ATTACHMENT 1

Medical Clearance Procedures for the RAO Program and RAO Medical Screening Questionnaire

RAO members are required to maintain a current medical clearance for the entire time they are employed in the RAO program. This includes a **Pre-Employment** medical questionnaire screening before being accepted into the program, as well as an **Annual** medical questionnaire review for the duration of their employment in the RAO. The forms to be submitted are the same for the pre-employment and the annual review.

Categories of Medical Clearance:

There are two general categories of Medical Clearance, and you must select which you are applying for, when you fill out the Medical Questionnaire. The categories are "Field" and "Office" and you must select only one.

- **"Field"** clearance essentially clears you for all types of positions. It includes positions in the **field and in office settings** and it provides for the most options for deployment. You should consider that "field" conditions may include work that involves some strenuous activity such as standing for long periods of time, or walking over rough terrain. It also frequently involves being outside for up to 12 hours at a time, and can include weather extremes of cold, or heat and humidity. QA personnel, construction inspectors, field engineers and many other positions require 'field' clearance. If you are willing to work in field conditions, and if you feel you are in good enough physical condition to work in that setting, select "Field".

- "**Office"** clearance is a more limited clearance. It means you can only be deployed to positions primarily in indoor office settings. This somewhat restricts your opportunities for deployment, but you can still be deployed to a variety of office positions. If you are interested only in indoor office settings, or if your physical condition is such that you could not safely work outside for extended periods of time, then select "Office**". If you select this option, you will automatically be considered "non-deployable" for field positions**.

How to Submit the Medical Questionnaire:

RAO Medical Screening Questionnaire (follows in this Attachment) – **Must be filled out completely, signed, and faxed by the applicant to the USACE contract medical provider, Washington Occupational Health Associates (WOHA) at 202-223-6525.** This ensures that confidential medical information is only seen by authorized medical personnel. WOHA will

evaluate the contents of the medical screening questionnaire, determine fitness to deploy and fax the results to RAO. **Note – If additional information is required to finalize a medical determination, the medical provider may contact the applicant directly and will allow a specified amount of time for response.**

Pre-Employment Procedures. Pre-Employment medical clearance procedures are explained in detail in the How to Apply Section – paragraph 7.b.(4) of this SOP. The pre-employment screening is required before a job offer is made.

Annual Medical Review Procedures. The RAO program support staff monitors the due dates for annual medical reviews and contact RAO members by email to remind them to submit an updated medical questionnaire each year. Since the medical clearance is valid for 12 months, normally the reminder is sent by email, 45 – 60 days in advance. You should ensure you return the completed form no later than 30 days before the expiration of your medical clearance. This gives the Occupational Health Physicians sufficient time to review the questionnaire and request any additional information that might be needed, in time to make the medical determination, before the expiration date.

Timely Submission and Suspension of Deployment Eligibility. You must submit the medical questionnaire, and if requested provide any additional information in a timely manner. The contract occupational health physician will give you a deadline by which you must provide the requested information. If for some uncontrollable reason you cannot meet the due date, you should notify your RAO point of contact to request an extension of time. If your medical clearance expires but you are in the process of obtaining additional information, you may remain in the program for a reasonable period of time, but you will not be deployed to work until the clearance is approved. If a medical clearance cannot be made in a reasonable period of time you will be removed from the RAO program.

Confidentiality of Information. The RAO complies with confidentiality of medical information requirements of the Health Insurance Portability and Accountability Act (HIPAA). For that reason the RAO requires that all medical questionnaires and any additional medical information be sent directly to the contract occupational health physicians. The RAO staff is not involved in any way in the medical review or medical issues. The RAO staff only tracks the status of medical clearances. The only information sent back from the occupational health physician to the RAO is the Physician Medical Clearance Memorandum, which specifies the type of medical clearance approved. It does not include any medical or personal information.

Decisions of Contract Occupational Health Physicians. Decisions of the contract occupational health physicians are final. There may be instances when the occupational health physician requests additional information, including information directly from your personal physicians. Whether you provide that information is your personal decision, however, you will not be deployed and you will not be continued in the RAO program unless the occupational

health physician has sufficient information to approve a medical clearance for either “field” or “office” deployments.

Notice to RAO Members. Normally, RAO members will receive an email notification which is generated from ENGLink, advising them that the medical clearance has been completed. It does not specify the nature of the clearance in order to protect confidentiality. Occasionally there may be problems with ENGLink which interfere with the automatic notification. RAO members are welcome to contact their RAO POC or WOHA to request information regarding their medical clearance status.

RAO Medical Screening Questionnaire

Fax

To: K. Chase, MD & S. Scott, MD

From:

Fax: **202-223-6525**

Pages:

Phone:

Date:

Re:

CC:

Comments

My completed Civil Emergency Medical Screening Packet and additional information, if necessary, is included in this fax.

After you have completed your review, please fax the Physician Medical Clearance Memorandum to my home duty station Emergency Operations Center.

My organization assignment is **CECW-HS, RAO**.

My assigned office can be reached by fax at 202-761-0378 or by telephone at 202-761-8548.

If you have any questions regarding the information provided, I can be contacted at

_____.

Thank you,

RAO Reemployed Annuitants

[BEGIN] MEDICAL SCREENING QUESTIONNAIRE
Version 3.RAO (August 2009)

Complete this Civil Emergency Medical Screening Packet according to the attached instructions. Your civil emergency deployment status is dependent on the Medical Provider receiving ALL the required information. Double Check! It is important to complete this information to the best of your ability. Our primary goal is to ensure that you can perform the job tasks assigned while working long hours under stressful and sometimes physically demanding working conditions without jeopardizing your health.

Section I. Personal Identifiers

The following Personal Identifiable Information (PII) is required in order to process your Civil Emergency Medical Screening Packet. All data is subject to HIPAA and Privacy Act requirements and is stored in a secure method.

*1. Last Name | First Name | Middle Initial

*2. Social Security | *3. Date of Birth (DD-Mon-YYY)

*4. Telephone (Home) | *5. Telephone (Cellular)

Section II. Duty Description

You may choose only one of the following Civil Emergency Operations positions. Please read the descriptions below. The qualifications for your chosen deployment will be determined by the information you supply in the following sections.

FIELD DEPLOYMENT:
If you are cleared for Field Deployment you will also be cleared for Office Deployment. Field work is primarily conducted outdoors at a CONUS or OCONUS disaster site such as that performed by a Debris Quality Assurance Inspector, Construction Representative, etc. It often involves strenuous activities such as standing for long periods of time or walking over rough terrain and can include weather extremes of cold or heat and heat and humidity. **FIELD must be selected if you wish to deploy OCONUS.**

OFFICE DEPLOYMENT (only):
Office work is conducted primarily in an office setting at a State, Division, or District EOC, ROC, DFO, RFO, or EFO.

CHOOSE ONE ONLY:

☐ **FIELD** or ☐ **OFFICE - ONLY**

Section III. General Information

Please answer the following questions regarding prior deployment experience and general physical ability.

*****Many questions require additional information. THIS INFORMATION MUST BE DOCUMENTED IN THE "REMARKS" SECTION AT THE END OF THE PACKET (PAGE 9).**

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*1. Are you taking any medications or prescription drugs? ☐ Yes ☐ No
If **Yes**, you must describe in full HERE.

_____
_____
_____
_____

*2. Has your doctor restricted you from performing certain activities? If **Yes**, you must describe in full in Remarks. ☐ Yes ☐ No

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*3. Do you have any condition that would...

3a. Interfere with your ability to evacuate a site during an emergency? If **Yes**, you must describe in full in Remarks. ☐ Yes ☐ No

3b. Make you prone to sudden incapacitation? If **Yes**, you must describe in full in Remarks. ☐ Yes ☐ No

3c. Be aggravated by significant exertion? If **Yes**, you must describe in full in Remarks. ☐ Yes ☐ No

3d. Interfere in any way with the full performance of emergency duties? If **Yes**, you must describe in full in Remarks. ☐ Yes ☐ No

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*4. Have you ever been denied deployment to emergency response operations due to medical condition? If **Yes**, you must describe in full in Remarks. ☐ Yes ☐ No

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*5. Have you ever been sent home from emergency response operations due to a medical condition? If **Yes**, you must describe in full in Remarks. ☐ Yes ☐ No

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*6. Are you currently pregnant? If **Yes**, you must include a medical release form from your obstetrician with this completed questionnaire to the USACE Medical Provider @ 202-223-6525 (Fax). ☐ Yes ☐ No

Section IV. Medical History

Please answer the following questions related to your past medical history and current medical conditions, if applicable.

*7. Do you have an active case of a communicable disease e.g. Tuberculosis, chicken pox? If **Yes**, you must describe in full in Remarks. ☐ Yes ☐ No

*8. Do you bleed excessively after injury or tooth extraction? If **Yes**, you must describe in full in Remarks. ☐ Yes ☐ No

*9. Do you wear a leg brace, back brace, back support, or any other type of brace? If **Yes**, you must describe in full in Remarks. ☐ Yes ☐ No

*10. Have you been told within the past year that you have an abnormal EKG? If **Yes**, you must describe in full in Remarks. ☐ Yes ☐ No

*11. Do you have swollen or painful joints? If **Yes**, you must describe in full in Remarks. ☐ Yes ☐ No

*12. Do you have dizziness or fainting spells? If **Yes**, you must describe in full in Remarks. ☐ Yes ☐ No

*13. Have you had an asthma attack within this past year? If **Yes**, you must describe in full. ☐ Yes ☐ No

*14. Have you ever been hospitalized for asthma? If **Yes**, you must describe in full in Remarks. ☐ Yes ☐ No

*15. Do you have shortness of breath? If **Yes**, you must describe in full in Remarks. ☐ Yes ☐ No

*16. Do you have pain or pressure in chest? If **Yes**, you must describe in full in Remarks. ☐ Yes ☐ No

*17. Do you have palpitations (flutter or pounding heart beat)? If **Yes**, you must describe in full in Remarks. ☐ Yes ☐ No

*18. Do you have high or low blood pressure? If **Yes**, Please answer 18a. ☐ Yes ☐ No

18a. If you do have high or low blood pressure, is it well controlled? If **No,** you must describe in full in Remarks.	☐ Yes	☐ No
*19. Do you have a history of heart attack or stroke? If **Yes**, you must describe in full in Remarks.	☐ Yes	☐ No
*20. Do you have cramps in your legs? If **Yes,** you must describe in full in Remarks.	☐ Yes	☐ No
*21. Have you been told that you have a hernia? If **Yes**, you must describe in full in Remarks.	☐ Yes	☐ No
*22. Do you have any life-threatening allergic reaction e.g. bee sting, shellfish or medications? If **Yes**, bring your Epi-pen with you on your deployment.	☐ Yes	☐ No
*23. Are you currently being treated for depression? If **Yes**, you must describe in full in Remarks.	☐ Yes	☐ No
*24. Are you currently suffering from depression or excessive worry? If **Yes**, you must describe in full in Remarks.	☐ Yes	☐ No
*25. Are you currently being treated for any current illness? If **Yes**, you must describe in full in Remarks.	☐ Yes	☐ No
*26. Have you been hospitalized or had surgery within the past year? If **Yes**, you must describe in full in Remarks.	☐ Yes	☐ No
*27. Are you currently using any medications that may make you sleepy or reduce your level of attention during working hours? If **Yes**, you must describe in full in Remarks.	☐ Yes	☐ No
*28. Are you currently using any medications that require refrigeration? If **Yes**, you must describe in full in Remarks.	☐ Yes	☐ No
*29. Are you diabetic? If **Yes**, please answer questions 29a & b	☐ Yes	☐ No

29a. Do you take insulin? If **Yes**, you must describe in full in Remarks. ☐ Yes ☐ No

29b. Do you take medication by mouth for elevated blood sugar? If **Yes**, you must describe in full in Remarks. ☐ Yes ☐ No

*30. Do you have any history of any seizure disorder? If **Yes**, please answer question 30a. ☐ Yes ☐ No

30a. Are your seizures controlled? If **No**, you must describe in full in Remarks. ☐ Yes ☐ No

*31. Are you taking Anticoagulants (blood thinner)? If **Yes**, you must describe in full in Remarks. ☐ Yes ☐ No

*32. Do you have migraines or severe headaches? If **Yes**, you must describe in full in Remarks. ☐ Yes ☐ No

*33. Do you have any gastrointestinal disorder or disease? If **Yes**, you must describe in full in Remarks. ☐ Yes ☐ No

Section V. Physical Capacity - OFFICE Work

Complete this section (Questions 34-50) only if you have selected to be cleared for Office-only deployments. If you have selected Field Deployment, skip this section and go to Section VI (Questions #51-75).

*34. Can you perform light lifting (up to 15 lbs.) associated with office tasks on a regular basis without pain? If **No**, you must describe in full in Remarks. ☐ Yes ☐ No

*35. Can you perform light carrying (up to 15 lbs.) associated with office tasks on a regular basis without pain? If **No**, you must describe in full in Remarks. ☐ Yes ☐ No

*36. Can you reach above your shoulders and work comfortably? If **No**, you must describe in full in Remarks. ☐ Yes ☐ No

*37. Can you use the fingers on both hands comfortably? If **No**, you must describe in full in Remarks. ☐ Yes ☐ No

*38. Can you walk/stand up to perform normal office functions on a daily basis without pain? If **No**, you must describe in full in Remarks. ☐ Yes ☐ No

*39. Can you kneel without pain? If **No**, you must describe in full in Remarks. ☐ Yes ☐ No

*40. Can you use your legs to climb up steps on a daily basis without pain? If **No**, you must describe in full in Remarks. ☐ Yes ☐ No

*41. **With or without the aid of corrective lenses**, are you able to read a typewritten letter at arms length? If **No**, you must describe in full in Remarks. ☐ Yes ☐ No

*42. **With or without the aid of corrective lenses,** is your vision at least 20/20 in one eye and at least 20/40 in the other? If **No**, you must describe in full in Remarks. ☐ Yes ☐ No

*43. **With or without the use of hearing aid(s)**, can you hear normal conversational speech? If **No**, you must describe in full in Remarks. ☐ Yes ☐ No

*44. Can you tolerate excessive heat and humidity (typical Florida summer weather)? If **No**, you must describe in full in Remarks. ☐ Yes ☐ No

*45. Can you tolerate excessive cold (temperatures less than 4 degrees C / 40 degrees F)? If **No**, you must describe in full in Remarks. ☐ Yes ☐ No

*46. Can you perform your normal job duties without fatigue? If **No**, you must describe in full in Remarks. ☐ Yes ☐ No

*47. Are you able to work closely with others under stressful conditions? If **No**, you must describe in full in Remarks. ☐ Yes ☐ No

*48. Are you able to work alone and away from your normal routine? If **No**, you must describe in full in Remarks. ☐ Yes ☐ No

*49. Are you able to work protracted or irregular hours away from your home? If **No**, you must describe in full in Remarks. ☐ Yes ☐ No

*50. Height_____ Weight:_____

Section VI. Physical Capacity – FIELD/OFFICE Work

Complete this section only if you have selected to be cleared for Field deployments, which may include Office work. This section must be completed if you intend to deploy OCONUS.

*51. Do you have complete use of your arms and legs? ☐ Yes ☐ No
If **No**, you must describe in full in Remarks.

*52. Can you perform light lifting (under 15 pounds) on a regular basis without pain? If **No**, you must describe in full in Remarks. ☐ Yes ☐ No

*53. Can you reach above your shoulders and work comfortably? If **No**, you must describe in full in Remarks. ☐ Yes ☐ No

*54. Can you reach below your knees and work comfortably? ☐ Yes ☐ No
If **No**, you must describe in full in Remarks.

*55. Can you use your fingers on both hands comfortably? ☐ Yes ☐ No
If **No**, you must describe in full in Remarks.

*56. Can you walk/stand up to four hours daily? ☐ Yes ☐ No
If **No**, you must describe in full in Remarks.

*57. Can you kneel without pain? If **No**, you must describe in full in Remarks. ☐ Yes ☐ No

*58. Can you use your legs only to climb (e.g. hills or steps) for up to 1 hour without pain? If **No**, you must describe in full in Remarks. ☐ Yes ☐ No

*59. Can you climb using your legs or arms to safely work on ladders or scaffolding? If **No**, you must describe in full in Remarks. ☐ Yes ☐ No

*60. Can you work at heights, below ground, or in confined spaces (tunnels/basements)? If **No**, you must describe in full in Remarks. ☐ Yes ☐ No

*61. Can you work in a noisy environment using hearing protection? If **No**, you must describe in full in Remarks. ☐ Yes ☐ No

*62. Can you work outside, exposed to the weather, nuisance dust and air pollutants? If **No**, you must describe in full in Remarks. ☐ Yes ☐ No

*63. Can you wear personal protective equipment such as respirators and protective clothing? If **No**, you must describe in full in Remarks. ☐ Yes ☐ No

*64. **With or without the aid of corrective lenses**, are you able to read a typewritten letter at arms length? If **No**, you must describe in full in Remarks. ☐ Yes ☐ No

*65. **With or without the aid of corrective lenses**, is your vision at least 20/20 in one eye and at least 20/40 in the other? If **No**, you must describe in full in Remarks. ☐ Yes ☐ No

*66. **With or without the use of hearing aid(s)**, can you hear normal conversational speech? If **No**, you must describe in full in Remarks. ☐ Yes ☐ No

*67. Can you tolerate excessive heat and humidity (typical Florida summer weather)? If **No**, you must describe in full in Remarks. ☐ Yes ☐ No

*68. Can you tolerate excessive cold (temperatures less than 4 degrees C / 40 degrees F)? If **No**, you must describe in full in Remarks. ☐ Yes ☐ No

*69. Can you perform your normal job duties without fatigue? If **No**, you must describe in full in Remarks. ☐ Yes ☐ No

*70. Are you able to work closely with others under stressful conditions? If **No**, you must describe in full in Remarks. ☐ Yes ☐ No

*71. Are you able to work alone and away from your normal routine? If **No**, you must describe in full in Remarks. ☐ Yes ☐ No

*72. Are you able to work protracted or irregular hours away from your home? If **No**, you must describe in full in Remarks. ☐ Yes ☐ No

*73. Do you have a current valid drivers license? If **No**, you must describe in full in Remarks. ☐ Yes ☐ No

*74. If **Yes** to # 73, does your license have any restrictions? If **Yes**, you must describe in full in Remarks. ☐ Yes ☐ No

*75. Height_____ Weight:_____

REMARKS

PLEASE INCLUDE ALL ADDITIONAL INFORMATION HERE

Question Number	Description

If you need more space use additional sheets of paper

SECTION VII. Employee Consent

PRIVACY ACT NOTICE: This information is provided in accordance with the requirements of the Privacy Act of 1974. (See AR 340-21.)

AUTHORITY: 5 USC 3301, 33 USC 701n, 42 USC 5121 et. Seq., E.O. 9397. System notices A0690-200TAPC, Army Civilian Personnel Systems; OPM Govt 1, General Personnel Records; OPM Govt 10, Employee Medical File System Records. Collection is also addressed in ER690-1-321, Staffing for Civilian Support to Emergency Operations. The purpose for collecting information in the Medical Data Sheet (MDS)is to allow the Medical provider to review your medical condition to ensure that you can perform the job tasks assigned while working long hours, under stressful and sometimes physically demanding conditions without jeopardizing your health. Emergency Managers will use the Medical provider clearance determination to assign tasks and manage staff during deployment to emergency events. Providing information in the MDS strictly voluntary. If you fail to provide the information the Medical provider will not be able to evaluate your medical condition and you may not be selected for deployment.

PURPOSE: The medical screening questionnaire, interviews, data obtained from tests, review of existing records and review by a medical professional is utilized to determine whether assigned or volunteer employees have any health problems that would prevent them from deployment to, or adversely impact their assigned duties at, emergency response sites. The medical information collected will be filed with other medical record information in the employee's medical file (EMF).

ROUTINE USE: Information may be shared with other Federal agencies such as OSHA and FEMA and state and local agencies for law enforcement, and occupational and/or public health purposes.

DISCLOSURE: Providing this information is voluntary. However, refusal to provide the information requested, including medical information and social security number, may result in the employee not being deployed to perform emergency response assignments at emergency response sites.

I certify that I have reviewed the information I have supplied, it is true and complete to the best of my knowledge, and that I have read the Privacy Act Notice assigned to the use of this information.

Write Name in Full

Sign Name in Full

Date

[END] MEDICAL SCREENING QUESTIONNAIRE

The section below is for USACE Medical Provider use only.

THRU: US Army Corps of Engineers, District/Division/FOA
ATTN: Emergency Operations Center

ADDRESS:
HQ, US Army Corps of Engineers GAO Building,
CSCW-HS-RAO
441 G Street, NW
Washington, DC 20314-1000

PHONE/FAX: 202-761-8548 & 0378

TO: CE-CW-HS-RAO

SUBJECT: Civil Emergency Physician Medical Clearance

1. Mr./Ms. _____ has been medically evaluated and:

a. ☐ is fit to deploy with a clearance code of:

b. ☐ is <u>not</u> fit to deploy.

This determination is based on a review of the completed medical screening questionnaire, follow-up with employee where determined necessary, and the anticipated work/environmental conditions described in the work-related and medical information sheet.

Comments to be entered by the USACE Medical Provider only.

2. Physician's Signature:

_____ _____
Signature Date

_____ _____
Printed Name Phone Number