

**Student Information Package - ACBIRC**

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**OSHA RESPIRATOR MEDICAL EVALUATION  
MANDATORY QUESTIONNAIRE**

*Fax to State Homeland Security Training Coordinator at 850-488-7842.*

Name: \_\_\_\_\_ SSN: \_\_\_\_\_  
Sex (circle one): Male / Female Height: \_\_\_\_\_ in. Weight : \_\_\_\_\_ lbs.  
Age (to nearest year): \_\_\_\_\_ Job Title: \_\_\_\_\_  
Have worn a respirator before (circle one): Yes / No  
If “yes”, what type(s): \_\_\_\_\_

**MANDATORY MEDICAL QUESTIONS**

1. Do you currently smoke tobacco, or have you smoked tobacco in the last month: Yes / No  
Pack history: \_\_\_\_\_
  
  2. Have you ever had any of the following conditions?
    - 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: 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 problem 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 at an ordinary pace on level ground: Yes / No
    - d. Have to stop for breath when walking at your own pace on level ground: 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
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- h. Coughing that wakes you 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 problems?
- 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 problem 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 problems 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 had any of the following problems? (If you've never used a respirator, 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 problem that interferes with your use of a respirator: Yes / No
9. Have you ever lost vision in either eye (temporarily or permanently): Yes / No

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10. 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 or vision problem: Yes / No
11. Have you ever had an injury to your ears, including a broken eardrum? 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 problems: Yes / No
13. Have you ever had a back injury? Yes / No
14. Do you currently have any of the following musculoskeletal problems?
- 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 25 pounds: Yes / No

Student's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

This student has been screened per OSHA regulation 29 CFR 1910.134 for respirator use, and is medically cleared for fit testing.

Physician or Medical Officer Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
(RN, PA, M.D. or Nurse Practitioner)

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**Sizing Sheet for (Name) \_\_\_\_\_**

*Circle the appropriate size in each category.*

*Fax to State Homeland Security Training Coordinator at 850-488-7842*

**For shoe size please indicate actual shoe size**

**SCBA MASK**      small      medium      large      X-large      XX-large  
(if known)

**JACKET**      small      medium      large      X-large      XX-large

**PANTS**      small      medium      large      X-large      XX-large

**MSA MASK**      small      medium      large      X-large

**GLOVES**      small      medium      large      X-large      XX-large

**SHOES**      M \_\_\_\_\_ W \_\_\_\_\_  
(please indicate actual shoe size)

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# Student Information Sheet

*Fill in the appropriate information.*

*Fax to State Homeland Security Training Coordinator at 850-488-7842*

Your Name: \_\_\_\_\_

Your Title: \_\_\_\_\_

Social Security Number: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Organization You Are Representing: \_\_\_\_\_

Address: Street: \_\_\_\_\_

City: \_\_\_\_\_

State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Contact Information:

Cell Phone: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Email address: \_\_\_\_\_

Have you attended the ODP Course PER-222 Sampling Techniques and Guidelines \_\_\_ Yes \_\_\_ No (Completion certificate must be faxed along with application)



## Security Voucher Form

*Fill in the appropriate information and have your supervisor sign it.  
Fax to State Homeland Security Training Coordinator at 850-488-7842*

1. The listed personnel are on official duty at US Army Dugway Proving Ground for training from (Date) \_\_\_\_\_ to \_\_\_\_\_, 2006 from \_\_\_\_\_

(e.g. *San Antonio Fire Station xx, San Antonio, Texas*). The class being attended is **ACBIRC**.

2. I understand that part of this training will include entry into a biological safety level 3 facility at the Life Sciences Division and work with vaccine strains of agents such as *Bacillus anthracis*, *Yersinia pestis* and *Francisella tularensis*.

3. Mr./Ms. \_\_\_\_\_ has been with the department for \_\_\_\_\_ years during which time he/she has given no reason to question his/her loyalty to the department, the State of \_\_\_\_\_, or the United States Government.

4. Insofar as I am able, I vouch for Mr./Ms. \_\_\_\_\_ in terms of security while he/she is participating in the training at US Army Dugway Proving Ground, Utah.



\_\_\_\_\_  
Supervisor's Name

\_\_\_\_\_  
Supervisor's Organization