MABAS DIVISIONS 4 & 5 SRT

Work Capacity (Pack) Test Record

PART I (To be Completed by Team Member Prior to Testing)

Name: _____ Date: _____

Supervisor/Proctor: _____

Performance Level Needed (check one): ☐ Arduous ☐ Moderate ☐ Light

Type of Test Taken (check one): ☐ Pack Test ☐ Field Test ☐ Walk Test

PART II (To be Completed by Test Administrator/Proctor Prior to Testing)

	Pack Test	Field Test	Walk Test
Pack Weight	45 lbs.	25 lbs.	none
Distance	3 miles	2 miles	1 mile
Time	45 minutes	30 minutes	16 minutes

Test Result: ☐ Pass ☐ Fail ☐ Not Completed

Time Started: _____ Time Completed: _____

Comments (note first-aid treatments required, problems observed or complaints made by individual)

_____

_____

_____

_____

I certify that the work capacity (pack) test was administered according to WCT administration guidelines.

Signature: _____

Test Administrator: _____ Date: _____

Privacy Statement

The information obtained in the completion of this form is used to help determine whether an individual being considered for wildland firefighting can carry out those duties in a manner that will not place the candidate unduly at risk due to inadequate physical fitness and health. Its collection and use are covered under Privacy Act System of Records OPM/Govt-10 and are consistent with the provisions of 5 USC 552a (Privacy Act of 1974).

MABAS DIVISIONS 4 & 5 SRT

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WORK CAPACITY TEST: INFORMED CONSENT

• **Pack Test - Arduous** The 3-mile test with a 45 pound pack in 45 minutes is strenuous, but no more so than the duties of wildland firefighting. • **Field Test - Moderate** The 2-mile test with a 25 pound pack in 30 minutes is fairly strenuous, but no more so than the field duties. • **Walk Test - Light** The 1-mile walk in 16 minutes is moderately strenuous, but no more so than the duties assigned.	• **Risks -** There is a slight risk of injury (blisters, sore legs, sprained ankles) especially for those who have not practiced the test. If you have been inactive and have not practiced or trained for the test, you should engage in several weeks of specific training before you take the test. Be certain to warm up and stretch before taking the test, and to cool down after the test. The risk of more serious consequences (such as respiratory or heart problems) is diminished by completing the (HSQ) physical activity readiness questionnaire.

☐ **I have read the information on this form, the "Work Capacity Test" brochure (available at https://www.fs.usda.gov/sites/default/files/media_wysiwyg/wct_brochure_2002_0.pdf) and understand the purpose, instructions, and risks of the job related to the work capacity test.**

☐ **I have read the information, understood, and truthfully answered the HSQ.**

Type of Test to be Taken (check one): ☐Pack Test ☐Field Test ☐Walk Test

Signature: _____

Printed Name: _____ Date: _____

Proctor Name: _____

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HEALTH SCREENING QUESTIONNAIRE (HSQ)

Assess your health needs by marking all true statements.

The purpose is to identify individuals who may be at risk in taking the Work Capacity Test (WCT) and to recommend an exercise program and/or medical examination prior to taking the WCT.

Members are required to answer the following questions. The questions were designed, in consultation with occupational health physicians, to identify individuals who may be at risk when taking a WCT. The HSQ is not a medical examination. Any medical concerns you have that place you or your health at risk should be reviewed with your personal and/or department physician prior to participating in the WCT.

This form must be handed to the WCT proctor at the time of testing. All information will be kept confidential.
Check 'Yes' or 'No' in response to the following questions:

☐Y ☐N 1) During the past 12 months have you at any time (during physical activity or while resting) experienced pain, discomfort or pressure in your chest.

☐Y ☐N 2) During the past 12 months have you experienced difficulty breathing or shortness of breath, dizziness, fainting, or blackout?

☐Y ☐N 3) Do you have a blood pressure with systolic (top #) greater than 140 or diastolic (bottom #) greater than 90?

☐Y ☐N 4) Have you ever been diagnosed or treated for any heart disease, heart murmur, chest pain (angina), palpitations (irregular beat), or heart attack?

☐Y ☐N 5) Have you ever had heart surgery, angioplasty, or a pace maker, valve replacement, or heart transplant?

☐Y ☐N 6) Do you have a resting pulse greater than 100 beats per minute?

☐Y ☐N 7) Do you have any arthritis, back trouble, hip /knee/joint /pain, or any other bone or joint condition that could be aggravated or made worse by the Work Capacity Test?

☐Y ☐N 8) Do you have personal experience or doctor's advice of any other medical or physical reason that would prohibit you from taking the Work Capacity Test?

☐Y ☐N 9) Has your personal physician recommended against taking the Work Capacity Test because of asthma, diabetes, epilepsy or elevated cholesterol or a hernia?

Regardless of whether you are taking the Work Capacity test at the Arduous, Moderate or Light duty level, a "Yes" answer requires a determination from your personal and/or department physician stating that you are able to participate. The MABAS Divisions 4 & 5 SRT is not responsible for fees incurred in this process.

I understand that if I need to be evaluated, it will be based on the fitness requirements of the position(s) for which I am qualified.

Signature: _____

Printed Name: _____ Date: _____

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WORK CAPACITY TEST ADMINISTRATION REPORT

Date: _____ **Course Location:** _____ **Elevation (ft):** _____

Test Administrator: _____

Test Administration Support Personnel

First Aid Spec./EMT(s): _____

Course Monitor(s): _____

Lap Counter(s): _____

Timer(s): _____

Temperature: _____ F

Relative Humidity: Heat _____ %

Stress: _____ L,M,H

Correction: Pack Test _____ sec.

Field Test _____ sec.

Walk Test _____ sec.

Name	1/ HSQ	2/ Consent	3/Test Level Taken	4/ Passed	5 / Comments

1/ Health Screening Questionnaire, medical release or physical exam record on file? ***REQUIRED FOR PACK TEST***
Y = Yes **N** = No

2/ Informed Consent form signed and in hand? ***REQUIRED FOR ALL WORK CAPACITY TESTS***
Y = Yes **N** = No

3/ **P** = Pack **F** = Field **W** = Walk

4/ **Y** = Yes, **N** = No, **I** = Not Completed, **MI** = Medically Injured

5/ If "**I**" indicated in "Pass" column, provide reason.
If **"MI"** indicated in "Pass" column describe injury type, location on body, and medical attention provided.