FEDERAL BUREAU OF INVESTIGATION
HAZARDOUS DEVICES SCHOOL PHYSICAL CAPACITIES FORM

Applicant’s Name: ____________________________

Dear Doctor:

The above named individual is applying to attend bomb technician certification training at the Hazardous Devices School (HDS), Redstone Arsenal, Alabama. This training is physically demanding in that it requires students to wear protective equipment while performing certain tasks. For instance, the bomb suit with helmet weighs up to 70 pounds and is quite restrictive. The combination chemical suit (level B) and WMD bomb suit (40 pounds) also requires the wearing of a self-contained breathing apparatus (SCBA) with respirator. The micro-environment within this equipment can expose the wearer to temperatures in excess of 100 degrees Fahrenheit, and humidity of 100% for periods of up to 30 minutes. Tasks to be performed include carrying a portable X-Ray (25 pounds) and disrupter (40 pounds) a distance of at least 600 feet. During these tasks the student must kneel, position the tools, and get back up on their own accord. If a student should fall, they must be able to get back up without assistance. In order to be accepted at the HDS, the applicant must not have any of the restrictions listed below. Please check any of the following medical restrictions that may apply to the applicant:

☐ Restricted from lifting more than 50 pounds.

☐ Restricted from kneeling, bending or twisting.

☐ Restricted from working in a respirator (including negative pressure or SCBA types).

☐ Overweight to the degree that wearing a 70 pound bomb suit while carrying equipment would present health risks.

☐ Restricted from wearing protective chemical and/or bomb suits.

Comments: ______________________________________

________________________________________________________________________

I have discussed the OSHA Respirator Medical Evaluation Questionnaire with the patient. (Questionnaire may be maintained by health care provider and need not be returned to the patient or the FBI.)

_____________________________  ________________________________
Physician’s Printed Name     Physician’s Signature

_____________________
Date