

## County Finance PCF Sign UP Procedure

1. Application packet is submitted to County Finance - NOTE : EMQ must be in a sealed envelope marked "CONFIDENTIAL" with PCF's name on the outside.
2. County Finance requests a vendor # from the County Auditor and when received - e mails the Station to let them know the vendor # for their records
3. Direct Deposit form is sent to County Auditor to enter in Database
4. County Finance requests a Lab Slip from Med Stop and when notified that it is ready - takes the EMQ to Med Stop and picks up Lab Slip.
5. County Finance sends the Lab Slip with full instructions to the PCF's home address.
6. PCF does Labs and schedules physical with Med Stop (at Madonna Plaza)
7. Med Stop e mails County Finance the FIT Test Clearance form - County Finance records information in RPP Spreadsheet - puts one copy in PCF's file and sends the second in an envelope marked Confidential to the PCF's attention at their Station.
8. County Finance then sends an E Mail to the Station advising that the PCF has been cleared and can proceed with FIT Test. A copy of the e mail is sent to Bob Hunt and Terry Winter at the warehouse.
9. PCF will call the warehouse to schedule an appointment to get their gear.
10. George Nagy is the FIT Test Coordinator for the unit and each battalion has their own FIT Tester that works under George. See the Station Captain for direction on who to contact.
11. All individuals who complete FIT Test receive a card and documentation the FIT Test is complete. The card is for OSHA FIT Test information only.
12. To purchase uniforms the PCF must get a letter from George Huang or their Station Captain confirming that they are on the company and serving as a PCF.
13. There are two locations to purchase uniforms :  
Templeton Uniform or Range Master



**CAL FIRE**  
**San Luis Obispo**  
**County Fire Department**



635 N. Santa Rosa • San Luis Obispo, CA 93405  
 Phone: 805.543.4244 • Fax: 805.543.4248  
[www.calfireslo.org](http://www.calfireslo.org)

Scott M. Jalbert, Unit Chief

**PAID CALL FIREFIGHTER APPLICATION – (Please Print)**

<b>Vendor #</b>	<b>Company :</b>		
<b>Name:</b> _____			
First	Middle	Last	<b>Birthdate:</b> ____ / ____ / ____
<b>E MAIL Address:</b> _____			
<b>Mailing Address:</b> _____			
Street	City	State	Zip
<b>Physical Address:</b> _____			
Street	City	State	Zip
<b>Home Phone :</b> (____) _____ - _____	<b>Social Security #</b> _____ - _____ - _____		
<b>Cell Phone :</b> (____) _____ - _____	<b>Driver's License #</b> _____		
<b>Work Phone :</b> (____) _____ - _____ <b>Employer's Name</b> _____			
<b>Occupation :</b> _____		<b>Years worked</b> _____	
<b>Emergency Contact</b> _____	(____) _____ - _____	(____) _____ - _____	<b>Relationship</b> _____
NAME	PHONE		
<b>A PAID CALL FIREFIGHTER IS NOT AN "EMPLOYEE" OF SAN LUIS OBISPO COUNTY FIRE OR CALFIRE. STIPENDS ARE PAID ON A MONTHLY BASIS. STIPENDS ARE REIMBURSEMENT FOR INCIDENTAL EXPENSES OF PAID CALL FIREFIGHTERS RESPONDING, DRILLS, ETC.</b>			
<b>Due to the Public trust placed in firefighters, SAN LUIS OBISPO COUNTY FIRE will require a criminal history background check to be completed. The record search includes Department of Justice and the Department of Motor Vehicle Records. Applicants with convictions for certain crimes will not be allowed to serve as Paid Call Firefighters.</b>			
<b>List 2 References (not your employer or relative; list name, address and phone Please!)</b>			
NAME	Address	ZIP	PHONE
NAME	Address	ZIP	PHONE
<b>I CERTIFY THAT THE ABOVE INFORMATION IS TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE. I UNDERSTAND THAT ANY MISSTATEMENTS OF MATERIAL FACTS WILL SUBJECT ME TO DISQUALIFICATION OR DISMISSAL.</b>			
<b>SIGNATURE OF</b> <b>Applicant:</b> _____		<b>date</b> ____ / ____ / ____	
<b>SIGNATURE OF</b> <b>STATION CAPTAIN:</b> _____		<b>date</b> ____ / ____ / ____	
<b>Revised 09/2017</b>			

## **Paid Call Firefighters (PCF) Physical and Mental Requirements**

*Duties for the position of PCF involve field work requiring physical performance calling for above average ability, endurance, and superior physical condition, including occasional demand for extraordinarily strenuous activities in emergencies, under adverse environmental conditions, and over extended periods of time. A PCF's duties require running, walking, difficult climbing, jumping, twisting, bending, and lifting over 25 pounds. Pace of work is typically set by the emergency situation.*

*A PCF must have visual acuity (SNELLEN) of not less than 20/100 without correction in each eye. One eye only may be corrected to not less than 20/30. A PCF must have full use of both hands and feet, with hearing within speech frequencies (not corrected). A PCF must have the necessary strength and agility required for extensive bending, stooping, and squatting. A PCF must have the ability to lift or carry heavy objects in a situation that may cause sudden jerking movements of his/her back and limbs. For instance, carrying or lifting while being endangered by falling rocks or trees. A PCF must be able to work in conditions with intense heat, heavy smoke, dust and long hours.*

*A PCF responds to fires, rescues, and other emergencies as the driver or crew member on fire engines, rescue units and other vehicles. A PCF will be required to learn and use equipment and tools to perform such procedures as: raise, climb, and lower ladder; extend and advance hose lines into burning buildings; cut holes in buildings with axe or other tools; fight wild land fires using a shovel, axe, McLeod, Pulaski, and back pump. A PCF may need to perform other firefighting duties and operate other tools as is necessary.*

**CALFIRE / SAN LUIS OBISPO COUNTY FIRE DEPARTMENT**

*As an applicant for Paid Call Firefighter appointment with the San Luis Obispo County Fire Department, I am required to furnish information for use in determining my moral, physical, and mental qualifications.*

*I authorize release of any and all information that you may have concerning me, including information of a confidential or privileged nature.*

*I hereby release you, your organization, or others from any liability or damage which may result from furnishing the information requested.*

*A photocopy of this authorization shall be as valid as the original.*

Name: \_\_\_\_\_

Signature: \_\_\_\_\_ date \_\_\_\_\_

Dear Volunteer Paid Call Firefighter,

The San Luis Obispo County Fire Department, consistent with past practice, utilizes a Volunteer Paid Call Firefighter workforce to supplement the full time career firefighter personnel who provide life safety and property protection services to the public. Volunteer Paid Call Firefighters are individuals wishing to serve their community. As a Volunteer Paid Call Firefighter there are significant time commitments to duties other than emergency response that are performed on a voluntary basis including attendance at meetings and community events; fire apparatus, equipment and facility maintenance; training, and the completion of reports, logs, timesheets and other documentation. Serving as a Volunteer Paid Call Firefighter may result in less time with family, absences from employment, and commitment to duties on nights and weekends.

As a Volunteer Paid Call Firefighter with the San Luis Obispo County Fire Department you are required to read and sign this document. Please return it with your application to:

SLO CO FIRE HQ - ATTN: Carroll Anderson

*I understand that I am serving as a Volunteer Paid Call Firefighter for the San Luis Obispo County Fire Department. In this capacity, I will perform various duties or tasks for the San Luis Obispo County Fire Department without pay. I further understand that I will receive stipends for some, but not all activities, and that those stipends are reimbursement for some, but not all, of my personal costs resulting from my activities as a Volunteer Paid Call Firefighter.*

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Print Name

Signature

---

Date

# Request for Taxpayer Identification Number and Certification

Give Form to the requester. Do not send to the IRS.

Print or type  
See Specific Instructions on page 2.

1 Name (as shown on your income tax return). Name is required on this line; do not leave this line blank.						
2 Business name/disregarded entity name, if different from above						
3 Check appropriate box for federal tax classification; check only one of the following seven boxes: <input type="checkbox"/> Individual/sole proprietor or <input type="checkbox"/> C Corporation <input type="checkbox"/> S Corporation <input type="checkbox"/> Partnership <input type="checkbox"/> Trust/estate <input type="checkbox"/> Limited liability company. Enter the tax classification (C=C corporation, S=S corporation, P=partnership) ► _____ <small>Note. For a single-member LLC that is disregarded, do not check LLC; check the appropriate box in the line above for the tax classification of the single-member owner.</small> <input type="checkbox"/> Other (see instructions) ► _____						
5 Address (number, street, and apt. or suite no.)				Requester's name and address (optional)		
6 City, state, and ZIP code						
7 List account number(s) here (optional)						

## Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on line 1 to avoid backup withholding. For individuals, this is generally your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the Part I instructions on page 3. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN* on page 3.

**Note.** If the account is in more than one name, see the instructions for line 1 and the chart on page 4 for guidelines on whose number to enter.

Social security number											
<input type="text"/>	<input type="text"/>	<input type="text"/>	-	<input type="text"/>	<input type="text"/>	<input type="text"/>	-	<input type="text"/>	<input type="text"/>	<input type="text"/>	
or											
Employer identification number											
<input type="text"/>	<input type="text"/>	-	<input type="text"/>								

## Part II Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me); and
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding; and
3. I am a U.S. citizen or other U.S. person (defined below); and
4. The FATCA code(s) entered on this form (if any) indicating that I am exempt from FATCA reporting is correct.

**Certification instructions.** You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the certification, but you must provide your correct TIN. See the instructions on page 3.

Sign Here	Signature of U.S. person ►	Date ►
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## General Instructions

Section references are to the Internal Revenue Code unless otherwise noted.

**Future developments.** Information about developments affecting Form W-9 (such as legislation enacted after we release it) is at [www.irs.gov/fw9](http://www.irs.gov/fw9).

## Purpose of Form

An individual or entity (Form W-9 requester) who is required to file an information return with the IRS must obtain your correct taxpayer identification number (TIN) which may be your social security number (SSN), individual taxpayer identification number (ITIN), adoption taxpayer identification number (ATIN), or employer identification number (EIN), to report on an information return the amount paid to you, or other amount reportable on an information return. Examples of information returns include, but are not limited to, the following:

- Form 1099-INT (interest earned or paid)
- Form 1099-DIV (dividends, including those from stocks or mutual funds)
- Form 1099-MISC (various types of income, prizes, awards, or gross proceeds)
- Form 1099-B (stock or mutual fund sales and certain other transactions by brokers)
- Form 1099-S (proceeds from real estate transactions)
- Form 1099-K (merchant card and third party network transactions)

- Form 1098 (home mortgage interest), 1098-E (student loan interest), 1098-T (tuition)
- Form 1099-C (canceled debt)
- Form 1099-A (acquisition or abandonment of secured property)

Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN.

*If you do not return Form W-9 to the requester with a TIN, you might be subject to backup withholding. See What is backup withholding? on page 2.*

By signing the filled-out form, you:

1. Certify that the TIN you are giving is correct (or you are waiting for a number to be issued),
2. Certify that you are not subject to backup withholding, or
3. Claim exemption from backup withholding if you are a U.S. exempt payee. If applicable, you are also certifying that as a U.S. person, your allocable share of any partnership income from a U.S. trade or business is not subject to the withholding tax on foreign partners' share of effectively connected income, and
4. Certify that FATCA code(s) entered on this form (if any) indicating that you are exempt from the FATCA reporting, is correct. See What is FATCA reporting? on page 2 for further information.



## Employment Eligibility Verification

Department of Homeland Security  
U.S. Citizenship and Immigration Services

USCIS

Form I-9

OMB No. 1615-0047  
Expires 08/31/2019

►START HERE: Read instructions carefully before completing this form. The instructions must be available, either in paper or electronically, during completion of this form. Employers are liable for errors in the completion of this form.

**ANTI-DISCRIMINATION NOTICE:** It is illegal to discriminate against work-authorized individuals. Employers **CANNOT** specify which document(s) an employee may present to establish employment authorization and identity. The refusal to hire or continue to employ an individual because the documentation presented has a future expiration date may also constitute illegal discrimination.

PCF

### Section 1. Employee Information and Attestation (Employees must complete and sign Section 1 of Form I-9 no later than the first day of employment, but not before accepting a job offer.)

Last Name (Family Name)	First Name (Given Name)	Middle Initial	Other Last Names Used (if any)											
Address (Street Number and Name)		Apt. Number	City or Town	State ZIP Code										
Date of Birth (mm/dd/yyyy)	U.S. Social Security Number <table border="1"><tr><td> </td><td> </td><td> </td><td>-</td><td> </td><td> </td><td>-</td><td> </td><td> </td><td> </td></tr></table>				-			-				Employee's E-mail Address		Employee's Telephone Number
			-			-								

I am aware that federal law provides for imprisonment and/or fines for false statements or use of false documents in connection with the completion of this form.

I attest, under penalty of perjury, that I am (check one of the following boxes):

1. A citizen of the United States  
 2. A noncitizen national of the United States (See instructions)  
 3. A lawful permanent resident (Alien Registration Number/USCIS Number): \_\_\_\_\_  
 4. An alien authorized to work until (expiration date, if applicable, mm/dd/yyyy): \_\_\_\_\_  
Some aliens may write "N/A" in the expiration date field. (See instructions)

Aliens authorized to work must provide only one of the following document numbers to complete Form I-9:  
An Alien Registration Number/USCIS Number OR Form I-94 Admission Number OR Foreign Passport Number.

QR Code - Section 1  
Do Not Write In This Space

1. Alien Registration Number/USCIS Number: \_\_\_\_\_

OR

2. Form I-94 Admission Number: \_\_\_\_\_

OR

3. Foreign Passport Number: \_\_\_\_\_

Country of Issuance: \_\_\_\_\_

Signature of Employee

Today's Date (mm/dd/yyyy)

### Preparer and/or Translator Certification (check one):

I did not use a preparer or translator.  A preparer(s) and/or translator(s) assisted the employee in completing Section 1.  
(Fields below must be completed and signed when preparers and/or translators assist an employee in completing Section 1.)

I attest, under penalty of perjury, that I have assisted in the completion of Section 1 of this form and that to the best of my knowledge the information is true and correct.

Signature of Preparer or Translator

Today's Date (mm/dd/yyyy)

Last Name (Family Name)

First Name (Given Name)

Address (Street Number and Name)

City or Town

State

ZIP Code

Station Captain

STOP Employer Completes Next Page STOP

# Station Captain



## Employment Eligibility Verification

Department of Homeland Security  
U.S. Citizenship and Immigration Services

USCIS

Form I-9

OMB No. 1615-0047  
Expires 08/31/2019

### Section 2. Employer or Authorized Representative Review and Verification

(Employers or their authorized representative must complete and sign Section 2 within 3 business days of the employee's first day of employment. You must physically examine one document from List A OR a combination of one document from List B and one document from List C as listed on the "Lists of Acceptable Documents.")

Employee Info from Section 1	Last Name (Family Name)	First Name (Given Name)	M.I.	Citizenship/Immigration Status	
List A Identity and Employment Authorization		OR	List B Identity	AND	List C Employment Authorization
Document Title	Document Title		Document Title		Document Title
Issuing Authority	Issuing Authority		Issuing Authority		Issuing Authority
Document Number	Document Number		Document Number		Document Number
Expiration Date (if any) (mm/dd/yyyy)	Expiration Date (if any) (mm/dd/yyyy)		Expiration Date (if any) (mm/dd/yyyy)		Expiration Date (if any) (mm/dd/yyyy)
Document Title	Additional Information				QR Code - Sections 2 & 3 Do Not Write In This Space
Issuing Authority					
Document Number					
Expiration Date (if any) (mm/dd/yyyy)					
Document Title					
Issuing Authority					
Document Number					
Expiration Date (if any) (mm/dd/yyyy)					

**Certification:** I attest, under penalty of perjury, that (1) I have examined the document(s) presented by the above-named employee, (2) the above-listed document(s) appear to be genuine and to relate to the employee named, and (3) to the best of my knowledge the employee is authorized to work in the United States.

The employee's first day of employment (mm/dd/yyyy): \_\_\_\_\_ (See instructions for exemptions)

Signature of Employer or Authorized Representative		Today's Date (mm/dd/yyyy)	Title of Employer or Authorized Representative		
Last Name of Employer or Authorized Representative	First Name of Employer or Authorized Representative			Employer's Business or Organization Name	
Employer's Business or Organization Address (Street Number and Name)		City or Town		State	ZIP Code

### Section 3. Reverification and Rehires (To be completed and signed by employer or authorized representative.)

A. New Name (if applicable)		B. Date of Rehire (if applicable)	
Last Name (Family Name)	First Name (Given Name)	Middle Initial	Date (mm/dd/yyyy)

C. If the employee's previous grant of employment authorization has expired, provide the information for the document or receipt that establishes continuing employment authorization in the space provided below.

Document Title	Document Number	Expiration Date (if any) (mm/dd/yyyy)
----------------	-----------------	---------------------------------------

I attest, under penalty of perjury, that to the best of my knowledge, this employee is authorized to work in the United States, and if the employee presented document(s), the document(s) I have examined appear to be genuine and to relate to the individual.

Signature of Employer or Authorized Representative	Today's Date (mm/dd/yyyy)	Name of Employer or Authorized Representative
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# COUNTY OF SAN LUIS OBISPO

AUDITOR • CONTROLLER • TREASURER • TAX COLLECTOR  
POST OFFICE BOX 1149  
SAN LUIS OBISPO, CA 93406-1149  
(805) 781-5831 • FAX (805) 781-5362  
<http://sloacttc.com>

JAMES P. ERB, CPA

Auditor-Controller  
Treasurer-Tax Collector

James W. Hamilton, CPA  
Assistant

## ELECTRONIC PAYMENT REGISTRATION FOR VENDORS

Thank you for your interest in receiving ACH (electronic) payments from San Luis Obispo County. By registering for electronic payments, you authorize us to pay your invoices by initiating direct deposit entries to your checking or savings account. This authorizes us to make deposits only (not withdrawals). You may revoke your direct deposit authorization at any time by providing written notification to us at the address below:

James P. Erb, ACTTC  
Accounts Payable Division  
PO Box 1149  
San Luis Obispo, CA 93406-1149

To register for ACH payments, complete this form and return it to us at the address listed above. PRINT CLEARLY:

### Direct Deposit

Please provide your bank's ABA number and the number of the checking or savings account to which we should deposit payments. Attach a voided or copied check below. For a savings account, contact your bank to obtain the correct ABA routing number. You should also verify with your bank that their institution is a member of the Automated Clearing House.

Bank name & Branch Location \_\_\_\_\_

Bank ABA Routing Number \_\_\_\_\_

Account Number (include dashes) \_\_\_\_\_

This Account is      Checking  Savings

### Remittance

To receive remittance information when a deposit is made to your account, please provide your email address below. If you do not provide an email address payments will still be deposited into your account, but you will not be notified. In all cases payments will appear on your monthly bank statement.

E-mail address \_\_\_\_\_

### Authorization

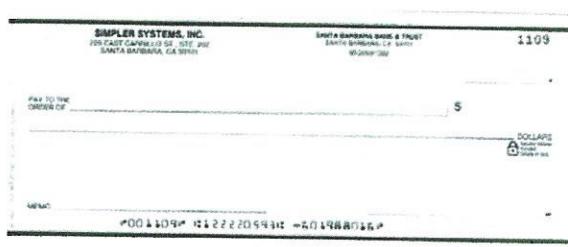
Name \_\_\_\_\_ Company \_\_\_\_\_

Title \_\_\_\_\_ Fed ID # \_\_\_\_\_

Phone # \_\_\_\_\_

Date \_\_\_\_\_ Signature \_\_\_\_\_

### Sample Check



ATTACH VOIDED CHECK HERE

Direct Deposit information can be found on the bottom of one of your checks. Use this sample as a guide to find your information. In the sample, the ABA# is 122220593 and the account # is 601988016.

The Bank ABA or routing number will be 9 digits.

Include any dashes (-) in your bank account number.

Bank ABA #

Account #

122220593 601988016

## Beneficiary Designation for Accident & Sickness Policy

Complete this block each time this form is used—Please Print

Name of Organization SAN LUIS OBISPO COUNTY FIRE State CALIFORNIA

Member's Name \_\_\_\_\_

Member's Date of Birth \_\_\_\_\_ Date Member Joined Organization \_\_\_\_\_

Complete, sign and date this block if you wish to name or change your beneficiary.

I hereby designate the following beneficiary(ies) with respect to amounts payable as indemnity for loss of life under the referenced Accident & Sickness Policy and hereby revoke any designation of beneficiary thereunder heretofore made by me. I direct that any amounts payable under said policy to my beneficiary(ies) named below be paid to those of Primary Beneficiary who survive me, otherwise to those surviving in Contingent Beneficiary, in proportion to the percentages listed.

Primary (Please refer to back of form for examples)

Beneficiary: Name \_\_\_\_\_ Relationship \_\_\_\_\_ Date of Birth \_\_\_\_\_ Share \_\_\_\_\_ %  
 Name \_\_\_\_\_ Relationship \_\_\_\_\_ Date of Birth \_\_\_\_\_ Share \_\_\_\_\_ %

Contingent

Beneficiary: Name \_\_\_\_\_ Relationship \_\_\_\_\_ Date of Birth \_\_\_\_\_ Share \_\_\_\_\_ %  
 Name \_\_\_\_\_ Relationship \_\_\_\_\_ Date of Birth \_\_\_\_\_ Share \_\_\_\_\_ %

If none of the above-named beneficiaries are living at the time of my death, I direct that payment be made in accordance with the terms of the policy. I reserve the right to revoke or change this designation.

**Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

This form should be retained in the files of your department or organization and reviewed and updated on a regular basis.

### Specifying Beneficiaries

Individual (always show relationship to the insured)	*Primary Beneficiary	**Contingent Beneficiary	Second Contingent Beneficiary
One Beneficiary	Jane Ann Jones, wife, 100%	(leave blank)	(leave blank)
One Primary Beneficiary and one Contingent Beneficiary	Jane Ann Jones, wife, 100%	David Lee Jones, son, 100%	(leave blank)
Two primary beneficiaries and one contingent beneficiary	Arthur Leo Jones, father, 50% Grace Hays Jones, mother 50%	Marie Jones Ford, sister, 100%	(leave blank)
One Primary Beneficiary, unnamed children as first Contingent Beneficiary and two second Contingent Beneficiaries	Jane Ann Jones, wife, 100%	Children born of my marriage to Jane Ann Jones, to share equally	Arthur Leo Jones, father, 50% Grace Hays Jones, mother, 50%
Unequal distribution (always use percentages)	Grace Hays Jones, mother, 50% Mary Jones Ford, sister, 25% William Roger Jones, brother, 25%	Surviving Primary Beneficiaries share equally in the portion designated for any Beneficiary(ies) who predeceases the insured	(leave blank)
Insured's Estate	Executors, Administrators or Assigns of the Insured	(leave blank)	(leave blank)

\* Primary Beneficiary is the person(s) who will receive the insurance proceeds.

\*\* Contingent Beneficiary is the person(s) who will receive the insurance proceeds if the primary beneficiary is not alive at your death.

## HEALTH QUESTIONNAIRE WITH PHYSICIAN'S REPORT

SLO CO Fire Status: (Check One)	<input type="checkbox"/> New	<input type="checkbox"/> Active PCF	<input type="checkbox"/> HAZMAT
Date:	SSN:		
Last Name:	First Name:	MI:	Suffix:
Mailing Address:	City:	State:	Zip Code:
Home Phone No: ( )	Alternate Phone No: ( )	Date of Birth:	Age:
<b>RECRUITMENT/ASSIGNMENT</b>			
Company #	Battalion #	Classification:	

**To the Applicant:** Can you read (check one): Yes  No

The medical questionnaire was developed by **San Luis Obispo County Fire** as part of the comprehensive medical evaluation process to determine fitness to respond to emergency incidents within **San Luis Obispo County Fire**. **It is important that this confidential medical questionnaire not be shared with co-workers, supervisors, or others not involved in the medical review process.**

Your **San Luis Obispo County Fire** supervisor must allow you to answer this questionnaire during normal hours, or at a time and place that is convenient to you. To maintain your confidentiality, your supervisor must tell you how to deliver or send this questionnaire to the health care professional who will review it.

**Neither your supervisor nor management may look at or review your answers.**

**Part A - Section 1. The following information must be provided by every employee who is required to use any type of respirator (please print).**

1. Sex (check one):  Male  Female
2. Your height \_\_\_\_\_ Ft. \_\_\_\_\_ In.
3. Your weight: \_\_\_\_\_ Lbs
4. Your job title: \_\_\_\_\_
5. Phone number where you can be reached by the health care professional who reviews this questionnaire (include Area code) \_\_\_\_\_ ( ) \_\_\_\_\_
6. The best time to phone you at this number \_\_\_\_\_
7. Has your supervisor told you how to contact the health care professional who will review this questionnaire? Yes
8. 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. \_\_\_\_\_ Half- or full-facepiece type.
  - c. \_\_\_\_\_ Powered-air purifying, supplied-air.
  - d. \_\_\_\_\_ Self-contained breathing apparatus.
9. Have you worn a respirator (check one):  
If yes, " what type(s):
  - a. \_\_\_\_\_ N, R, or P disposable respirator (filter-mask, non-cartridge type only).
  - b. \_\_\_\_\_ Half- or full-facepiece type.
  - c. \_\_\_\_\_ Powered-air purifying, supplied-air.
  - d. \_\_\_\_\_ Self-contained breathing apparatus.

**Section 2. (Please check applicable "YES" or "NO" box.)**

- 1 Do you currently smoke tobacco, or have you smoked tobacco in the last month? Yes  No
- 2 Have you ever had any of the following conditions?
  - 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 pulmonary or lung problems?
  - a. Asbestosis.
  - b. Asthma.
  - c. Chronic bronchitis.
  - d. Emphysema.
  - e. Pneumonia.
  - f. Tuberculosis.
  - g. Silicosis.
  - h. Pneumothorax (collapsed lung).

NAME: \_\_\_\_\_

I.	Lung cancer.	Yes <input type="checkbox"/>	No <input type="checkbox"/>
j.	Broken ribs.	Yes <input type="checkbox"/>	No <input type="checkbox"/>
k.	Any chest injuries or surgeries.	Yes <input type="checkbox"/>	No <input type="checkbox"/>
l.	Any other lung problem that you have been told about.	Yes <input type="checkbox"/>	No <input type="checkbox"/>
<b>4</b>	<b>Do you currently have any of the following symptoms of pulmonary or lung illness?</b>		
a.	Shortness of breath.	Yes <input type="checkbox"/>	No <input type="checkbox"/>
b.	Shortness of breath when walking fast on level ground or walking up a slight hill or incline.	Yes <input type="checkbox"/>	No <input type="checkbox"/>
c.	Shortness of breath when walking with other people at an ordinary pace on level ground.	Yes <input type="checkbox"/>	No <input type="checkbox"/>
d.	Have to stop for breath when walking at your own pace on level ground.	Yes <input type="checkbox"/>	No <input type="checkbox"/>
e.	Shortness of breath when washing or dressing yourself.	Yes <input type="checkbox"/>	No <input type="checkbox"/>
f.	Shortness of breath that interferes with your job.	Yes <input type="checkbox"/>	No <input type="checkbox"/>
g.	Coughing that produces phlegm (thick sputum).	Yes <input type="checkbox"/>	No <input type="checkbox"/>
h.	Coughing that wakes you early in the morning.	Yes <input type="checkbox"/>	No <input type="checkbox"/>
i.	Coughing that occurs mostly when you are lying down.	Yes <input type="checkbox"/>	No <input type="checkbox"/>
j.	Coughing up blood in the last month.	Yes <input type="checkbox"/>	No <input type="checkbox"/>
k.	Wheezing.	Yes <input type="checkbox"/>	No <input type="checkbox"/>
l.	Wheezing that interferes with your job.	Yes <input type="checkbox"/>	No <input type="checkbox"/>
m.	Chest pain when you breathe deeply.	Yes <input type="checkbox"/>	No <input type="checkbox"/>
n.	Any other symptoms that you think may be related to lung problems.	Yes <input type="checkbox"/>	No <input type="checkbox"/>
<b>5</b>	<b>Have you ever had any of the following cardiovascular or heart problems?</b>		
a.	Heart attack.	Yes <input type="checkbox"/>	No <input type="checkbox"/>
b.	Stroke.	Yes <input type="checkbox"/>	No <input type="checkbox"/>
c.	Angina.	Yes <input type="checkbox"/>	No <input type="checkbox"/>
d.	Heart failure.	Yes <input type="checkbox"/>	No <input type="checkbox"/>
e.	Swelling in your legs or feet (not caused by walking).	Yes <input type="checkbox"/>	No <input type="checkbox"/>
f.	Heart arrhythmia (heart beating irregularly).	Yes <input type="checkbox"/>	No <input type="checkbox"/>
g.	High blood pressure.	Yes <input type="checkbox"/>	No <input type="checkbox"/>
h.	Any other heart problem that you've been told about.	Yes <input type="checkbox"/>	No <input type="checkbox"/>
<b>6</b>	<b>Have you ever had any of the following cardiovascular or heart symptoms?</b>		
a.	Frequent pain or tightness in your chest.	Yes <input type="checkbox"/>	No <input type="checkbox"/>
b.	Pain or tightness in your chest during physical activity.	Yes <input type="checkbox"/>	No <input type="checkbox"/>
c.	Pain or tightness in your chest that interferes with your job.	Yes <input type="checkbox"/>	No <input type="checkbox"/>
d.	In the past two years, have you noticed your heart skipping or missing a beat.	Yes <input type="checkbox"/>	No <input type="checkbox"/>
e.	Heartburn or indigestion that is not related to eating.	Yes <input type="checkbox"/>	No <input type="checkbox"/>
f.	Any other symptoms that you think may be related to heart or circulation problems.	Yes <input type="checkbox"/>	No <input type="checkbox"/>
<b>7</b>	<b>Do you currently take medication for any of the following problems?</b>		
a.	Breathing or lung problems.	Yes <input type="checkbox"/>	No <input type="checkbox"/>
b.	Heart trouble.	Yes <input type="checkbox"/>	No <input type="checkbox"/>
c.	Blood pressure.	Yes <input type="checkbox"/>	No <input type="checkbox"/>
d.	Seizures (fits).	Yes <input type="checkbox"/>	No <input type="checkbox"/>
<b>8</b>	<b>If you have used a respirator, have you ever had any of the following problems?</b>		
If no, go to question 9. If you have used a respirator, check all that apply.			
a.	Eye irritation.	Yes <input type="checkbox"/>	No <input type="checkbox"/>
b.	Skin allergies or rashes.	Yes <input type="checkbox"/>	No <input type="checkbox"/>
c.	Anxiety.	Yes <input type="checkbox"/>	No <input type="checkbox"/>
d.	General weakness or fatigue.	Yes <input type="checkbox"/>	No <input type="checkbox"/>
e.	Any other problem that interferes with your use of a respirator.	Yes <input type="checkbox"/>	No <input type="checkbox"/>
<b>9.</b>	<b>Have you ever lost vision in either eye (temporarily or permanently)?</b>	Yes <input type="checkbox"/> No <input type="checkbox"/>	
<b>10.</b>	<b>Do you currently have any of the following vision problems?</b>		
a.	Wear contact lenses.	Yes <input type="checkbox"/>	No <input type="checkbox"/>
b.	Wear glasses.	Yes <input type="checkbox"/>	No <input type="checkbox"/>
c.	Color blind.	Yes <input type="checkbox"/>	No <input type="checkbox"/>
d.	Any other eye or vision problem.	Yes <input type="checkbox"/>	No <input type="checkbox"/>
<b>11</b>	<b>Have you ever had an injury to your ears, including a broken eardrum?</b>		
<b>12</b>	<b>Do you currently have any of the following hearing problems?</b>		
a.	Difficulty hearing.	Yes <input type="checkbox"/>	No <input type="checkbox"/>
b.	Wear a hearing aid.	Yes <input type="checkbox"/>	No <input type="checkbox"/>
c.	Any other hearing or ear problem.	Yes <input type="checkbox"/>	No <input type="checkbox"/>

NAME: \_\_\_\_\_

13. Have you ever had a back injury? Yes  No
14. Do you currently have any of the following musculoskeletal problems?
- a. Weakness in any of your arms, hands, legs, or feet. Yes  No
  - b. Back pain. Yes  No
  - c. Difficulty fully moving your arms and legs. Yes  No
  - d. Pain or stiffness when you lean forward or backward at the waist. Yes  No
  - e. Difficulty fully moving your head up or down. Yes  No
  - f. Difficulty fully moving your head side to side. Yes  No
  - g. Difficulty bending at your knees. Yes  No
  - h. Difficulty squatting to the ground. Yes  No
  - i. Climbing a flight of stairs or a ladder carrying more than 25 lbs. Yes  No
  - j. Any other muscle or skeletal problem that interferes with using a respirator. Yes  No
15. Have you ever suffered from a heat-related illness? Yes  No
- If yes, please describe: \_\_\_\_\_

**Part B**

1. List medications you use on a regular basis (include over-the-counter medications):  
\_\_\_\_\_  
\_\_\_\_\_

2. Have you ever had or been advised to have an exercise treadmill test? Yes  No   
 If yes, when was the last treadmill done? \_\_\_\_\_  
 Were you advised to restrict your activities based on the results? Yes  No

3. List previous occupations or activities which you believe may have exposed you to airborne toxic substances (include items such as pertinent military service, pesticide application, mining activities, rock drilling, asbestos abatement, lead abatement, etc.):

Previous Occupation/ActivitiesExposure

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

4. List any present activities other than SLO CO FIRE or activities that you feel may expose you to airborne toxic substances (mining, smelting metals, welding, etc.):

Present Occupation/ActivitiesExposure

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

5. Are you on a HAZMAT Team?

- 5a. When was your last medical clearance examination for HAZMAT work?

Date: \_\_\_\_\_

Yes  No 

6. Please add any additional information you feel may be important. This should include a complete explanation of any yes answers from above

Question # \_\_\_\_\_

Explanation \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

7. Would you like to talk to the health care professional about your answers to this questionnaire?

Yes  No **CERTIFICATION:** I certify that I have provided true and complete information concerning my health.

SIGNATURE

DATE