REQUEST FOR PROPOSALS (RFP)
OCCUPATIONAL HEALTH SERVICES
FOR THE CITY OF STOCKTON, CALIFORNIA
(PUR 20-019)

ADDENDUM No.2
DATE: 9/3/20
To All Potential Bidders:

A. This Addendum shall be considered part of the proposal documents for the above-mentioned project as though it had been issued at the same time and shall be incorporated integrally therewith. Where provisions of the following supplementary data differ from those of the original bid documents, this Amendment shall govern and take precedence. PROPONENTS MUST SIGN THE ADDENDUM AND SUBMIT IT WITH THEIR PROPOSALS.

B. Proponents are hereby notified that they shall make any necessary adjustments in their estimates as a result of this Addendum. It will be construed that each proponent's proposal is submitted with full knowledge of all modifications and supplemental data specified herein.

PLEASE NOTE THE FOLLOWING CHANGES TO RFP OCCUPATIONAL HEALTH SERVICES FOR THE CITY OF STOCKTON, CALIFORNIA (PUR 20-019)

1. What specific services are required for the bomb squad physical exams?

Please see attached Appendix A, Hazardous Devices School (HDS) Certification/Recertification Application. Page 11 includes minimum requirements for HDS applicants.

2. Is there an allowance for a dedicated provider of Drug & Alcohol Testing to bid on only the portion of the project related to Drug & Alcohol Testing?

Yes, interested proponents may submit proposals for only drug and alcohol testing. However, the City of Stockton will be reviewing proponents in accordance with the full scope of work detailed in the RFP specifications.

BIDDER MUST ACKNOWLEDGE THIS AMENDMENT BY SIGNING BELOW AND ATTACHING THE SIGNED AMENDMENT TO THE BID FORM:

Company Name _____

Contact Person _____

Signature _____

Date _____

Proposals Due – Promptly by 2:00 P.M., Thursday, September 10, 2020, to city.clerk@stocktonca.gov.

----------City of Stockton Use Only below this line----------
Addendum acknowledged and signed?_____(Procurement Specialist's initials)

Appendix A

Hazardous Devices School
CERTIFICATION / RECERTIFICATION APPLICATION
(Effective Dec 2017)

INSTRUCTIONS FOR SUBMISSION

Hazardous Devices School (HDS) Registrars' Office personnel: Questions about submitting an application can be directed to the appropriate personnel below:

REGISTRAR OFFICE SUPERVISOR
Mark Wall
mhwall@fbi.gov
256-313-8912

CERTIFICATION	RE-CERTIFICATION	ADVANCE
Rene Moskol	Darren Pechon	Barbara Sawyer
rbmoskol@fbi.gov	dpechon@fbi.gov	bjsawyer@fbi.gov
256-313-8837	256-313-8828	256-313-8814

Things to Consider: Enrollment in a Certification course is based on an applicant's eligibility and the bomb squad's needs. A Certification applicant will receive notification of a tentative enrollment date no later than six months prior to the class start date. Then, no later than 60 days prior to class start date AND if the applicant has a complete AND eligible application, the official invitation will be sent. The time period between the tentative enrollment notification and official invitation allows applicants sufficient time to complete all the requirements of the National Guidelines for Bomb Technicians and their department to backfill the applicant's position within the department during their absence. If an applicant withdraws for any reason, HDS will first communicate directly with the Bomb Squad Commander to fill the vacated seat with that bomb squad's alternate who has a complete AND eligible application. It's in the bomb squad's best interest to submit a complete AND eligible application for both their primary and alternate (if applicable) as soon as possible in the event the primary applicant withdraws. If the bomb squad doesn't have an applicant with a complete AND eligible application within 60 days of the class start date, the bomb squad forfeits the seat and the primary applicant will be provided a seat in a later class.

Target Staffing Level (TSL) Process: Verify your bomb squad's TSL before submitting an application to the Special Agent Bomb Technician Coordinator (SABT-C) at the Federal Bureau of Investigation (FBI) field office in your area.

a. If the application is to increase the number of bomb technicians that are not included in your bomb squad's current TSL, do not submit the application yet. First, submit a Squad Expansion Request form to the SABT-C. An approved Squad Expansion Request must be in place before submission of any application. **Questions about the TSL process can be directed to Christy Markham, chmarkham@fbi.gov, 256-313-8874.**

b. If the application is being submitted to replace a bomb technician that will no longer be a member of the bomb squad, submit the application to the SABT-C. HDS does not accept applications directly from any other source. You can expect 3 to 4 weeks for the field office to process the application before forwarding it to HDS. After HDS receives the application, the Registrar reviews it for compliance with the current National Guidelines for Bomb Technicians. A copy of the National Guidelines can be email to you by requesting one from the Registrars.

CERTIFICATION APPLICATION PROCESS:

The point of contact for all Certification matters is Rene Moskol, rmoskol@fbi.gov, 256-313-8837.

A Certification application contains the following documents:

- ✓ FD-731, Course Application with the Certification box checked.
- ✓ FD-979a, Non-Personnel Consent to Release Information (FBI employees use FD-979)
- ✓ FD-1065, Report of Medical History (to be maintained by medical provider and/or applicant)
- ✓ SF-88, Report of Medical Examination (to be maintained by medical provider and/or applicant)
- ✓ OSHA Respirator Medical Evaluation Questionnaire (to be maintained by medical provider and/or applicant)
- ✓ HAZMAT Training Prerequisite Notice
- ✓ Certificate of completion of HAZMAT training that complies with 29 CFR 1910.120(q)(6)(iii), Emergency Responder to Hazardous Materials Technicians for CBRNE Incidents.
- ✓ National Incident Management System (NIMS) Training Prerequisite Notice
- ✓ Certificates of completion of NIMS IS-100, IS-200, IS-700, and IS-800.

The only documents required to be return to HDS for Certification applications:

- ✓ FD-731, Course Application
- ✓ Hazardous Devices School Student Physical Health Standards Form **NEW**
- ✓ FD-979a, Non-Personnel Consent to Release Information (FBI employees use FD-979)
- ✓ HAZMAT Training Prerequisite Notice
- ✓ Certificate of completion of HAZMAT training that complies with 29 CFR 1910.120(q)(6)(iii), Emergency Responder to Hazardous Materials Technicians for CBRNE Incidents.
- ✓ National Incident Management System (NIMS) Training Prerequisite Notice
- ✓ Certificates of completion of NIMS IS-100, IS-200, IS-700, and IS-800.

What to expect:

- ✓ Review: After the application is reviewed, the applicant will be *tentatively* enrolled in a Certification class. For planning purposes, an applicant can expect to attend a Certification class approximately 16 months after the application is submitted to the SABT-C (one month for the field office to process and 14-15 months for the next available class at HDS).

- ✓ Notification: After all seats in the class are filled, a single notification email is sent to every applicant enrolled in the class, as well as the Bomb Squad Commander, and the SABT-C. The notification will be emailed no later than six months prior to the class start date and provide the applicant with the start and graduation dates, a deadline to submit all required documentation, and the date the official invitation will be sent to applicants with complete AND eligible applications.
- ✓ Deadline: After the deadline stated in the notification email has passed, all applications will be reviewed for eligibility. Applicants who have not submitted the required documentation or does not meet the National Guidelines, will be notified via email they are ineligible to attend the class.
- ✓ Invitation: Approximately 60 days prior to the class start date, applicants with a complete AND eligible application will receive an official invitation. The invitation will provide applicants with all the information they need to attend.

RECERTIFICATION APPLICATION PROCESS:

The point of contact for all Re-certification matters is Darren Pechon, dpechon@fbi.gov, 256-313-8828.

A complete Re-certification application contains the following documents:

- ✓ FD-731, Course Application with the Certification box checked.
- ✓ FD-979a, Non-Personnel Consent to Release Information (FBI employees use FD-979)
- ✓ FD-1065, Report of Medical History (to be maintained by medical provider and/or applicant)
- ✓ SF-88, Report of Medical Examination (to be maintained by medical provider and/or applicant)
- ✓ OSHA Respirator Medical Evaluation Questionnaire (to be maintained by medical provider and/or applicant)

The only documents required to be return to HDS for Recertification applications:

- ✓ FD-731, Course Application
- ✓ Hazardous Devices School Student Physical Health Standards Form **NEW**
- ✓ FD-979a, Non-Personnel Consent to Release Information (FBI employees use FD-979)

What to expect:

- ✓ Review: Once reviewed, the application will be reviewed for completeness.
- ✓ Notification: After all documentation has been received, applicants will be provided class dates to choose from for attendance.
- ✓ Invitation: Applicants will be notified approximately 60 days prior to class start date and offered an invitation.

HAZARDOUS DEVICES SCHOOL

Date: _____

Squad Expansion Request Form

This form must be completed and returned to the FBI Hazardous Devices School (HDS) through your local FBI SABT to request an increase to your current staffing level prior to submitting the Basic Application. Submit one request for each slot ***beyond*** **your approved Staffing Level.** This form is NOT required if you are replacing an existing tech due to retirement/attrition or if your squad is below its target staffing level.

Bomb Squad Name, Address and Identification Number:

_____

_____

Bomb Squad Commander (BSC): _____

BSC Certification Expiration Date: _____

Commander's Phone and e-mail: _____

Current number of certified bomb techs on the Squad: _____

What is your Squad's approved Staffing Level Number:_____

Number of calls per year for the last two years: (Actual IEDs, hoaxes, suspicious packages, destruction of explosives, etc.; do not include bomb threats.) _____ & _____

Name and location of bomb squad closest to your location (distance in miles):

_____

Are you requesting a Basic Course slot to replace a tech who has left your squad or is intending to leave the squad due to retirement, reassignment, etc? If yes, please provide the name of the tech and date of departure:

_____

Are you requesting a Basic slot to expand your squad? If yes, how many new techs? _____

Justification for expansion: _____

_____

_____

_____

Submit this form to your local field office FBI SABT. Questions can be directed to HDS, (256) 313-8828 or 313-8837.

Field office SABT recommendation: _____

(SABT please sign & date, then fax or scan/email to HDS)

Revised 03/21/2016

FD-731 (Rev. 5-8-2014)
U.S. Department of Justice
Federal Bureau of Investigation

FEDERAL BUREAU OF INVESTIGATION
HAZARDOUS DEVICES SCHOOL
COURSE APPLICATION

Privacy Act Statement - Solicitation of information on this form is authorized by Title 42, United States Code (USC), Section 3771(a), which authorizes the Director of the FBI to establish and conduct training programs for state and local criminal justice personnel, and, in the case of your Social Security Number (SSAN), by Executive Order 9397. The primary purpose of soliciting the requested information is to determine your eligibility for enrollment in the FBI Hazardous Devices School. Although provision of the information on this form is voluntary, failure to provide the requested information (with the exception of your SSAN) shall result in the denial of this application. Information provided on this form may be disseminated according to the provisions of Title 5, USC, Section 552a, more commonly known as the Privacy Act of 1974.

This information form is required for all Hazardous Devices School applicants.

1. Date of Application

2. Type of class desired: ☐ Basic Course ☐ Recertification Course ☐ Other _____
Basic Course Applicants Only: Do you understand that all travel, lodging and subsistence expenditures incurred during the Hazardous Devices School Basic Course are to be borne by your agency? ☐ Yes ☐ No

3. Last Name | First Name | Middle Name

4. Residence Address (Street, City, State, Zip Code)

5. Birth Date	6. Place of Birth	7. Social Security Number
8. a. Name of relative to be contacted in case of emergency		8. b. Relationship to applicant
9. ☐ Male ☐ Female	10. Height	11. Weight

12. Do you have any physical defects which would preclude unrestricted, regular participation in the handling of live explosives or wearing of bomb suits, chemical protective suits, respirators and other protective equipment during the Hazardous Devices School training? ☐ Yes ☐ No (If "yes", explain)

13. Name, address, and phone number of present family physician

14. E-mail Address: a. Business _____

b. Personal _____

15. Business Telephone Number	16. Facsimile Telephone Number
17. Home Telephone Number	18. Cellular Telephone Number

19. a. Name of public safety agency where candidate employed :

b. Length of employment:	c. Full Time ☐ Yes ☐ No
20. Employment Address (Street, City, State, Zip Code)	21. Rank or Title

22. **Signature of Nominating Official** (from the applicant's agency)

Name and Title (Print or Type)

Bomb Squad Information

23. a. Name of Accredited Bomb Squad to which assigned	b. Bomb Squad Identifier Number

c. Name of Bomb Squad Commander (Defined as the certified bomb technician point of contact who will speak for the squad)

d. Mailing Address of Bomb Squad (Street, City, State, Zip Code)

e. Telephone Number of Bomb Squad	f. Fax Number of Bomb Squad

g. E-mail of Bomb Squad

h. **Signature of Bomb Squad Commander** (Required if the Bomb Squad Commander is employed by a different agency)

24. **Waiver:** I am about to take a course of instruction at the Hazardous Devices School and am aware that this course may necessitate my personal handling of live explosives, incendiary materials, hazardous chemicals, as well as the wearing of bomb suits, respiratory protective equipment and other personal protective equipment. I acknowledge that I am taking this course on my own initiative. I am fully aware of the dangers and risks involved in this course of instruction and realize that neither the United States Government nor the Federal Bureau of Investigation is agreeing to act as insurers of my safety. Therefore, in consideration of the permission extended to me by the United States, through its officers and Agents, to take this course of instruction, I do hereby, forever discharge the Government of the United States and all its officers, Agents, and employees, acting officially or otherwise, from any and all claims or causes of action on account of any injury to me or my property which results through no fault or wrongdoing on behalf of the Government or its employees during the course of instruction or the handling of any hazardous device. I further acknowledge and agree that any claims or causes of actions against the Federal Government I may have for injuries to myself or to my property during my instruction will be those provided for by the Federal Tort Claims Act or other applicable federal statutes.

25. **All Applicants:** Return this form and other designated forms, including medical forms, to the Training Coordinator in the FBI Field Office in your region.

26. _____ _____

Signature of Applicant **Date**

FD-979a (9-9-04)

FBI File Number: _____-_____-_____

Non-Personnel Consent to Release Information

To Whom It May Concern:

I hereby give consent to any authorized representative of the Federal Bureau of Investigation to obtain any information in your files pertaining to my academic, achievement, athletic, attendance, credit (including credit card and payment device numbers), disciplinary, employment, law enforcement (including, but not limited to, any record of charge, prosecution, or conviction for civil or criminal offenses), military, or professional license records (including any grievance records). I hereby direct each entity to which this form is presented to release such information upon request of the authorized recipient as described above, regardless of any other agreement or direction I may have made.

This consent is executed with full knowledge and understanding that the information is for the official use of the Federal Bureau of Investigation in connection with the determination of suitability for employment and/or eligibility for new or continued access to classified information of a current or prospective government employee with whom I am associated. Consent is granted for the Federal Bureau of Investigation to furnish such information as is described above to third parties in the course of fulfilling its official responsibilities.

Copies of this consent that show my signature are as valid as the original signed by me. This consent is valid for one (1) year from the date signed.

Signature (sign in ink)	Full Name (type or print clearly)	Date Signed
Other Names Used		Social Security Account No.
Signature of Parent or Guardian (if required)	Place of Birth	Date of Birth
Signature of Witness	Name & Title of Witness	

PRIVACY ACT STATEMENT

Authority: The collection of information requested by this form is authorized under Executive Order 10450, Security Requirements for Government Employees; Executive Order 12968, Access to Classified Information; and the Fair Credit Reporting Act, 15 U.S.C. §§1681 et seq. Providing requested information is voluntary; however, failure to furnish the requested information and consent may affect our ability to complete the determination of suitability for employment and/or eligibility for new or continued access to classified information of a current or prospective government employee with whom you are associated.

Principal Purpose: The information will be used principally to obtain such academic, achievement, athletic, attendance, credit, disciplinary, educational, employment, law enforcement, military, and professional license records as may be necessary to determine the suitability for employment and/or eligibility for new or continued access to classified information of a current or prospective government employee with whom you are associated. Your Social Security Account Number (SSAN) identifies you in most of the above-listed transactions. We will use your SSAN to accurately identify your records and to process investigations, inquiries, and/or determinations related to this consent.

Routine Uses: In addition to disclosures within the Department of Justice on a need-to-know basis, information reported on this form may be disclosed in accordance with all applicable routine uses as may be published at any time in the Federal Register, including all routine uses for the FBI Central Records System. These routine uses include the following disclosures: to potential sources in order to locate, seek, and obtain information or records pertaining to you; to any appropriate governmental authorities responsible for civil or criminal law enforcement, counterintelligence, or security matters to which the information may be relevant; to non-FBI employees performing Federal assignments; to courts or adjudicative bodies when the FBI considers it has an interest in the proceedings; or as otherwise mandated by law, treaty, or Executive Order.

FD-1065 (Rev. 02-03-2014)

INSTRUCTIONS

Block 1: Name – Use your OFFICIAL BUREAU NAME (Last, first, middle initial)

Block 4: Division/Field Office Address – Use your Division of assignment, even if exam is conducted at another location.

Block 5: Purpose of Exam – Response is "Periodic Physical – Fitness for Duty" (when you complete your physical) or "FD-1065- Interim update"(on years you do not complete a physical exam).

Block 6a: List your current medications, dose and frequency. Include dietary supplements and over-the-counter medications taken regularly, as well as prescribed medications. **If none - state "none".**

Block 6b: List any allergies that you might have. **If none - state "none".**

Block 7: Job Titles –Electronic Technician, Latent Fingerprint Examiner, Photographer (Latent Fingerprint or Forensic), Physical Security Specialist, Police Officer, Special Agent, Support Surveillance Group Member and other (please describe "other" in section 17 comments if needed). Special Team: SWAT, ERT, HAZMAT, Bomb Squad, Diver, Pilot, Primary Firearms Instructor.

Blocks 16a, 16b, and 16c: Print your OFFICIAL BUREAU NAME, **sign, date, scan and email the FD-1065** to your Health Services office or Fitness for Duty Coordinator. You may also have the capability to electronically sign, save and submit via e-mail attachment. **To minimize paper volume in medical files, please DO NOT print and/or send the Instruction Sheet (page 1) of the FD-1065.**

All **"YES"** answers must have a ***detailed description*** of this history, to include:

a. the date(s) of occurrence,
b. what occurred,
c. treatments and/or surgeries received,
d. the current status of this condition,
e. any related restrictions or limitations,

Please use additional pages if necessary to provide requested medical documentation.

Privacy Act Statement: The collection of this information on this form, which is authorized by 5 U.S.C. § 301 and 5 U.S.C. § 3301, is relevant and necessary to provide appropriate medical care and to determine eligibility and/or fitness for duty. Completion of this form is voluntary; however, your failure to supply all the information requested on this form may impede or preclude agency action regarding medical care or continued employment. This information is maintained in your medical file in the FBI Central Records System, Justice/FBI-002, a description of which can be found at **http://home.fbinet.fbi/DO/OGC/LTB/PCLU/PrivacyCivil%20Liberties% 20Library/Forms/FBI002.aspx**. This information may be disclosed in accordance with the routine uses referenced in this notice.

GINA Notice: Do Not Provide Genetic Information, Including Family Medical History

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. "Genetic information," as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services. *See* 29 C.F.R. § 1635.8(b)(1)(i)(B).

FD-1065 (Rev. 02-03-2014)	REPORT OF MEDICAL HISTORY	DATE COMPLETED

NOTE: This information is for official and medically-confidential use only and will not be released to unauthorized persons

1. NAME OF PATIENT (*LAST,FIRST,MIDDLE*)	2. DATE OF BIRTH / Age	3. Are you ☐ Right Handed ☐ Left Handed
4. Division/Field Office Address	4a. Examining Facility	
4b. Division City	4c. Division State	4d. Zip Code

5. Purpose of Examination
☐ Fitness for Duty Exam ☐ FD-1065 Interim Update

STATEMENT OF PATIENT'S PRESENT HEALTH AND MEDICATIONS CURRENTLY USED (Use additional pages if necessary)

6. Present Health	6a. Current Medications /Dose and Frequency	6b. Allergies (include insect bites/stings and common foods)
7. Job Title/Special Team		

8. PAST/CURRENT MEDICAL HISTORY – Check Each Item; if "YES" Explain in Blank Space on Page 2. List explanation by condition item.

Check each item	Yes	No	Don't know	Check each item	Yes	No	Don't know	Check each item	Yes	No	Don't know
Tuberculosis or positive TB skin test result	☐	☐	☐	Foot trouble (e.g., pain, corns, bunions, etc.)	☐	☐	☐	Frequent or severe headaches	☐	☐	☐
Lived with someone who had tuberculosis	☐	☐	☐	Impaired use of arms, legs, hands, or feet	☐	☐	☐	A head injury, memory loss or amnesia	☐	☐	☐
Coughed up blood	☐	☐	☐	Swollen or painful joint(s)	☐	☐	☐	Seizures, convulsions, epilepsy, fits, or paralysis	☐	☐	☐
Asthma or any breathing problems related to exercise, weather, or pollen	☐	☐	☐	Knee trouble (e.g., locking, giving out)	☐	☐	☐	A period of unconsciousness or concussion	☐	☐	☐
Shortness of breath	☐	☐	☐	Surgery or scope of a joint (Ex: knee, shoulder)	☐	☐	☐	Meningitis, encephalitis, or other neurological problems	☐	☐	☐
Bronchitis	☐	☐	☐	Use of prosthetic device, knee brace/back support	☐	☐	☐	Sexually transmitted disease	☐	☐	☐
Wheezing or problems with wheezing or used an inhaler	☐	☐	☐	Bone, joint, or other deformity	☐	☐	☐	Prolonged bleeding (as after an injury or tooth extractions)	☐	☐	☐
A chronic cough or cough at night	☐	☐	☐	Plate, screw, rod or pin in any bone	☐	☐	☐	Pain or pressure in the chest	☐	☐	☐
Sinusitis	☐	☐	☐	Broken bone(s) (cracked or fractured)	☐	☐	☐	Palpitation, pounding heart or abnormal heartbeat	☐	☐	☐
Hay fever	☐	☐	☐	Frequent indigestion or heartburn	☐	☐	☐	Heart trouble or murmur	☐	☐	☐
Chronic or frequent colds	☐	☐	☐	Stomach, liver, intestinal trouble, or ulcer	☐	☐	☐	High or low blood pressure	☐	☐	☐
Severe tooth or gum trouble	☐	☐	☐	Gall bladder trouble or gallstones	☐	☐	☐	Nervous trouble of any sort (anxiety or panic attacks)	☐	☐	☐
Thyroid trouble or goiter	☐	☐	☐	Jaundice or hepatitis (liver disease)	☐	☐	☐	Habitual stammering or stuttering	☐	☐	☐
Eye disorder or trouble	☐	☐	☐	Rupture/hernia	☐	☐	☐	Loss of memory or amnesia	☐	☐	☐
Ear, nose, or throat trouble	☐	☐	☐	Rectal disease or blood from the rectum	☐	☐	☐	Frequent trouble sleeping	☐	☐	☐
Loss of vision in either eye	☐	☐	☐	Skin diseases (e.g., acne, eczema, psoriasis, etc.)	☐	☐	☐	Received mental health counseling of any type	☐	☐	☐
Worn contact lenses or glasses	☐	☐	☐	Frequent or painful urination	☐	☐	☐	Depression or excessive worry	☐	☐	☐
A hearing loss or wear a hearing aid	☐	☐	☐	High or low blood sugar	☐	☐	☐	Been evaluated or treated for a mental condition	☐	☐	☐
Surgery to correct vision (RK, PRK. LASIK, etc.)	☐	☐	☐	Kidney stone or blood, sugar, or protein in urine	☐	☐	☐	Attempted suicide	☐	☐	☐
Painful shoulder, elbow or wrist (pain, dislocation, etc.)	☐	☐	☐	Adverse reaction to serum, food, insect stings or medicine	☐	☐	☐	Used illegal drugs or abused prescription drugs	☐	☐	☐
Arthritis, rheumatism, or bursitis	☐	☐	☐	Recent unexplained gain or loss of weight	☐	☐	☐	**QUESTIONS FOR FEMALES ONLY**			
Recurrent back pain or any back problem	☐	☐	☐	Car, train, sea, or air sickness	☐	☐	☐	Treatment for Gynecological (female) Disorder	☐	☐	☐
Numbness or tingling	☐	☐	☐	Tumor, growth, cyst, or cancer	☐	☐	☐	A change of menstrual pattern	☐	☐	☐
Loss of finger or toe	☐	☐	☐	Dizziness or fainting spells	☐	☐	☐	Any abnormal PAP smears	☐	☐	☐

Check Each Item, if "Yes" Explain in Blank Space Below. List explanation by item number

Item	Yes	No
9. Have you been treated for a mental condition? If yes, specify when, where, and give details.	☐	☐
10. Have you been denied life insurance? If yes, state reason and give details.	☐	☐
11. Have you had, or have been advised to have any operation? If yes, describe.	☐	☐
12. Have you been a patient in any type of hospital? If yes, specify when, where, why and name of doctor and complete address of hospital?	☐	☐
13. Have you consulted or been treated by clinics, physicians, healers, or other practitioners within the year, for other than minor illness?	☐	☐
14. Do you have a past or current medical history of any other condition not mentioned on this form?	☐	☐
15. Have you ever received, is there pending, or have you ever applied for pension or compensation for existing disability? If yes, specify what kind, granted by whom, and what amount, when, why.	☐	☐
Explanation of all "Yes" findings		

16. I certify that I have reviewed the foregoing information supplied by me and that it is true and complete to the best of my knowledge. I authorize any of the doctors, hospitals, or clinics mentioned above to furnish the Government a complete transcript of my medical record for purpose of processing my application for this employment or service. I understand that falsification of information on Government forms is punishable by fine and/or imprisonment.

16a. OFFICIAL BUREAU NAME, Typed or Printed	16b. Signature of Examinee	16c. Date

Note: HAND TO THE DOCTOR OR NURSE, OR IF MAILED MARK ENVELOPE "TO BE OPENED BY MEDICAL PERSONNEL ONLY"

17. HEALTH CARE PROFESSIONAL SUMMARY AND ELABORATION OF ALL PERTINENT DATA (COMMENT ON ALL POSITIVE ANSWERS IN ITEM 6 – 15. ***Reviewer may develop any additional medical history deemed important, and record any significant findings here.***

Privacy Act Statement: The collection of the information on this form, which is authorized by 5 U.S.C. § 301 and 5 U.S.C. § 3301, is relevant and necessary to provide appropriate medical care and to determine eligibility and/or fitness for duty. Completion of this form is voluntary; however, your failure to supply all the information requested on this form may impede or preclude agency action regarding medical care or continued employment. This information is maintained in your medical file in the FBI Central Records System, Justice/FBI-002, a description of which can be found at **http://home.fbinet.fbi/DO/OGC/LTB/PCLU/PrivacyCivil%20Liberties%20Library/Forms/FBI002.aspx**. This information may be disclosed in accordance with the routine uses referenced in this notice.

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18. Typed or Printed Name of Physician or Health Care Professional (HCP)	18a. Signature of Physician or HCP	18b. Date

PLEASE USE ADDITIONAL PAGES IF NECESSARY

Instructions for Conducting & Documenting the Medical Exam on SF-88

Only white boxes are required tests; shaded boxes are not required.

Here are the minimum requirements HDS reviews for each applicant:

- **Urinalysis** – simple dipstick test;
- **Microscopic Urine** – only required if simple UA is abnormal;
- **EKG Results** – we only need to know if the EKG is normal or abnormal. If abnormal, please include an explanation. If referral to a specialist is necessary, please notate that in section #44; If documented properly on the SF-88 (and it is normal), HDS does NOT need a copy of the EKG tracing.
- **Either a Chest X-Ray or a PPD/TB skin test** is required, but not both tests. We accept a "NORMAL" TB skin test in lieu of the chest x-ray. We need confirmation of lung health to include ruling out the presence of TB. We do not need a copy of the actual xray;
- **Height / Weight** (see the HDS Chart). Must be documented for all applicants. For BASIC applicants only-they MUST meet either the Height/Weight chart OR the body fat percentage/composition standard. Body Mass Index (BMI) is NOT accepted. The body fat percentage caliper/pinch test must be performed by a nurse/doctor or FBI Fit Coordinator. We cannot accept these results from a gym. (For Recert applicants not meeting the standards, there is a waiver form which must be signed by the Bomb Squad Commander of the agency);
- **Blood pressure** Actual reading required, and a doctor's assessment of blood pressure within a normal range is required (list any medications taken for hypertension);
- **Sitting Pulse Rate**
- **Distance Vision Test Results –** Each eye must be measured individually- we can only accept Snellen or J1 codes for vision. The HDS standard states at least one eye must measure 20/20 or better, with or without corrective lenses, while the other eye is 20/40 or better
- **Near Vision Test Results** - Each eye must be measured individually- we can only accept Snellen or J1 codes for vision. The HDS standard states each eye must measure 20/40 or better, with or without corrective lenses.
- **Color Vision Test Results** – This is only required for BASIC applicants. HDS requires the type/name of test used to measure color vision, so please document that on the form, along with results. Results such as 14/14 are preferred. Ishihara, Pseudo-Isochromatic Plates, and Farnsworth D-15, are typical tests used.
- **Audiometer/Hearing Test Results** – Each ear must be tested individually and documented as such. HDS MUST have the actual decibel numbers for each frequency tested, as we must calculate an average for the 4 frequencies. The maximum we can accept is an ***average*** of 25 decibels. Results such as 10, 20, 35, 35 or some other combination are still acceptable, as long as the average is 25 or less. The frequencies required are 500, 1000, 2000, and either 3000 or 4000.

The doctor* MUST sign & date the form and document whether or not the patient/applicant is physically qualified for bomb tech activity, which involves wearing an 80-lb bomb suit in hot and/or cold weather, while bending, walking, and kneeling.

HDS also requires the doctor to sign the separate FD-1097 Physical Capacities Form, declaring the patient/applicant has no physical restrictions.

The FD-1065, Medical History Form, should also be completed & signed by the doctor.

The OSHA Questionnaire (7 pages) should be filled out by the patient/applicant and reviewed with/by the doctor. The doctor may keep the 7 pages if he/she so chooses.

*The medical exam can also be conducted by a Physician's Assistant or Nurse Practitioner.

If the doctor's office fills in only the boxes on the enclosed medical forms that are not shaded, the exam should be simple. HDS does not require any blood test results or the results of the pulmonary fit test. However most officers have those items completed during the hazmat physical exam anyway, but you do not have to submit that information to HDS.
HDS requires actual numbers for Blood Pressure, Sitting Pulse, Height/Weight, Distance Vision, Near Vision, Color Vision (BASIC only), and Hearing Test for each ear. We cannot accept "normal" for these test results.

MEDICAL RECORD	REPORT OF MEDICAL EXAMINATION	DATE OF EXAM

1. LAST NAME - FIRST NAME - MIDDLE NAME	2. IDENTIFICATION NUMBER	3. GRADE AND COMPONENT OR POSITION
4. HOME ADDRESS (*Number, street or RFD, city or town, state and ZIP Code*)	5. EMERGENCY CONTACT (*Name and address of contact*)	

6. DATE OF BIRTH	7. AGE	8. SEX ☐ FEMALE ☐ MALE	9. RELATIONSHIP OF CONTACT

10. PLACE OF BIRTH	11. RACE ☐ WHITE ☐ BLACK ☐ AMERICAN INDIAN/ ALASKA NATIVE ☐ HISPANIC WHITE ☐ HISPANIC BLACK ☐ ASIAN/PACIFIC ISLANDER

12a. AGENCY	12b. ORGANIZATION UNIT	13. TOTAL YEARS GOVERNMENT SERVICE	
		a. MILITARY	b. CIVILIAN

14. NAME OF EXAMINING FACILITY OR EXAMINER AND ADDRESS	15. RATING OR SPECIALTY OF EXAMINER
	16. PURPOSE OF EXAMINATION

17. CLINICAL EVALUATION

NOR-MAL	(*Check each item in appropriate column, enter "NE" if not evaluated*)	ABNOR-MAL	NOR-MAL	(*Check each item in appropriate column, enter "NE" if not evaluated.*)	ABNOR-MAL
	A. HEAD, FACE, NECK AND SCALP			O. PROSTATE (*Over 40 or clinically indicated*)	
	B. EARS - GENERAL (*INTERNAL CANALS*) (*Auditory acuity under items 39 and 40*)			P. TESTICULAR	
				Q. ANUS AND RECTUM (*Hemmorhoids, Fistulae*) (*Hemocult Results*)	
	C. DRUMS (*Perforation*)			R. ENDOCRINE SYSTEM	
	D. NOSE			S. G-U SYSTEM	
	E. SINUSES			T. UPPER EXTREMITIES (*Strength, range of motion*)	
	F. MOUTH AND THROAT			U. FEET	
	G. EYES - GENERAL (*Visual acuity and refraction under items 28, 29, and 36*)			V. LOWER EXTREMITIES (*Except feet*) (*Strength, range of motion*)	
	H. OPTHALMOSCOPIC			W. SPINE, OTHER MUSCULOSKELETAL	
	I. PUPILS (*Equality and reaction*)			X. IDENTIFYING BODY MARKS, SCARS, TATTOOS	
	J. OCULAR MOTILITY (*Associated parallel movements nystagmus*)			Y. SKIN, LYMPHATICS	
	K. LUNGS AND CHEST			Z. NEUROLOGIC (*Equilibrium tests under item 41*)	
	L. HEART (*Thrust, size, rhythm, sounds*)			AA. PSYCHIATRIC (*Specify any personality deviation*)	
	M. VASCULAR SYSTEM (*Varicosities, etc.*)			BB. BREASTS	
	N. ABDOMEN AND VISCERA (*Include hernia*)			CC. PELVIS (*Females only*)	

NOTES: (*Describe every abnormality in detail. Enter pertinent item number before each comment. Continue in item 42 and use additional sheets if necessary.*)

18. DENTAL (*Place appropriate symbols, shown in examples, above or below number of upper and lower teeth.*)

0 / 1 2 3 Restorable Teeth 32 31 30

Non- 1 2 3 restorable Teeth 32 31 30 /

X 1 2 3 Missing Teeth 32 31 30 X

X X X 1 2 3 Replaced by Dentures 32 31 30 X X X

(X) 1 2 3 Fixed Partial 32 31 30 (X)

RIGHT	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	LEFT
	32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	

REMARKS AND ADDITIONAL DENTAL DEFECTS AND DISEASES

19. TEST RESULTS (Copies of results are preferred as attachments)

A. URINALYSIS: (1) SPECIFIC GRAVITY		B. CHEST X-RAY OR PPD (*Place, date, film number and result*) **TB Tyne Test**
(2) URINE ALBUMIN	(4) MICROSCOPIC	
(3) URINE SUGER		

C. SYPHILIS SEROLOGY (*Specify test used and results*)	D. EKG	E. BLOOD TYPE AND RH FACTOR	F. OTHER TESTS

NAME	IDENTIFICATION NUMBER	NO. OF SHEETS ATTACHED

MEASUREMENTS AND OTHER FINDINGS

20. HEIGHT	21. WEIGHT	22. COLOR HAIR	23. COLOR EYES	24. BUILD	25. TEMPERATURE
				☐ SLENDER ☐ MEDIUM ☐ HEAVY ☐ OBESE	

26. BLOOD PRESSURE (*Arm at heart level*)						27. PULSE (*Arm at heart level*)				
A. SITTING	SYS. / DIAS.	B. RECUM-BENT	SYS. / DIAS.	C. STANDING (*5 mins.*)	SYS. / DIAS.	A. SITTING	B. RECUMBENT	C. STANDING (3 mins)	D. AFTER EXERCISE	E. 2 MINS. AFTER

28. DISTANT VISION		29. REFRACTION			30. NEAR VISION	
RIGHT 20/	CORR. TO 20/	BY	S.	CX	CORR. TO	BY
LEFT 20/	CORR. TO 20/	BY	S.	CX	CORR. TO	BY

31. HETEROPHORIA *(Specify distance)*

ESO	EXO	R.H.	L.H.	PRISM DIV.	PRISM CONV. CT	PC	PD

32. ACCOMMODATION		33. COLOR VISION *(Test used and result)*	34. DEPTH PERCEPTION *(Test used and score)*	UNCORRECTED
RIGHT	LEFT			CORRECTED
35. FIELD OF VISION		36. NIGHT VISION *(Test used and score)*	37. RED LENS TEST	38. INTRAOCULAR TENSION
RIGHT	LEFT			RIGHT / LEFT

39. HEARING			40. AUDIOMETER								41. PSYCHOLOGICAL AND PSYCHOMOTOR *(Tests used and score)*
RIGHT W/V	/15 SV	/15		250 256	500 512	1000 1024	2000 2048	3000 2896	4000 4096	6000 6144	8000 8192	
			RIGHT									
LEFT W/V	/15 SV	/15	LEFT									

42. NOTES *(Continued)* AND SIGNIFICANT OR INTERVAL HISTORY

(Use additional sheets if necessary)

43. SUMMARY OF DEFECTS AND DIAGNOSES *(List diagnoses with item numbers)*

44. RECOMMENDATIONS - FURTHER SPECIALIST EXAMINATIONS INDICATED *(Specify)*	45A. PHYSICAL PROFILE
	P U L H E S
46. EXAMINEE *(Check)*	45B. PHYSICAL CATEGORY
A. IS QUALIFIED FOR Bomb Technician Training at Hazardous Devices School	
B. IS NOT QUALIFIED FOR Bomb Technician Training at Hazardous Devices School	
47. IF NOT QUALIFIED, LIST DISQUALIFYING DEFECTS BY ITEM NUMBER	A B C E

48. TYPED OR PRINTED NAME OF PHYSICIAN	SIGNATURE
49. TYPED OR PRINTED NAME OF PHYSICIAN	SIGNATURE
50. TYPED OR PRINTED NAME OF DENTIST OR PHYSICIAN *(Indicate which)*	SIGNATURE
51. TYPED OR PRINTED NAME OF REVIEWING OFFICER OR APPROVING AUTHORITY	SIGNATURE

U.S. Department of Justice

Federal Bureau of Investigation

Hazardous Devices School
November 27, 2017

Hazardous Devices School Student Physical Health Standards

Applicant has applied to attend the Federal Bureau of Investigation, Hazardous Devices School (HDS). Prior to attending training, applicant must meet the below:

- Completed Standard Physical examination that complies with the requirements set forth in 29 CFR, Section 1910.120.

- Completed OSHA 29CFR, Appendix C to Sec. 1910.134: OSHA Respirator Medical Evaluation Questionnaire.

- Physical Standards - The Federal Bureau of Investigation, Hazardous Devices School is located at Redstone Arsenal, Alabama. This training is physically demanding. Training will require students to wear heavy (70 lbs or more) protective equipment in potentially high environmental temperatures, while simultaneously performing focused tasks in time-sensitive and high pressure scenarios that require precision and attention to visually small and/or color-coded details. The combination chemical suit (level B) and WMD bomb suit (40 pounds) also requires the wearing of a self-contained breathing apparatus (SCBA) with respirator. The micro-environment within this equipment can expose the wearer to temperatures in excess of 100 degrees Fahrenheit as well as humidity of 100% for periods of up to 30 minutes. Other tasks the applicant must perform include carrying a portable X-Ray (25 pounds) and disrupter (40 pounds) for a distance of at least 600 feet. During these tasks, the student must kneel, position the tools, and stand without assistance.

- Distant Vision - At least 20/20 in one eye and 20/40 in the opposite eye, as measured by the 20 foot Snellen chart or equivalent, with or without corrective lenses or surgery, and with a normal visual field (peripheral vision).

- Near Vision – At least 20/40 in each eye, as measured by the Snellen chart or equivalent, with or without corrective lenses or surgery, and with a normal visual field (peripheral vision).

- Eye Disorders – Please note any diagnosis, symptoms, high-risk factors, or treatments (including surgeries) for: Pre-glaucoma, Glaucoma, Glaucoma suspect, or Cataract. Please note any other eye disorder that may cause central or periphery vision loss.

- Color Perception – This test is only required for the Certification course. Normal color perception as measured by Pseudoisochromatic Plates (PIP) or Farnsworth F-15.

- Hearing – Average (mean) hearing level of 25dB at the 500, 1000, 2000 and 3000 Hz audiometer test frequencies with or without a hearing aid.

- Seizure Disorders – Should any history of seizure disorders exist, a currently licensed and board-certified neurologist must certify that the applicant is: 1) safe to perform the stated HDS requirements; and 2) the patient has been free from seizures for at least 365 days prior to the date of certification.

- Cardiovascular Disease - Should any history of cardiac issues exist, a currently licensed and board-certified physician must certify that the applicant is: 1) safe to perform the stated HDS requirements; and 2) specifically note any related issue that this course may affect.

- Anticoagulants - Should any history of anticoagulant use exist, a currently licensed and board-certified physician must certify that the applicant is: 1) safe to perform the stated HDS requirements; and 2) specifically note any related issue that this course may affect.

Please check all of the following restrictions that may apply to the applicant, any one of which may disqualify the applicant from HDS entry:

- o Restricted from lifting more than 50 pounds;
- o Restricted from kneeling, bending or twisting;
- o Restricted from working in a respirator (including negative pressure or SCBA types); or
- o Restricted from wearing protective chemical clothing and/or bomb suits.

Disclosure of this information is voluntary. However, failure to disclose this information or provide false or misleading information may result in termination of the applicant from this program, or the student from any HDS course, or the possible revocation of any issued HDS certification.

All provided information for FBI employees is subject to review by the FBI's Chief Medical Officer.

HDS may request supplemental information from any applicant as deemed necessary.

I, _____, certify the below listed candidate meets or exceeds all of the physical health standards as defined in the HDS Student Physical Health Standards.

Candidate's Name	
Rank or Title	
Agency	
Agency Address	
(Street, City, State, ZIP)	
Business Telephone	

Comments/Notes/Concerns/Other

_____ _____

Signature of Physician Date

_____

Name and Title (Print or Type)

_____

Address (Street, City, State, ZIP)

_____

Business Telephone

Maximum Weight by Height

From the *National Guidelines for Bomb Technicians*

Height (inches)	Male				Female			
	Age Group				Age Group			
	21-29	30-39	40-49	50+	21-29	30-39	40-49	50+
58					100	103	106	109
59					105	108	111	114
60	166	169	172	175	110	113	116	119
61	170	173	176	179	115	118	121	124
62	173	176	179	182	120	123	126	129
63	176	179	182	185	125	128	131	134
64	180	183	186	189	130	133	136	139
65	183	186	189	192	135	138	141	144
66	186	189	192	195	140	143	146	149
67	190	193	196	199	145	148	151	154
68	193	196	199	202	150	153	156	159
69	196	199	202	205	155	158	161	164
70	200	203	206	209	160	163	166	169
71	203	206	209	212	165	168	171	174
72	206	209	212	215	170	173	176	179
73	210	213	216	219	175	178	181	184
74	213	216	219	222	180	183	186	189
75	216	219	222	225	185	188	191	194
76	220	223	226	229	190	193	196	199
77	223	226	229	232	195	198	201	204
78	226	229	232	235	200	203	206	209
79	230	233	236	239	205	208	211	214
80	233	236	239	242	210	213	216	219

Alternative Body Fat Test	Age Group			
	21-27	28-39	40-49	50+
Maximum Body Fat (Male)	22%	24%	26%	28%
Maximum Body Fat (Female)	30%	32%	34%	36%

OSHA 29CFR, Appendix C to Sec. 1910.134:
OSHA Respirator Medical Evaluation Questionnaire (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 (check one): ☐ 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. Additionally, 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) The following information must be provided by every employee who has been selected to use any type of respirator (please print).

1. Today's date:_____
2. Your name:_____
3. Your age (to nearest year):_____
4. Sex (check one): ☐ Male ☐ Female
5. Your height: _____ ft. _____ in.
6. Your weight: _____ lbs.
7. Your job title:_____
8. A phone number where you can be reached by the health care professional who reviews this questionnaire (include the Area Code): _____
9. The best time to phone you at this number: _____
10. Has your employer told you how to contact the health care professional who will review this questionnaire (check one): ☐ Yes ☐ No
11. Check the type of respirator you will use (you can check more than one category):
    a. ☐ N, R, or P disposable respirator (filter-mask, non-cartridge type only).
    b. ☐ Other type (for example, half- or full-face piece type, powered-air purifying, supplied-air, self-contained breathing apparatus).
12. Have you worn a respirator (check one): ☐ Yes ☐ No
    If "**yes**," what type(s):_____

Part A. Section 2. (Mandatory) Questions 1 through 9 below must be answered by every employee who has been selected to use any type of respirator (please check "yes" or "no").

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 (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
   - **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 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 used a respirator, check here ☐ 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 problem 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

Questions 10 to 15 below must be answered by every employee who has been selected to use either a full-facepiece respirator or a self-contained breathing apparatus (SCBA). For employees who have been selected to use other types of respirators, answering these questions is voluntary.

10. Have you ***ever*** lost vision in either eye (temporarily or permanently): ☐ 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 or vision problem: ☐ Yes ☐ No

12. Have you ***ever had*** an injury to your ears, including a broken ear drum: ☐ Yes ☐ No

13. 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

14. Have you ***ever had*** a back injury: ☐ Yes ☐ No

15. 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 lbs: ☐ 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: ☐ Yes ☐ No
   - **b.** Silica (e.g., in sandblasting): ☐ Yes ☐ No
   - **c.** Tungsten/cobalt (e.g., grinding or welding this material): ☐ Yes ☐ No
   - **d.** Beryllium: ☐ Yes ☐ No
   - **e.** Aluminum: ☐ Yes ☐ No
   - **f.** Coal (for example, mining): ☐ Yes ☐ No
   - **g.** Iron: ☐ Yes ☐ No
   - **h.** Tin: ☐ Yes ☐ No
   - **i.** Dusty environments: ☐ Yes ☐ No
   - **j.** Any other hazardous exposures: ☐ Yes ☐ No

   If "**yes**," describe these 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: ☐ Yes ☐ No
    b. Canisters (for example, gas masks): ☐ Yes ☐ No
    c. Cartridges: ☐ Yes ☐ No

11. How often are you expected to use the respirator(s) (check "**yes**" or "**no**" for all answers that apply to you)?:
    a. Escape only (no rescue): ☐ Yes ☐ No
    b. Emergency rescue only: ☐ Yes ☐ 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:_____
_____

14. Will you be working under hot conditions (temperature exceeding 77° 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):
_____
_____

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

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):
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):

U.S. Department of Justice
Federal Bureau of Investigation
Critical Incident Response Group
Hazardous Devices School
Redstone Arsenal, AL 35898

HAZMAT Training Prerequisite Notice

FBI Hazardous Devices School - Basic Course Applicants

Hazardous Devices School (HDS) Basic Course students are required to furnish documentation that they have completed training that meets or exceeds requirements set forth in 29 Code of Federal Regulations (CFR), section 1910.120(q)(6)(iii), Emergency Responder to Hazardous Materials Technician for CBRNE Incidents. If the training was completed more than one year prior to the class date, annual HAZMAT refresher training must be current. During the Weapons of Mass Destruction (WMD) related training in the HDS Basic Course you will be required to demonstrate proficiency in wearing Personal Protective Equipment (PPE) and performing decontamination procedures. Therefore, please ensure that your training included these elements. If not, you should obtain the following additional elements of training on your own through your local HAZMAT team or fire department:

(1) Wearing level A or B
(2) Wearing level C
(3) Familiarization with the decontamination process

Your Basic application packet can be submitted prior to your completion of the HAZMAT training. Upon completion of the HAZMAT training, you can fax the documentation directly to the HDS Registrar at (256) 313-1907. If you have completed the HAZMAT training and are certified at the Technician level for HAZMAT, a copy of the documentation should be sent in with your Basic application packet. Documentation **must** be received by the HDS Registrar **before** a letter of invitation to a class will be sent to you. Invitation letters are usually emailed approximately two months prior to the class date. Documentation can be in the form of a certificate received upon completion of training or in the form of a letter from your department indicating that you are certified at the Technician level for HAZMAT.

If you have any questions, please call the HDS Registrar (256) 313-8945 or SSABT Ira D. Jones, Jr., HDS Basic Certification Program Manager (256) 842-1721.

For applicants who have not completed the above referenced HAZMAT training, please sign and date the acknowledgment below and send this Notice in with your Basic application packet.

I, _____, acknowledge that I have read and understand the HAZMAT training prerequisite as stated above. I further understand that before I can receive a letter of invitation to the Hazardous Devices School Basic Course, I must provide the HDS Registrar with documentation that I am certified at the TECHNICIAN level for HAZMAT.

Signature of Applicant _____ Date_____

U.S. Department of Justice
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Critical Incident Response Group
Hazardous Devices School
Redstone Arsenal, AL 35898

NIMS Training Prerequisite Notice

FBI Hazardous Devices School – Basic Certification Course Applicants

Commencing July 1, 2015, all Hazardous Devices School (HDS) **Basic Certification** Course applicants are required to furnish documentation that they have completed the FOUR (4) following National Incident Management System (NIMS) courses:

IS 100.b http://www.training.fema.gov/IS/courseOverview.aspx?code=IS-100.b

(Law Enforcement Officers may take the LEb course—Do Not Take Both 100.b and 100.LEb)

IS 100.LEb http://www.training.fema.gov/IS/courseOverview.aspx?code=IS-100.LEb

IS 200.b http://www.training.fema.gov/IS/courseOverview.aspx?code=IS-200.b

IS 700.a http://www.training.fema.gov/IS/courseOverview.aspx?code=IS-700.a

IS 800.b http://www.training.fema.gov/IS/courseOverview.aspx?code=IS-800.b

These courses can all be completed online and are located at www.training.fema.gov. Once completed, please print the certificates and include copies in your HDS Basic Course application packet.

If you have questions, please contact the HDS Registrar at (256) 313-8945 or SSABT Ira D. Jones, Jr. at (256) 842-1721.