Appendix C

Office of Attorney General
Medical Forms

SUBJECT: **REQUIRED MEDICAL EXAMINATIONS**
PA OAG, CRIMINAL LAW DIVISION
SPECIAL OPERATIONS GROUP

Dear Doctor:

The purpose of this medical examination is to obtain a medical clearance for the execution of high risk arrest and search warrants, surveillance, and other assignments as a Special Operations Group member. In addition to traditional law enforcement activities, the examinee will be required to use personal protective equipment for protection from chemical, gas, and fire exposure.

The personal protective equipment, work place, and environmental factors of concern are described below. Suggested guidelines for annual medical evaluation have been provided to your examining facility.

Protective Equipment - Will use goggles for eye protection, a full Nomex face mask, Nomex suit, Kevlar helmet, 100 lb. Level III protective vest and carry additional ammunition and equipment. May also be required to wear CN/CS gas mask (military issue), as well as, equipment for clandestine laboratory entry.

Type of Work - Includes pursuit, confrontation, control and arrest of suspects, which may involve strenuous physical activity; includes moderate to excessive exertion while wearing personal protective equipment with increased work of breathing, cardiovascular stress and heat load; includes responsibility for safety of others and responsiveness in rescue and emergency situations; includes a quarterly physical fitness test that consists of a 1.5 miles run, a 6 foot wall climb, a body transport, an agility run, and sit-ups; this will test the strength/short burst of energy output, ability to maneuver job related obstacles with minimal risk of injury (flexibility and coordination), ability to sustain required activities for extended periods of time (stamina and long term energy output), and overall physical conditioning. Also includes enormous hours of shooting firearms and distraction devices in an outdoor/indoor environment.

Work Setting - Work in uncontrolled, poorly ventilated makeshift laboratories with unidentified chemical processes in progress. Potential for fire, explosion, and chemical spills are likely. Potential for exposure to organic solvents, inorganic acids, and alkalis, cyanides, other drug precursors, unknown chemicals, reactants and by-products of chemical reactions to include gases, and controlled substances in solution or powdered form. Potential for contact with violent and armed suspects, as well as, subjects that have been exposed to contagious and transmittable diseases. Includes work outdoors and indoors in extremes of seasonal environmental temperatures and humidity. Prior acclimatization of hot environments is unlikely. Also includes climbing 16 foot ladders and unduly large series of steps in interior of buildings.

If you find the individual cleared for performing the duties described above, and able to wear respiratory personal protective equipment in accordance with 29 CFR 1910.134, please sign and date the certification below and forward it with the results of your examination and related health screening reports to the Office of Attorney General.

MEDICAL CERTIFICATION

I have examined_____on _____ and find the individual to be medically able to perform the duties described above without unusual medical risk or harm to the individual or others.

Physician's Signature: _____ Date: _____

Physician's Printed Name:

_____

SUBJECT: **REQUIRED MEDICAL EXAMINATIONS**
PA OAG, CRIMINAL LAW DIVISION
(ENVIRONMENTAL CRIMES SECTION, CLANDESTINE LABORATORY UNIT)

Dear Doctor:

The purpose of this medical examination is to obtain a medical clearance for the below-listed individual to perform his/her duties as an Agent with the Pennsylvania Office of Attorney General, Criminal Law Division. In addition to traditional law enforcement activities, the examinee will be required to use personal protective equipment for protection from potential chemical and/or hazardous material exposure, including the evaluation of illegal drug-manufacturing laboratories.

The personal protective equipment, work place and environmental factors of concern are described below. Suggested guidelines for the annual medical evaluation have been provided to your examining facility.

Protective Equipment: Employee will use a twin cartridge full face mask, air purifying MSA respirator, (Level C), which weighs approximately 3 pounds, and/or a MSA (pressure demand, open circuit) self-contained breathing apparatus, (Level B), which weighs approximately 25 pounds with a full 30-minute fully-wound composite II cylinder, and will use neoprene boots, chemically resistant gloves and a chemically resistant suit of Tyvex or Saranex.

The total number of times that either Level C or Level B protection is worn during the year varies, but an average would be between three (3) to five (5) times. The average length of time used for each level also varies, but normally the protection would be worn about 30 minutes per occurrence. The expected physical work effort required to do the job in the various levels of protection ranges from walking to using shovels to move ground. Temperature extremes can vary from near zero to the mid-90 degrees. Humidity, at times, can reach near 100%.

Type of Work: Includes pursuit, confrontation, control and arrest of suspects which may involve strenuous physical activity; includes light to moderate to possibly heavy exertion while wearing the personal protective equipment described above which may increase breathing, cardiovascular stress and heat load; includes responsibility for the safety of others and responsiveness in rescue and emergency situations.

Work Setting: Work can be in uncontrolled, poorly ventilated makeshift facilities/areas with unidentified chemical processes in progress. Potential for fire, explosion and chemical spills are likely. The potential exists for, but is not limited to, exposure to organic solvents, inorganic material, acids and alkalis, cyanides, hydrocarbons, precursors, unknown chemicals and materials, reactants and by-products of chemical processes and reactions to include gases, and controlled substances in solution or powdered form. Includes work indoors and outdoors in extremes of seasonal environmental temperatures and humidity. Prior acclimatization to hot or cold environments is unlikely.

If you find the individual cleared to wear respiratory personal protective equipment in accordance with 29 CFR 1910.134 and able to perform the duties described above, please sign and date the certification below and forward it with the results of your examination and related health screening reports to the Office of Attorney General.

MEDICAL CERTIFICATION

I have examined _____on _____ and find the individual to be medically able to perform the duties described above without unusual medical risk or harm to the individual or others.

Physician's Signature: _____ Date: _____

Physician's Printed Name: _____

SUBJECT: **REQUIRED MEDICAL EXAMINATIONS**
PA OAG, CRIMINAL LAW DIVISION
(EVIDENCE CUSTODIANS)

Dear Doctor:

The purpose of this medical examination is to obtain a medical clearance for the below-listed individual to perform his/her duties as an Evidence Custodian with the Pennsylvania Office of Attorney General, Criminal Law Division.

The work place and environmental factors of concern are described below. Suggested guidelines for the annual medical evaluation have been provided to your examining facility.

Type of Work: In the course of official duties handles, packages, labels and stores controlled substances, drug paraphernalia, containers, firearms, ammunitions, knives, clothing, documents and other evidentiary items. The investigator maintains the inventory of evidentiary items. In addition, the investigator transports the subject items to and from a forensic laboratory and to a destruction facility. The size and weight of the items varies. Suggested guidelines for the annual medical evaluation have been provided to your examining facility

Work Setting: Maintains custody of the subject items in an interior evidence room that is ventilated. The potential for exposure to controlled substances, drug paraphernalia, glassware, firearms, ammunition, sharp objects, unknown substances/chemicals in various solids, liquids, powder/granular, plants/leaves/seeds in various storage containers and packages that are capable of releasing vapors is present.

If you find the individual cleared for performing the duties described above, please sign and date the certification below and forward it with the results of your examination and related health screening reports to the Office of Attorney General.

MEDICAL CERTIFICATION

I have examined _____on _____ and find the individual to be medically able to perform the duties described above without unusual medical risk or harm to the individual or others.

Physician's Signature: _____ Date: _____

Physician's Printed Name: _____

APPENDIX F

Respirator Medical Evaluation Questionnaire

Part A. Section 1. (Mandatory) Every employee who has been selected to use any type of respirator (please print) must provide the following information.

Today's date _____ Date of Birth: _____

Name _____ SSN: _____

Job Title _____ Sex: Male ◯ Female ◯

Home Phone: _____ Height: ____ (ft) ____ (in) Weight ____ (lbs)

Work Phone: _____

Can you read English? . . . . . Yes ◯ NO ◯

Has your employer told you how to contact the health care professional who will review this? Yes ◯ NO ◯

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

☐ Half-face ☐ Powered-air purifier

☐ Full-facepiece type (includes gas mask) ☐ Supplied-air

☐ Self-contained breathing apparatus

Have you worn a respirator in the past?: . . . . . Yes ◯ NO ◯

If ``yes,'' what type(s): _____

Physical exertion while wearing a respirator ☐ Mild ☐ Moderate ☐ Strenuous

Maximum time you wear a respirator in a single day?: ____ hours

Do you exercise? . . . . . Yes ◯ NO ◯

If ``yes,' describe how often and what exercise activities are: _____

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 select ``yes'' or ``no'').

1. Do you currently smoke tobacco, or have you smoked tobacco in the last month? Yes ◯ NO ◯

If Yes, how many packs per day? ☐ 1/2 or less ☐ 1 ☐ 2 ☐ 2 or more

How many years have you smoked? ☐ 1-9 ☐ 10-19 ☐ 20-29 ☐ 30 or more

2. Have you ever had any of the following conditions?

Seizures (fits) Yes ◯ NO ◯

Diabetes (sugar disease) Yes ◯ NO ◯

Allergic reactions that interfere with your breathing Yes ◯ NO ◯

Claustrophobia (fear of closed-in places) Yes ◯ NO ◯

Trouble smelling odors Yes ◯ NO ◯

3. Have you ever had any of the following pulmonary or lung problems?

Asbestosis Yes ◯ NO ◯

Asthma Yes ◯ NO ◯

Chronic bronchitis: Yes ◯ NO ◯

Emphysema: Yes ◯ NO ◯

Pneumonia Yes ◯ NO ◯

Tuberculosis Yes ◯ NO ◯

Silicosis Yes ◯ NO ◯

Pneumothorax (collapsed lung) Yes ◯ NO ◯

Lung cancer Yes ◯ NO ◯

Broken ribs: Yes ◯ NO ◯

Any chest injuries or surgeries: Yes ◯ NO ◯

Any other lung problem that you've been told about: Yes ◯ NO ◯

Name _____

4. Do you currently have any of the following symptoms of pulmonary or lung illness?

Shortness of breath:	Yes ◯ NO ◯
Shortness of breath when walking fast on level ground or walking up a slight hill/incline	Yes ◯ NO ◯
Shortness of breath when walking with other people at an ordinary pace on level ground:	Yes ◯ NO ◯
Have to stop for breath when walking at your own pace on level ground:	Yes ◯ NO ◯
Shortness of breath when washing or dressing yourself:	Yes ◯ NO ◯
Shortness of breath that interferes with your job:	Yes ◯ NO ◯
Coughing that produces phlegm (thick sputum):	Yes ◯ NO ◯
Coughing that wakes you early in the morning:	Yes ◯ NO ◯
Coughing that occurs mostly when you are lying down:	Yes ◯ NO ◯
Coughing up blood in the last month:	Yes ◯ NO ◯
Wheezing:	Yes ◯ NO ◯
Wheezing that interferes with your job:	Yes ◯ NO ◯
Chest pain when you breathe deeply:	Yes ◯ NO ◯
Any other symptoms that you think may be related to lung	Yes ◯ NO ◯

5. Have you ever had any of the following cardiovascular or heart problems?

Heart attack	Yes ◯ NO ◯
Stroke:	Yes ◯ NO ◯
Angina:	Yes ◯ NO ◯
Heart Failure:	Yes ◯ NO ◯
Swelling in your legs or feet (not caused by walking):	Yes ◯ NO ◯
Heart arrhythmia (heart beating irregularly):	Yes ◯ NO ◯
High blood pressure:	Yes ◯ NO ◯
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?

Frequent pain or tightness in your chest :	Yes ◯ NO ◯
Pain or tightness in your chest during physical activity	Yes ◯ NO ◯
Pain or tightness in your chest that interferes with your job	Yes ◯ NO ◯
In the past two years, have you noticed your heart skipping or missing a beat :	Yes ◯ NO ◯
Heartburn or symptoms that is not related to eating	Yes ◯ NO ◯
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?

Breathing or lung problems:	Yes ◯ NO ◯
Heart trouble:	Yes ◯ NO ◯
Blood Pressure:	Yes ◯ NO ◯
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 the following space and go to question 9)

Eye irritation:	Yes ◯ NO ◯
Skin allergies or rashes:	Yes ◯ NO ◯
Anxiety:	Yes ◯ NO ◯
General weakness or fatigue:	Yes ◯ NO ◯
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 ◯

Name _____

SUPPLEMENTAL: If you are required to use a full-face peice respirator or a Self-Contained Breathing Aparatus (SCBA), complete the following: (If you do not, please sign below.)

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?

- Wear glasses: Yes ◯ NO ◯
- Wear contact lenses: Yes ◯ NO ◯
- Color blind: Yes ◯ NO ◯
- 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?

- Difficulty hearing: Yes ◯ NO ◯
- Wear a hearing aid: Yes ◯ NO ◯
- 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?

- Weakness in any of your arms, hands, legs, or feet: Yes ◯ NO ◯
- Back pain: Yes ◯ NO ◯
- Difficulty fully moving your arms and legs: Yes ◯ NO ◯
- Pain or stiffness when you lean forward or backward at the waist: Yes ◯ NO ◯
- Difficulty fully moving your head up or down: Yes ◯ NO ◯
- Difficulty fully moving your head side to side: Yes ◯ NO ◯
- Difficulty bending at your knees: Yes ◯ NO ◯
- Difficulty squatting to the ground: Yes ◯ NO ◯
- Climbing a flight of stairs or a ladder carrying more than 25 lbs: Yes ◯ NO ◯
- Any other muscle or skeletal problem that interferes with using a respirator: Yes ◯ NO ◯

Any additional comments you would like to make:

_____

To the best of my knowledge, the information I have provided is true and accurate.

Employee Signature _____ **Date** _____

TO BE COMPLETED BY THE EXAMINER/REVIEWER:

This employee has been found to be physically able to use the following (check each [ ] that applies):

- ☐ Single use, filter mask (four attachment points)
- ☐ Half-faced cartridge-type, negative pressure
- ☐ Full-faced cartridge-type respirator, negative pressure
- ☐ Half-faced powered cartridge-type (PAPR)
- ☐ Full-faced powered cartridge-type (PAPR)
- ☐ Self-contained breathing apparatus (SCBA)
- ☐ Hood/helmet powered cartridge-type (PAPR)
- ☐ Half-faced/Full-faced/Hood/Helmet (NOT positive pressure)

Restrictions / Limitations (if any) when wearing a respirator:

_____

- ☐ ***This employee has been found to be physically NOT able to use a respirator***
- ☐ ***There is insufficient information to make a determination at this time***
- ☐ ***The mandatory questionnaire has been reviewed, and the employee has been found to be physically able to use a respirator.***
- ☐ ***The mandatory questionnaire has been reviewed but there is insufficient information to make a determination at this time.***

This respirator clearance expires 1 ◯ 2 ◯ 3 ◯ years from the date below. (*If not marked, clearance expires in 1 year*)

Reviewer's Name (Print) _____ **Reviewer's Signature** _____ **Date:** _____