergency and non-emergency responses.
5. Performs minor repair and inspection work to firefighting vehicles. Makes necessary adjustments as needed.
6. Completes routine daily fire station janitorial and maintenance tasks.

Class 4 – Light duty firefighter

A firefighter on light duty is restricted to the following:

1. Attend department related meetings.
2. Take advantage of all house privileges.
3. Participate in social affairs such as installation dinner, holiday gatherings, etc.
4. Funerals
5. Participate in classroom related training that does not involve physical exertion.

Information for evaluating individuals for Class 1 Firefighter (interior firefighting)

Physicians shall evaluate the ability of active members to safely complete the following activities. Any person that may not safely complete the activity shall not pass a physical exam.

The Oswego Town Vol. Fire Dept. uses Scott Aviation, 4500-PSI positive pressure self-contained breathing apparatus (SCBA). The SCBA utilizes 30-minute cylinders and the total unit (air pack and bottle) weighs approximately 25 lbs.

Each interior qualified volunteer will wear the air pack at least once per calendar quarter in training. They will also wear the air pack during any emergency where required, approximately 2-3 times per month.

The department policy limits interior qualified volunteer's to two (2) 30 minute cylinders before requiring a medical evaluation at the scene (Re-hab).

An extreme work effort will be required while performing duties in an air pack.

Whenever an interior qualified volunteer is wearing an air pack they will be in full turnout gear that includes coat, pants, boots, protective hood, gloves and helmet. This gear will add an additional 15-20 pounds to the volunteer.

Work temperatures can reach upwards of 1200 degrees during use of the air pack. Humidity will be extreme.

Medical Determination

The Oswego Town Vol. Fire Dept. will obtain a written recommendation regarding the interior qualified volunteer's ability to use our air pack.

Any restrictions or limitations will be designated on the form provided in this document.

Any interior qualified volunteer passing the physical exam will be required to pass a pulmonary function test and certified mask fitting prior to using any fire department SCBA.

Physicians shall evaluate the ability of active members to safely complete the assigned activities. Any person that may not safely complete the activity shall not pass the physical exam.

If needed, any follow-up medical evaluations will be ordered.

The volunteer may obtain a copy of the PLHCP's written recommendation from the Oswego Town Vol. Fire Dept.

Additional medical evaluations will be required if:

Any volunteer reports signs or symptoms that are related to the use of the air pack.

A PLHCP or fire department official informs the volunteer that he/she needs to be re-evaluated.

Information from the respiratory protection program, including observations made during fit testing and program evaluation indicates the need.

OSHA Medical Evaluation Questionnaire for firefighter wearing respiratory apparatus

To the volunteer please complete the following questions:

Can you read (circle one): Yes / No

This questionnaire can be completed at a time and place that is convenient to you. To maintain your confidentiality, the fire district or fire chief must not look at or review your answers. This questionnaire is to be given to the PLHCP doing the exam and kept in your medical files with that person.

Section 1. General Information (Mandatory) The following information must be provided by every volunteer 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 (circle one): INTERIOR QUALIFIED VOLUNTEER FIREFIGHTER
or _____

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. _____ Other type (for example, half- or full-face piece type, powered-air purifying, supplied-air, self-contained breathing apparatus). This is the correct choice for the Oswego Town FD air packs.

b. _____ N, R, or P disposable respirator (filter-mask, non- cartridge type only).

12. Have you ever worn a respirator (circle one): Yes / No

If yes, please circle which type

a. Oswego Town FD - Scott Aviation, 4500 PSI positive pressure SCBA – Full face piece

b. Other type(s): _____

Section 2. Medical History (Mandatory) Questions 1 through 9 below must be answered by every volunteer 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?

Yes / No - Seizures (fits)

Yes / No - Diabetes (sugar disease)

Yes / No - Allergic reactions that interfere with your breathing

Yes / No - Claustrophobia (fear of closed-in places)

Yes / No - Trouble smelling odors

3. Have you **ever had** any of the following pulmonary or lung problems?

Yes / No - Asbestosis

Yes / No - Asthma

Yes / No - Chronic bronchitis

Yes / No - Emphysema

Yes / No - Pneumonia

Yes / No - Tuberculosis

Yes / No - Silicosis

Yes / No - Pneumothorax (collapsed lung)

Yes / No - Lung cancer

Yes / No - Broken ribs

Yes / No - Any chest injuries or surgeries

Yes / No - Any other lung problem that you've been told about

If yes to any of the above problems, please provide details _____

4. Do you **currently** have any of the following symptoms of pulmonary or lung illness?

Yes / No - Shortness of breath

Yes / No - Shortness of breath when walking fast on level ground or walking up a slight hill or incline

Yes / No - Shortness of breath when walking with other people at an ordinary pace on level ground

Yes / No - Have to stop for breath when walking at your own pace on level ground

Yes / No - Shortness of breath when washing or dressing yourself

Yes / No - Shortness of breath that interferes with your job

Yes / No - Coughing that produces phlegm (thick sputum)

Yes / No - Coughing that wakes you early in the morning

Yes / No - Coughing that occurs mostly when you are lying down

Yes / No - Coughing up blood in the last month

Yes / No - Wheezing

Yes / No - Wheezing that interferes with your job

Yes / No - Chest pain when you breathe deeply

Yes / No - Any other symptoms that you think may be related to lung problems

If yes to any of the above problems, please provide details _____

5. Have you **ever had** any of the following cardiovascular or heart problems?

Yes / No - Heart attack

Yes / No - Stroke

Yes / No - Angina

Yes / No - Heart failure

Yes / No - Swelling in your legs or feet (not caused by walking)

Yes / No - Heart arrhythmia (heart beating irregularly)

Yes / No - High blood pressure

Yes / No - Any other heart problem that you've been told about

If yes to any of the above problems, please provide details _____

6. Have you **ever had** any of the following cardiovascular or heart symptoms?

Yes / No - Frequent pain or tightness in your chest

Yes / No - Pain or tightness in your chest during physical activity

Yes / No - Pain or tightness in your chest that interferes with your job

Yes / No - In the past two years, have you noticed your heart skipping or missing a beat

Yes / No - Heartburn or indigestion that is not related to eating

Yes / No - Any other symptoms that you think may be related to heart or circulation problems

If yes to any of the above problems, please provide details _____

7. Do you **currently** take medication for any of the following problems?

Yes / No - Breathing or lung problems

Yes / No - Heart trouble

Yes / No - Blood pressure

Yes / No - Seizures (fits)

If yes to any of the above problems, please provide details _____

8. If you've used a respirator, have you **ever had** any of the following problems? (If you've never used a respirator, check the following space and go to question 9:)

Yes / No - Eye irritation

Yes / No - Skin allergies or rashes

Yes / No - Anxiety

Yes / No - General weakness or fatigue

Yes / No - Any other problem that interferes with your use of a respirator

If yes to any of the above problems, please provide details _____

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 interior qualified volunteer who has been selected to use either a full-face piece respirator or a self-contained breathing apparatus (SCBA).

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?

Yes / No - Wear contact lenses

Yes / No - Wear glasses

Yes / No - Color blind

Yes / No - Any other eye or vision problem

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?

Yes / No - Difficulty hearing

Yes / No - Wear a hearing aid

Yes / No - Any other hearing or ear problem

14. Have you **ever had** a back injury: Yes / No

15. Do you **currently** have any of the following musculoskeletal problems?

Yes / No - Weakness in any of your arms, hands, legs, or feet

Yes / No - Back pain

Yes / No - Difficulty fully moving your arms and legs

Yes / No - Pain or stiffness when you lean forward or backward at the waist

Yes / No - Difficulty fully moving your head up or down

Yes / No - Difficulty fully moving your head side to side

Yes / No - Difficulty bending at your knees

Yes / No - Difficulty squatting to the ground

Yes / No - Climbing a flight of stairs or a ladder carrying more than 25 lbs

Yes / No - Any other muscle or skeletal problem that interferes with using a respirator

If yes to any of the above problems, please provide details _____

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:

Yes / No - Asbestos

Yes / No - Silica (e.g., in sandblasting)

Yes / No - Tungsten/cobalt (e.g., grinding or welding this material)

Yes / No - Beryllium

Yes / No - Aluminum

Yes / No - Coal (for example, mining)

Yes / No - Iron

Yes / No - Tin

Yes / No - Dusty environments

Yes / No - Any other hazardous exposures

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)?

Yes / No - HEPA Filters

Yes / No - Canisters (for example, gas masks)

Yes / No - Cartridges

11. How often are you expected to use the respirator(s) (circle "yes" or "no" for all answers that apply to you)?:

Yes / No - OTVFD Standard – At least once quarterly and as necessary for emergency calls, approximately 1-2/month

Yes / No - 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

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

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

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

c. **Heavy** (above 350 kcal per hour): Yes / No (Interior Firefighting falls in this category)

Examples:

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 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 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: Fire department turnout gear includes Boots, Firefighting bunker pants, Firefighting coat, thermal hood, gloves and helmet

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):

Yes / No - Physically demanding firefighting tasks as assigned based on the emergency

Yes / No - Other, please describe _____

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

Yes / No - Firefighting tasks as assigned including the potential for confined space search and rescue, hazardous materials

incidents.

Yes / No - Other, please describe _____

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):

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 security):

OSHA Medical Evaluation Questionnaire for Class 2 and Class 3 firefighters

To the volunteer please complete the following questions:

Can you read (circle one): Yes / No

This questionnaire can be completed at a time and place that is convenient to you. To maintain your confidentiality, the fire district or fire chief must not look at or review your answers. This questionnaire is to be given to the PLHCP doing the exam and kept in your medical files with that person.

Section 1. General Information (Mandatory) The following information must be provided by every volunteer 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 (circle one): CLASS 2 EXTERIOR FIREFIGHTER CLASS 3 FIREFIGHTER
or _____
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

Section 2. Medical History (Mandatory) Questions 1 through 9 below must be answered by every volunteer 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?

Yes / No - Seizures (fits)

Yes / No - Diabetes (sugar disease)

Yes / No - Allergic reactions that interfere with your breathing

Yes / No - Claustrophobia (fear of closed-in places)

Yes / No - Trouble smelling odors

3. Have you **ever had** any of the following pulmonary or lung problems?

Yes / No - Asbestosis

Yes / No - Asthma

Yes / No - Chronic bronchitis

Yes / No - Emphysema

Yes / No - Pneumonia

Yes / No - Tuberculosis

Yes / No - Silicosis

Yes / No - Pneumothorax (collapsed lung)

Yes / No - Lung cancer

Yes / No - Broken ribs

Yes / No - Any chest injuries or surgeries

Yes / No - Any other lung problem that you've been told about

If yes to any of the above problems, please provide details _____

4. Do you **currently** have any of the following symptoms of pulmonary or lung illness?

Yes / No - Shortness of breath

Yes / No - Shortness of breath when walking fast on level ground or walking up a slight hill or incline

Yes / No - Shortness of breath when walking with other people at an ordinary pace on level ground

Yes / No - Have to stop for breath when walking at your own pace on level ground

Yes / No - Shortness of breath when washing or dressing yourself

Yes / No - Shortness of breath that interferes with your job

Yes / No - Coughing that produces phlegm (thick sputum)

Yes / No - Coughing that wakes you early in the morning

Yes / No - Coughing that occurs mostly when you are lying down

Yes / No - Coughing up blood in the last month

Yes / No - Wheezing

Yes / No - Wheezing that interferes with your job

Yes / No - Chest pain when you breathe deeply

Yes / No - Any other symptoms that you think may be related to lung problems

If yes to any of the above problems, please provide details _____

5. Have you **ever had** any of the following cardiovascular or heart problems?

Yes / No - Heart attack

Yes / No - Stroke

Yes / No - Angina

Yes / No - Heart failure

Yes / No - Swelling in your legs or feet (not caused by walking)

Yes / No - Heart arrhythmia (heart beating irregularly)

Yes / No - High blood pressure

Yes / No - Any other heart problem that you've been told about

If yes to any of the above problems, please provide details _____

6. Have you **ever had** any of the following cardiovascular or heart symptoms?

Yes / No - Frequent pain or tightness in your chest

Yes / No - Pain or tightness in your chest during physical activity

Yes / No - Pain or tightness in your chest that interferes with your job

Yes / No - In the past two years, have you noticed your heart skipping or missing a beat

Yes / No - Heartburn or indigestion that is not related to eating

Yes / No - Any other symptoms that you think may be related to heart or circulation problems

If yes to any of the above problems, please provide details _____

7. Do you **currently** take medication for any of the following problems?

Yes / No - Breathing or lung problems

Yes / No - Heart trouble

Yes / No - Blood pressure

Yes / No - Seizures (fits)

If yes to any of the above problems, please provide details _____

8. Would you like to talk to the health care professional who will review this questionnaire about your answers to this questionnaire: Yes / No

9. Have you **ever lost** vision in either eye (temporarily or permanently): Yes / No

10. Do you **currently** have any of the following vision problems?

Yes / No - Wear contact lenses

Yes / No - Wear glasses

Yes / No - Color blind

Yes / No - Any other eye or vision problem

11. Have you **ever had** an injury to your ears, including a broken ear drum: Yes / No

12. Do you **currently** have any of the following hearing problems?

Yes / No - Difficulty hearing

Yes / No - Wear a hearing aid

Yes / No - Any other hearing or ear problem

13. Have you **ever had** a back injury: Yes / No

14. Do you **currently** have any of the following musculoskeletal problems?

Yes / No - Weakness in any of your arms, hands, legs, or feet

Yes / No - Back pain

Yes / No - Difficulty fully moving your arms and legs

Yes / No - Pain or stiffness when you lean forward or backward at the waist

Yes / No - Difficulty fully moving your head up or down

Yes / No - Difficulty fully moving your head side to side

Yes / No - Difficulty bending at your knees

Yes / No - Difficulty squatting to the ground

Yes / No - Climbing a flight of stairs or a ladder carrying more than 25 lbs

Yes / No - Any other muscle or skeletal problem that interferes with using a respirator

If yes to any of the above problems, please provide details _____

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. List any second jobs or side businesses you have: _____

2. List your previous occupations: _____

3. List your current and previous hobbies: _____

4. 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

5. 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: _____

Oswego Town Fire District
640 County Route 20
Oswego, New York 13126
315-343-2030

Firefighter Medical Evaluation Form

This form certifies that _____ has been examined by the doctor listed below and is medically fit to perform the tasks listed for their appropriate classification.

Please **circle the classification** that you are qualifying this individual for (definitions found on Pg 3)

Class 1 - Interior Firefighter w/SCBA use

Class 2 - Exterior Firefighter

Class 3 – Firefighter

Class 4 – Light Duty

Test to be completed:
Bloodwork
EKG
PFT
TB Test

Please list any specific restrictions that apply to this person.

Physical findings to be filled out by Doctor:

Pulse: _____ B/P: _____ Weight: _____

Pulmonary Function Test: _____

Eye test – far vision: _____

Hearing test (whispered voice or mechanical): _____

T-B Test date completed _____ Re-check completed _____

Doctor's Signature _____

Doctor's Name (Please print) _____

Date _____

Complete Oswego Town VFD Physical Includes the Following that **MUST** be done:

Blood work – You **MUST** fast 12 hrs. Prior to giving blood, make sure the technician drawing blood knows you are with the **Oswego Town VFD** and the billing is done accordingly. You can have the blood work done ahead of time if you prefer. If OFP is your primary care physician and you have other blood work done for personal reasons, then the billing **MUST** be split, they can do this, all arrangements are made. The next page is a copy of the bloodwork order form you can give directly to the person taking your blood.

EKG – Evaluated by physician.

Pulmonary Function Test – **All personnel**, regardless of SCBA qualification.

TB test – You **MUST** be able to return to the Drs. Office in 48 hrs. To have the injection site evaluated. You **MUST** bring a note from the Drs. Office that says your TB test was negative or that he is ordering further testing.

Make sure you take the firefighter evaluation form for the Dr. to sign off on your physical (last page of the medical evaluation policy). Turn that in to the Captain.

When checking out you must make sure they know you are with the Oswego Town VFD. The bill is to go to the Oswego Town VFD **ONLY**. No personal insurance is to be billed. No co-pay is required. You have **NO** financial responsibility for the physical

Make an appointment for your next physical, 12 months.

If there are any questions please contact Dan Pritchard 342-3041 or Greg Herrmann 592-1558, preferably before leaving the doctor's office.



Oswego Hospital
 110 West Sixth Street • Oswego, NY 13126
 (315) 349-5591 • Fax (315) 349-5693

Date _____
 Lab #6 revised

Laboratory Requisition Form

Required Client Information:

| | | |
|---|---------------|------------------|
| Client Name | | |
| Address | | |
| City, State, Zip Code | | |
| Sex | Date of Birth | Telephone Number |
| Ordering Clinician (Print) | | |
| Ordering Clinician Signature (Required) Oswego Family Physicians | | |

Results/Copy to:

| |
|--|
| Name |
| Address |
| City, State, Zip Code |
| Telephone Number |
| Fax Number <input type="checkbox"/> Fax Results <input type="checkbox"/> |

Financial Information:

| | | |
|--|--|------------------|
| <input type="checkbox"/> Self Pay | <input type="checkbox"/> Worker's Comp | Group # _____ |
| <input type="checkbox"/> Medicaid | <input type="checkbox"/> HMO | Sequence # _____ |
| <input type="checkbox"/> Medicare | <input type="checkbox"/> Commercial | Plan Code _____ |
| <input type="checkbox"/> Blue Cross | <input type="checkbox"/> Other | |
| Guarantor | Employer | |
| Insured Name Town of Oswego VFD | Telephone Number 315-343-2030 | |
| Address 640 County Route 20 | | |
| City, State, Zip Code Oswego NY 13126 | | |

Specimen Information:

| | |
|--|--|
| Hours Fasting | |
| Last Medication Time | |
| Collection Date | |
| Collection Time | |
| <input type="checkbox"/> Routine <input type="checkbox"/> STAT | <input type="checkbox"/> Call <input type="checkbox"/> Fax |
| Telephone Number | |

Diagnostic Testing Orders

Medicare Approved Panels

- Basic Metabolic Panel
- Comprehensive Metabolic Panel (Includes carbon dioxide)
- Renal Panel
- Hepatic (Liver) Panel
- CBC

Oswego Hospital Panels

- | | |
|--|--|
| Comprehensive Chemistry | Arthritis Panel |
| <input type="checkbox"/> Sodium | <input type="checkbox"/> Uric Acid |
| <input type="checkbox"/> Potassium | <input type="checkbox"/> Sedimentation Rate |
| <input type="checkbox"/> Chloride | <input type="checkbox"/> ANA |
| <input type="checkbox"/> Carbon Dioxide | <input type="checkbox"/> Rheumatoid Factor |
| <input type="checkbox"/> Glucose | Lipid Panel |
| <input type="checkbox"/> BUN | <input type="checkbox"/> Cholesterol, Total |
| <input type="checkbox"/> Creatinine | <input type="checkbox"/> HDL Cholesterol |
| <input type="checkbox"/> Uric Acid | <input type="checkbox"/> Triglycerides |
| <input type="checkbox"/> Calcium | Thyroid Panel |
| <input type="checkbox"/> Inorganic Phos. | <input type="checkbox"/> T-4 (Total) |
| <input type="checkbox"/> Total protein | <input type="checkbox"/> T-3 Uptake |
| <input type="checkbox"/> Albumin | <input type="checkbox"/> TSH |
| <input type="checkbox"/> Total Bilirubin | General Health Panel |
| <input type="checkbox"/> Alkaline Phos. | <input type="checkbox"/> Comprehensive Chemistry Panel |
| <input type="checkbox"/> GGT | <input type="checkbox"/> CBC |
| <input type="checkbox"/> SGPT | |
| <input type="checkbox"/> SGOT | |
| <input type="checkbox"/> LDH | |

These panels are not reimbursable under Medicare but the included individual tests can be ordered with the appropriate ICD-9 codes

Individual Tests (check under panels also)

- | | | | |
|---|--|---|---|
| Coagulation | General Chemistry | <input type="checkbox"/> Lyme Disease | Therapeutic Drugs |
| <input type="checkbox"/> Bleeding Time | <input type="checkbox"/> Amylase | <input type="checkbox"/> MonoScreen | <input type="checkbox"/> Acetaminophen |
| <input type="checkbox"/> FDP | <input type="checkbox"/> Bilirubin Conjugated | <input type="checkbox"/> Rheumatoid Factor | <input type="checkbox"/> Carbamazepine |
| <input type="checkbox"/> Fibrinogen | <input type="checkbox"/> Bilirubin Neonatal | <input type="checkbox"/> Rubella (Immune Status) | <input type="checkbox"/> Digoxin |
| <input type="checkbox"/> Prothrombin Time | <input type="checkbox"/> CPK | <input type="checkbox"/> Syphilis Serology | <input type="checkbox"/> Dilantin |
| <input type="checkbox"/> PTT | <input type="checkbox"/> Glycosylated Hgb | Microbiology | <input type="checkbox"/> Gentamicin |
| Endocrinology | <input type="checkbox"/> Iron | <input type="checkbox"/> Culture Aerobic | <input type="checkbox"/> trough <input type="checkbox"/> peak |
| <input type="checkbox"/> CA15-3 | <input type="checkbox"/> Iron Binding Capacity | source _____ | <input type="checkbox"/> Lithium |
| <input type="checkbox"/> CEA | <input type="checkbox"/> Lead Level | <input type="checkbox"/> Culture Anaerobic | <input type="checkbox"/> Phenobarbital |
| <input type="checkbox"/> Ferritin | <input type="checkbox"/> Lipase | source _____ | <input type="checkbox"/> Quinidine |
| <input type="checkbox"/> Folic Acid | <input type="checkbox"/> Magnesium | <input type="checkbox"/> Culture, Stool | <input type="checkbox"/> Salicylate |
| <input type="checkbox"/> Free T3 | <input type="checkbox"/> Microalbumin Urine | <input type="checkbox"/> Culture, Sputum | <input type="checkbox"/> Theophylline |
| <input type="checkbox"/> Free T4 | Hematology | <input type="checkbox"/> Culture, Throat (Full) | <input type="checkbox"/> Valproic Acid |
| <input type="checkbox"/> FSH | <input type="checkbox"/> Hemogram | <input type="checkbox"/> Culture, Throat (Strep) | |
| <input type="checkbox"/> LH | <input type="checkbox"/> Reticulocyte Count | <input type="checkbox"/> Culture, Urine | |
| <input type="checkbox"/> Prolactin | <input type="checkbox"/> Sedimentation rate | <input type="checkbox"/> Culture, Viral | Urinalysis |
| <input type="checkbox"/> PSA Screen V76.44 | Immunology | <input type="checkbox"/> DNA probe for Chlamydia/GC | <input type="checkbox"/> Routine Urinalysis |
| <input type="checkbox"/> PSA Diagnostic | <input type="checkbox"/> ANA | <input type="checkbox"/> Herpes Culture & Type | |
| <input type="checkbox"/> Qualitative B-HCG | <input type="checkbox"/> Chlamydiazyme | <input type="checkbox"/> Ova + Parasites | |
| <input type="checkbox"/> Quantitative B-HCG | <input type="checkbox"/> CRP | <input type="checkbox"/> RSV | |
| <input type="checkbox"/> Troponin I | <input type="checkbox"/> H. Pylori AB (Qual.) | <input type="checkbox"/> Rotavirus | |
| <input type="checkbox"/> Vitamin B12 | | | |

Additional tests 31105330 Fire Dept. Profile that includes:
 CBC; Comprehensive Metabolic, Cardiovascular Eval and Venipuncture