



U.S. FISH AND WILDLIFE SERVICE

SCUBA DIVING MEDICAL EXAMINATION FORM

INSTRUCTIONS

EMPLOYEE:

1. Before your scheduled physical examination, please complete all questions in Sections A and B on Page 3.
2. If you have any positive answers in the medical history section, please explain fully.
3. Incomplete forms may result in delay of approval for Service underwater diving activities.
4. Sign and date in the spaces provided.
5. Take the entire package (FWS Forms 3-2224 and 3-2224-A) to the examining physician.
- 6.** When complete and returned to you by the physician, send the entire package to your Regional Dive Officer. Use this form for any medical examination used to qualify for underwater diving. If a combined examination (e.g., Diver and Law Enforcement) is needed, please use an alternative form, such as DOI's "Standard Medical History and Examination Form" 6-27-2000 (found on the DOI SafetyNet's Occupational Medical Program web page at <http://www.doi.gov/safetynet>).

ATTENDING PHYSICIAN: The purpose of this examination is to determine employee fitness for working in hyperbaric conditions underwater (SCUBA diving). The minimal laboratory requirements are as follows:

Initial (baseline) examination under age 40:

- * Medical History
- * Complete Physical Exam, emphasis on neurological and otological components
- * Chest X-ray
- * Spirometry
- * Hematocrit or Hemoglobin
- * Urinalysis
- * Fasting Blood Glucose
- * Audiometry

Periodic re-examination under age 40 (every 5 years):

- * Medical History
- * Complete Physical Exam, emphasis on neurological and otological components
- * Hematocrit or Hemoglobin
- * Urinalysis
- * Audiometry

Initial (baseline) exam over age 40:

- * Medical History
- * Complete Physical Exam, emphasis on neurological and otological components
- * Assessment of coronary artery disease using Multiple-Risk-Factor Assessment1 (age, lipid profile, blood pressure, diabetic screening, smoker)
- * Resting EKG
- * Chest X-ray
- * Spirometry
- * Urinalysis
- * Hematocrit or Hemoglobin
- * Fasting Blood Glucose
- * Audiometry

Periodic re-examination over age 40 (every 3 years); over age 60 (every two years):

- * Medical History
- * Complete Physical Exam, emphasis on neurological and otological components
- * Assessment of coronary artery disease using Multiple-Risk-Factor Assessment1 (age, lipid profile, blood pressure, diabetic screening, smoker)
- * Resting EKG
- * Urinalysis
- * Hematocrit or Hemoglobin
- * Fasting Blood Glucose
- * Audiometry
- * Spirometry

The following diagnostic health procedures must be included as well:

Color Discrimination - Baseline Only
 Lab Panel (sickle cell prep, blood type and group) - Baseline Only
 Lab Panel (CBC, UA, fasting chemistry panel) - Both

Best Corrected and Uncorrected Near Vision Acuity - Both
 Best Corrected and Uncorrected Far Vision Acuity - Both

PLEASE:

1. Review the Functional Requirements Section C (Page 3), complete all portions of Section D (Page 4), and complete Section 2 of the Physician's Qualification Statement (FWS Form 3-2224-A).
2. Provide complete explanations/clarifying information for all findings not in the normal range.
3. Return this package including hard copies of test results (lab, spirometry, audiometry, EKG, etc.) and any additional reports/forms to the employees Regional Dive Officer.

IMPORTANT: The following medical conditions (current or past) may be considered a contraindication to an employee participating in underwater diving activities: Epilepsy, pregnancy*, lung cysts, severe and uncontrolled allergies, and angina/heart attack.

* Diving will generally be deferred for employees that are pregnant. Consult with the attending or reviewing physician.

NOTE: Per 5 CFR 339.104, you are authorized to request additional medical information from employee's personal physician, such as: history of any medical conditions; clinical findings; diagnosis/prognosis; narrative explanations of conclusions which indicate the employee is able to carry out the tasks or duties for a specific activity. Each potentially disqualifying medical condition will be evaluated on a case-by-case basis.

REGIONAL DIVE OFFICER:

Please forward the entire package including hard copies of all tests (lab, spirometry, audiometry, EKG, etc.) to the reviewing physician (if attending physician is not hyperbaric trained). Once the reviewing physician has completed their review, a copy of the Physician's Qualification Statement (FWS Form 3-224-A) will be returned to the RDO. RDO's will ensure that a copy of the Physician's Qualification Statement (FWS Form 3-224-A) is placed into the individual diver's personal medical file. The reviewing physician will act as the custodian for all files until instructed otherwise. In the case that the attending physician is hyperbaric trained, they will maintain medical information. If the physicians' office is not to maintain this information, have all information sent to the servicing personnel office.

Privacy Act Information

The collection and use of this information are consistent with the provisions of 5 U.S.C. 552a (the Privacy Act of 1974). This information is sensitive and protected by the Privacy Act. It is only available to staff on a need to know basis. Electronic material must be password protected and must not be used except in accordance with routine uses identified in "OPM/GOVT-10, Employee Medical File System Records". Paper records must be similarly used and protected in a locked file or room that is available only to staff who have a need to know this information and in accordance with OPM/GOVT-10.

FWS SCUBA Diving Medical Examination Form

DIVING MEDICAL EXAMINATION FORM

A. Employee Information (Employee)

Name/Address of Agency:		
Employee Name:	Job Title:	SS#:
Address:	Work Location:	Region:
	Home Phone:	Work Phone:
Date of Exam:	Date of Birth:	Gender: Male <input type="checkbox"/> Female <input type="checkbox"/>

B. Medical History (Employee)

If you answer "Yes" to any question, please provide explanation.	NO	YES	When/Where/Details if "Yes"
1. Do you currently take any medications? If so, list ALL (including prescriptions, non-prescriptions, vitamins, herbs, and inhalers).			
2. Have you ever used tobacco? If so, list type, amount per day, and years used.			
3. Do you consume alcohol? If so, list average consumption per week.			
4. Which of the following conditions have you ever had? Allergies (Specify _____) <input type="checkbox"/> Anemia <input type="checkbox"/> High Blood pressure <input type="checkbox"/> Decompression <input type="checkbox"/> Asthma <input type="checkbox"/> Head injury Sickness/Embolicism <input type="checkbox"/> Bronchitis/Emphysema <input type="checkbox"/> Kidney disease <input type="checkbox"/> Stroke <input type="checkbox"/> Cancer history <input type="checkbox"/> Loss of consciousness <input type="checkbox"/> Depression <input type="checkbox"/> Claustrophobia <input type="checkbox"/> Migraines <input type="checkbox"/> High Cholesterol <input type="checkbox"/> Collapsed lung <input type="checkbox"/> Positive TB skin test <input type="checkbox"/> Vertigo <input type="checkbox"/> Diabetes <input type="checkbox"/> Lung cysts <input type="checkbox"/> Disorders of <input type="checkbox"/> Heart attack/angina <input type="checkbox"/> Ruptured ear drum Bleeding <input type="checkbox"/> Heart murmur <input type="checkbox"/> Seizures <input type="checkbox"/> Congenital Heart <input type="checkbox"/> Hepatitis <input type="checkbox"/> Thyroid trouble Disease <input type="checkbox"/> Herniated disc <input type="checkbox"/> Epilepsy			<u>Describe checked items:</u>
5. Which of the following have you experienced in the last year? <input type="checkbox"/> Fever > 100 deg. <input type="checkbox"/> Shivering/chills <input type="checkbox"/> Generalized weakness <input type="checkbox"/> Unexplained weight loss/gain <input type="checkbox"/> Excessive fatigue <input type="checkbox"/> Swollen glands <input type="checkbox"/> Loss of appetite <input type="checkbox"/> Change in vision <input type="checkbox"/> Difficulty hearing <input type="checkbox"/> Sinus trouble <input type="checkbox"/> Nosebleeds <input type="checkbox"/> Chest pain/pressure <input type="checkbox"/> Irregular heartbeat <input type="checkbox"/> Shortness of breath <input type="checkbox"/> Headaches <input type="checkbox"/> Dizziness/passing out <input type="checkbox"/> Hyperventilation <input type="checkbox"/> Pregnancy			<u>Describe checked items:</u>
6. Is there a family history of the following: High Cholesterol Heart Disease/Stroke Diabetes Asthma			
7. Inoculation/Tests: Tetanus booster; year given: _____, Chest x-ray; year given: _____, Hepatitis B vaccine; year given _____; number of shots received: _____; year vaccination completed _____			
8. Have you ever been hospitalized?			
9. Have you ever had surgery?			
10. Do you participate in hobbies/activities? If so, please list.			
11. Have you experienced difficulties with previous diving?			
12. Employee Signature:	13. Date:		

C. Functional Requirements (Required in SCUBA Diving Activities)

- Employee Name: _____
- | | | |
|---|--|---|
| <input type="checkbox"/> Heavy Lifting - 45 lbs. and over | <input type="checkbox"/> Heavy Carrying - 45 lbs. and over | <input type="checkbox"/> Reaching Over Shoulder |
| <input type="checkbox"/> Use of Fingers | <input type="checkbox"/> Both Hands Required | <input type="checkbox"/> Climbing, Use of Legs and Arms |
| <input type="checkbox"/> Both Legs Required | <input type="checkbox"/> Both Eyes Required | <input type="checkbox"/> Far Vision Correctable in One Eye to 20/50, and to 20/100 in the other |

- Hearing Without Aid Free of Cardiovascular and Respiratory Ability for Rapid Mental and Muscular Disease Coordination Simultaneously
 Mental and Physical Stress Working in Hyperbaric Conditions Underwater

FWS SCUBA Diving Medical Examination Form

D. Attending Physician (Physician)

NOTE: The employee you examine will have to cope with the functional requirements and environmental factors listed above (Part C). Please take them, along with the work activity (SCUBA diving), into consideration as you make your examination and report your findings and conclusions.

Baseline Exam:

Periodic Exam:

1. Height: _____ Feet _____ Inches	2. Weight: _____ Pounds	3. Body Mass Index: _____
<p>4. Eyes:</p> <p>a) Near vision (Snellen)</p> <p>Without glasses: Right ²⁰ Left ²⁰ Both ²⁰</p> <p>With glasses: Right ²⁰ Left ²⁰ Both ²⁰</p> <p>b) Far vision (Snellen)</p> <p>Without glasses: Right ²⁰ Left ²⁰ Both ²⁰</p> <p>With glasses: Right ²⁰ Left ²⁰ Both ²⁰</p> <p>c) What is the longest and shortest distance at which Jaeger No. 2 type can be read by the employee? Test each eye separately =</p> <p>Without glasses: R. ____ in. to ____ in.; L. ____ in. to ____ in.</p> <p>With glasses: R. ____ in. to ____ in.; L. ____ in. to ____ in.</p>	<p>5. Color Vision:</p> <p>Is color vision normal when Ishihara or other color plate test is used?</p> <p><input type="checkbox"/> Normal <input type="checkbox"/> Abnormal</p> <p>Number of Correct: ____ of ____ tested.</p> <p>If not, can employee pass lantern, yarn, or other comparable test?</p> <p><input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>Can individual see Red/Green/Yellow? ____ Yes ____ No</p>	
6. Ears: Audiometer Test:		<p style="text-align: center;"><u>250</u> <u>500</u> <u>1000</u> <u>2000</u> <u>3000</u> <u>4000</u> <u>5000</u> <u>6000</u> <u>7000</u> <u>8000</u></p> <p>Left:</p> <p>Right:</p>
7. Other Findings: In Items a through l briefly describe any <i>abnormality</i> (including diseases, scars, and disfigurements); please also indicate if normal. Include brief history, if permanent.		
a. Eyes, Ears, Nose, and Throat	b. Head and Back	

c. Speech		d. Skin and Lymph Nodes
e. Abdomen		f. Peripheral Blood Vessels
g. Extremities		h. Urinalysis (if indicated) Sp. Gr. _____ Sugar _____ Blood _____ Albumen _____ Casts _____ Pus _____
i. Respiratory Tract (Spirometry): FEV1 _____ (% predicted) FVC _____ (% predicted) FEV1/FVC Ratio _____	j. Respiratory Tract (X-ray if indicated):	k. Chest X-Ray (baseline only if recent x-ray not available)
l. Heart (size, rate, rhythm, function) Blood Pressure _____ Pulse _____ EKG _____ (to anyone 40 or older - baseline).		
m. Back (special consideration since diving activities require heavy lifting and strenuous duties).		
n. Neurological and Mental Health (e.g., claustrophobia, suicidal ideation, Psychosis, anxiety disorders, untreated depression, etc.):		

FINDINGS: Note any condition which would limit or exclude the employee participating in SCUBA diving work activities. If none, please indicate.

No Limiting Conditions

Limiting Conditions:

Not Recommended for Diving

Physician Signature:

Date Completed:

Office Address:

Office Telephone:

**** PLEASE COMPLETE SECTION B OF THE "PHYSICIAN'S QUALIFICATION STATEMENT" ****