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

From: Marc Barenberg, Purchasing Agent

RE: Annual Physical Exams

Date: FEBRUARY 2017

All members of the WVFD/EMS 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 insurance provider in such circumstances.

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

OPTION 1:

You may use your own insurance and physician to complete these tests/exams. In this case, please submit under your own medical 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.

OPTION 2:

For those that do not choose to use their own physicians, the department has partner agreements in place with the following providers that will bill us directly:

<table>
<tr><td colspan="2">***AFC Urgent Care***
607 Main Avenue
Norwalk, CT
(203) 845-9100
(call 24-hours in advance)</td></tr>
<tr><td>Occupational Health Services
520 West Avenue, Norwalk, CT
Phone: (203) 852-2417</td><td>Soundview Medical Associates
761 Main Ave, Norwalk, CT
Phone: (203) 299-0154
Please request: Dr. Kelly or Dr. Bande</td></tr>
</table>

Please be sure to correctly identify yourselves as members of the Weston Volunteer Fire Department or Weston EMS.

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 discounted corporate rate[s].

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 Emergency Medical Technicians **[EMS]**
- OSHA N95 Respirator Medical Evaluation Review Disposition **[EMS]**

All other materials that may be included in this package (e.g Medical Evaluation Questionnaire) 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@westonfirerescue.com or 203-253-3317.

Sincerely,

Marc Barenberg
Purchasing Agent
Weston Fire Department

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

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

_____

Copy to Firefighter at Address Above

SCBA
MEDICAL PACKAGE

3 Parts

- Questionnaire/Instructions
- Letter to Doctor
- Doctor's Report

Bring 2 copies if you want a copy for your records

Bring all 3 items to the doctor. Return ONLY the completed report to the Chief. The doctor keeps the questionnaire.

You ALSO need to have an annual medical report completed by the doctor and filed with the Chief.

TOWN OF WESTON, CONNECTICUT

Incorporated 1787

Weston Volunteer Fire Dept.

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 and humid environment, when performing fire suppression activities.

You may need to (a) conduct further examination or (b) obtain more detailed answers to the questions in the questionnaire. In either event, the Department's secretary 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 OSHA 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 Fire Department.

OSHA RESPIRATOR MEDICAL EVALUATION QUESTIONNAIRE

Date:_____

Age:_____ **Sex:**_____

Name:_____ **ID #**_____ **Job Title:** FIREFIGHTER

Employer Name: WVFD **Department:** FIRE

TO THE EMPLOYER
Answer to questions in Section 1, and to question 9 in section 2 of part A, do not require a medical examination. However, it does require that a Physician or Licensed Health Care Professional (PLHCP) review this questionnaire and answer any questions you may have concerning the questionnaire.

TO THE EMPLOYEE
Can you read? (circle one) Yes No
Your employer must allow you to answer this questionnaire during normal working hours, or at a time and place that is convenient to you. To maintain your confidentiality, your employer or supervisor must not look at or review your answers, and your employer must tell you how to deliver or send this questionnaire to the health care professional who will review it.

TO THE PHYSICIAN OF OTHER LICENSED HEALTH CARE PROFESSIONAL (PLHCP)
Review Part A Sections 1 and 2. When an employee answers YES to any of the questions in Section 2 and the questionnaire is not administered in conjunction with a physical examination, the employee needs to be considered for a follow-up physical examination with particular emphasis on those areas in which the employee answered YES. When an employee answers YES to any of the questions in Section 2 and this questionnaire is completed in conjunction with a physical examination, the physician will place a particular emphasis upon those areas to which the employee answered YES. In either situation the PLHCP will complete the "PLHCP's Written Statement" to both the employee and the employer **within 2 days.**

PART A SECTION 1 (MANDATORY)
The following information must be provided by every employee who has been selected to use any type of respirator (please print).

1. Your height:_____ft. _____in.
2. Your weight:_____lbs.
3. Your job title:_____FIREFIGHTER_____
4. A phone number where you can be reached by the health care professional who will review this questionnaire (include area code):_____
5. The best time to phone you at this number is:_____am/_____pm.
6. Has your employer told you how to contact the health care professional who will review this questionnaire? (circle one) Yes No
7. Check the type of respirator you will use (you can check more than one category):
   a.____ N, R, or P disposable respirator (filter-mask, non-cartridge type only).
   b.____ Other type (for example, half – or full-facepiece type, powered – air purifying, supplied – air, self-contained breathing apparatus).
8. Have you worn a respirator (circle one): Yes No
   If "Yes", what type(s):_____FULL FACEPIECE SCBA_____

OSHA RESPIRATOR MEDICAL EVALUATION QUESTIONNAIRE

PART A SECTION 2 (MANDATORY)
Questions 1 through 9 below must be answered by every employee who has been selected to use any type of respirator. (please circle "Yes" or "No").

1. Yes No **Do you currently smoke tobacco, or have you smoked tobacco in the last month?**
2. **Have you ever had any of the following conditions?**
   - Yes No a. Seizures (fits)
   - Yes No b. Diabetes (sugar disease)
   - Yes No c. Allergic reactions that interfere with your breathing
   - Yes No d. Claustrophobia (fear of closed-in places)
   - Yes No e. Trouble smelling odors

3. **Have you ever had any of the following pulmonary or lung problems?**
   - Yes No a. Asbestosis
   - Yes No b. Asthma
   - Yes No c. Chronic bronchitis
   - Yes No d. Emphysema
   - Yes No e. Pneumonia
   - Yes No f. Tuberculosis
   - Yes No g. Silicosis
   - Yes No h. Pneumothorax (collapsed lung)
   - Yes No i. Lung cancer
   - Yes No j. Broken ribs
   - Yes No k. Any chest injuries or surgeries
   - Yes No l. Any other lung problem that you've been told about

4. **Do you currently have any of the following symptoms of pulmonary or lung disease?**
   - Yes No a. Shortness of breath
   - Yes No b. Shortness of breath when walking on level ground or walking up a slight hill or incline
   - Yes No c. Shortness of breath when walking with other people at an ordinary pace on level ground
   - Yes No d. Have to stop for breath when walking
   - Yes No e. Shortness of breath when washing or dressing yourself
   - Yes No f. Shortness of breath that interferes with your job
   - Yes No g. Coughing that produces phlegm (thick sputum)
   - Yes No h. Coughing that wakes you early in the morning
   - Yes No i. Coughing that mostly occurs 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

OSHA RESPIRATOR MEDICAL EVALUATION QUESTIONNAIRE

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

Yes No 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
Yes No g. High blood pressure
Yes No h. Any other heart problems that you've been told about

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

Yes No 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 might be related to heart or circulation problems

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

Yes No a. Breathing or lung problems
Yes No b. Heart trouble
Yes No c. Blood pressure
Yes No d. Seizures (fits)

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 a. Eye irritation
Yes No b. skin allergies or rashes
Yes No c. Anxiety
Yes No d. General weakness or fatigue
Yes No e. Any other problem that interfere with your use of a respirator

9. Yes No Would you like to talk to the health care professional who will review this questionnaire about your answers to this question?

Question 10 to 15 below must be answered by every employee who has been selected to use either a full-facepiece respirator or self-contained breathing apparatus (SCBA). For employees who have been selected to use other types of respirators, answering these questions is voluntary.

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

11. Yes No Do you currently have any of the following vision problems?

Yes No a. Wear contact lenses
Yes No b. Wear glasses
Yes No c. Color blindness
Yes No d. Any other eye or vision problems

12. Yes No **Have you ever had an injury to your ears, including a broken ear drum?**

13. **Do you currently have any of the following hearing problems?**
- Yes No a. Difficulty hearing
- Yes No b. Wear a hearing aide
- Yes No c. Any other hearing or ear problems

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

15. Yes No **Do you currently have any of the following musculoskeletal problems?**
- Yes No a. Weakness in any of your arms, hands, legs, or feet
- Yes No b. Back Pain
- Yes No c. Difficulty fully moving your arms and legs
- Yes No d. Pain or stiffness when you lean forward or backward at the waist
- Yes No e. Difficulty fully moving your head up or down
- Yes No f. Difficulty fully moving your head side to side
- Yes No g. Difficulty bending at your knees
- Yes No h. Difficulty squatting to the ground
- Yes No i. Climbing a flight of stairs or a ladder carrying more than 25lbs.
- Yes No j. Any other muscle or skeletal problem that interferes with using a respirator

OSHA RESPIRATOR MEDICAL EVALUATION QUESTIONNAIRE

PART B of this question OSHA Questionnaire is discretionary. The health care professional who will be reviewing this questionnaire will determine if this part needs to be completed by the employee.

Part B (DISCRETIONARY)

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. Yes No **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 are working under these conditions?
2. Yes No **At work or at home, have you ever been exposed to hazardous solvents, hazardous airborne chemicals (for example: gases, fumes, or solvents)?**
   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 (for example: sandblasting)
   Yes No Tungsten/Cobalt (for example: 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 business you have:**_____
   _____
5. **List your previous occupations:**_____
   _____
6. **List your current and previous hobbies:**_____
   _____
7. **Yes No Have you been in the military services?**
   If "Yes", were you exposed to biological or chemical agents (either in training or combat)
   Yes No
8. **Yes No Have you ever worked on a HAZMAT team?**
9. **Yes No Other than medication 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)**
   If "Yes", name the medications if you know them:_____

OSHA RESPIRATOR MEDICAL EVALUATION QUESTIONNAIRE

10. Will you be using any of the following items with your respirator:

Yes (No) a. HEPA Filters
Yes (No) b. Canisters (for example; gas masks)
Yes (No) c. 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) 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

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

Yes (No) a. Light (less than 200kcal per hour)
Examples of light work are sitting while writing, drafting, or performing light assembly Work; or standing while operating a drill press (1-3 lbs.) or controlling machines.
If "Yes", how long does this period last during the average shift: _____hrs. ____mins.

Yes (No) b. Moderate (200 to 350 kcal per hour)
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 2mp or down a 5 – degree grade about 3mph; or pushing a wheelbarrow with a heavy load (about 100 lbs.) on a level surface.
If "Yes", how long does this period last during the average shift:_____hrs _____mins.

(Yes) No c. Heavy (above 350 kcal per hour)
Examples of heavy work are lifting 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 2mph; climbing stairs with a heavy load (about 50 lbs.)
If "Yes", how long does this period last during the average shift _____hrs. ____mins.

13. (Yes) No **Will you be wearing protective clothing and/or equipment (other than the Respirator) when you're using your respirator.**
If "Yes", describe this protective clothing and/or equipment
Structural Firefighting gear with SCBA tank

14. (Yes) No **Will you be working under hot conditions (temperature exceeding 77 deg. F)**

15. (Yes) No **Will you be working under humid conditions?**

16. Describe the work you'll be doing while you're using the 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 (for example, confined spaces, life-threatening gases):
TOXIC conditions; low oxygen

18. **Provide the following information, if you know it, for each substance that you'll be exposed to when you're using your respirator:**
Name the first toxic substance: unknown at this time
Estimated maximum exposure to shift: _____
Duration of exposure per shift: _____
Name of second toxic substance: _____
Estimated maximum exposure per shift: _____
Duration of exposure per shift: _____
Name of third toxic substance: _____
Estimated maximum exposure per shift: _____
Duration of exposure per shift: _____
Name of any other toxic substances that you'll be exposed to while using your respirator(s):
_____
_____

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 & RESCUE
_____

Appendix D to Section 1910.134 (Mandatory) Information for Employees Using Respirators When Not Required Under the Standard

Respirators are an effective method of protection against designated hazards when properly selected and worn. Respirator use is encouraged, even when exposures are below the exposure limit, to provide additional level of comfort and protection for workers. However, if a respirator is used improperly or not kept clean, the respirator itself can become hazard to the worker. Sometimes, workers may wear respirators to avoid exposures to hazards, even if the amount of hazardous substance does not exceed the limits set by OSHA standards. If your employer provides respirators for your voluntary use, or if you provide your own respirator, you need to take certain precautions to be sure that the respirator itself does not represent a hazard.

You should do the following:

1. Read and heed all instructions provided by the manufacturer on use, maintenance, cleaning and care, and warnings regarding the respirator limitations.
2. Choose respirators certified for use to protect against the contaminant of concern. NIOSH, the National Institute for Occupational Safety and Health of the U.S. Department of Health and Human Services, certifies respirators. A label or statement of certification should appear on the respirator packaging. It will tell you what the respirator is designated for and how much it will protect you.
3. Do not wear your respirator into atmospheres containing contaminants for which your respirator is not designated to protect against. For example, a respirator designated to filter dust particles will not protect you against gases, fumes, vapors, or very small solid particles of fumes or smoke.
4. Keep track of your respirator so that you do not mistakenly use someone else's respirator.