TEXAS CITY FIRE DEPARTMENT
STANDARD OPERATING GUIDELINES

Name	Annual Medical Examination								
Volume	2	Chapter	2-7-2	Page	1 of 37	Written	1-31-18	Revised	5-13-24

Introduction

The following SOG contains the procedures to be followed for the scheduling, conducting, and follow-up of the annual medical examination. This SOG is intended as an expansion of SOG 2A-26 Wellness/Fitness Policy, Section 5. Medical Component.

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Authorized for Distribution:
David B. Zacherl
Fire Chief
(Electronically Signed)

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Section 1 Responsibility

1.1. All Uniformed personnel:

1.1.1 Will respond to all email and memo notifications from Fire Administration regarding the annual medical examination.

1.1.2 May choose to either use the licensed department physician or their licensed personal physician subject to Section 5 Personal Physician.

1.1.3 Fill out, sign and date all required medical forms where indicated.

1.1.4 Notify Fire Administration of any changes or delay to attending annual medical examination.

1.1.5 Attend all scheduled annual medical examination appointments on time and submit all required medical forms to the department or personal physician.

1.2. [1]**Battalion Chief**, Company Officer and/or Acting Officers:

1.2.1 Ensure personnel assigned to their command, either permanently or temporarily, attend all scheduled appointments on the dates identified in [1]**FirstDue** Scheduling.

1.2.2 Adjust staffing to accommodate personnel attending annual medical examination.

1.2.3 Notify Fire Administration of any changes, delays, or cancellations.

1.2.4 **Notify [1]Fire Chief of any changes, delays, or cancellations not caused by sick leave or other forms of Paid Time Off (PTO).**

1.3. Administrative Support Staff:

1.3.1 Notify personnel of upcoming annual medical examination.

1.3.2 Contact facility performing annual medical examination and schedule annual medical examination and pre-exam laboratory work.

1.3.3 Record on Annual Medical Tracking spreadsheet

1.3.4 Notify personnel of appointment dates.

1.3.5 If applicable, provide a copy of Personal Physician Option General Release form to H.R.

1.3.6 Schedule exams in Fire House, Employee Calendar and Staffing Calendar.

1.3.7 Supply personnel with all annual medical forms prior to annual exam.

1.3.8 Process receipt of “Request for Fitness Evaluation”.

1.3.9 Receive and process completed “Fit for Duty” Certification Form.

1.3.10 File “Fit for Duty” Certification Form in employee’s g-File.

1.4. Human Resources:

1.4.1 Receive sealed employee packet from facility conducting annual medical examination and secure in employees personnel file located at City Hall.

1.4.2 Provide copies of sealed employee’s medical packet when requested by employee.

1.4.3 In the event the Department Physician was unable to mail a copy of the completed Form C Medical Examination Form and Lab Test results to the employee the copy will be forward to H.R. for mailing to the employee's home address (See Appendix E).

1.5 Department Physician (Or Personal Physician)

1.5.1 Conduct annual medical exam in accordance with supplied Examination Forms and acceptable medical practices.

1.5.2 Fax a copy of the completed Form A "Fit For Duty" Certification Form to Fire Administration.

1.5.3 Provide sealed copy of results to City's Human Resources Department personnel.

1.5.4 Mail employee a copy of completed Form C Medical Examination Form and Lab Test results to each employee in pre-addressed envelope provided (See Appendix E).

1.6 Fire Chief

1.6.1 [1]Approve all requests for cancelation and/or rescheduling of medical appointments on a case-by-case basis.

Section 2 Key Points

2.1 Confidentiality of behavioral, medical, and fitness evaluations

2.1.1 All medical information obtained from medical and physical evaluations is confidential.

2.1.2 Pre-exam Laboratory testing will take place not later than one week prior to the medical exam. Personnel will report for the pre-exam laboratory work fasting, i.e. no food or drink after midnight the night before.

2.1.3 Annual Medical Examinations will not be scheduled on Wednesdays.

2.1.4 No more than two personnel will be scheduled for the medical exam on the same date

2.1.5 The department will only have access to information regarding fitness for duty, necessary work restrictions, and appropriate accommodations as identified on the completed "Fit for Duty" Certification Form.

2.1.6 At no time will confidential medical information be left out in the open, all information will be secured or filed immediately.

2.1.7 All medical information will be maintained in separate files from all other personnel information as required by applicable standards and/or law.

Section 3 - Medical Component

3.1 All uniformed members of the department will undergo a comprehensive mandatory annual medical examination by a licensed physician selected by the department and/or a licensed

personal physician selected by the firefighter. This examination is designed to help identify health problems affecting the individual, his/her department, and the professional fire service. This examination will take place during the employee's birth month, when possible, beginning in May 2010 and continuing.

3.2 The medical component will consist of:

- 3.2.1 Physical examination
- 3.2.2 Laboratory tests
- 3.2.3 Vision tests
- 3.2.4 Hearing evaluation
- 3.2.5 Spirometry
- 3.2.6 ECG Screening
- 3.2.7 Exercise Electrocardiogram
- 3.2.8 Cancer Screening
- 3.2.9 Immunizations and infectious disease screening
- 3.2.10 Referrals
- 3.2.11 Data Collection

Section 4 Scheduling Annual Evaluations

4.1 Administrative Support Staff will:

- 4.1.1 Only schedule annual medical examination and pre-exam labs for employees who choose to use the licensed physician selected by the Department.
- 4.1.1.1 Annual medical examinations are not to be scheduled on Wednesdays.
- 4.1.1.2 No more than 2 firefighters will be scheduled on any given day.
- 4.1.2 Pre-exam labs are to be scheduled to take place no later than one week prior to annual medical examination.
- 4.1.3 Request available dates from facility for examinations via TCFD email for all personnel who elect to have their annual medical examination done by a licensed physician selected by the Department.
- 4.1.4 Confirm appoints by TCFD Email with facility performing annual medical examination.
- 4.1.5 Will provide a sealed copy of all medical forms to all personnel taking an annual medical examination.
  - 4.1.5.1 Form A
  - 4.1.5.2 Form B
  - 4.1.5.3 Form C
  - 4.1.5.4 Medical History Questionnaire
  - 4.1.5.5 Physicians Memorandum Fit for Duty Document

4.1.5.6 VO2 Max Scores Medical Release, if requested by the employee
4.1.5.7 Request for Fitness Evaluations
4.1.5.8 Addressed Envelope to Employee's Address of Record
4.1.5.9 Personal Physician Option General Release form

4.1.6 Email employee of scheduled annual medical examination appointments: Pre–exam Laboratory date and annual medical examination date.
4.1.7 Add appointment to [1]**FirstDue** as a Departmental Event.
4.1.8 Add appointment to Employee Calendar.
4.1.9 Add appointment to Staffing Calendar.
4.1.10 If applicable, provide a copy of Personal Physician Option General Release form to H.R.
4.1.11 Record on Annual Medical Tracking spreadsheet
4.1.12 With receipt of 'Request for Fitness Evaluation' form:
4.1.12.1 Add the 'yes' or 'no' from Request for Fitness Evaluation form to excel spreadsheet located in Admin Secure/Medical/Annual/Annual Medical Fitness/Annual Completed Exams and Assessments
4.1.13 Record the faxed copy of the completed Form A "Fit For Duty" Form in g-file.
4.1.14 Record Fit for Duty is received on Annual completed Exams and Assessment excel sheet.
4.1.15 Record VO2 (if applicable) on Annual Completed Exams and Assessment excel sheet.
4.1.16 If VO2 & Yes to Request for Fitness Evaluation, then schedule Fitness Evaluation with appropriate Facility.
4.1.17 IF **NOT** FIT FOR DUTY, submit to Fire Chief ASAP.

4.2 Uniformed Personnel will:

4.2.1 Respond to email and memo notifications from Fire Administration and notify Fire Administration of their intent to either use the licensed physician selected by the Department or voluntarily use their own personal physician.
4.2.2 Provide notification of employee's intent to voluntarily use their personal physician no later than 48 business hours after receipt of notification from Fire Administration. The failure to respond within 48 business hours constitutes a waiver of the personal physician option.
4.2.3 Check your address on the self-addressed envelope, inside your packet.
4.2.4 If your address is not correct, please correct it and send a Change of Address form to fire administration so that we can update our records.
4.2.4.1 Change of Address form is located at TCFD Access / Forms / Hr-change of address phone number form
4.2.5 Check your paperwork for accuracy of SSN, DOB, Address, etc.

4.2.6 Employees requesting the optional fitness evaluation must fill out and sign the Request for Fitness Evaluation form and return to Fire Administration on or before your medical appointment.

4.2.7 Fill out the Medical History Statement and sign all forms where indicated. Take all forms, medical history report, and pre-addressed envelope to your appointment

4.2.8 Must fast for pre-exam labs – no food or water after midnight.

4.2.9 Wear comfortable clothing and rubber soled shoes for your annual medical examination.

4.2.10 Report to appropriate facility for your pre-exam labs, as scheduled.

4.2.11 Report to appropriate facility and sign in at the Company Physicals desk and turn in all of your completed paperwork.

Section 5 Personal Physician

5.1 Personnel who voluntarily elect to use their own personal physician will be responsible for:

5.1.1 Obtaining prior permission from Fire Administration before scheduling.

5.1.2 Completing Appendix J Personal Physician Option General Release.

5.1.3 Scheduling their own annual medical examination and pre-exam lab work during the employee's birth month. The scheduled date of the examination and required lab work must be during off-duty time only.

5.1.4 Ensure that a completed "Fit for Duty" Form is received at Fire Administration no later than 10 days after the annual medical examination.

5.1.5 Ensure that a sealed copy of all medical exam forms is delivered to the City's Human Resource Department no later than 30 days after the annual medical examination.

5.1.6 Obtaining a personal copy of the results of their examination.

5.1.7 The Department will reimburse personnel who elect to have their own physician perform the annual examination up to an amount equal to the Department cost of the Department Physician performed medical examination.

5.1.8 Any additional costs above the Department's approved cost are the responsibility of the employee. Individuals who choose their own physician will be responsible to negotiate a price equal to the cost of the Department Physician performed medical examination and pre-exam lab work or must pay the difference. Under no circumstance will Personal Insurance benefits provided by the City be used to pay for any of the departmental required annual medical examination.

5.1.9 Personnel must turn in a copy of their receipt for reimbursement. In all cases, reimbursement will be limited to the maximum approved cost of the Department Physician performed medical examination.

Section 6 "Not Fit for Duty" Evaluation

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6.1 A rating of "Not Fit for Duty" may only be reversed by the Departmental Physician. Therefore, it is imperative that the individual firefighter and his personal physician cooperate fully with the Department Physician to resolve any identified issue(s).

6.2 Personnel receiving a "Not Fit for Duty" classification shall:

6.2.1 Seek consultation with their personal physician (or may choose to use the Departmental Physician, as a personal physician).

6.2.2 Costs associated with getting the issue(s) under control are the responsibility of the employee using their health insurance benefits including any required co-pays.

6.2.3 Employees may be placed on sick leave, personal leave, or a combination of both to maintain salary and benefits. Light duty options will be assessed on a case by case basis depending on the nature of the issue(s).

6.2.4 Provide necessary information and feedback to the Departmental Physician to obtain a "Fit for Duty" rating.

6.2.5 Resume regular assignment upon receiving a "Fit for Duty" rating by the Department Physician indicating that the issue(s) has/have been satisfactorily resolved.

6.3 Personnel receiving a "Fit for Duty" rating with required follow-up shall:

6.3.1 Costs associated with getting the issue(s) under control are the responsibility of the employee using their health insurance benefits including any required co-pays.

6.3.2 Seek consultation with their personal physician (or may choose to use the Departmental Physician as a personal physician).

6.3.3 Continue their regular assignment.

6.3.4 Provide necessary information and feedback in a timely manner to the Departmental Physician to obtain a clear "Fit for Duty" rating.

6.3.5 Recognize that the failure to timely respond and address the "follow-up" notification may result in a change of rating to "Not Fit for Duty" which will then subject the employee to the requirements of 6.2 in order to obtain a "Fit for Duty" rating.

[1]Amended May 13, 2024

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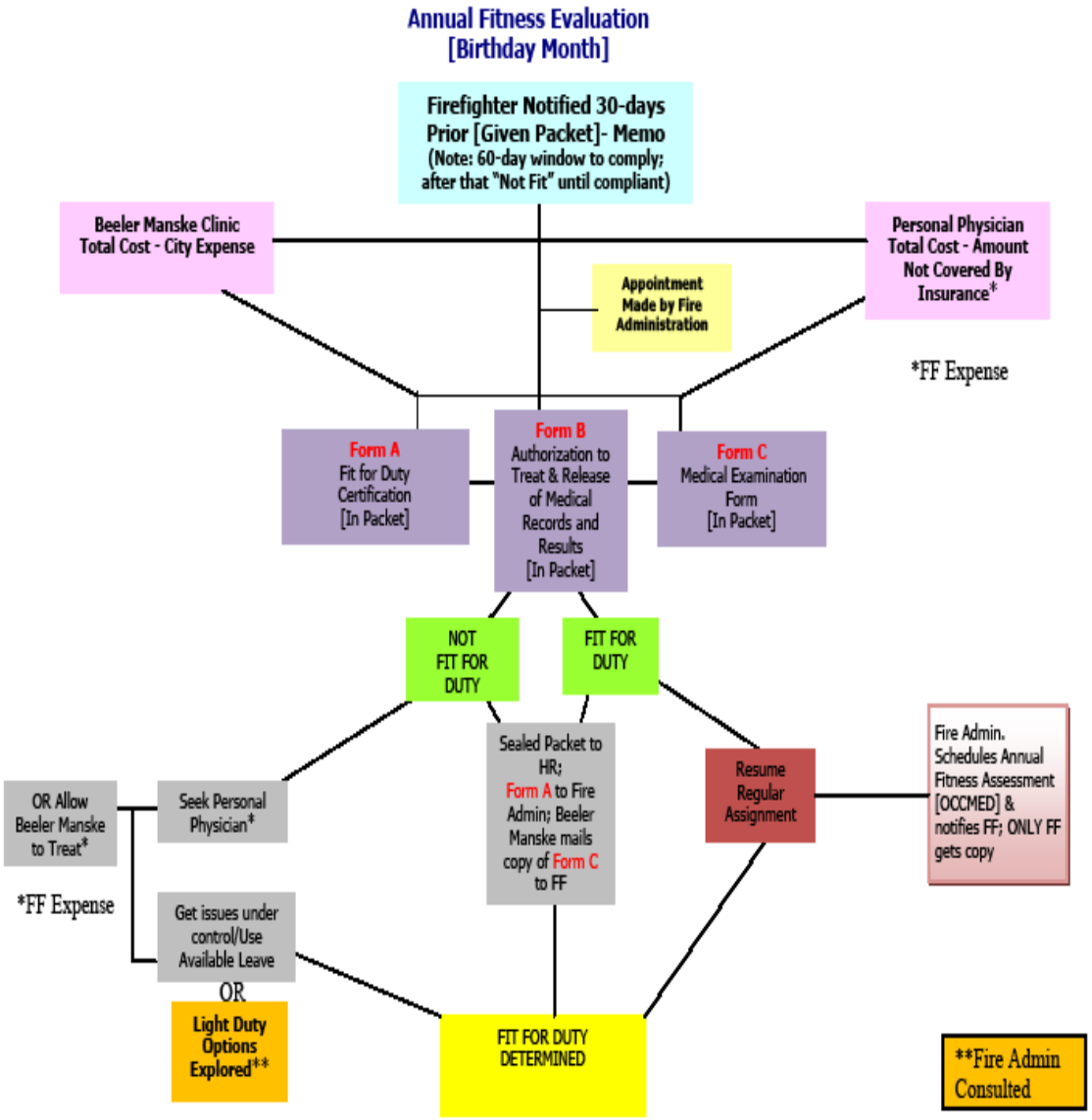
Appendix A
FIT FOR DUTY CHART



Appendix B

Memorandum – Fire Department

Date:

To: **John Doe**

From: **Fire Administration**

RE: Annual Fitness Evaluation Test

Your annual fitness evaluation test is due on or before your birthday, _____.
And no later than 30 days after your birthday. This notification is given to advise you that you must have your evaluation test completed by said date.

I have made an appointment for you at XYZ Facility on _____.
If you choose to have this evaluation performed by your personal physician, you must notify me by _____ so that your appointment with Beeler Manske can be cancelled in a timely fashion.

Attached is your packet which includes the following:

1) **Form A:** Fit for Duty Certification, short form [to be placed on the outside of sealed envelope and 1 extra copy enclosed in envelope provided];

2) **Form B**: Authorization to Treat and Release Medical Records and Results [which includes Medical History Questionnaire]; and

3) **Form C**: Medical Examination form [to be completed by physician] and extra copy mailed to firefighter (envelope provided).

If you have any questions or concerns, please contact _____, Director, Human Resources Department, phone number 409-643-5930; fax no. 409-643-5952, e-mail: XXXX@texas-city-tx.org.

Thank you for your assistance and cooperation in this matter.

Appendix C

FORM A
TEXAS CITY FIRE DEPARTMENT MEDICAL EXAMINATION
FIT FOR DUTY CERTIFICATION

Name: Occupation:

Job Description: Under supervision, provides service delivery in mitigation, response, control, and recovery of fire related emergencies, hazardous materials incidents, emergency medical services, and other emergent and non-emergent tasks inherent to the fire service necessary to protect life and property. Performs related work as required.

Gender: Male Female SSN:

Examination For: Pre-Placement D.O.T.
In-Service Fitness For Duty

I certify that I have performed and/or verified the medical examination performed on the above named individual on _____ and administered the following immunizations, and/or verified from existing shot (immunization) records that they have been administered.

MMR	Chicken Pox Virus
Varicella Vaccine	TB Test
Tetanus/diphtheria	Polio Vaccine
Hep B Antibody	Hep B Shot
VO2 Max Scores	

I certify that the above named individual is:

FIT	NOT FIT	To continue his/her duties as a Texas City Fire Fighter.
YES	NO	This individual is cleared to perform Annual Fitness Assessment.
YES	NO	This individual is fit to perform Physical Ability Test.

_____ _____/_____
Physician Phone/Fax Number
PRINTED
PHYSICIAN NAME:_____ Date:_____

QUESTIONS OR CONCERNS: Please direct to Jennifer Price, Director, Human Resources Department, Phone: 409-643-5930; Fax No. 409-643-5952; e-mail: jprice@texas-city-tx.org.
****

HR Use: Copy mailed to Fire Admin. (Date) _____ (Initials) _____

Appendix D

FORM B

BEELER MANSKE CLINIC

OR PERSONAL PHYSICIAN ANNUAL MEDICAL EXAM AUTHORIZATION TO TREAT AND RELEASE MEDICAL RECORDS AND RESULTS

Employer: _____ **Date:** _____

Employee: _____

Birth Date: _____ **SS#:** _____

PLEASE RETURN IN A SEALED ENVELOP ALL MEDICAL RECORDS, TEST RESULTS, LAB RESULTS, FIT FOR DUTY QUESTIONNAIRE, ETC. WITHOUT DELAY TO CITY OF TEXAS CITY, HUMAN RESOURCE DEPARTMENT, 1801 9TH AVENUE NORTH, TEXAS CITY, TEXAS 77590 FOR PLACEMENT INTO EMPLOYEES MEDICAL FILE. PLACE FORM A ON FIT FOR DUTY FORM ON THE OUTSIDE OF SEALDED ENVELOP.

ONLY THE CATEGORIES CHECKED ARE AUTHORIZED AND SUBJECT TO PAYMENT:

Individualized Health Risk Appraisal

Written feedback to uniformed personnel concerning health risks and health status is required following the annual examination. Reporting findings and risks and suggesting plans for modifying risks improves the physician-patient relationship and helps uniformed personnel claim ownership of their health status. Individualized health risk appraisals also must include questions that attempt to accurately measure the uniformed personnel's perception of their health. Health perception can be a useful indicator of potential problems.

Medical History Questionnaire

An initial pre-employment history questionnaire must be completed to provide baseline information with which to compare future medical concerns. A periodic medical history questionnaire must be completed to provide follow-up information. Periodic questionnaires focus on changes in health status.

Hands-on Physical Examination **Vital Signs Head, Eyes, Ears, Nose, and Throat Neck Cardiovascular**

Inspection, auscultation, percussion and palpation

Pulmonary

Inspection, auscultation, percussion and palpation **Gastrointestinal**

Inspection, auscultation, percussion and palpation

Genitourinary

Hernia exam (Also, see cancer screening).

Rectal – MANDATORY FOR BOTH SEXES

(See cancer screening).

Lymph Nodes

Appendix D

The examination of organ systems must be supplemented with an evaluation of lymph nodes in the cervical, axillary, and inguinal regions.

Neurological

The neurologic exam for uniformed personnel must include a general mental status evaluation and general assessment of the major cranial/peripheral nerves (motor, sensory, reflexes).

Musculoskeletal

Includes an overall assessment of range of motion (ROM) of all joints. Additionally, observation of the personnel performing certain standard office exercises or functions is helpful in assessing joint mobility and function.

Blood Analysis

The following are components of the blood analysis. At a minimum, laboratory services must provide these components in their automated chemistry panel (aka SMAC 20) and complete blood count (CBC) protocols:

Prostate Specific Antigen
White Blood Cell Count
Differential
Red Blood Cell Count (Hematocrit)
Platelet Count
Liver Function Tests

Includes SCOT/AST, SGPT/ALT, LDH, Alkaline Phosphatase, and Bilirubin

Triglycerides
Glucose
Blood Urea Nitrogen Creatinine
Sodium
Potassium
Carbon Dioxide
Total Protein
Albumin
Calcium
Cholesterol

Includes Total Cholesterol. Low Density Lipoprotein (LDL-C) level, High Density Lipoprotein (HDL-C) level, and Total Cholesterol/HDL Ratio

Urinalysis

Dip Stick (included)

Includes pH, Glucose, Ketones, Protein, Blood, and Bilirubin

Microscopic

Includes WBC, RBC, WBC Casts, R C Casts, and Crystals

Vision Tests

Assessment of vision must include evaluation of distance, near, peripheral, and color vision. Evaluate for common visual disorders including cataracts, macular degeneration, glaucoma, and diabetic retinopathy.

Hearing (Audiogram)

Pulmonary (Spirogram)

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Appendix D

Chest X-Ray
Initial Baseline
Repeat Chest X-Ray (Every three years - optional)
Repeat Chest X-Ray (Every five years - mandatory)

EKG (Resting)

Cancer Screening Elements
MALE:
Annual PSA required on all male uniformed personnel.
Digital Rectal Exam (included)
Skin Exam (included)
Testicular Exam (included)

FEMALE:
Clinical Breast Examination, (included)
Pap Smear

Mammogram REQUIRES PRE-APPROVAL IF DIRECTED BY THE PHYSICIAN.
Annual beginning at age 40

Immunizations and Infectious Disease Screening
Tuberculosis Screen (Mandatory annual PPI 1)
Hepatitis B Virus Screen **Hepatitis B Virus**
Vaccine (Mandatory)
HIV Screening (Required to be offered)
HIV testing should be offered on a confidential basis as part of post-exposure protocols and as requested by the physician and patient.

PRE-APPROVAL REQUIRED FOR THE FOLLOWING:

Hepatitis C Virus Screen (Baseline) **Tetanus/Diphtheria**
Vaccine (Booster every 10 years)
Measles, Mumps, Rubella Vaccine (MMR)
Polio Vaccine
Vaccine shall be given to uniformed personnel if vaccination or disease is not documented.
Varicella Vaccine (Required to be offered)
Influenza Vaccine (Required to be offered)
Tetanus/Diphtheria Vaccine (Booster every 10 years)

Annual Fitness Evaluation
Aerobic Capacity
Maximal cardiopulmonary test with EKG

I, _____, hereby give my permission and direct Beeler Manske Clinic and/or Personal Physician to release all medical records, test results, and other related documents to my employer in a sealed envelope as specifically directed on Page 1 of Form B

_____ _____
Signature Date

Appendix E

FORM C
TEXAS CITY FIRE DEPARTMENT
MEDICAL EXAMINATION

1. NAME:				2. SEX:		3. DATE OF EXAMINATION
4. DIVISION:	5. SSN#:			6. OCCUPATION:		7. DATE OF LAST EXAMINATION
8. REASON FOR PRESENT EXAMINATION ☐ PRE-PLACEMENT ☐ D.O.T. ☐ IN-SERVICE ☑ FITNESS FOR DUTY ☐ OTHER						
9. TEMP 10. PULSE		11. BLOOD PRESSURE		12. HEIGHT		13. WEIGHT 14. TITMUS SNELLING
15. VISION	UNCORRECTED			CORRECTED		16. COLOR VISION (use code)*
Distant	RE 20/	Both	LE 20/	RE/20	Both	LE/20
Near	RE 20/	Both	LE 20/	RE/20	Both	LE/20 17. PERIPHERAL

CLINICAL EVALUATION

Areas Examined	*Use CodeRemarks (Describe all "Code 1s in Detail)		
18	Head and Neck		
19	Thyroid		
	Lymph Nodes		
20	Eyes		
	Fundi		
21	Ears		
22	Nose and Sinuses		
23	Mouth and Throat		
24	Teeth		
25	Chest and Lungs		
	Breast		

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26	Heart		
27	Abdomen		
28	Inguianal, e.g., hernia		
29	Genitalia		
30	Pelvis		
31	Anus and Rectum		
	Prostate		
	Proctoscopic		
32	Spine		

* Code: 0 - Within Normal limits 1 - Significantly abnormal x - Not examined

CLINICAL EVALUATION continued:

Areas Examined	*Use Code	Remarks (Describe all "Code 1s in Detail)	
33	Skin		
34	Arms		
	Hands		
35	Legs		
	Feet		
36	Peripheral - Vascular		
37	Neurologic		
38	Emotional Status		
39	Other		

40. Urine dip: Glucose: Albumin: S.G.:

Heme: Leukocyte-Esterase:

Other:

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41. Flex	42. Step Test	43. Body Fat	44. PFT	45. Audio

46. Chest X-Ray (use 0, 1, or X)	47. EKG (use 0, 1, or X) specify test used	48. Hemocult

49. Back Evaluation	50. Tetanus	51. PPD	52. Stress Test

53. Other X-Ray or Laboratory Findings:								

		Within Normal Limits	Abnormal, Able to perform Job Tasks	Abnormal, Unable to Perform Job Tasks	Comments
TB Skin Test					
HIV Screening					
Hepatitis A (if applicable)					
Hepatitis B					
Hepatisit C					
Cancer Screening Results					
Breast Exam					
PAP					

53. Other X-Ray or Laboratory Findings continued:

	Within Normal Limits	Abnormal, Able to perform Job Tasks	Abnormal, Unable to Perform Job Tasks	Comments
Cancer Screening Results continued:				
POB				
Skin				
DRE				
Testicular				
PSA				

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Heavy Metals					

54. Physician's summary, remarks, and diagnoses, including recommendations made to patient (include code numbers for diagnoses and conditions found)

55. Restrictions (if applicable)

I certify that I have examined _____ on _____ and find that he/she is _____fit or _____ not fit to continue his/her duties as a Texas City Fire Department Fire Fighter.

_____ _____

Examining Physicians Signature Phone Number

_____ _____

Date FAX Number

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Appendix F

MEDICAL HISTORY QUESTIONNAIRE
(To be Attached to Form B)

Since your last visit, please signify and changes:

Health History	Yes	No	If "Yes", Give Details.
Ringing in ears?	☐	☐	_____
Other ear problems?	☐	☐	_____
Glaucoma or cataracts?	☐	☐	_____
Red eyes?	☐	☐	_____
Eye injury/vision loss?	☐	☐	_____
Other eye problems (e.g., strain from VDT use)?	☐	☐	_____
Glasses/contacts?	☐	☐	_____
Date of last vision screen?	☐	☐	_____

Head/Neck – Have You Ever Had or Do You Currently Have:

Date of last dental exam:	☐	☐	_____
Recent problems with teeth/dentures?	☐	☐	_____
Frequent mouth ulcers/infections?	☐	☐	_____
Sinus or hay fever?	☐	☐	_____
Frequent sore throats?	☐	☐	_____
Frequent nose bleeds?	☐	☐	_____
Trouble with thyroid (e.g., taking Thyroid medication)?	☐	☐	_____
Problem requiring radiation	☐	☐	_____
Treatment to the neck area?	☐	☐	_____

Lungs – Have You Ever Had or Do You Currently Have:

Asthma or wheezing?	☐	☐	_____
Coughed up any blood?	☐	☐	_____
Shortness of breath without apparent reason?	☐	☐	_____
TB or positive skin test for TB?	☐	☐	_____
Pneumonia or pleurisy?	☐	☐	_____
Do you cough every day, especially in the morning?	☐	☐	_____
Pain or tightness in chest?	☐	☐	_____
More than three episodes of			

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bronchitis in one year? ☐ ☐ _____

Ever smoked tobacco in any form? ☐ ☐ Long: Yrs. / Packs per day: When quit:_____

Had a chest x-ray? ☐ ☐ Last time:_____

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Appendix F

MEDICAL HISTORY QUESTIONNAIRE
(To be Attached to Form B)

Since your last visit, please signify and changes:

Health History	**Yes**	**No**	**If "Yes", Give Details.**
Heart – Have you Ever Had or Do You Currently Have:			
Rheumatic fever or heart murmur?	☐	☐	_____
Heart disease?	☐	☐	_____
Treated for heart condition?	☐	☐	_____
Unusually cold or blush-colored hands/feet?	☐	☐	_____
High blood pressure. If "Yes", how is it treated?	☐	☐	☐Medicine ☐ Diet ☐ Exercise
Do you have a history of elevated cholesterol?	☐	☐	_____
Anemia or any blood disease?	☐	☐	_____
Phlebitis, varicose veins, or blood clots/ poor circulation?	☐	☐	_____
Chest pain with activity?	☐	☐	_____
GI – Have You Ever Had or Do You Currently Have:			
Ulcers?	☐	☐	_____
Hiatal hernia?	☐	☐	_____
Indigestion, pain, or unusual burning in stomach?	☐	☐	_____
Vomiting of blood?	☐	☐	_____
Bloody/tarry bowel movements?	☐	☐	_____
Colitis or nervous stomach?	☐	☐	_____
Yellow jaundice or hepatitis?	☐	☐	_____
Problem with your pancreas?	☐	☐	_____
Gallbladder disease?	☐	☐	_____
Kidneys – Have You Ever Had or Do You Currently Have:			
Bladder or kidney infections?	☐	☐	_____
Kidney stones?	☐	☐	_____
Burning or discomfort on urination, or Frequent urination?	☐	☐	_____
Hernia?	☐	☐	_____
Blood in urine?	☐	☐	_____
Miscellaneous – Have You Ever Had or Do you Current Have:			
Diabetes or sugar in your blood or urine?	☐	☐	_____
Cancer of any kind?	☐	☐	_____

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Appendix F

MEDICAL HISTORY QUESTIONNAIRE
(To be Attached to Form B)

Since your last visit, please signify and changes:

Health History	**Yes**	**No**	**If "Yes", Give Details.**
Muscle-Skeletal – Have you Ever Had or Do You Currently Have:			
Arthritis, rheumatism, neck, back, or spine Injury or disease?	☐	☐	_____
Been treated for a back problem?	☐	☐	_____
Recurrent stiffness or back pain?	☐	☐	_____
Bursitis, tendonitis?	☐	☐	_____
Recurrent pulled muscles or sprains?	☐	☐	_____
Hand or wrist injury or problem?	☐	☐	_____
Hip or knee injury or problem?	☐	☐	_____
Ankle or foot injury or problem?	☐	☐	_____
Frostbite?	☐	☐	_____
Job requiring heavy lifting or standing or sitting for long periods of time?	☐	☐	_____
Any broken bones?	☐	☐	_____
For Females Only – Have You Ever Had or Do You Currently Have:			
Menstrual irregularities?	☐	☐	_____
Recurrent problems of the female organs?	☐	☐	_____
Brest masses or lumps?	☐	☐	_____
Do you practice monthly breast self-exam?	☐	☐	_____
Have you ever had a mammogram?	☐	☐	_____
Date of last pap smear:	☐	☐	_____
For Males Only – Have You Ever Had or Do You Currently Have:			
Prostate or testicular problems?	☐	☐	_____
Breast tenderness, swelling, or lumps?	☐	☐	_____
Do you practice monthly testicular self-exam?	☐	☐	_____

General Lifestyle I. Check the answer that best describes you.

General health	☐Poor	☐Fair	☐Good	☐Excellent
% Seatbelt use	☐0-24%	☐25-49%	☐50-74%	☐75-100%
Daily stress	☐Low	☐Moderate	☐ High	
Average hours sleep	☐6 hours or less	☐7-8 hours	☐8 hours or more	
Average meals daily	☐1 mea l	☐2 meals	☐3 meals or more	
Number of eggs per week	☐0-1	☐2	☐3 or more	
Average number red meat per wk	☐0-1	☐2-3	☐3 or more	

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General Lifestyle I. Continued

Average number of alcoholic Beverages/beers per week ☐0-5 ☐6-14 ☐15 or more

	Yes	No	If "Yes", Give Details.
Do you exercise three times per week:	☐	☐	_____
30 – 40 minutes each time?	☐	☐	_____
Identify types of exercise.	☐	☐	_____
Are you more than 30% above your ideal weight?	☐	☐	_____
Have you received a tetanus booster in the Last 10 years?	☐	☐	_____
Have you been immunized against hepatitis B?	☐	☐	Year immunized:_____
Do you take any prescription medication?	☐	☐	_____
Do you take nonprescription medication (or over-the-counter drug) on a regular basis?	☐	☐	_____

General Lifestyle II.

Do you participate in a workplace wellness/ help promotional program?	☐	☐	_____
Which of the following would you like to see offered and would you participate in?			
Cholesterol screen	☐	☐	_____
Blood pressure screen	☐	☐	_____
Weight loss	☐	☐	_____
Nutrition program	☐	☐	_____
Stress management	☐	☐	_____
Smoking cessation	☐	☐	_____
CPR	☐	☐	_____
Blood drive	☐	☐	_____
Health risk appraisal	☐	☐	_____
Self-directed exercise	☐	☐	_____
Health education program	☐	☐	_____

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Women's health	☐	☐	_____

Work History I. Have you ever:

	Yes	No	If "Yes", Give Details.
Been restricted in your work or given "light duty" because of your health or injury?	☐	☐	_____
Left a job because of health problems?	☐	☐	_____
Been injured on the job and treated by a doctor?	☐	☐	_____
Received compensation for an industrial injury or illness?	☐	☐	_____
Are you receiving any health care treatment (e.g. physical therapy, chiropractic, Acupuncture, medical, etc.)?	☐	☐	_____
Been hospitalized in the last five years?	☐	☐	_____
Have you had any illness or injury that we have not asked you about?	☐	☐	_____

Work History II.

Do you have hobbies, such as furniture refinishing, painting, hunting, shooting, or model building?	☐	☐	_____
Do you moonlight or have a second job?	☐	☐	_____

Work History III. Exposures – Have You Ever Worked Around the Following:

Chemical plant?	☐	☐	_____
Coke oven?	☐	☐	_____
Construction?	☐	☐	_____
Cotton, flax, or hemp mill?	☐	☐	_____
Electronics plant?	☐	☐	_____
Farm?	☐	☐	_____
Foundry?	☐	☐	_____

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Hazardous waste industry?	☐	☐	_____
Hospital?	☐	☐	_____

Work History III. Continued

Yes	**No**	**If "Yes", Give Details.**
Lumber mill?	☐	☐	_____
Metal productions?	☐	☐	_____
Mine?	☐	☐	_____
Nuclear industry?	☐	☐	_____
Paper mill?	☐	☐	_____
Pharmaceutical?	☐	☐	_____
Plastic production?	☐	☐	_____
Pottery mill?	☐	☐	_____
Refinery?	☐	☐	_____
Rubber processing plant?	☐	☐	_____
Sand pit or quarry?	☐	☐	_____
Service station?	☐	☐	_____
Shipyard?	☐	☐	_____
Smelter?	☐	☐	_____

Have You Ever Worked With or Been Exposed To:

Aldrin?	☐	☐	_____
Arsenic?	☐	☐	_____
Asbestos?	☐	☐	_____
Benzene?	☐	☐	_____
Benzidine?	☐	☐	_____

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Beryllium?	☐	☐	_____
BIS chlormethyl ether?	☐	☐	_____
Cadmium?	☐	☐	_____
Carbon disulfide?	☐	☐	_____

Have You Ever Worked With or Been Exposed To: Contined

Yes No If "Yes", Give Details.

Carbon tetrachloride?	☐	☐	_____
Chlorine?	☐	☐	_____
Chlorodane?	☐	☐	_____
Chloraform?	☐	☐	_____
Chloroprene?	☐	☐	_____
Chromates?	☐	☐	_____
Chromic acid mist?	☐	☐	_____
Cutting oils?	☐	☐	_____
DDT?	☐	☐	_____
Dieldrin?	☐	☐	_____
Dioxin?	☐	☐	_____
Dust, coal?	☐	☐	_____
Dust, sandblasting?	☐	☐	_____
Dust, other?	☐	☐	_____
Ethyl dibromide?	☐	☐	_____
Ethylene oxide?	☐	☐	_____
Extreme heat or cold?	☐	☐	_____
Heptachlor?	☐	☐	_____

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Hexachlorobenzene?	☐	☐	_____
Isocyanates (TDI, MDI)?	☐	☐	_____
Loud or continuous noise?	☐	☐	_____
Mercury?	☐	☐	_____
Methylene chloride?	☐	☐	_____
Microwaves, lasers?	☐	☐	_____

Have You Ever Worked With or Been Exposed To: Continued

Yes	**No**	**If "Yes", Give Details.**	
Nickel?	☐	☐	_____
PCBs?	☐	☐	_____
Pesticides, herbicides?	☐	☐	_____
Phenois?	☐	☐	_____
Phosgene?	☐	☐	_____
Plastics?	☐	☐	_____
Radioactive materials?	☐	☐	_____
Roofing materials?	☐	☐	_____
Rubber?	☐	☐	_____
Silica?	☐	☐	_____
Solvent/degreasers?	☐	☐	_____
Soots and tars?	☐	☐	_____
Spray painting?	☐	☐	_____
TRI/PER chloroethylene?	☐	☐	_____
Vinyl chloride?	☐	☐	_____

List any toxins/chemicals/biological hazards you might currently be exposed to: _____

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Work History IV. Job – Start with the Most Recent:

Date (Year to Year)		Company	Position	Any Work Hazards
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

I certify that the above information is true and complete to the best of my knowledge. I hereby give _____ permission to release work-related information to the proper authorities of my employer or the company for which I am a job applicant.

Date: _____ Signature: _____

Examiner: _____

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Appendix G

Memorandum – Fire Department

Date:

To: **Physician**

From: **Fire Administration**

RE: Annual Fitness Evaluation Test

Dear Physician,

Attached is the following:

4) **Form A:** Fit for Duty Certification, short form [to be placed on the outside of sealed envelope and 1 extra copy enclosed in envelope provided];

5) **Form B**: Authorization to Treat and Release Medical Records and Results [which includes Medical History Questionnaire]; and

6) **Form C**: Medical Examination form [to be completed by physician] and extra copy mailed to firefighter (envelope provided).

If you have any questions or concerns, please contact _____, Director, Human Resources Department, phone number 409-643-5930; fax no. 409-643-5952, e-mail: _____@texas-city-tx.org.

Thank you for your assistance and cooperation in this matter.

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Appendix H

CITY OF TEXAS CITY, TEXAS
TEXAS CITY FIRE DEPARTMENT * OFFICE: (409) 643-5700 * FAX: (409) 643-5719

AUTHORIZATION TO RELEASE
VO2 MAX NUMBERS TO OCCMED CLINIC

Employee's Name _____

Date of Birth: _____ SSN: _____

_____ I **authorize** Beeler Manske Clinic and/or Personal Physician to release, in a sealed envelope, the VO2 Max results from my annual stress test to OCCMED Solutions Clinic located at 6801 Emmett F. Lowry Expressway, Texas City, TX 77591 for use in my Annual Fitness Evaluation and Assessment.

_____ _____

Signature of Employee Date

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Request for Fitness Evaluation

Employee's Name: _____

_____***I request a Fitness Evaluation and Assessment at OCCMed Clinic after my Annual Medical Examination and upon receipt of notification of "Fit for Duty" from Beeler Manske Clinic and/or Personal Physician.***

_____***I DO NOT request a Fitness Evaluation and Assessment at OCCMed Clinic after my Annual Medical Examination and upon receipt of notification of "Fit for Duty" from Beeler Manske Clinic and/or Personal Physician.***

_____ _____

Signature of Employee ***Date***

FORM MUST BE RETURNED TO FIRE ADMINISTRATION ON OR BEFORE DATE OF MEDICAL PHYSICAL AT BEELER MANSKE. FAILURE TO RETURN FORM TO FIRE ADMINISTRATION WILL BE CONSIDERED AS A "DO NOT REQUEST"

Date of Medical Exam _____

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Appendix I

Mainland Medical Center ***PHYSICAL THERAPY***

6801 Emmett F. Lowry Expressway PHONE:(409) 938-5790
Texas City. Texas 77591 Fax: (409) 938-5794

TEXAS CITY FIRE DEPARTMENT
ANNUAL FITNESS ASSESSMENT

Name:_____ Age _____ Date: _____

Pre-evaluation procedure:
Current medical status is reviewed and confirmed and the individual has been cleared within 12(+ 3) months by MD. History includes _____
_____
_____

RESTING HEART RATE _____ bpm (cannot exceed 110) TARGET EXERCISE HR 220 - ___ x .85 = _____
BLOOD PRESSURE _____ mmHg (cannot exceed 160/100) WAIST TO HIP RATIO _____
HEIGHT _____ INCHES / WEIGHT _____ POUNDS / BMI _____ /BODY COMPOSITION _____ % FAT
Since your last medical evaluation have you experienced any of the following: Y=yes, N=no
___Chest Pain during or absence of physical activity
___Loss of consciousness
___Loss of balance due to dizziness (ataxia)
___Recent injury resulting in bone, joint, or muscle problem
___Current prescribed drug that inhibits physical activity
___Chronic infectious disease (e.g., hepatitis)
___Pregnancy
___Any recent disorders that can be exacerbated by exercise
___Any other reason why you believe that you should not be physically evaluated

Instructions to individual being tested:

In order, you will undergo tests to determine your current level of muscular strength, muscle endurance, flexibility and aerobic capacity. As a benefit to you, a copy of your test will be sent to your home address along with a personal wellness plan to assist you with maintaining or improving your level of fitness.
We are interested in keeping you safe during testing and your heart rate will be monitored during your testing today. You are encouraged to ask questions about your test or for clarification.
If at any time during any test you experience chest pain, light-headedness, ataxia (dizziness), confusion, nausea, pain, or clamminess you are to stop testing and inform the evaluator.

I, _____ have reviewed the safety rule above regarding my responsibility to report any adverse reactions to the evaluator, and my signature is my agreement to do so.
Print Name

_____
Signature

Appendix I

Mainland Medical Center ***PHYSICAL THERAPY***

6801 Emmett F. Lowry Expressway PHONE:(409) 938-5790
Texas City. Texas 77591 Fax: (409) 938-5794

TEXAS CITY FIRE DEPARTMENT
ANNUAL FITNESS ASSESSMENT

Name:_____ Age _____ Date: _____

Muscular Strength

Hand Grip Strength (measured in Kg) Right Left
Circle peak force _____ _____
_____ _____
_____ _____

Leg Strength (measured in Kg) Trial 1 _____ rest 30 sec
Trial 2 _____ rest 30 sec
Trial 3 _____

Arm Strength (measured in Kg) Trial 1 _____ rest 30 sec
Trail 2 _____ rest 30 sec
Trail 3 _____

Muscle Endurance

5 " prop place under chin, metronome set on 80, stopwatch 2 min bout
Push-ups successfully completed _____
Test stopped due to ____ reached 80 push-ups
____ performed three consecutive push-ups incorrectly
____ did not maintain continuous motion with the metronome cadence

Mat, metronome set on 60, stopwatch 3 min bout
Curl-Ups successfully completed _____
Test stopped due to ____ reached 90 curl-ups
____ performed three consecutive incorrect curl-ups
____ does not maintain continuous motion with metronome cadence

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Appendix I

Flexibility

Sit-and-Reach

Novel Acuflex I
Trial 1 _____ rounded to nearest ¼ inch
Rest 30 sec
Trial 2 _____
Rest 30 sec
Trial 3 _____

Aerobic Capacity Assessment

This **Single Stage treadmill** is the preferred test for aerobic capacity assessment. Any "YES" response to the following heart disease questions requires consultation with, and further clearance by the prescribing physician before further testing should continue!

Heart Disease Questions	YES	NO
Have you ever had a heart attack?	___	___
Have you ever had heart surgery?	___	___
Have you had an abnormal electrocardiogram?	___	___
Do you have heart disease?	___	__
Have you been told by a physician you have had angina?	___	___
Have you been told by a physician you have had palpitations?	___	___
Have you had a stroke?	___	___
Is your blood pressure (BP) 180/104 or higher?	___	___
Are you pregnant?	___	___

Physician Contacted: _____ Clearance granted YES NO Plan: _____
Sex: Male / Female Age: _____ Resting HR: ____ Resting BP _____ / _____
Maximum Predicted Heart Rate = 220 – age _____ = _____
Maximum Predicted Heart Rate _____ x .85 = _____ Maximum Target Heart Rate
Maximum Predicted Heart Rate _____ x .50 = _____
Maximum Predicted Heart Rate _____ x .70 = _____ = Target HR for Stage 1

Single Stage Treadmill Protocol

Each stage is to last for 4 minutes. HR and BP will be recorded during the final minute of each stage. Begin warm-up at a comfortable pace for 1 to 2 minutes. Increase speed to between 2.0 and 4.5 mph depending on the condition of the patient; note speed and take HR and BP in the final minute. Increasing incline to 5% maintaining speed at end of stage 1. Stage 2 begins when the 5% grade is reached. Return to 0% grade for stage 3 at a comfortable speed.

Stage 1 (4 minutes) Warm –up speed_____% grade __0_____

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HR _____
Stage 2 (4 minutes) Exercise speed_____% grade __5_____
HR _____
Stage 3 (4 minutes) Recovery speed_____% grade ___0_____
HR _____

Use the following prediction equation to obtain max VO2. All values inserted are from stage 2.

15.1 + (21.8 x speed _____) =
_____ minus
(.327 x HR _____) =
_____ minus
(.263 x speed _____ x age ____) =
_____ plus
(.00504 x HR _____ x age ____) =
_____ plus
(5.98 x gender _____) 0=female, 1=male =
_____ equals
Predicted Max VO2 =
_____ ml/kg/min

Reason for stopping: _____Predicted Max VO2 _____ / 3.5 = _____ Predicted Max MET Level x .40 = _____ = Functional Aerobic Capacity / Safe MET level.
Classification of Aerobic capacity: ____ Poor____ Fair ____ Average ____ Good ____ Excellent

Sex	Age	Poor	Fair	Average	Good	Excellent
Male	20-29	< 25	25-33	34-42	43-52	53+
	30-39	< 23	23-30	31-38	39-48	49+
	40-49	< 20	20-26	27-35	36-44	45+
	50-59	< 18	18-24	25-33	34-42	43+
	60-69	< 16	16-22	23-30	31-40	41+

Approximate Energy Required	
PDL	(METS)
Sedentary	1.0-1.5
Sed-Light	1.5-2.0
Light	2.0-3.0
Lt-Medium	3.0-3.5

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Female Age	Poor	Fair	Average	Good	Excellent
20-29	<24	24-30	31-37	38-48	49+
30-39	<20	20-27	28-33	34-44	45+
40-49	<17	17-23	24-30	31-41	42+
50-59	<15	15-20	21-27	28-37	38+
60-69	<13	13-17	18-23	24-34	35+

Medium	3.5-5.0
Med-Heavy	6.0-7.5
Heavy	8.0-9.0
Very Heavy	over 9.0

PERSONAL FITNESS PLAN

NAME: _____ **DATE:** _____

NOTE: It is important to warm up your large muscles prior to stretching to prevent muscle strains, so perform at least 10 minutes of aerobic training before stretching.

AEROBIC TRAINING

FLEXIBILITY

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STRENGTHENING

MUSCLE ENDURANCE

Other:

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Appendix J

Texas City Fire Department
Annual Medical Examination
Personal Physician Option GENERAL RELEASE

I, _____, (hereafter referred to as the "First Party"), voluntarily elect to use my licensed personal physician, _____, for the purpose of obtaining the required annual medical examination, and in consideration of the maximum sum of _____ Dollars, to be received from or on behalf of The City of Texas City and the Texas City Fire Department, (hereafter referred to as the "Second Party"), the promise of reimbursement upon satisfactory evidence, as determined by the Second Party, of completion of the annual medical examination and receipt of payment made by the First Party which is hereby acknowledged. The First Party accepts personal financial responsibility for any and all charges or costs associated with obtaining the annual medical examination by use of his or her personal physician which exceeds or exceeded the maximum sum listed above. Furthermore, the First Party acknowledges that use of their personal insurance benefits provided by the City may not be used to pay for any part of the required annual medical examination.

Therefore, the First Party do(es) hereby remise, release, acquit, satisfy, and forever discharge the said Second Party, of and from all manner of action(s), cause(s) of action, suits, debts, sums of money, accounts, reckonings, bonds, bills, specialties, covenants, contracts, controversies, agreements, promises, variances, trespasses, damages, judgments, executions, claims and demands whatsoever, in law or in equity, which said First Party ever had, now has, or which any personal representative, successor, heir or assign of said First Party, hereafter can, shall or may have, against said Second Party, by reason of any matter, cause or thing whatsoever, from the beginning of time to the date of this instrument.

Party's further acknowledge that this Agreement is governed by the laws of the State of Texas, and venue for any legal proceeding relating to this Agreement shall lie in Galveston County, Texas.

_____ _____
Signature Print

Signed, sealed and delivered in the presence of:

_____ _____
Witness Signature Print
State of Texas
County of Galveston
The foregoing instrument was acknowledged by me this ___ day of _____, 20__ by _____who is/are personally known by me or who has/have produced: _____ as identification and who did not take an oath.

(Seal)

Notary Public
State of_____
My Commission Expires:_____