PHYSICAL FITNESS VERIFICATION
For Apollo Firefighting Students

Students Full Name: ____ D.O.B __________________
(First, Middle, & Last) (MM/DD/YYYY)

TO THE PHYSICIAN (M.D or D.O. ONLY)

Your patient will be engaging in very strenuous and physically demanding exercise and activities while enrolled in the Firefighter Training Program at Apollo Career Center Public Safety Academy, and, as such, is required by law to undergo a **National Fire Protection Association (NFPA) 1582** compliant medical evaluation prior to beginning this course of study.

Please use the attached pages as your guidance for the **NFPA 1582** ***Standard on Medical Requirements for Firefighters.***

Physician's Statement:

After conducting a thorough **NFPA 1582** compliant examination and considering the physical, physiological, intellectual, and psychological demands of Firefighting training, I find no medical reason that ___________________________________ should be excluded from performing the
(Student's Full Name)
essential job tasks associated with the occupational course of study for firefighting.

________________________________	______________________________	______________
Physician's Name (Printed)	Physician's Signature	Date
________________________________	______________________________	
Physician's Office Address	Physician's Medical License #	
________________________________		
City, State, & Zip Code		
________________________________		
Physician's Phone Number		
________________________________	______________________________	
Student's Signature	Date	

SECTION 1: PERSONAL INFORMATION

Street Address		Email Address	
City		State	Zip
Date of Birth	Home Number	Cell Number	Gender
Name of Emergency Contact		Relationship	Contact Number

SECTION 2: INFLUENZA INJECTION

Date of Injection / /	I understand that if I cannot participate in the influenza injection process as a result of a medical condition, religious beliefs, or otherwise refuse to participate in the influenza injection, I may be required to participate in additional measures established by a clinical site. Additionally, it may jeopardize my ability to participate in the clinical portion of the program.
Student Signature	Date

SECTION 3: REQUIRED TITERS/TESTS

Parts A and B ARE TO BE COMPLETED BY AUTHORIZED MEDICAL PERSONNEL ONLY

A. **REQUIRED TITERS:** (Documentation must be attached) A Varicella, Mumps, Rubeola (Measles), and Rubella (German Measles) Titer must be drawn and the results attached. **A record of Vaccines WILL NOT BE ACCEPTED as documentation for the required titers.** The dates of the titers and the results must be indicated in the appropriate area below. **(INDICATING THE DISEASE PROCESS OR IMMUNIZATION DATES IS NOT ACCEPTABLE FOR DOCUMENTATION IN THIS AREA).**

TITER	DATE	LAB RESULTS Documentation must be attached Numerical Value of Results Must Be Reported	PLEASE CIRCLE
Tetanus/ diphtheria/ pertussis (Tdap)	______/______/ ______		**Immune/ Not Immune**
Mumps Titer	______/______/ ______		**Immune/ Not Immune**
Rubeola (Measles) Titer	______/______/ ______		**Immune/ Not Immune**
Rubella (German Measles) Titer	______/______/ ______		**Immune/ Not Immune**

B. **TB SKIN TEST/CHEST X-RAY:** Two consecutive TB Skin Tests are required. ***The TB Skin tests can be repeated a minimum of three days apart.*** The dates and results of each TB Skin Test must be attached. The Skin Tests must have been performed within the last three (3) months to be considered a recent test. **In the event the results indicate a positive skin test or the student has a history of a positive TB skin test, a chest x-ray is required. The chest x-ray must have been completed within the last three (3) months to be considered current. Results must be attached.**

TEST	DATE	RESULTS	
TB Skin Test 1st Test	______/______/ ______	**Positive** ☐ **Negative** ☐	**If positive skin test, current chest x-ray is required.** **Results of TB skin test must be attached.**

Chest X-ray	_____/______/ ______	**Positive** □ **Negative** □	**RESULTS OF CHEST X-RAY MUST BE ATTACHED**

SECTION 4: HEPATITIS

Introduction: Health care professionals are at risk of exposure to blood and body fluids contaminated with the viruses that cause HIV and Hepatitis. Consistent use of Standard Precautions is the best known means to avoid transmission of these viruses or other contaminants. Students will be taught Standard Precautions before they provide care to any patient in the clinical setting. Although it is rare, a health care worker may become exposed to one of these viruses through accidental transmission. Currently, there is no vaccine that protects against the HIV virus. However, the Hepatitis B vaccine is an effective means of preventing Hepatitis B. As a student who will be providing direct patient care, you should discuss this vaccine with your health care provider

About the Vaccine: The Hepatitis B Vaccine is a genetically engineered "yeast" derived vaccine. It is administered in the deltoid muscle (arm) in a series of three doses over a six month period. You should seek additional information about the vaccine from your health care provider; especially if you have an allergy to yeast or may be pregnant, or are a nursing mother.

I have initiated the Hepatitis B Vaccine Series with my first dose listed below:

1st Dose Date:_____/_____/_____ **2nd Dose Date:_____/_____/_____** (One month after 1st dose) **3rd Dose Date_____/_____/ _____** (Six month after 1st dose)

OR

I have already completed a Hepatitis B Vaccine Program with dates of injections listed below:

1st Dose Date:_____/_____/_____ **2nd Dose Date:_____/_____/_____** (One month after 1st dose) **3rd Dose Date_____/_____/ _____** (Six month after 1st dose)

OR

Antibody testing has revealed that I have immunity to Hepatitis B. Yes □ No □ **(ATTACH COPY OF LAB REPORT).**

OR

I understand that, due to my occupational exposure to blood or other potentially infectious materials, I am at risk of acquiring Hepatitis B infection. I understand that the Hepatitis B Vaccine is recommended to help prevent illness due to the Hepatitis B Virus. I have discussed the risks and benefits with my personal health care provider and ***decline*** the Hepatitis B Vaccine at this time.

Student Signature	Date

SECTION 5: STUDENT'S STATEMENT

In order to satisfy medical program requirements, I hereby consent to the release and disclosure of my personal health information provided on the **Health Examination Report** to Butler Tech and any health care facility in which I am assigned for on-site clinical training. I understand that my personal health information is required to facilitate my participation in the clinical training, which is required for program completion. I also hereby release and hold harmless Apollo Public Safety Academy and receiving health care facilities from any claim of violation of HIPAA or any other medical privacy rights that may arise for the release of my personal health information provided in the **Health Examination Report**.

Print Name	
Student Signature	Date

Medical History and Examination Form for Firefighters

Clinic Performing Exam		Address	
Physician Name		Phone Number	(865)
CFNP		Fax Number	(865)

Name of Employing Agency		Address	
Department		Phone Number	(865)
Health Coordinator		Fax Number	(865)

Candidate						Address			
Position / Job Title						Phone Number		Mobile	
Date of Birth		Age		Sex	❒ Male ❒ Female	Social Security Number			

Incomplete forms or missing information may result in a delay clearing you for firefighter duties. Submitting information that is misleading or untruthful may result in termination, criminal sanctions, or failure to be cleared for duty.

This history form and review does not substitute for routine health care or a periodic health examination conducted by your physician. It is being conducted for occupational purposes only. I certify that all the information I have provided on this form is complete and accurate to the best of my knowledge. I authorize release of information within this form to the Interagency Medical Standards Program Manager or their representative for the purpose of fit for duty clearance as a firefighter.

Candidate's Signature (Required): ______________________________________ Date: __________ / __________ /__________

☒ **Baseline** ❒ Exit ❒ Periodic Exam

- ☒ Medical History Review
- ☒ Physical Examination
- ☒ Far Vision Only (corrected and uncorrected); Color; Peripheral; Depth Perception
- ☒ Audiogram (500 Hz – 8000 Hz)
- ☒ EKG (12 lead with interpretation)
- ☒ Pulmonary Function Test (attach tracings)
- ☒ PPD test (Mantoux) – PPD placement
- ☒ PPD test (Mantoux) – PPD read
- ☒ Lab Collection – CBC, Urinalysis, Glucose, BUN, Creatinine, Liver Function, Lipid Panel, PSA
- ☒ Chest X-Ray
- ☒ Physician must sign completed exam

PPD

1. Have you ever had a Mantoux or tuberculosis test before? ❒ Yes ❒ No
2. Was the test positive? ❒ Yes ❒ No
3. Have you ever had INH prophylazis (preventative treatment)? ❒ Yes ❒ No
4. Have you ever had treatment for active TB? ❒ Yes ❒ No
5. Have you ever had a BCG vaccine? ❒ Yes ❒ No

I understand that I must return to the examining facility to have my PPD interpreted within 48-72 hours after administration.

Signature ______________________________

Arm Given: __________________ Date: _____ /_____ /_____

Given By: ____________________________________

Test results – induration (hardness): ______ mm Date: _____ /_____ /_____

Signature ____

MEDICAL HISTORY

Smoking History

This information is needed since tobacco use increases your risk for lung cancer and several other types of cancer, chronic bronchitis, emphysema, asbestos related lung diseases, coronary heart disease, high blood pressure, and stroke. Please check your tobacco use status and complete this section.

	Current Smoker ❒ Yes ❒ No		**Former Smoker** ❒ Yes ❒ No	
❒ Never Smoked	Number of cigarettes per day	___________	Number of cigarettes per day	___________
	Number of cigars per day	___________	Number of cigars per day	___________
	Number of pipe bowls per day	___________	Number of pipe bowls per day	___________
	Amount of chewing tobacco per day	___________	Amount of chewing tobacco per day	___________
	Total years of tobacco use	___________	Total years of tobacco use	___________

Describe your Physical Activity Program

Type of Activity or Exercise ____

Intensity	❒ Low	❒ Moderate	❒ High	Duration of minutes per session_____________
Examples	Walking	Jogging, Cycling	Sustained heavy breathing and perspiration	Frequency, in days per week _____________

Medications

List all medications you are currently taking, including those prescribed and over-the-counter (including herbal) as well as the reasons that you are taking them. (Use additional sheets as necessary)

____
____
____

Date of last Tetnus (Td) Shot:

______ / ______ / _____

Booster recommended every 10 years

Summary of your medical history

____
____
____

Allergies

____
____
____

Examiner: Use this space to comment on positive history or findings on this page

MEDICAL HISTORY

Note: For every item checked "Yes" provide dates, treatments, and current status. Use the blank spaces below.

Question	Answer	Details
A. Have you ever been treated with an organ transplant, prosthetic device (e.g. artificial hip), or an implanted pump (e.g. for insulin) or electrical device (e.g. cardiac defibrillator)?	❒ Yes ❒ No	
B. Have you had or have you been advised to have an operation?	❒ Yes ❒ No	
C. Have you ever been a patient in any type of hospital?	❒ Yes ❒ No	
D. Have you consulted or been treated by clinics, physicians, healers, or other practitioners within the past year for other minor illnesses?	❒ Yes ❒ No	
E. Have you been rejected for military service because of physical, mental, or other reasons?	❒ Yes ❒ No	
F. Have you ever been treated for a mental or emotional condition?	❒ Yes ❒ No	
G. Have you ever been diagnosed with or treated for alcoholism or alcohol dependence?	❒ Yes ❒ No	
H. Have you ever been diagnosed as being dependent on illegal drugs, or treated for drug abuse?	❒ Yes ❒ No	
I. Have you ever received, is there pending, or have you applied for a pension or compensation for a disability?	❒ Yes ❒ No	
J. Do you have any allergies?	❒ Yes ❒ No	
K. Are you allergic to any medications?	❒ Yes ❒ No	

Examiner: Use this space to comment on positive history or findings on this page:

Medical History and Examination Form for Firefighters

Vision

	Yes	No
Any eye disease	❒	❒
Do you wear eyeglasses	❒	❒
❒ far ❒ near ❒ both		
Do you wear contact lenses	❒	❒
❒ hard ❒ soft		
Do you have a history of frequent headaches	❒	❒
Blurred vision	❒	❒
Difficulty reading	❒	❒
Glaucoma	❒	❒
Cataracts	❒	❒
Color blindness	❒	❒

Please explain any YES answers, including dates:

____

____

Head and Neck

NL	ABNL	
❒	❒	Head, Face, Neck (thyroid), Scalp
❒	❒	Nose / Sinuses / Eustachian tube
❒	❒	Mouth / Throat
❒	❒	Pupils equal / reactive
❒	❒	Ocular motility
❒	❒	Ophthalmoscopic findings
❒	❒	Speech

Otoscopic Exam

	Right		Left	
	NL	ABNL	NL	ABNL
Canal / External Ear	❒	❒	❒	❒
Tympanic Membrane	❒	❒	❒	❒

Vision (Must complete A and B)

Color Vision A:

Type of ❒ Ishihara plate (# of plates = ____________)
❒ OPTEC 2000 Vision Tester
❒ Titmus Vision Tester
❒ Famsworth D-15
❒ Other (specify) ______________________

Number Correct ____________ of ___________ tested

Color Vision B: (Red, Green, and Yellow) (Ishihara does not test for yellow)

Able to see red / green / yellow? ❒ Yes ❒ No

Type of test: ______________________________________

Clinician, please use a qualitative testing method

Far Vision Acuity: (Near vision not required)

Uncorrected

Right 20 / _____ Left 20 / _____ Both 20 / _____

Only soft contact lens wearers do not need uncorrected vision recorded

Corrected

Right 20 / _____ Left 20 / _____ Both 20 / _____

Peripheral Vision: Right _________° Left _________ °

Depth Perception:

Type of test:

❒ Stereo Numbers: Number Correct: ____ of ____ tested
❒ Stereo Animals: ____ seconds of arc
❒ ____ % Shepard Frye
❒ Other: type of test Response: ____ seconds of arc

Hearing

	Yes	No
Any ear disease	❒	❒
Loud, constant noise or music in the last 14 hours	❒	❒
Loud, impact noise in the last 14 hours	❒	❒
Ringing in the ears	❒	❒
Difficulty hearing	❒	❒
Ear infections or cold in the last 2 weeks	❒	❒
Dizziness or balance problems	❒	❒
Eardrum perforation	❒	❒
Use of a hearing aid ❒ Left ❒ Right ❒ Both	❒	❒
Use of protective hearing equipment when working around loud noise ❒ foam ❒ pre-mold/plugs ❒ ear muffs	❒	❒

Please explain any YES answers, including dates:

____

____

Audiogram (Attach Printout)

Type of Test:

❒ Baseline
❒ Periodic
❒ Exit

Calibration Method:

❒ Oscar ❒ Biological Date ___ / ___ / ___

Hearing must be done without hearing aid, and must meet OSHA standard for testing

Frequency	500 Hz	1000 Hz	2000 Hz	3000 Hz	4000 Hz	6000 Hz	8000 Hz
Right Ear dB @							
Left Ear dB @							

Verify Audiogram if >40 dB for 5k, 1k, 2k, or 3k ❒ Audio verified

Examiner: Use this space to comment on positive history or findings on this page:

Medical History and Examination Form for Firefighters

Vascular

	Yes	No
Any vascular disease	❒	❒
Enlarged superficial veins, phlebitis, or blood clots	❒	❒
Anemia	❒	❒
Hardening of the arteries	❒	❒
High Blood Pressure	❒	❒
Stroke or Transient Ischemic Attack (TIA)	❒	❒
Aneurysms	❒	❒
Poor circulation to hands and feet	❒	❒
White fingers with cold / vibration	❒	❒

Respiratory

	Yes	No
Any respiratory disease	❒	❒
Asthma (including exercise induced asthma)	❒	❒
Bronchitis or Emphysema	❒	❒
Excessive, unexplained fatigue	❒	❒
Use of inhalers	❒	❒
Acute or chronic lung infection	❒	❒
Collapsed lung	❒	❒
Scollosis (curved spine) with breathing limitations	❒	❒
History of Tuberculosis	❒	❒

(Date: _____ / _____ / _____)

Heart

	Yes	No
Any heart disease or heart murmurs	❒	❒
Heart or chest pain (angina) with or without exertion	❒	❒
Heart rhythm disturbance or palpitations	❒	❒
History of Heart Attack	❒	❒
Organic heart disease (including prosthetic heart valves, mitral stenosis, heart block, heart murmur, mitral valve prolapse, pacemakers, implanted defibrillator, WPW, etc.	❒	❒
Heart surgery	❒	❒
Sudden loss of consciousness	❒	❒

Please explain any YES answers, including dates:

____

____

____

Cardio/Pulmonary Assessment

NL	ABNL	
❒	❒	Lungs / Chest
❒	❒	Heart (thrill, murmur)
❒	❒	Major blood vessels
❒	❒	Peripheral blood vessels
❒	❒	Resting 12 lead EKG (Supine Only) *(Attach with signed interpretation)*
❒	❒	Chest X-Ray

Please explain any ABNL answers, including dates:

____

____

____

Coronary Risk Factors

	Yes	No
Blood Pressure > $^{140}/_{90}$	❒	❒
Diabetes or Fasting Glucose > 126 mg/dl	❒	❒
Total Cholesterol > 200 mg/dl or HDL > 40 mg/dl	❒	❒
Family history of CVD in males <55	❒	❒
Age (men > 45, women > 55)	❒	❒
No regular exercise program	❒	❒
Current smoker	❒	❒

Please explain any YES answers, including dates:

____

____

____

Vital Signs

Height _______ (in.) Weight _______ (lbs)

Resp. _______ / min Temp. _______

Blood Pressure _______ /_______ (sitting)

Pulse _______ / min ❒ Regular ❒ Irregular

If blood pressure is > 180/100 repeat after 10-15 minutes

Spirometry (3 good attempts required) (Attach all 3 tracings)

Technician ID: _________________

Calibration Date: ______ / ______ /______

Daily calibration performed: ❒ yes ❒ no

Machine Make / Model: _______________

____

Examinee effort: ❒ Good ❒ Fair ❒ Poor

Actual FVC	Actual FEV1	Actual FEV 1/FVC	Actual FEF 25-75
% Predicted FVC	% Predicted FEV 1	% Predicted FEV 1/ FVC	% Predicted FEF 25-75

Examiner: Use this space to comment on positive history or findings on this page:

Medical History and Examination Form for Firefighters

Endocrine	**Yes**	**No**
Any endocrine disease	❒	❒
Thyroid disease	❒	❒
Obesity	❒	❒
Unexplained weight loss or gain	❒	❒
Diabetes (Insulin requiring)	❒	❒
If yes, units per day ______. Year diagnoses ______		
Diabetes (Non-insulin requiring)	❒	❒
Year diagnosed ______		
If you have diabetes		
Current medications: ______________________________		
______________________________		
Last hemoglobin A1c ________% date performed __________		
Have you ever had a hypoglycemic episode	❒	❒
If yes, last date _____________		
Have you ever been hospitalized for diabetes	❒	❒
If yes, dates ___________, __________, __________		

Examiner: Use this space to comment on positive history or findings on this page:

Gastrointestinal	**Yes**	**No**
Any gastrointestinal disease	❒	❒
Hernias	❒	❒
Colostomy	❒	❒
Persistent stomach / abdominal pain / active ulcer	❒	❒
Hepatitis or other liver disease	❒	❒
Irritable bowel syndrome	❒	❒
Rectal bleeding	❒	❒
Vomiting	❒	❒

Gastrointestinal Assessment

NL	**ABNL**		**Yes**	**No**
❒	❒ Auscultation		❒	❒ Organomegaly
❒	❒ Palpation		❒	❒ Tenderness
			❒	❒ Hernia

(Specify type: ________________________)

Examiner: Use this space to comment on positive history or findings:

Genitourinary	**Yes**	**No**
Any genitourinary disease	❒	❒
Blood in urine	❒	❒
Kidney stones	❒	❒
Difficult or painful urination	❒	❒
Infertility (difficulty having children)	❒	❒

Please explain any YES answers, including dates:

____

____

____

Genitourinary Assessment

NL	**ABNL**	
❒	❒ External genitalia	❒ Deferred

Note: this clearance exam does not require a pelvic exam or PAP smear for females, or a rectal or prostate exam for males

Examiner: Use this space to comment on positive history or findings:

Medical History and Examination Form for Firefighters

Musculoskeletal	Yes	No
Any musculoskeletal disease	❒	❒
Moderate to severe joint pain, arthritis, tendonitis	❒	❒
Amputations	❒	❒
Loss of use of arm, leg, fingers, or toes	❒	❒
Loss of sensation	❒	❒
Loss of strength	❒	❒
Loss of coordination	❒	❒
Chronic back pain	❒	❒
Chronic back pain associated with leg numbness, weakness, or pain	❒	❒
Back surgery within last 2 years	❒	❒

Are you ❒ right handed ❒ left handed

Please explain any YES answers, including dates:

____

____

____

Musculoskeletal Assessment

NL	ABNL	
❒	❒	Upper extremities (Strength)
❒	❒	Upper extremities (Range of motion)
❒	❒	Lower extremities (Strength)
❒	❒	Lower extremities (Range of motion)
❒	❒	Feet
❒	❒	Hands
❒	❒	Spine, other musculoskeletal
❒	❒	Flexibility of neck, back, spine, hips

Please explain any ABNL answers, including dates:

____

____

____

Neurological	Yes	No
Any neurological disease	❒	❒
Tremors, shakiness	❒	❒
Seizures (current or previous)	❒	❒
Spinal cord injury	❒	❒
Numbness or tingling	❒	❒
Head / Spine surgery	❒	❒
History of head trauma with persistent problems	❒	❒
Chronic or recurring headaches (migraines)	❒	❒
History of brain tumor	❒	❒
Loss of memory	❒	❒
Insomnia (difficulty sleeping)	❒	❒

Please explain any YES answers, including dates:

____

____

____

Neurological Assessment

NL	ABNL	
❒	❒	Cranial nerves (I-XII)
❒	❒	Cerebellum
❒	❒	Motor / Sensory (Including vibratory and proprioception
❒	❒	Deep tendon reflexes
❒	❒	Mental status exam

Please explain any ABNL answers, including dates:

____

____

____

Examiner: Use this space to comment on positive history or findings on this page:

Dermatology	**Yes**	**No**
Any skin disease	❐	❐
Sun sensitivity	❐	❐
History of chronic dermatitis	❐	❐
Active skin disease	❐	❐
Moles that have changed in size or color	❐	❐

Please explain any YES answers, including dates:

____

____

____

Dermatology Assessment

NL	**ABNL**	
❐	❐	Skin

Please explain any ABNL answers, including dates:

____

____

____

Examiner: Use this space to comment on positive history or findings on this page:

Examiner: Use this space to make additional comments about this examination:

Examining Physicians Signature		**Examining Physicians Printed Name**	**Date:** ______ / ______ / ______	
Examiner's Address			**Phone Number**	(865)

Essential Structural Firefighting Functions

The medical requirements in this standard were based on in-depth consideration of essential structural fire-fighting functions. These essential functions are what members are expected to perform at emergency incidents and are derived from the performance objectives stated in NFPA 1001, Standard for Fire Fighter Professional Qualifications.

Essential functions are performed in and affected by the following environmental factors:

(1) Operating both as a member of a team and independently at incidents of uncertain duration
(2) Spending extensive time outside exposed to the elements
(3) Tolerating extreme fluctuations in temperature while performing duties; fire fighters are required to perform physically demanding work in hot (up to 400°F), humid (up to 100 percent) atmospheres while wearing equipment that significantly impairs body-cooling mechanisms
(4) Experiencing frequent transition from hot to cold and from humid to dry atmospheres
(5) Working in wet, icy, or muddy areas
(6) Performing a variety of tasks on slippery, hazardous surfaces such as on rooftops or from ladders
(7) Working in areas where sustaining traumatic or thermal injuries is possible
(8) Facing exposure to carcinogenic dusts such as asbestos, toxic substances such as hydrogen cyanide, acids, carbon monoxide, or organic solvents, either through inhalation or skin contact
(9) Facing exposure to infectious agents such as Hepatitis B or HIV
(10) Wearing personal protective equipment that weighs approximately 50 lb. while performing fire-fighting tasks
(11) Performing physically demanding work while wearing positive-pressure breathing equipment with 1.5 in. of water column resistance to exhalation at a flow of 40 L/min
(12) Performing complex tasks during life-threatening emergencies
(13) Working for long periods of time, requiring sustained physical activity and intense concentration
(14) Facing life-or-death decisions during emergency conditions
(15) Being exposed to grotesque sights and smells associated with major trauma and burn victims
(16) Making rapid transitions from rest to near-maximal exertion without warm-up periods
(17) Operating in environments of high noise, poor visibility, limited mobility; at heights; and in enclosed or confined spaces
(18) Using manual and power tools in the performance of duties
(19) Relying on senses of sight, hearing, smell, and touch to help determine the nature of the emergency, to maintain personal safety, and to make critical decisions in a confused, chaotic, and potentially life-threatening environment throughout the duration of the operation

Medical Standards

This standard shall contain medical requirements for members, including full-time or part-time employees and paid or unpaid volunteers. It also shall provide information for physicians regarding other areas of fire department medicine, including infection control and fireground rehabilitation.

The purpose of this standard shall be to specify minimum medical requirements for candidates and current members. It also shall provide other information regarding fire department activities that assist the department physician in providing proper medical support for members.

Category A Medical Condition	**Category B Medical Condition**
A medical condition that would preclude a person from performing as a member in a training or emergency operational environment by presenting a significant risk to the safety and health of the person or others.	A medical condition that, based on its severity or degree, could preclude a person from performing as a member in a training or emergency operational environment by presenting a significant risk to the safety and health of the person or others.

Head

Category A Medical Condition	**Category B Medical Condition**
There shall be no Category A medical conditions.	(1) Deformities of the skull such as depressions or exostoses (2) Deformities of the skull associated with evidence of disease of the brain, spinal cord, or peripheral nerves (3) Loss or congenital absence of the bony substance of the skull (4) Any other head condition that results in a person not being able to perform as a member

Neck

Category A Medical Condition	**Category B Medical Condition**
There shall be no Category A medical conditions.	(1) Thoracic outlet syndrome (2) Congenital cysts, chronic draining fistulas, or similar lesions (3) Contraction of neck muscles (4) Any other neck condition that results in a person not being able to perform as a member

Eyes and Vision

Category A Medical Condition	**Category B Medical Condition**
(a) Far visual acuity. Far visual acuity shall be at least 20/30 binocular, corrected with contact lenses or spectacles. Far visual acuity uncorrected shall be at least 20/100 binocular for wearers of hard contacts or spectacles. (b) Peripheral vision. Visual field performance without correction shall be 140 degrees in the horizontal meridian in each eye.	(1) Diseases of the eye such as retinal detachment, progressive retinopathy, or optic neuritis (2) Ophthalmological procedures such as radial keratotomy or repair of retinal detachment (3) Any other eye condition that results in a person not being able to perform as a member

Ears and Hearing

Category A Medical Condition	Category B Medical Condition
There shall be no Category A medical conditions.	a) Hearing deficit in the pure tone thresholds in the unaided worst ear that is (1) Greater than 25 dB in three of the four frequencies a. 500 Hz b. 1000 Hz c. 2000 Hz d. 3000 Hz OR (2) Greater than 30 dB in any one of the three frequencies a. 500 Hz b. 1000 Hz c. 2000 Hz AND (3) In addition averages greater than 30 dB for the four frequencies a. 500 Hz b. 1000 Hz c. 2000 Hz d. 3000 Hz (b) Unequal hearing loss (c) Atresia, severe stenosis, or tumor of the auditory canal (d) Severe external otitis (e) Severe agenesis or traumatic deformity of the auricle (f) Severe mastoiditis or surgical deformity of the mastoid (g) Meniere's syndrome or labyrinthitis (h) Otitis media (i) Any other ear condition that results in a person not being able to perform as a member and results in a person being unable to pass a job-specific functional hearing task test or a hearing in noise test

Dental

Category A Medical Condition	Category B Medical Condition
There shall be no Category A medical conditions.	1) Diseases of the jaws or associated tissues (2) Orthodontic appliances (3) Oral tissues, extensive loss (4) Relationship between the mandible and maxilla that precludes satisfactory postorthodontic replacement or ability to use protective equipment (5) Any other dental condition that results in a person not being able to perform as a member

Nose, Oropharynx, Trachea, Esophagus, and Larynx

Category A Medical Condition	Category B Medical Condition
(1) Tracheostomy (2) Aphonia	(1) Congenital or acquired deformity (2) Allergic respiratory disorder (3) Sinusitis, recurrent (4) Dysphonia (5) Anosmia (6) Any other nose, oropharynx, trachea, esophagus, or larynx condition that results in a person not being able to perform as a member or to communicate effectively

Lungs and Chest Wall

Category A Medical Condition	Category B Medical Condition
(1) Active hemoptysis (2) Empyema (3) Pulmonary hypertension (4) Active tuberculosis	(1) Pulmonary resectional surgery, chest wall surgery, pneumothorax (2) Bronchial asthma or reactive airways disease (3) Fibrothorax, chest wall deformity, diaphragm abnormalities (4) Chronic obstructive airways disease (5) Hypoxemic disorders (6) Interstitial lung diseases (7) Pulmonary vascular diseases, pulmonary embolism (8) Bronchiectasis (9) Infectious diseases of the lung or pleural space (10) Any other pulmonary condition that results in a person not being able to perform as a member

Heart

Category A Medical Condition	Category B Medical Condition
(1) Angina pectoris, current (2) Heart failure, current (3) Acute pericarditis, endocarditis, or myocarditis (4) Syncope, recurrent (5) Automatic implantable cardiac defibrillator	(1) Significant valvular lesions of the heart, including prosthetic valves (2) Coronary artery disease, including history of myocardial infarction, coronary artery bypass surgery, or coronary angioplasty, and similar procedures (3) Atrial tachycardia, flutter, or fibrillation (4) Left bundle branch block, second- and third-degree atrioventricular block (5) Ventricular tachycardia (6) Hypertrophy of the heart (7) Recurrent paroxysmal tachycardia (8) History of a congenital abnormality (9) Chronic pericarditis, endocarditis, or myocarditis (10) Cardiac pacemaker (11) Coronary artery vasospasm (12) Any other cardiac condition that results in a person not being able to perform as a member

Vascular System

Category A Medical Condition	Category B Medical Condition
There shall be no Category A medical conditions.	(1) Hypertension (2) Peripheral vascular disease such as Raynaud's phenomenon (3) Recurrent thrombophlebitis (4) Chronic lymphedema due to lymphadenopathy or severe venous valvular incompetency (5) Congenital or acquired lesions of the aorta or major vessels (6) Marked circulatory instability as indicated by orthostatic hypotension, persistent tachycardia, and severe peripheral vasomotor disturbances (7) Aneurysm of the heart or major vessel (8) Any other vascular condition that results in a person not being able to perform as member

Abdominal Organs and Gastrointestinal System

Category A Medical Condition	Category B Medical Condition
There shall be no Category A medical conditions.	(1) Cholecystitis (2) Gastritis (3) GI bleeding (4) Acute hepatitis (5) Hernia (6) Inflammatory bowel disease (7) Intestinal obstruction (8) Pancreatitis (9) Resection, bowel (10) Ulcer, gastrointestinal (11) Cirrhosis, hepatic or biliary (12) Chronic active hepatitis (13) Any other gastrointestinal condition that results in a person not being able to perform the duties of member

Reproductive

Category A Medical Condition	Category B Medical Condition
There shall be no Category A medical conditions.	(1) Pregnancy, for its duration (2) Dysmenorrhea (3) Endometriosis, ovarian cysts, or other gynecologic conditions (4) Testicular or epididymal mass (5) Any other genital condition that results in a person not being able to perform as a member

Urinary System

Category A Medical Condition	Category B Medical Condition
There shall be no Category A medical conditions.	(1) Diseases of the kidney (2) Diseases of the ureter, bladder, or prostate (3) Any other urinary condition that results in a person not being able to perform as a member

Spine, Scapulae, Ribs, and Sacroiliac Joints

Category A Medical Condition	Category B Medical Condition
There shall be no Category A medical conditions.	(1) Arthritis (2) Structural abnormality, fracture, or dislocation (3) Nucleus pulposus, herniation of, or history of laminectomy, discectomy or fusion (4) Ankylosing spondylitis (5) Any other spinal condition that results in a person not being able to perform as a member

Extremities

Category A Medical Condition	Category B Medical Condition
There shall be no Category A medical conditions.	(1) Limitation of motion of a joint (2) Amputation or deformity of a joint or limb (3) Dislocation of a joint (4) Joint reconstruction, ligamentous instability, or joint replacement (5) Chronic osteoarthritis or traumatic arthritis (6) Inflammatory arthritis (7) Any other extremity condition that results in a person not being able to perform as a member

Neurological Disorders

Category A Medical Condition	Category B Medical Condition
(1) Ataxias of heredo-degenerative type (2) Cerebral arteriosclerosis as evidenced by documented episodes of neurological impairment (3) Multiple sclerosis with activity or evidence of progression within previous three years (4) Progressive muscular dystrophy or atrophy (5) All epileptic conditions to include simple partial, complex partial, generalized, and psychomotor seizure disorders other than those with complete control during previous five years, normal neurological examination, and definitive statement from qualified neurological specialist. If an epileptic member experiences a five-year seizure-free interval resulting from a change in the medical regimen, that individual shall not be cleared for return to firefighting duty until he or she has completed five years without a seizure on the new regimen.	(1) Congenital malformations (2) Migraine (3) Clinical disorders with paresis, paralysis, dyscoordination, deformity, abnormal motor activity, abnormality of sensation, or complaint of pain (4) Subarachnoid or intracerebral hemorrhage (5) Abnormalities from recent head injury such as severe cerebral contusion or concussion (6) Any other neurological condition that results in a person not being able to perform as a member

Skin	
Category A Medical Condition	**Category B Medical Condition**
There shall be no Category A medical conditions.	(1) Acne or inflammatory skin disease (2) Eczema (3) Any other dermatologic condition that results in the person not being able to perform as a member

Blood and Blood-Forming Organs	
Category A Medical Condition	**Category B Medical Condition**
(1) Hemorrhagic states requiring replacement therapy (2) Sickle cell disease (homozygous)	(1) Anemia (2) Leukopenia (3) Polycythemia vera (4) Splenomegaly (5) History of thromboembolic disease (6) Any other hematological condition that results in a person not being able to perform as a member

Endocrine and Metabolic Disorders	
Category A Medical Condition	**Category B Medical Condition**
Diabetes mellitus, which is treated with insulin or an oral hypoglycemic agent and where an individual has a history of one or more episodes of incapacitating hypoglycemia, shall be a Category A medical condition.	(1) Diseases of the adrenal gland, pituitary gland, parathyroid gland, or thyroid gland of clinical significance (2) Nutritional deficiency disease or metabolic disorder (3) Diabetes mellitus requiring treatment with insulin or oral hypoglycemic agent without a history of incapacitating hypoglycemia (4) Any other endocrine or metabolic condition that results in a person not being able to perform as a member

Systemic Diseases and Miscellaneous Conditions	
Category A Medical Condition	**Category B Medical Condition**
There shall be no Category A medical conditions.	(1) Connective tissue disease, such as dermatomyositis, lupus erythematosus, scleroderma, and rheumatoid arthritis (2) Residuals from past thermal injury (3) Documented evidence of a predisposition to heat stress with recurrent episodes or resulting residual injury (4) Any other systemic condition that results in a person not being able to perform as a member

Tumors and Malignant Diseases

Category A Medical Condition	Category B Medical Condition
There shall be no Category A medical conditions.	(1) Malignant disease that is newly diagnosed, untreated, or currently being treated. a. Candidates shall be subject to the provisions of 2-3.5 of this standard. b. Current members shall be subject to the provisions of 2-4.4 of this standard (2) Treated malignant disease that is evaluated on the basis of an individual's current physical condition and on the likelihood of the disease to recur or progress. (3) Any other tumor or similar condition that results in a person not being able to perform as a member

Psychiatric Conditions

Category A Medical Condition	Category B Medical Condition
There shall be no Category A medical conditions.	(1) A history of psychiatric condition or substance abuse problem (2) Any other psychiatric condition that results in a person not being able to perform as a member

Chemicals, Drugs, and Medications

Category A Medical Condition	Category B Medical Condition
There shall be no Category A medical conditions.	(1) Anticoagulant agents (2) Cardiovascular agents (3) Narcotics (4) Sedative-hypnotics (5) Stimulants (6) Psychoactive agents (7) Steroids (8) Any other chemical, drug, or medication that results in a person not being able to perform as a member