**PLEASE INDICATE THE PARTICIPATION LEVEL REQUESTED & DATE COMPLETED**

| ENTRY ☐ | NON-ENTRY ☐ | REHAB UNIT ONLY ☐ | DATE: |
|---|---|---|---|

MFRI/BALTIMORE COUNTY FIRE SERVICE TRAINING FITNESS QUESTIONNAIRE

# CONFIDENTIAL

This questionnaire is used in determining whether or not you have a medical condition that may affect your ability to safely participate in Fire and EMS services. IT IS NOT USED (BY ITSELF) TO DETERMINE YOUR FITNESS TO ENGAGE IN STRENUOUS EMERGENCY ACTIVITIES. By completing this application, you give permission for the Medical Review Board to query the CRISP database, the regional database for health information.

INSTRUCTIONS – READ CAREFULLY

1. **You MUST answer EVERY question**. Failure to do so will cause unnecessary delay in completing review of your questionnaire.
2. There are questions on BOTH sides of all pages in this questionnaire.
3. You MUST print your Fire Service I.D. number in the space below and in the space provided on page four.
4. You MUST print the number of your station in the space below and in the space provided on page four.
5. You MUST sign your name in the space provided on page four.
6. You MUST print the date you completed this document in the space provided on page four.
7. Review the completed document to be sure that you have left nothing out.
8. Place the completed document in the envelope that has been provided.
9. Be sure that you have placed your name, fire service I.D. number and Station number in the spaces on the upper left hand corner of the envelope. If submitting by U.S. Postal Service, include your home address there.
10. Seal the envelope, and then write your name over the flap of the envelope.
11. When you have done all of the above, return the envelope to your designated station representative or place a stamp on it and place it in the U. S. Postal Service Mail. If no envelope, please return form to: **BCVFA office, 700 East Joppa Road, 3rd Floor, Towson, MD 21286-5501 – Attn: Medical Board.**

| Company Name | Station Number | Date of Entry | Member ID Number |
|---|---|---|---|
| | | | |

| PLACE AN X IN THE CORRECT BOX → | YES | NO |
|---|---|---|
| 1. Do you **currently** use tobacco products, or have you used tobacco products within the last six (6) months? | | |
| 2. Have you **ever had** any of the following conditions: If yes, state when. | | |
| a. Seizures (fits): | | |
| b. Diabetes (sugar disease): | | |
| c. Allergic reactions that interfere with your breathing | | |
| d. Claustrophobia (fear of closed-in places): | | |
| e. Trouble smelling odors: | | |
| 3. Have you **ever had** any of the following breathing or pulmonary or any other lung problems? | | |
| a. Asthma: If yes, when was the date of your last attack? | | |
| b. Asbestosis | | |
| c. Chronic bronchitis: | | |
| d. Chronic obstructive pulmonary disease (COPD): | | |
| e. Cystic fibrosis: | | |
| f. Emphysema: | | |
| g. Interstitial lung disease: | | |
| h. Pneumonia: | | |
| i. Tuberculosis: | | |
| j. Pneumothorax (collapsed lung): | | |
| k. Lung cancer: | | |
| l. Broken ribs: | | |
| m. Any chest injuries or surgeries: (if yes – provide details: | | |
| n. Any other lung problem: Yes/No (if yes, provide details) | | |
| 4. Do you **currently** have any of the following symptoms of pulmonary or lung illness? | | |
| ☐ a. Shortness of breath: ☐ b. Wheezing ☐ c. Persistent coughing | | |
| 5. Have you **ever had** any of the following heart or cardiovascular or health problems? | | |
| a. Heart attack: | | |
| b. Stroke: | | |
| c. Angina: | | |
| d. Heart failure: | | |
| e. Heart murmur: | | |
| f. Swelling in your legs or feet (not caused by walking): | | |
| g. Heart arrhythmia (heart beating irregularly): | | |
| h. High blood pressure: | | |
| i. High cholesterol: | | |
| j. Any other heart condition: If yes, explain: | | |
| 6. Have you **ever had** any of the following cardiovascular or heart symptoms? | | |
| a. Frequent pain or tightness in your chest: Yes/No | | |
| b. In the past two years, have you noticed your heart skipping or missing a beat: | | |
| c. In the past two years, have you experienced abnormal rapid beating of the heart: | | |
| d. Heartburn or indigestion that was not related to eating: | | |
| e. Dizziness or fainting | | |
| f. Cramping pain and weakness in the legs, especially calves, during walking | | |

| PLACE AN X IN THE CORRECT BOX → | YES | NO |
|---|---|---|
| g. Unusual or unexplained fatigue | | |
| h. Any other symptoms that you think may be related to heart or circulation problems: | | |
| 7. Do you have any family history of heart attack, coronary revascularization or sudden death? If yes, respond to the following: | | |
| a. Was it before 55 years of age in a father or other male relative (brother or son)? | | |
| b. Was it before 65 years of age in a mother or other female relative (sister or daughter)? | | |
| 8. List ALL prescribed prescription and over the counter medications you are currently taking (use separate sheet of paper if needed.)<br>a. e.<br>b. f.<br>c. g.<br>d. h. | | |
| Reason for Medication a. | xxx | xxx |
| Reason for Medication b. | xxx | xxx |
| Reason for Medication c. | xxx | xxx |
| Use addition paper for remainder of medications | xxx | xxx |
| 9. Have you **ever used** a respirator? If yes, have you ever had any of the following problems? | | |
| a. Eye irritation: | | |
| b. Skin allergies or rashes: | | |
| c. Anxiety: | | |
| d. General weakness or fatigue: | | |
| e. Any other problem that interferes with your use of a respirator: (if yes, explain) | | |
| 10. Are you currently pregnant? | | |
| 11. Do you **currently** have any of the following vision problems? | | |
| a. Wear contact lenses: | | |
| b. Wear glasses: | | |
| c. Color blind: | | |
| d. Ever lost vision in either eye (temporarily or permanently): | | |
| e. Any other eye or vision problem: | | |
| 12. Have you **ever had** an injury to your ears, including a broken ear drum? | | |
| 13. Do you **currently** have any of the following musculoskeletal problems? | | |
| a. Weakness in any of your arms, hands, legs or feet: | | |
| b. Back pain: | | |
| c. Difficulty fully moving your arms and legs: | | |
| d. Pain or stiffness when you lean forward or backward at the waist: | | |
| e. Difficulty fully moving your head up or down or side to side: | | |
| f. Difficulty bending at your knees: | | |
| g. Difficulty squatting to the ground: | | |
| h. Climbing a flight of stairs or a ladder carrying more than 50 lbs: | | |
| i. Any other muscle or skeletal problem that interferes with using a respirator: Yes | | |
| j. Have you **ever had** a neck or back injury: (if yes, explain (when, details) | | |
| 14. List prior surgeries and their dates (Attach separate sheet) | | |
| 15. Have you **ever been** in the military services? If yes, were you exposed to biological or chemical agents (either in training or combat)? List Years. | | |
| 16. Have you **ever worked** on a HAZMAT team? | | |

| PLACE AN X IN THE CORRECT BOX → | YES | NO |
|---|---|---|
| 17. As a MFRI student, you may be required to wear fire protective clothing and self-contained breathing apparatus weighing at least 50 pounds in hazardous atmospheres, perform firefighting and rescue operations that expose you to extreme heat, toxic products of combustion and hazardous materials. You may also be required to lift and operate heavy machinery, carry and raise ladders, and climb ladders up to 135 feet in height. Students may achieve heart rates of 85 to 100% of their maximum capacity during training operations. Do you believe that you **currently** have any medical conditions that would prohibit you from performing these duties? | | |

I hereby affirm that the answers to the above questions are true and complete, to the best of my knowledge. I authorize and direct Mercy Medical Centers, the Respiratory Protection Review Board, the Baltimore County Retirement Medical Review Board and/or the Baltimore County Volunteer Firemen's Association's Medical Review Board to provide its medical opinion(s) regarding the evaluation of my fitness for respirator use to the designated representative of the Baltimore County Fire Department authorized to receive such an evaluation, Mercy Medical Centers, the Respiratory Protection Review Board, the Baltimore County Retirement Medical Review Board and/or The Baltimore County Volunteer Firemen's Association Medical Review Board, and the President (or designee of the member's Volunteer Company(ies) and the Maryland Fire Rescue Institute. I hereby acknowledge that in the event of a conflict in opinion concerning respirator use, the opinion of the Maryland Fire Rescue Institute shall prevail. This authorization shall be effective from the date of the execution below.

| STATION NUMBER | NAME OF COMPANY | | MFRI CLASS LOG NUMBER: |
|---|---|---|---|
| | | | |
| **PRINTED LAST NAME OF MEMBER** | **PRINTED FIRST NAME OF MEMBER** | **MIDDLE INITIAL** | **MEMBER ID NUMBER** |
| | | | |
| **MEMBER'S EMAIL ADDRESS:** | | | |
| **SIGNATURE OF MEMBER** | **SEX** MALE ☐ FEMALE ☐ | | **DATE OF BIRTH** |
| **HOME ADDRESS OF MEMBER** | **ACTUAL WEIGHT IN POUNDS** | | **HEIGHT** ----------FOOT ----------INCHES |
| **CITY** | **STATE** | **ZIP CODE** | **(LEAVE THIS SPACE BLANK)CALC. BODY MASS INDEX** |
| **HOME PHONE OF MEMBER** | **WORK PHONE OF MEMBER** | **CELL PHONE OF MEMBER** | |
| **SIGNATURE OF PARENT OR LEGAL GUARDIAN IF MEMBER IS LESS THAT EIGHTEEN YEARS OF AGE** | | **DATE** | |

## DO NOT WRITE BELOW THIS LINE – FOR USE OF MEDICAL BOARD ONLY

**PHYSICIAN'S COMMENTS:**

| ☐ PMD **OR** ☐ MERCY | | ☐ UNABLE TO PARTICIPATE |
|---|---|---|
| ☐ APPROVED FOR FIT TESTING | ☐ NOT APPROVED FOR FIT TESTING | ☐ PHYSICAL EXAMINATION REQUIRED |
| **DATE** | **INITIALS OF REVIEWING OFFICIAL** | |

**REV 2/19**