

WESTON FIRE

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

From: Marc Barenberg, Purchasing Agent

RE: Annual Physical Exams

Date: FEBRUARY 2017

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

The department recommends that all physicals include the following:

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

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

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

Option 1:

You may use your own insurance and physician to complete these tests/exams. 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:

AFC Urgent Care 607 Main Avenue Norwalk, CT (203) 845-9100 (call 24-hours in advance)	
Occupational Health Services 520 West Avenue, Norwalk, CT Phone: (203) 852-2417	Soundview Medical Associates 761 Main Ave, Norwalk, CT Phone: (203) 299-0154 Please request: Dr. Kelly or Dr. Bande

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

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

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

Sincerely,

A handwritten signature in black ink, appearing to read 'Marc Barenberg', with a large, stylized flourish extending to the right.

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

To: Medical Professional
From: Deputy Fire Chief, Terrence Blake
Re: Medical Evaluation-OSHA Respiratory Regulations

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

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

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

- The respirator to be used will be a Self-Contained Breathing Apparatus (SCBA), which consists of an air tank, harness and full-face piece, which is carried on the person's back. The SCBA weighs approximately 25 pounds.
- The firefighter, while wearing the SCBA will also be wearing structural firefighting gear, which weighs approximately 25 pounds. Due to the nature of the gear, core body temperature will be raised.
- In addition to the above factors, the firefighter may often be performing strenuous exercise in a very hot environment when performing fire suppression activities.
- You may want to (a) conduct further examination or (b) obtain more detailed answers to the questions in the questionnaire. In either event, the Department's Office Manager can assist you in contacting the firefighter directly.

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

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

OSHA RESPIRATOR MEDICAL EVALUATION QUESTIONNAIRE

1910.134 Appendix C (mandatory)

To the Employer:

Answers to questions in Section 1, and to question 9 in section 2 of Part A, do not require a medical examination.

To the Employee:

Can you read? Yes No

Your employer must allow you to answer this questionnaire during normal working hours, or at a time and place that is convenient to you. To maintain your confidentiality, your employer or supervisor must not look at or review your answers, and your employer must tell you how to deliver or send this questionnaire to the health care professional who will review it.

Part A. Section 1. (Mandatory)

Date: ____/____/____

Employee Number: _____

Name: _____

Age: _____

Job Title: Firefighter

Height: _____ ft. ____ in.

Weight: _____ lbs.

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

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

Check the type of respirator you will use (you can check more than one category):

- N, R, or P disposable respirator (filter-mask, non-cartridge type only) **N95**
- Other type (for example, half – or full-facepiece type, powered-air purifying, supplied-air, self-contained breathing apparatus)

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

Part A. Section 2. (Mandatory)

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

e. Trouble smelling odors Yes No

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

a. Asbestosis Yes No

b. Asthma Yes No

c. Chronic Bronchitis Yes No

d. Emphysema Yes No

e. Pneumonia Yes No

f. Tuberculosis Yes No

g. Silicosis Yes No

h. Pneumothorax / Collapsed lung Yes No

i. Lung cancer Yes No

j. Broken ribs Yes No

k. Any chest injuries or surgeries Yes No

l. Any other lung problems that you've been told about Yes No

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

a. Shortness of breath Yes No

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

c. Shortness of breath when walking with other people in an ordinary place Yes No

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

e. Shortness of breath when washing or dressing yourself Yes No

f. Shortness of breath that interferes with your job Yes No

g. Coughing that produces phlegm (thick sputum) Yes No

h. Coughing that wakes you up early in the morning Yes No

i. Coughing that occurs mostly when you are lying down Yes No

j. Coughing up blood in the last month Yes No

k. Wheezing Yes No

l. Wheezing that interferes with your job Yes No

m. Chest pain when you breathe deeply Yes No

n. Any other symptoms that you think may be related to lung problems Yes No

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

a. Heart Attack Yes No

b. Stroke Yes No

c. Angina Yes No

d. Heart failure Yes No

e. Swelling in your legs or feet (not caused by walking) Yes No

f. Heart arrhythmia (heart beating irregularly) Yes No

g. High blood pressure Yes No

h. Any other heart problems that you've been told about Yes No

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

a. Frequent pain or tightness in your chest Yes No

b. Pain or tightness in your chest during physical activity Yes No

c. Pain or tightness in your chest that interferes with your job Yes No

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

e. Heartburn or indigestion that is not related to eating Yes No

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

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

a. Breathing or lung problems Yes No

b. Heart trouble Yes No

c. Blood pressure Yes No

d. Seizures (fits) Yes No

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

a. Eye irritation Yes No

b. Skin allergies or rashes Yes No

c. Anxiety Yes No

d. General weakness or fatigue Yes No

e. Any other problems that interferes with your use of a respirator Yes No

9. Would you like to talk to the health care professional who will review this questionnaire about your answers to this questionnaire?

Yes No

10. Have you ever lost vision in either eye (permanently or temporarily)?

Yes No

11) Do you currently have any of the following vision problems:

a. Wear contact lenses Yes No

b. Wear glasses Yes No

c. Color blind Yes No

d. Any other eye vision problem Yes No

12) Do you currently have any of the following hearing problems:

a. Difficulty hearing Yes No

b. Wear a hearing aid Yes No

c. Any other hearing or ear problem Yes No

13) Have you ever had a back injury:

Yes No

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

a. Weakness in arms, hands, legs, or feet Yes No

b. Back Pain Yes No

c. Difficulty moving arms and legs Yes No

d. Pain or stiffness when you lean forward or backward at waist Yes No

e. Difficulty moving head up or down Yes No

f. Difficulty moving head side to side Yes No

g. Difficulty bending at knees Yes No

h. Difficulty squatting to the ground Yes No

i. Difficulty climbing a ladder or flight of stairs carrying more than 25lbs Yes No

j. Any other muscle or skeletal problem that interferes with using a respirator Yes No

Part B

Any of the following questions, and other questions not listed, may be added to the questionnaire at the discretion of the health care professional who will review the questionnaire.

1. In your present job, are you working at high altitudes (over 5,000 feet) or in a place that has lower than normal amounts of oxygen Yes No

If "yes," do you have feelings of dizziness, shortness of breath, pounding in your chest, or other symptoms when you're working under these conditions: Yes No

2. At work or at home, have you ever been exposed to hazardous solvents, hazardous airborne chemicals (e.g., gases, fumes, or dust), or have you come into skin contact with hazardous chemicals: Yes No

If "yes," name the chemicals if you know them:

3. Have you ever worked with any of the materials, or under any of the conditions, listed below:

- | | | |
|---|------------------------------|-----------------------------|
| a. asbestos: | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| b. Silica (e.g., in sandblasting): | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| c. Tungsten/cobalt (e.g., grinding or welding this material): | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| d. Beryllium: | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| e. Aluminum: | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| f. Coal (for example, mining): | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| g. Iron: | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| h. Tin: | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| i. Dusty environments: | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| j. Any other hazardous exposures: | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

If "yes," describe exposures:

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

5. List your previous occupations: _____

6. List your current and previous hobbies _____

7. Have you been in the military services? Yes No

If "yes," were you exposed to biological or chemical agents (either in training or combat): Yes No

8. Have you ever worked on a HAZMAT team? Yes No

9. Other than medications for breathing and lung problems, heart trouble, blood pressure, and seizures mentioned earlier in this questionnaire, are you taking any other medications for any reason (including over-the-counter medications): Yes No

If "yes," name the medications if you know them: _____

10. Will you be using any of the following items with your respirator(s)?

- | | | |
|--|------------------------------|--|
| a. HEPA Filters: | <input type="checkbox"/> Yes | <input checked="" type="checkbox"/> No |
| b. Canisters (for example, gas masks): | <input type="checkbox"/> Yes | <input checked="" type="checkbox"/> No |
| c. Cartridges: | <input type="checkbox"/> Yes | <input checked="" type="checkbox"/> No |

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

- | | | |
|-----------------------------|---|--|
| a. Escape only (no rescue): | <input type="checkbox"/> Yes | <input checked="" type="checkbox"/> No |
| b. Emergency rescue only: | <input checked="" type="checkbox"/> Yes | <input type="checkbox"/> No |

- c. Less than 5 hours *per week*: Yes No
- d. Less than 2 hours *per day*: Yes No
- e. 2 to 4 hours per day: Yes No
- f. Over 4 hours per day: Yes No

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

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

If "yes," how long does this period last during the average shift: _____ hrs. _____ mins.

Examples of a light work effort are *sitting* while writing, typing, drafting, or performing light assembly work; or *standing* while operating a drill press (1-3 lbs.) or controlling machines.

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

If "yes," how long does this period last during the average shift: _____ hrs. _____ mins.

Examples of moderate work effort are *sitting* while nailing or filing; *driving* a truck or bus in urban traffic; *standing* while drilling, nailing, performing assembly work, or transferring a moderate load (about 35 lbs.) at trunk level; *walking* on a level surface about 2 mph or down a 5-degree grade about 3 mph; or *pushing* a wheelbarrow with a heavy load (about 100 lbs.) on a level surface.

- c. *Heavy* (above 350 kcal per hour): Yes No

If "yes," how long does this period last during the average shift: _____ hrs. _____ mins.

Examples of heavy work are *lifting* a heavy load (about 50 lbs.) from the floor to your waist or shoulder; working on a loading dock; *shoveling*; *standing* while bricklaying or chipping castings; *walking* up an 8-degree grade about 2 mph; climbing stairs with a heavy load (about 50 lbs.).

13. Will you be wearing protective clothing and/or equipment (other than the respirator) when you're using your respirator: Yes No

If "yes," describe this protective clothing and/or equipment: Structural firefighter gear with SCBA tank

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

15. Will you be working under humid conditions: Yes No

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

Fire suppression, rescue, working with hand and power tools

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

18. Provide the following information, if you know it, for each toxic substance that you'll be exposed to when you're using your respirator(s): Unknown at this time

Name of the first toxic substance: _____

Estimated maximum exposure level per shift: _____

Duration of exposure per shift: _____

Name of the second toxic substance: _____

Estimated maximum exposure level per shift: _____

Duration of exposure per shift: _____

Name of the third toxic substance: _____

Estimated maximum exposure level per shift: _____

Duration of exposure per shift: _____

The name of any other toxic substances that you'll be exposed to while using your respirator:

19. Describe any special responsibilities you'll have while using your respirator(s) that may affect the safety and well-being of others (for example, rescue, security): Fire suppression and rescue
