Civil Emergency Medical Screening Questionnaire FAX/Email Cover Sheet

To: K. Chase, MD & S. Scott, MD From:

Fax: **202-223-6525** Pages:

Phone: Date:

Re: CC:

Email: usace@woha.com **Email:**

Sample Questionnaire Do Not Use

Comments

My completed Civil Emergency Medical Screening Questionnaire and additional information, if necessary, is included in this fax or email. Please note that email submissions over the internet are not secure.

After you have completed your review, please send the Physician Medical Clearance Memorandum to **WOHA** by fax at 202-223-6525.

My assigned office can be reached at 202-761-8548.

If you have any questions regarding the information provided, I can be contacted at

_____.

Thank you,

RAO Reemployed Annuitants

[BEGIN] MEDICAL SCREENING QUESTIONNAIRE
Version 4. RAO (April 2013)

Complete this Civil Emergency Medical Screening Questionnaire and provide attachments according to the attached instructions. Your civil emergency deployment status is dependent on the Medical Provider receiving ALL the required information. Double Check! It is important to complete this information to the best of your ability. Our primary goal is to ensure that you can perform the job tasks assigned while working long hours under stressful and sometimes physically demanding working conditions.

The completed questionnaire and attachments should be faxed or emailed to the Medical Provider, as indicated in the FAX/Email Cover Sheet above. Please note that email submissions over the internet are not secure. The Medical Provider will review the information, contact you with any questions, and then send the Physician Medical Clearance Memorandum with a deployment determination to the Headquarters Reemployed Annuitant Office, CECO-C-RAO. The RAO will notify you of the deployment determination.

Sample Questionnaire Do Not Use

PRIVACY ACT STATEMENT:
AUTHORITY: 5 USC 3301, 33 USC 701n, 42 USC 5121 et. Seq. System notices: A0690-200TAPC, Army Civilian Personnel Systems; OPM Govt 1, General Personnel Records; OPM Govt 10, Employee Medical File System Records. Collection is also addressed in ER690-1-321, Staffing for Civilian Support to Emergency Operations.
PURPOSE: The information you provide in the Civil Emergency Medical Screening Questionnaire and attachments will be reviewed by a medical professional to determine whether you have any medical condition that would prevent you from deployment to, or adversely impact performance of assigned duties at, emergency response sites. Such deployments normally involve working long hours, under stressful and physically demanding conditions. The medical information collected will be maintained by the medical professional with other medical record information in the employee's medical file (EMF) for a period of three years. Emergency Managers will use the Physician Medical Clearance Memorandum to assign tasks and manage staff during deployment to emergency events. The Medical Screening Questionnaire will not be shared with the Reemployed Annuitant Office or other agencies. The Physician's Medical Clearance determination will be provided to the Reemployed Annuitant Office and may be shared on a need to know basis.
ROUTINE USE: The Physician's Medical Clearance determination may be shared with other Federal agencies such as OSHA and FEMA and state and local agencies for law enforcement and occupational and/or public health purposes.
DISCLOSURE: Providing this information is voluntary. However, refusal to provide the information requested may result in the employee not being deployed to perform emergency response assignments at emergency response sites.

Section I. Personal Identifiers

*1. Last Name (legal) *First Name (legal) * Middle Name (legal)

*4. Telephone (Home) * 5. Telephone (Cellular)

5. Date of Birth

Section II. Duty Description

Sample Questionnaire Do Not Use

You may choose only one of the following Civil Emergency Operations position descriptions. The qualifications for your chosen deployment will be determined by the information you supply in the following sections.
Note: FIELD must be selected if you wish to deploy OCONUS.

***1. FIELD DEPLOYMENT:** Are you requesting a medical clearance for Field work? Field work is primarily conducted outdoors at a CONUS or OCONUS disaster site such as that performed by a Debris Quality Assurance Inspector, Construction Representative, etc. It often involves strenuous activities such as standing for long periods of time or walking over rough terrain and can include weather extremes of cold or heat and high humidity. **If you are cleared for Field Deployment you will also be cleared for Office Deployment.** ☐ Yes

***2. OFFICE (only) DEPLOYMENTS:** Are you requesting a medical clearance for Office work only? Office work is conducted primarily in an office setting at a State, Division, or District Operations Center or Field Office. ☐ Yes

Last Name:_____ Phone:_____

Section III. General Information

Please answer the following questions regarding prior deployment experience and general physical ability. ALL DESCRIPTIONS WITH THE EXCEPTION OF "MEDICATIONS AND PRESCRIPTION DRUGS (BEOLOW)" SHOULD BE DONE IN THE "REMARKS" SECTION AT THE END OF THE FORM.

*1. Are you taking any medications or prescription drugs? ☐ Yes ☐ No
If **Yes**, you must describe in full.

Sample

*2. Has your doctor restricted you from performing certain activities? If **Yes**, you must describe in full in Remarks. ☐ Yes ☐ No

Questionnaire

3. Do you have any condition that would...

*3a. Interfere with your ability to evacuate a site during an emergency? If **Yes**, you must describe in full in Remarks . ☐ Yes ☐ No

Do Not Use

*3b. Make you prone to sudden incapacitation? If **Yes**, you must describe in full in Remark. ☐ Yes ☐ No

*3c. Be aggravated by significant exertion? If **Yes**, you must describe in full in Remarks. ☐ Yes ☐ No

*3d. Interfere in any way with the full performance of emergency duties? If **Yes**, you must describe in full in Remarks. ☐ Yes ☐ No

*4. Have you ever been denied deployment to emergency response operations due to medical condition? If **Yes**, you must describe in full in Remarks. ☐ Yes ☐ No

Last Name:_____ Phone:_____

*5. Have you ever been sent home from emergency response operations due to a medical condition? If **Yes**, you must describe in full in Remarks. ☐ Yes ☐ No

*6. Are you currently pregnant? If **Yes**, you must include a medical release form from your obstetrician with this completed questionnaire to the USACE Medical Provider @ 202-223-6525 (Fax). ☐ Yes ☐ No

Section IV. Medical History

Please answer the following questions related to your past medical history and current medical conditions, if applicable.

*7. Do you have an active case of a communicable disease e.g. tuberculosis, chicken pox? If **Yes**, you must describe in full in Remarks . ☐ Yes ☐ No

*8. Do you bleed excessively after injury or tooth extraction? If **Yes**, you must describe in full in Remarks . ☐ Yes ☐ No

*9. Do you wear a leg brace, back brace, back support, or any other type of brace? If **Yes**, you must describe in full in Remarks. ☐ Yes ☐ No

*10. Have you been told within the past year that you have an abnormal EKG? If **Yes**, you must describe in full in Remarks. ☐ Yes ☐ No

*11. Do you have swollen or painful joints? If **Yes**, you must describe in full in Remarks. ☐ Yes ☐ No

*12. Do you have dizziness or fainting spells? If **Yes**, you must describe in full in Remarks. ☐ Yes ☐ No

*13. Have you had an asthma attack within this past year? If **Yes**, you must describe in full. ☐ Yes ☐ No

*14. Have you ever been hospitalized for asthma? If **Yes**, you must describe in full in Remarks. ☐ Yes ☐ No

Sample Questionnaire Do Not Use

Last Name:_____ Phone:_____

*15. Do you have shortness of breath? If **Yes**, you must describe in full in Remarks. ☐ Yes ☐ No

*16. Do you have pain or pressure in chest? If **Yes**, you must describe in full in Remarks. ☐ Yes ☐ No

*17. Do you have palpitations (flutter or pounding heart beat)? If **Yes**, you must describe in full in Remarks. ☐ Yes ☐ No

*18. Do you have high or low blood pressure? If **Yes**, you must describe in full in Remarks. ☐ Yes ☐ No

18a. If you do have high or low blood pressure, is it well controlled? If **NO,** you must describe in full in Remarks. ☐ Yes ☐ No

*19. Do you have a history of heart attack or stroke? If **Yes**, you must describe in full in Remarks. ☐ Yes ☐ No

*20. Do you have cramps in your legs. If **Yes** you must describe in full in Remarks. ☐ Yes ☐ No

*21. Have you been told that you have a hernia? If **Yes**, you must describe in full in Remarks . ☐ Yes ☐ No

*22. Do you have any life-threatening allergic reaction e.g. bee sting, shellfish or medications? If **Yes**, bring your Epi-pen with you on your deployment. ☐ Yes ☐ No

*23. Are you currently being treated for depression? If **Yes**, you must describe in full in Remarks. ☐ Yes ☐ No

*24. Are you currently suffering from depression or excessive worry? If **Yes**, you must describe in full in Remarks . ☐ Yes ☐ No

*25. Are you currently being treated for any current illness? If **Yes**, you must describe in full in Remarks. ☐ Yes ☐ No

Sample Questionnaire Do Not Use

Last Name:_____ Phone:_____

*26. Have you been hospitalized or had surgery within the past year? If **Yes**, you must describe in full in Remarks. ☐ Yes ☐ No

*27. Are you currently using any medications that may make you sleepy or reduce your level of attention during working hours? If **Yes**, you must describe in full in Remarks. ☐ Yes ☐ No

*28. Are you currently using any medications that require refrigeration? If **Yes**, you must describe in full in Remarks. ☐ Yes ☐ No

*29. Are you diabetic? If **Yes**, please answer questions #31 and #32. ☐ Yes ☐ No

29a. Do you take insulin? If **YES**, you must describe in full in Remarks. ☐ Yes ☐ No

29b. Do you take medication by mouth for elevated blood sugar? If **YES**, you must describe in full in Remarks . ☐ Yes ☐ No

*30. Do you have any history of any seizure disorder? If **Yes**, please answer question #34. ☐ Yes ☐ No

30a. Are your seizures controlled? If **No**, you must describe in full in Remarks. ☐ Yes ☐ No

*31. Are you taking Anticoagulants (blood thinner)? If **YES**, you must describe in full in Remarks. ☐ Yes ☐ No

*32. Do you have migraines or severe headaches? If **Yes**, you must describe in full in Remarks. ☐ Yes ☐ No

*33. Do you have any gastrointestinal disorder or disease? If **Yes**, you must describe in full in Remarks . ☐ Yes ☐ No

Sample Questionnaire Do Not Use

Last Name:_____ Phone:_____

Section V. Physical Capacity - OFFICE Work

Complete this section only if you have selected to be cleared for Office-only deployments.

*34. Can you perform light lifting (up to 15 lbs.) associated with office tasks on a regular basis without pain? If **No**, you must describe in full in Remarks. ☐ Yes ☐ No

*35. Can you perform light carrying (up to 15 lbs.) associated with office tasks on a regular basis without pain? If **No**, you must describe in full in Remarks. ☐ Yes ☐ No

*36. Can you reach above your shoulders and work comfortably? If **No**, you must describe in full in Remarks. ☐ Yes ☐ No

*37. Can you use the fingers on both hands comfortably? If **No**, you must describe in full in Remarks. ☐ Yes ☐ No

*38. Can you walk/stand up to perform normal office functions on a daily basis without pain? If **No**, you must describe in full in Remarks. ☐ Yes ☐ No

*39. Can you kneel without pain? If **No**, you must describe in full in Remarks. ☐ Yes ☐ No

*40. Can you use your legs to climb up steps on a daily basis without pain? If **No**, you must describe in full in Remarks. ☐ Yes ☐ No

*41. **With or without** corrective lenses, are you able to read a typewritten letter at arms length? If **No**, you must describe in full in Remarks. ☐ Yes ☐ No

*42. **With or without** the aid of corrective lens is your vision at least 20/20 in one eye and at least 20/40 in the other? If **No**, you must describe in full in Remarks. ☐ Yes ☐ No

*43. **With or without** the use of hearing aid(s), can you hear normal conversational speech? If **No**, you must describe in full in Remarks. ☐ Yes ☐ No

Sample Questionnaire Do Not Use

Last Name:_____ Phone:_____

*44. Can you tolerate excessive heat and humidity (typical Florida summer weather)? If **No**, you must describe in full in Remarks. ☐ Yes ☐ No

*45. Can you tolerate excessive cold (temperatures less than 4 degrees C / 40 degrees F)? If **No**, you must describe in full in Remarks. ☐ Yes ☐ No

*46. Can you perform your normal job duties without fatigue? If **No**, you must describe in full in Remarks. ☐ Yes ☐ No

*47. Are you able to work closely with others under stressful conditions? If **No**, you must describe in full in Remarks. ☐ Yes ☐ No

*48. Are you able to work alone and away from your normal routine? If **No**, you must describe in full in Remarks. ☐ Yes ☐ No

*49. Are you able to work protracted or irregular hours away from your home? If **No**, you must describe in full in Remarks. ☐ Yes ☐ No

*50. Height_____ Weight:_____

Sample Questionnaire Do Not Use

Section VI. Physical Capacity – FIELD/OFFICE Work

Complete this section only if you have selected to be cleared for Field deployments, which may include Office work. This section must be completed if you intend to deploy OCONUS.

*51. Do you have complete use of your arms and legs? If **No**, you must describe in full in Remarks. ☐ Yes ☐ No

*52. Can you perform light lifting (under 15 pounds) on a regular basis without pain? If **No**, you must describe in full in Remarks. ☐ Yes ☐ No

*53. Can you reach above your shoulders and work comfortably? If **No**, you must describe in full in Remarks. ☐ Yes ☐ No

*54. Can you reach below your knees and work comfortably? If **No**, you must describe in full in Remarks. ☐ Yes ☐ No

Last Name:_____ Phone:_____

*55. Can you use your fingers on both hands comfortably? ☐ Yes ☐ No
If **No**, you must describe in full in Remarks.

*56. Can you walk/stand up to four (4) hours daily? ☐ Yes ☐ No
If **No**, you must describe in full in Remarks.

*57. Can you kneel without pain? If **No**, you must describe in full ☐ Yes ☐ No
in Remarks.

*58. Can you use your legs only to climb (e.g. hills or steps) for up ☐ Yes ☐ No
to 1 hour without pain? If **No**, you must describe in full in Remarks.

*59. Can you climb using your legs or arms to safely work on ☐ Yes ☐ No
ladders or scaffolding? If **No**, you must describe in full in Remarks.

Sample Questionnaire Do Not Use

*60. Can you work at heights, below ground, or in confined ☐ Yes ☐ No
spaces (tunnels/basements)? If **No**, you must describe in full in Remarks.

*61. Can you work in a noisy environment using hearing ☐ Yes ☐ No
protection? If **No**, you must describe in full in Remarks.

*62. Can you work outside, exposed to the weather, nuisance ☐ Yes ☐ No
dust and air pollutants? If **No**, you must describe in full in Remarks.

*63. Can you wear personal protective equipment such as ☐ Yes ☐ No
respirators and protective clothing? If **No**, you must describe in full in Remarks.

*64. **With or without** corrective lenses, are you able to read ☐ Yes ☐ No
a typewritten letter at arms length? If **No**, you must describe in full in Remarks.

*65. **With or without** the aid of corrective lens is your vision ☐ Yes ☐ No
at least 20/20 in one eye and at least 20/40 in the other?
If **No**, you must describe in full in Remarks.

*66. **With or without** the use of hearing aid(s), can you hear ☐ Yes ☐ No
normal conversational speech? If **No**, you must describe in full in Remarks.

Last Name:_____ Phone:_____

*67. Can you tolerate excessive heat and humidity (typical Florida summer weather)? If **No**, you must describe in full in Remarks. ☐ Yes ☐ No

*68. Can you tolerate excessive cold (temperatures less than 4 degrees C / 40 degrees F)? If **No**, you must describe in full in Remarks. ☐ Yes ☐ No

*69. Can you perform your normal job duties without fatigue? If **No**, you must describe in full in Remarks. ☐ Yes ☐ No

*70. Are you able to work closely with others under stressful conditions? If **No**, you must describe in full in Remarks. ☐ Yes ☐ No

*71. Are you able to work alone and away from your normal routine? If **No**, you must describe in full in Remarks. ☐ Yes ☐ No

*72. Are you able to work protracted or irregular hours away from your home? If **No**, you must describe in full in Remarks. ☐ Yes ☐ No

*73. Do you have a current valid drivers license? If **No**, you must describe in full in Remarks. ☐ Yes ☐ No

*74. If **Yes** to # 73, does your license have any restrictions? ☐ Yes ☐ No

Sample Questionnaire Do Not Use

*75. Height_____ Weight:_____

REMARKS

PLACE ALL DESCRIPTIONS WITH THE EXCEPTION OF "MEDICATIONS AND PRESCRIPTION DRUGS" HERE IN THE "REMARKS" SECTION.

Number	Description

Last Name:_____ Phone:_____

-REMARKS Continued

PLACE ALL DESCRIPTIONS WITH THE EXCEPTION OF "MEDICATIONS AND PRESCRIPTION DRUGS" HERE IN THE "REMARKS" SECTION.

Number	Description

Sample Questionnaire Do Not Use

If you need more space use additional sheets of paper

Last Name:_____ Phone:_____

SECTION VII. Employee Consent

I certify that I have reviewed the information I have supplied, it is true and complete to the best of my knowledge, that I have read the Privacy Act Statement and that I am voluntarily providing the information in the Questionnaire and attachments..

Write Name in Full

Sign Name in Full
Just type name to sign

Date

[END] MEDICAL SCREENING QUESTIONNAIRE

Physician Medical Clearance Memorandum

Applicants Full Legal Name	Phone No.	Email Address

The section below is for USACE Medical Provider use only.

THRU: US Army Corps of Engineers, District/Division/FOA

ATTN: Emergency Operations Center

TO: CECO-C-RAO
ADDRESS: HQ, US Army Corps of Engineers GAO Building,
CECO-C-RAO
441 G Street, NW
Washington, DC 20314-1000
PHONE: 202-761-8548

Sample Questionnaire Do Not Use

SUBJECT: Civil Emergency Physician Medical Clearance

1. Mr./Ms. _____ has been medically evaluated and:

a. ☐ is fit to deploy with a clearance code of:

b. ☐ is not fit to deploy.

This determination is based on a review of the completed medical screening questionnaire and attachments, follow-up with employee where necessary, and the anticipated work/environmental conditions described in the work-related and medical information sheet.

Comments to be entered by the USACE Medical Provider only.

2. Physician's Signature:

Signature of Physician	Date
Print Name	Phone Number