Comprehensive Health Services, Inc.
Attn: WLFF Client Service Administrator
8229 Boone Blvd., Suite 700
Vienna, VA 22182
Phone: (866) 416-5941 Fax: (703) 288-5482

Federal Interagency Annual Medical History and Rating Form
Wildland Firefighters (Arduous Duty)

Servicing Human Resources Officer (SHRO) or Fire Management Officer (FMO) : On a computer generated label or typewriter, enter the SHRO's and FMO's name, street address, city, state, zip code, telephone number and e-mail address in the space provided below:

Servicing Human Resources Officer (SHRO):	**Fire Management Officer (FMO):**
Name: _____	Name: _____
Street Address: _____	Street Address: _____
City, State, Zip: _____	City, State, Zip: _____
Telephone Number: _____	Telephone Number: _____
E-mail: _____	E-mail: _____

Firefighter:

- Complete ALL medical history questions on pages 2 through 6 of this form and attend the medical exam.
- All "Yes" answers in the medical history section must be explained, including dates, treatments and current status.
- Your signature is required on page 2. Failure to sign will result in a delay of rating determination.
- Return the "Arduous Duty Wildland Firefighter Rating Form" (page 9) to your FMO. (If the FMO does not receive the "Arduous Duty Wildland Firefighter Rating Form" you will not be allowed to perform arduous firefighter duties. In addition, you will be unable to take the Pack Test until you are cleared for arduous firefighter duties.)

Local Health Care Professional:

- Review the requirements for an arduous duty wildland firefighter (pages 7 and 10).
- Review the firefighter's medical history responses on pages 2 through 6 and provide comments regarding all "yes" answers. These comments should include dates and current status.
- Complete the "Medical Screening" exam and the "Exam Summary" on page 8 and the "Arduous Duty Wildland Firefighter Rating Form" on page 9.
- Fax pages 1 through 9 of this form to CHS (Fax 703-288-5482) and retain the original exam form for your records.
- Give the completed "Arduous Duty Wildland Firefighter Rating Form" (page 9) to the firefighter.
- All significant abnormal findings are to be discussed with the firefighter.
- Additional testing will NOT be covered under this program and must be paid for by the firefighter.

PRIVACY ACT INFORMATION

The information contained in this form will be used to determine whether an individual considered for arduous level wildland firefighting can safely and efficiently perform those duties in a manner that will not unduly risk aggravation, acceleration, exaggeration, or permanent worsening of a pre-existing medical condition. Its collection and use are consistent with the provisions of the 5 CFR 339 (Medical Qualification Determinations), 5 USC 552a (Privacy Act of 1974), 5 USC 3301 (Examination, Certification, and Appointment), and Executive Orders 12107 (Merit Systems Protection Board) and 12564 (Drug Free Federal Workplace). The information will be placed in your official Employee Medical File, and is to be used only for official purposes as explained and published annually in the Federal Register under OPM/GOVT-10, the OPM system of records notice.

Federal Interagency Annual Medical History and Rating Form
Wildland Firefighters (Arduous Duty)

Firefighter's Name: User Test	**SSN:** ***-**-0071
Name of Employing Agency:	**Date of Birth:** 02/20/1970
Position/Job Title:	**Gender:** ☑ Male ☐ Female
Home Address: 123 Main St	**Date of Last Physical Exam:**
City, State, Zip: Vienna, VA 22182	

Home Phone: (301) 555-1212	**Work Phone:**	**Cell Phone:**

Incomplete forms or missing information will result in a delay clearing you for arduous firefighter duties. Submitting information that is misleading or untruthful may result in termination, criminal sanctions, or failure to be cleared as a firefighter.

I understand that this history form and review do not substitute for routine health care or a periodic health examination conducted by my physician and that it is being conducted for occupational purposes only. I certify that all of the information I have provided on this form is complete and accurate to the best of my knowledge. I authorize release of information within this form to the Interagency Medical Standards Program Manager or their representatives for the purpose of medical clearance as an arduous duty wildland firefighter.

Firefighter's Signature: _____ **Date signed:** _____

Your signature is REQUIRED. Failure to sign will result in a delay of rating determination.

Answer all questions below. If you answer "yes" to any question(s), please provide all the requested information asked for in the "yes" box. Note: Missing information will result in a delay clearing you for arduous wildland firefighter duties.

MEDICAL HISTORY

1. Do you currently take any medications (prescribed and/or over-the-counter, including herbal)?	☐ No	☐ Yes (list all medications, prescribed and over-the-counter, including herbal) Name — Reason For Taking
2. Are you allergic to bee/wasp/hornet/ fire ant/yellow jacket stings?	☐ No	☐ Yes Check any of the reactions you have had: ☐ large amount of swelling at sting site only ☐ swelling or itching at site(s) other than site of sting, i.e. if stung on arm, swelling or itching has occurred somewhere other than on arm ☐ hives ☐ anaphylactic shock ☐ blood pressure problems ☐ difficulty breathing Explain in detail any positive response marked above: _____ _____ Have you ever been advised by a physician to carry an EpiPen for yourself? ☐ No ☐ Yes Do you carry an EpiPen for yourself? ☐ No ☐ Yes
3. Do you have any other allergies?	☐ No	☐ Yes List and describe reaction(s):

4.	Have you undergone treatment by doctors, healers, or other practitioners for any problem or illness within the past year?	☐ No	☐ Yes Reason / Date / Current Status 1. 2. 3.
5.	Have you had surgery or been advised to have surgery within the past year?	☐ No	☐ Yes Reason / Date / Current Status 1. 2.
6.	Treatment for a mental or emotional condition?	☐ No	☐ Yes Diagnosis: _____ Date(s): _____ Is this a current problem? ☐ No ☐ Yes Details:
7.	Diagnosed with or treated for alcoholism or alcohol dependence?	☐ No	☐ Yes Have you ever been in rehabilitation? ☐ No ☐ Yes If yes, when? _____ Details:
8.	Diagnosed or treated for drug dependence or abuse?	☐ No	☐ Yes Have you ever been in rehabilitation? ☐ No ☐ Yes If yes, when? _____ Details:
9.	Have you ever had any type of eye disease (cataracts, glaucoma, retinopathy, macular degeneration, detached retina, eye muscle surgery, etc)?	☐ No	☐ Yes Diagnosis: _____ Date(s): _____ Is this a current problem? ☐ No ☐ Yes Details:
10.	Do you wear corrective lenses?	☐ No	☐ Yes Type used during firefighting: / Reason: ☐ Glasses ☐ For seeing far ☐ Soft Contacts ☐ For seeing close up ☐ Hard Contacts ☐ Both ☐ Other _____
11.	Have you had surgery to correct your vision (LASIK, PRK, RK, etc.)?	☐ No	☐ Yes Date: _____
12.	Do you have any type of ear disease or hearing loss?	☐ No	☐ Yes Diagnosis: _____ Do you have difficulty hearing? ☐ No ☐ Yes Do you wear a hearing aid(s)? ☐ No ☐ Yes Details:
13.	Do you have any type of skin disease (other than acne)?	☐ No	☐ Yes Diagnosis: _____ Details:
14.	Have you ever had a blood clot in a vein or in your lungs?	☐ No	☐ Yes Diagnosis and location of clot: _____ Date: _____
15.	Do you currently have anemia?	☐ No	☐ Yes What type of anemia? _____ Any treatment? ☐ No ☐ Yes Type of treatment: _____
16.	Do you have high blood pressure?	☐ No	☐ Yes
17.	Have you ever had a stroke or TIA?	☐ No	☐ Yes Date: _____

18. Have you ever seen a doctor for poor circulation in your hands or feet?	☐ No	☐ Yes Explain and give date(s): _____
19. Have you ever had a heart attack, angioplasty or heart bypass surgery?	☐ No	☐ Yes Which of the three have you had? _____ Date(s): _____
20. Have you had chest pain or angina during the past year?	☐ No	☐ Yes Date(s): _____ Did you see a doctor about the pain? ☐ No ☐ Yes What tests were done? (Give results) _____ Diagnosis: _____ Treatment: _____
21. Have you ever had an irregular heart beat, skipped beats, or palpitations?	☐ No	☐ Yes Date(s): _____ How many times over the past year has this occurred? _____ Have you seen a doctor about them? ☐ No ☐ Yes Type of palpitations: _____ Test(s) done: _____ Treatment: _____ Have you ever passed out due to an irregular heart beat? ☐ No ☐ Yes
22. Do you have a heart murmur?	☐ No	☐ Yes Date diagnosed: _____ Cause of the murmur: _____
23. Ha[illegible] you[illegible]er pa[illegible]ed ou[illegible]fainted, or co[illegible]ious[illegible]s?	☐ [illegible]	☐ Yes D[illegible](s): _____ Details
24. Do you now, or have you ever had, any type of heart problem not mentioned above (heart valve problem, heart block, pacemaker, implanted defibrillator, Wolf-Parkinson-White syndrome, heart surgery, etc.)?	☐ No	☐ Yes Diagnosis: _____ Date(s): _____ Is this a current problem? ☐ No ☐ Yes Details:
25. Have you ever had asthma?	☐ No	☐ Yes Date diagnosed: _____ Date of last asthma attack: _____ Do you use an inhaler? ☐ No ☐ Yes If yes, list name(s) of inhaler(s) AND how many times per week you use each inhaler: _____ Have you ever been hospitalized or been to the emergency room or doctor's office because of an asthma attack? ☐ No ☐ Yes (give dates) _____ Does smoke, dust, or exercise trigger your asthma? ☐ No ☐ Yes (explain) _____
26. Do you have any type of lung disease other than asthma (reactive airway disease, emphysema, COPD, sleep apnea, etc.)?	☐ No	☐ Yes Diagnosis: _____ Current status: _____ Have you ever used an inhaler within the past 2 years? ☐ No ☐ Yes (give dates, name(s) of inhalers and frequency of use) _____

27. Have you ever had a positive PPD (TB) skin test or tuberculosis?	☐ No	☐ Yes Specify ☐ Positive PPD only ☐ Diagnosed with tuberculosis Date: _____ Did you receive any treatment? ☐ No ☐ Yes (explain with dates) _____ Was a chest x-ray done? ☐ No ☐ Yes (explain with dates) _____
28. Do you have any problems with dizziness or balance?	☐ No	☐ Yes Explain and give date(s): _____
29. Do you have a tremor or shakiness?	☐ No	☐ Yes Explain and give date(s): _____
30. Do you have any numbness in your hands or feet?	☐ No	☐ Yes Explain and give date(s): _____
31. Do you have migraines or severe headaches?	☐ No	☐ Yes Diagnosis: _____ Number of headaches/migraines per month: _____ When you have a headache, does it limit your work activities? ☐ No ☐ Yes (explain) _____
32. Have you ever had a seizure?	☐ No	☐ Yes Type of seizure: _____ Date of last seizure: _____
33. Do you have diabetes?	☐ No	☐ Yes Do you take insulin? ☐ No ☐ Yes Do you take pills for diabetes? ☐ No ☐ Yes Average blood sugar reading: _____ Most recent Hgb A1c result and test date: _____ Any episodes of low blood sugar in the last 2 years? ☐ No ☐ Yes (explain with dates) _____ Any heart disease, kidney disease, eye disease, or neuropathy due to diabetes? ☐ No ☐ Yes (explain with dates) _____
34. Do you have any thyroid disease?	☐ No	☐ Yes Type of thyroid disease: _____ Current status: _____
35. Have you ever had any type of stomach or intestinal disease?	☐ No	☐ Yes Diagnosis: _____ Date(s): _____ Current status: _____
36. Do you currently have a hernia?	☐ No	☐ Yes Type of hernia: ☐ Inguinal (groin) ☐ Umbilical ☐ Other _____ Is surgery planned or recommended? ☐ No ☐ Yes

37. Have you ever had hepatitis?	☐ No	☐ Yes Type of hepatitis: ☐ Type A ☐ Type B ☐ Type C ☐ Other (explain) _____ Date: _____ Current status: _____
38. Have you ever had any other type of liver disease?	☐ No	☐ Yes Diagnosis: _____ Date(s): _____ Current status: _____
39. Have you ever had any blood in the stool or vomited blood?	☐ No	☐ Yes Explain and give date(s): _____
40. Do you have any type of kidney or bladder disease?	☐ No	☐ Yes Diagnosis: _____ Date(s): _____ Current status: _____
41. Do you get back or neck pain?	☐ No	☐ Yes Location: ☐ lower back ☐ upper back ☐ neck Number of episodes over the last year: _____ Date of last episode: _____ Current status: _____ Any numbness or weakness in legs or arms? ☐ No ☐ Yes (explain) _____ When you get pain, does it limit your work activities? ☐ No ☐ Yes (explain) _____
42. Do you get joint pain?	☐ No	☐ Yes Which joint(s)? _____ Diagnosis: _____ Frequency of pain: _____ Current status: _____ Does the pain limit your work activities? ☐ No ☐ Yes (explain) _____
43. Do you have any amputations or are you unable to use any arm, leg, finger or toe?	☐ No	☐ Yes Explain and give date: _____ Does this loss limit your work activities? ☐ No ☐ Yes (explain) _____
44. Do you have any medical condition not listed elsewhere on this questionnaire?	☐ No	☐ Yes Explain with date(s) and current status:

45. Tobacco History: This information is needed since tobacco use increases your risk for many diseases including cancer, lung disease and heart disease. Please mark the appropriate box:

☐ Currently use tobacco:
cigarettes/day _____
other tobacco products/day _____
Total years of tobacco use _____

☐ Formerly used tobacco:
cigarettes/day _____
other tobacco products/day _____
Total years of tobacco use _____

☐ Never used tobacco

46. Physical Activity

Intensity: ☐ Low (walking, etc) ☐ Moderate (jogging, cycling, etc) ☐ High (strenuous exercise such as running, etc)
Duration in Minutes per Session: _____ Frequency in Days per Week: _____

47. Tetanus Booster
Date of Last Tetanus (Td) Booster: ☐ Within 10 Years ☐ More than 10 years ☐ I don't remember
(NOTE: Tetanus booster is recommended every 10 years. Should you elect to have this updated at the time of your exam, you are responsible for the payment.)

EXAMINER COMMENTS

EXAMINER MUST PROVIDE COMMENTS REGARDING ALL "YES" ANSWERS FOR MEDICAL HISTORY QUESTIONS 1-44.

Please be sure that date(s) and current status are documented.

(If additional space is needed, please insert another page.)

Question #	Comments

ESSENTIAL FUNCTIONS AND WORK CONDITIONS OF AN ARDUOUS DUTY WILDLAND FIREFIGHTER

Time/Work Volume	Physical Requirements	Environment	Physical Exposures
May Include			
❁ Long hours (minimum of 12-hour shifts) ❁ Irregular hours ❁ Shift work ❁ Time zone changes ❁ Multiple and consecutive assignments ❁ Pace of work typically set by emergency situations ❁ Ability to meet "arduous" level performance testing (the Pack Test), which includes carrying a 45 lb pack 3 miles in 45 minutes, approximating an oxygen consumption (VO2 max) of 45 mL/kg-minute ❁ Typically 14-day assignments but may extend up to 21-day assignments	❁ Use shovel, Pulaski and other hand tools to construct fire lines ❁ Lift and carry more than 50 pounds ❁ Lifting or loading boxes and equipment ❁ Drive or ride for many hours ❁ Fly in helicopters and fixed wing airplanes ❁ Work independently, and on small and large teams ❁ Use PPE (includes hard hat, boots, eyewear, and other equipment) ❁ Arduous exertion ❁ Extensive walking, climbing, kneeling, stooping, pulling hoses, running, jumping, twisting and bending ❁ Rapid pull-out to safety zones ❁ Provide rescue or evacuation assistance ❁ Use of a fire shelter	❁ Very steep terrain ❁ Rocky, loose or muddy ground surfaces ❁ Thick vegetation ❁ Down/standing trees ❁ Wet leaves/grasses ❁ Varied climates (cold/ hot/ wet/ dry/ humid/ snow/ rain) ❁ Varied light conditions, including dim light or darkness ❁ High altitudes ❁ Heights ❁ Holes and drop-offs ❁ Very rough roads ❁ Open bodies of water ❁ Isolated/ remote sites ❁ No ready access to medical help	❁ Light (bright sunshine/UV) ❁ Burning materials ❁ Extreme heat ❁ Airborne particulates ❁ Fumes, gases ❁ Falling rocks and trees ❁ Allergens ❁ Loud noises ❁ Snakes ❁ Insects/ticks ❁ Poisonous plants ❁ Trucks and other large equipment ❁ Close quarters, large number of other workers ❁ Limited/disrupted sleep ❁ Hunger/irregular meals ❁ Dehydration

MEDICAL SCREENING (To Be Completed By The Exam Facility)

VITAL SIGNS

1. Height: _____ inches Weight: _____ pounds

2. Blood Pressure: _____/_____

Repeat after 5-10 minutes if first blood pressure is greater than 140/90: _____/_____

3. Pulse: _____ beats/minute ☐ Regular ☐ Irregular

Repeat after 5-10 minutes if first pulse is greater than 100 or less than 50: _____beats/minute

HEARING

4. Heard?

	Yes	No
Right whisper	☐	☐
Left whisper	☐	☐
Right spoken	☐	☐
Left spoken	☐	☐

☐ If the examinee wears hearing aids, please check here to verify that hearing test was done without hearing aid(s)

Note: Hearing tests are done at 1 foot from ear (opposite ear should be covered)

VISION

5. **Uncorrected** Distance Vision (This must be done on all examinees except those who wear soft contacts.)

Right: 20/_____ Left: 20/_____

6. **Corrected** Distance Vision (This must be done on all examinees who wear glasses or contacts for distance vision.)

Right: 20/_____ Left: 20/_____

7. Color Vision:

	Yes	No
Can see: Red	☐	☐
Green	☐	☐
Yellow	☐	☐

EXAM SUMMARY (This Must Be Completed By Examiner)

1.	Was blood pressure greater than 140/90? (If two blood pressures were taken, was both greater than 140/90?)	☐ YES	☐ NO
2.	Did the examinee fail the whisper test in either ear?	☐ YES	☐ NO
3.	Did the examinee fail to distinguish red/green/yellow?	☐ YES	☐ NO
4.	Was distance visual acuity (uncorrected distance vision for those who do not wear corrective lenses and corrected distance vision for those who wear corrective lenses) worse than 20/40 in either eye?	☐ YES	☐ NO
5.	Are any of the medical history questions 1-44 not answered?	☐ YES	☐ NO
6.	Are there any medical history questions 1-44 which were answered "yes", that do not have an explanation, including a date(s) and current status?	☐ YES	☐ NO
7.	Is the firefighter's signature missing from page 2 or the examiner's signature missing from pages 8 or 9?	☐ YES	☐ NO

Does the examinee have any of the following?

8.	Coronary artery disease or other cardiac disease	☐ YES	☐ NO
9.	Diabetes	☐ YES	☐ NO
10.	Asthma requiring the use of 2 medications OR requiring the use of rescue inhalers more frequently than once a week OR for which he/she has ever been hospitalized as an adult OR which is triggered by smoke, dust or exercise	☐ YES	☐ NO
11.	Stinging insect allergy which requires carrying EpiPen OR with any systemic reaction or hives	☐ YES	☐ NO
12.	History of seizures	☐ YES	☐ NO
13.	Any limitations or restrictions due to a musculoskeletal condition	☐ YES	☐ NO
14.	Has the examinee had LASIK eye surgery within the last 3 months OR RK eye surgery within the past 6 months?	☐ YES	☐ NO
15.	Does the examinee have any condition that might prevent him/her from safely being able to perform the essential functions of an arduous duty wildland firefighter (see functional requirements on page 7)?	☐ YES	☐ NO
16.	Does the examinee have any medical condition for which further information is needed before a decision can be made regarding whether or not he/she can safely perform the essential functions of an arduous duty wildland firefighter?	☐ YES	☐ NO
17.	Does the examinee wear glasses or hard contacts AND have uncorrected distance vision worse than 20/100 in either eye?	☐ YES	☐ NO

EXAMINER CONCLUSIONS:

Based on the Exam Summary above, the rating for this examinee is:

☐ **A.** **Answers to all 17 questions above are "NO" (Cleared)**

☐ **B.** **Answers to 1-16 are "NO" AND answer to 17 is "YES" (Cleared but needs to carry a second pair of glasses)**

☐ **FE** **Answer is "YES" to any of questions 1-16 (Further Evaluation Needed)**

Examiner Printed Name	**Signature**	**Date**
Street Address (print)	**City, State, ZIP (print)**	**Telephone Number**

ARDUOUS DUTY WILDLAND FIREFIGHTER RATING FORM

Rating may be changed after review by Interagency CMC. SHRO/FMO will be notified if any change occurs.

Local Health Care Professional: Complete the information required below, then detach and provide this page to the firefighter at the end of the medical screening. The rating on this page must be the same as the rating you have listed on page 8.
Firefighter: You must return this page to the Fire Management Officer.

Firefighter Name: **User Test**

Agency, Unit and Location: BLM NVSTL

EXAM NE C NCL SIONS (e rati on th page ust be th ame as t ratin on e p vio page):

Based n th xa Sum ary, the rati fo his ex ninee :

☐ **A. Cleared** (Employee is cleared for arduous duty wildland firefighting and the Pack Test.)

☐ **B. Cleared, but needs to carry a second pair of glasses**

☐ **Further Evaluation Needed** (Comprehensive Health Services, Inc. will contact the firefighter for further information before a determination for arduous duty wildland firefighting is provided.)

Examiner Printed Name	**Signature**	**Date**
Address (Print Only)	**License/Certification Number**	**License/Certification State**
City, State, and Zip (Print Only)		**Telephone Number**

Medical Standards for Wildland Firefighter Arduous Duty

System	Standard
Psychiatric	Must have judgement, mental functioning and social interaction that will provide for the safe and efficient conduct of the job requirements.
Vision	Uncorrected far visual acuity at least 20/100 in each eye for those who wear hard contacts or glasses; far visual acuity of at least 20/40 each eye corrected (if necessary) with contact lenses or glasses; color vision sufficient to distinguish red, green and amber (yellow); no ophthalmologic condition that would increase ophthalmic sensitivity to bright light, fumes, airborne particles, or susceptibility to sudden incapacitation. Note: Successful users of soft contact lenses are not required to meet the "uncorrected" vision guideline.
Hearing	Whisper at about 30 dB must be heard in each ear.
HEENT	Normal conversational speech. No evidence by medical history of head, nose, mouth, throat, or neck conditions likely to present a safety risk or to worsen as a result of carrying out the essential functions of the job.
Dermatology	No evidence by medical history of dermatologic conditions likely to present a safety risk or to worsen as a result of carrying out the essential functions of the job.
Vascular	No current evidence of phlebitis, thrombosis, venous stasis or arterial insufficiency. No evidence by medical history of peripheral vasculature conditions likely to present a safety risk or to worsen as a result of carrying out the essential functions of the job.
Cardiac	No evidence by medical history that the cardiovascular system is outside the range of normal. Blood pressure must be less than or equal to 140 mmHg systolic and 90 mmHg diastolic.
Gastrointestinal	No evidence by medical history of gastrointestinal conditions likely to present a safety risk or to worsen as a result of carrying out the essential functions of the job.
Genito[illegible]nary	No evidence by medical history genitourinary conditions likely present safety risk or to worsen as a result of carrying out the essential functions of the job.
Endocrine	No evidence by medical history of endocrine conditions likely to present a safety risk or to worsen as a result of carrying out the essential functions of the job.
Nervous and Vestibular	Normal mental status. No evidence by medical history of nervous, cerebellar, or vestibular system conditions likely to present a safety risk or to worsen as a result of carrying out the essential functions of the job.
Chest/Respiratory	No evidence by medical history of respiratory conditions likely to present a safety risk or to worsen as a result of carrying out the essential functions of the job. Note: The requirement to use an inhaler (such as for asthma) requires agency review.
Immune/Allergic	No evidence by medical history of infectious disease, immune system disorder, or allergic conditions likely to present a safety risk or to worsen as a result of carrying out the essential functions of the job.
Hematopoietic	No evidence by medical history of hematopoietic conditions likely to present a safety risk or to worsen as a result of carrying out the essential functions of the job.
Musculoskeletal	No medical history or obvious evidence of decreased strength, flexibility or range of motion, or joint instability. No musculoskeletal conditions likely to present a safety risk or to worsen as a result of carrying out the essential functions of the job
Prosthetics; Transplants; Implants	No evidence by medical history that the transplant, prosthesis, implant, or conditions that led to the need for these treatments are likely to present a safety risk or to worsen as a result of carrying out the essential functions of the job. Note: For individuals with transplants, prosthetics or implanted pumps or electrical devices, the firefighter will need to provide documentation that the individual (and, if applicable, his/her prosthetic or implanted device) is considered fully cleared for the specified functional requirements of wildland firefighting.
Medication	The need for and use of prescribed or over-the-counter medications are not of themselves disqualifying. However, there must be no medical history of any impairment of body function, mental function or attention due to medications that are likely to present a safety risk or worsen as a result of carrying out the specified functional requirements.

Further information regarding the Medical Standards for Wildland Firefighter Arduous Duty can be found at:

http://www.nifc.gov/medical_standards/resources/medstand_review-criteria.pdf