

DEPARTMENT OF HOMELAND SECURITY
FEDERAL EMERGENCY MANAGEMENT AGENCY
Center for Domestic Preparedness
MEDICAL SCREENING FORM

*(Please fill in all fields
and e-mail or fax to
State Coordinator)*

Student's Name: _____

Submitting this paperwork for consideration of training at the Center for Domestic Preparedness constitutes your agreement and understanding of medical qualifications.

Course Requested: _____ Date Completed: _____

1. Students under consideration for attendance at the Center for Domestic Preparedness for the following courses **must** complete this medical screening questionnaire:

- | | |
|---|---|
| Emergency Medical Operations for CBRNE Incidents (EMO) | Emergency Responder Hazardous Materials Technician for CBRNE Incidents (ERHM) |
| Field Force Operations (FFO) | Environmental Health Training in Emergency Response Operations (EHTER OPS) |
| Hands-on-Training for CBRNE Incidents (HOT) | Hazard Assessment and Response Management for CBRNE Incidents (HARM) |
| Intermediate Hands-on-Training for CBRNE Incidents (HOT-I) | Hazardous Materials Evidence Collection for CBRNE Incidents (HEC) |
| Hazardous Materials Technician for CBRNE Incidents (HT) | Hospital Emergency Response Training for Mass Casualty Incidents (HERT) |
| Radiological Emergency Response Operations (RERO) | Law Enforcement Response Actions for CBRNE Incidents (LERA) |
| Respiratory Protection Program Development and Administration (RP) | Technical Emergency Response Training for CBRNE Incidents (TERT) |
| Threat Hazard Recognition and Emergency Actions Training for CBRNE Incidents (THREAT) | |

2. Do you now or have you previously been treated for or experienced:

- | | | | | | |
|-------------------------|------------------------------|-----------------------------|--|------------------------------|-----------------------------|
| Heart Problems | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Seizures or Epilepsy | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Heart Attack | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Heat Injury | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Bypass Surgery or Stent | <input type="checkbox"/> Yes | <input type="checkbox"/> No | (in the last 12 months, that required hospitalization) | | |
| Asthma (as an adult) | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Any condition that affects your immune system | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

Do you have physical impairments or special medical needs that will require consideration (e.g. limb prosthesis, wheelchair, etc.)	<input type="checkbox"/> Yes	If yes, please explain
	<input type="checkbox"/> No	

3. Any question with a **YES** answer requires the student to have a medical screening by a licensed physician certifying the student is in appropriate health to perform tasks in personal protective clothing and respirator systems. High blood pressure (150 over 90) may preclude participation in Toxic Agent Training.

4. Forward Medical Screening Form and Physician Certification (if required) with Training Course Application. Additional medical screening will be conducted prior to entering the Toxic Agent Training Facility.