



**NOTE: Red boxes indicate required fields.
The forms will not be accepted if these fields are blank.**

PIPELINE # _____

PARTICIPANT NAME: _____

MEDICAL HISTORY

The PARTICIPANT COMPLETES this Medical History form prior to any exam.

Polar Medical Staff Use Only	Date: _____	<input type="checkbox"/> Summer PQ	<input type="checkbox"/> Winter PQ	<input type="checkbox"/> NPQ
Medical Condition(s): _____				
Reviewed by:	_____			
Date: _____	Restrictions and Follow-up: _____			
Reason for NPQ: _____				

CONTACT INFORMATION (INCLUDE AREA CODES):

Name last, first, middle (must match official ID):	Age:	Birthdate: (MM/DD/YYYY)	Sex: <input type="checkbox"/> F <input type="checkbox"/> M
Nickname:	Maiden Name:	Previous Name or Other Legal Name:	
Street Address:			E-Mail:
City:	State:	Zip:	Country:
Day Telephone:	Evening Telephone:	Mobile:	Fax:

EMERGENCY POINT OF CONTACT:

Name:	Address:
Phone Number:	

DEPLOYMENT INFORMATION

Job Title:	Estimated Deployment Dates: (MM/YYYY) From: _____ To: _____	Prior Polar Deployment (Arctic or Antarctic)? (MM/YYYY) Location: _____ From: _____ To: _____
Affiliation: <input type="checkbox"/> NSF <input type="checkbox"/> Science Event <input type="checkbox"/> Technical Event <input type="checkbox"/> Company Name _____ <input type="checkbox"/> Other _____		

Proposed Antarctic Season	Worksite	Dates	<input type="checkbox"/> Field Camp :
<input type="checkbox"/> Summer (Sep-Feb)	<input type="checkbox"/> McMurdo Station	_____	
<input type="checkbox"/> Winter (Mar-Oct)	<input type="checkbox"/> South Pole Station	_____	
<input type="checkbox"/> WinFly	<input type="checkbox"/> Palmer Station	_____	<input type="checkbox"/> Other (specify):
_____ (dates)	<input type="checkbox"/> Vessel	_____	

Proposed Arctic Season	Worksite	Dates	<input type="checkbox"/> Field Camp:
<input type="checkbox"/> Summer (Mar-Sep)	<input type="checkbox"/> Summit	_____	
<input type="checkbox"/> Winter (Oct-Feb)	<input type="checkbox"/> Raven	_____	



PIPELINE # _____

PARTICIPANT NAME: _____

MEDICAL HISTORY

CURRENT MEDICATIONS - (Check box if None)

Name	Dose	Frequency	Name	Dose	Frequency

ALLERGIES - (Check box if None)

Name	Type of Reaction	Name	Type of Reaction

PAST HOSPITALIZATIONS - (Check box if None)

Condition	Date (YYYY)	Condition	Date (YYYY)

PAST SURGERIES - (Check box if None)

Condition	Date (YYYY)	Condition	Date (YYYY)

MEDICAL TESTING / PROCEDURES IN PREVIOUS 3 YEARS - (Check box if None)

Type (specify body location)	Date (YYYY)	Describe reason for test procedure and result:
MRI		
CT		
Ultrasound		
Angiogram		
Biopsy		
Other:		

VACCINATION HISTORY - (Check box if None)

Most recent vaccination	Date (YYYY)	Most recent vaccination	Date (YYYY)
Influenza		Hepatitis A	
DT		Hepatitis B	
DPT		Other (specify):	
Pneumococcus			
Tetanus			

LIFESTYLE

Tobacco	Yes	No	Describe: Packs/week	Total yrs.	Year last
Do you currently use tobacco products?	<input type="checkbox"/>	<input type="checkbox"/>			
Have you used tobacco products in the past?	<input type="checkbox"/>	<input type="checkbox"/>			



MEDICAL HISTORY FORM

PIPELINE #

PARTICIPANT NAME:

Alcohol	Yes	No	If abstinent, please enter date of your last alcoholic beverage: (MM/DD/YYYY)
Do you drink alcohol?			
Have you ever felt you should decrease your alcohol consumption?			
Have you ever received a DUI, DWAI or court ordered treatment for alcohol?			
Have you been diagnosed as an alcoholic?			Describe "yes" answers to alcohol questions:
Exercise and conditioning	Yes	No	Describe frequency and type of exercise :
Do you have a regular exercise program?			
Have you had a cardiovascular stress test?			Date of last treadmill: (MM/YYYY)

GENERAL MEDICAL HISTORY

New Government regulations require that you be informed of the following:

“The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. ‘Genetic information’ as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.”

Therefore, you should not forward any information related to your family’s medical history and only submit answers to these questions regarding your own personal/individual history.

ANSWER THE FOLLOWING QUESTIONS REGARDING YOUR PRESENT OR PAST MEDICAL HISTORY

<i>Condition</i>		<i>Yes</i>	<i>No</i>	<i>Condition</i>		<i>Yes</i>	<i>No</i>
1	Neurology			2D	Congestive heart failure		
1A	Cerebrovascular accident (CVA)			2E	Coronary angioplasty/stent/bypass		
1B	Concussion			2F	Coronary artery disease		
1C	Dizziness/Loss of Consciousness			2G	Heart murmur/valvular heart disease		
1D	Headaches (Migraine)			2H	Hypertension (high blood pressure)		
1E	Headaches (Other)			2I	Myocardial Infarction (MI)		
1F	Multiple sclerosis			2J	Supraventricular tachycardia (SVT)		
1G	Peripheral neuropathy			2K	Other cardiac condition		
1H	Seizures			3	Vascular disease		
1I	Transient Ischemic Attack (TIA)			3A	Abdominal aneurysm		
1J	Traumatic brain injury (TBI)			3B	Arterial emboli		
1K	Other neurological disorder			3C	Cerebral aneurysm		
2	Cardiology			3D	Deep venous thrombosis (DVT)		
2A	Angina/chest pain			3E	Venous stasis ulcers		
2B	Atrial fibrillation			3F	Other vascular condition		
2C	Cardiac pacemaker/defibrillator						

For all “yes” answers provide details to include age of onset, frequency of event, date of last episode, current medications, other therapies and current status of the condition.



PIPELINE #

PARTICIPANT NAME:

GENERAL MEDICAL HISTORY						
ANSWER THE FOLLOWING QUESTIONS REGARDING YOUR PRESENT OR PAST MEDICAL HISTORY						
Condition		Yes	No	Condition		No
4	Rheumatologic & Autoimmune disease			8H	Hepatitis (describe below)	
4A	Fibromyalgia			8I	Hernia	
4B	Osteoarthritis			8J	Irritable bowel syndrome (IBS)	
4C	Rheumatoid arthritis			8K	Pancreatitis	
4D	Systemic Lupus erythematosus			8L	Peptic ulcer disease	
4E	Other Rheumatologic/Autoimmune condition			8M	Ulcerative colitis	
5	Ears, Nose and Throat			8N	Other gastrointestinal disease	
5A	Hearing impairment			9	Dermatology	
5B	Nosebleeds			9A	Dermatitis	
5C	Seasonal allergies			9B	Melanoma	
6	Ophthalmology			9C	Psoriasis/Eczema	
6A	Glaucoma			9D	Skin Cancer	
6B	Visual impairment			9E	Other skin condition	
6C	Other eye condition			10	Orthopedic	
7	Pulmonary			10A	Cervical spine injury	
7A	Altitude sickness			10B	Chronic pain	
7B	Asthma			10C	Dislocation	
7C	Chronic bronchitis/bronchiectasis			10D	Fractures	
7D	Chronic obstructive pulmonary disease			10E	Low back injury	
7E	Dyspnea (shortness of breath)			10F	Orthopedic pins/plates	
7F	Obstructive sleep apnea			10G	Other orthopedic condition	
7G	Pulmonary embolism			11	Metabolic	
7H	BCG Vaccine or Positive TB Test			11A	Adrenal insufficiency	
7I	Chronic cough (>3 weeks)			11B	Diabetes Type I	
7J	Night sweats			11C	Diabetes Type II	
7K	Unexplained weight loss			11D	Gout	
7L	Exposed to anyone with known TB			11E	Hypercholesterolemia	
7M	Other pulmonary condition			11F	Hyperthyroidism	
8	Gastro intestinal disease			11G	Hypothyroidism	
8A	Black tarry stools			11H	Pituitary insufficiency	
8B	Blood in stool			11I	Other hormonal disorder	
8C	Cholelithiasis (gall stones)			12	Gynecology-female	
8D	Crohn's disease			12A	Menstrual period over 30 days ago?	
8E	Frequent or persistent diarrhea			12B	Date of last PAP smear	
8F	Gastroesophageal reflux (GERD)			12C	Premenstrual syndrome (PMS)	
8G	Hemorrhoids			12D	Endometriosis	

For all "yes" answers provide details to include age of onset, frequency of event, date of last episode, current medications, other therapies and current status of the condition.



PIPELINE #

PARTICIPANT NAME:

GENERAL MEDICAL HISTORY

ANSWER THE FOLLOWING QUESTIONS REGARDING YOUR PRESENT OR PAST MEDICAL HISTORY

Condition		Yes	No	Condition		Yes	No
12E	Severe menstrual cramps			14E	Other kidney condition		
12F	Ovarian cysts			15	Hematology/Oncology		
12G	Sexually transmitted disease			15A	Anemia		
12H	Other gynecological conditions			15B	Cancer (describe type)		
13	Psychiatric			15C	Leukemia		
13A	Addiction			15D	Lymphoma – Hodgkins		
13B	Anxiety/panic attacks			15E	Lymphoma – non-Hodgkins		
13C	Attention deficit disorder			15F	Platelet disorder		
13D	Bipolar			15G	Other hematologic/oncologic		
13E	Depression			16	Genitourinary - male		
13F	Eating disorder (bulimia/anorexia)			16A	Prostate disease		
13G	Hospitalization for psych condition			16B	Sexually transmitted disease		
13H	Post-traumatic stress disorder			16C	Testicular abnormality		
13I	Schizophrenia			16D	Other genitourinary condition		
13J	Suicidal thoughts or attempts			17	Diving		
13K	Other psychiatric condition			17A	Are you a diver?		
14	Renal disease			17B	Have you ever had the bends? If so, describe.		
14A	Chronic renal disease			18	Any other medical condition NOT listed above		
14B	Frequent urinary tract infection						
14C	Hematuria (blood in urine)						
14D	Kidney stones						

For all “yes” answers provide details to include age of onset, frequency of event, date of last episode, current medications, other therapies and current status of the condition.



PIPELINE #

PARTICIPANT NAME:

Dear Lab Collection (LabCorp or Physician),

This Participant is being considered for participation in the NSF/GEO/PLR Arctic or Antarctic Program. Collect specimens for the following laboratory analyses:

Standard Polar Panel (Blood work)

- Complete Blood Count with Differential
- Blood Chemistries (Sodium, Potassium, Chloride, Glucose, Creatinine, GFR/BUN, Calcium)
- Hepatic Panel (Alkaline Phosphatase, Total Bilirubin, AST, ALT)
- Uric Acid
- Lipid Panel (Cholesterol, HDL, LDL, Triglycerides)
- Iron, Total
- Total Iron Binding Capacity
- Iron % Saturation
- Hepatitis B core Antibody total
- Hepatitis C Antibody
- RPR (Syphilis)
- Blood Type (ABO and Rh)

Standard Polar Panel (Urine)

- Urinalysis with microscopy (and culture, if positive)

Additional Labs

- PSA (men age 50 and over)
- TSH (history of a thyroid disorder or wintering over)
- HIV (recommended for all summer participants, required for all winter over and for participation in the walking blood bank.)
- HgA1c (diabetics and recommended for those with a history of borderline glucose levels)

Additional Information:

If LabCorp is used to collect the lab work, UTMB will be able to access these results directly from LabCorp

If the physician collects the lab work, they need to return the results to the Participant so they can include them with this PQ packet.

For additional questions, please contact UTMB at polmedpq@utmb.edu or 1-855-300-9704 (toll free).

Thank you,
University of Texas Medical Branch – Center for Polar Medical Operations
(medical processor for NSF/GEO/Polar sponsored contractors)



PIPELINE #

PARTICIPANT NAME:

Dear Doctor:

This person is being considered for participation in the NSF Arctic or Antarctic Program. Polar medical facilities have limited diagnostic and therapeutic capabilities. In the event of a severe injury or medical emergency, transportation to a modern hospital or clinic may take several days or longer. Environmental conditions in the Polar Regions may be harsh. Temperatures range from 30 degrees above to 100 degrees below zero Fahrenheit. Physiologic altitude varies from 0 to over 10,000 feet above mean sea level. Participants may live in close quarters for extended periods of time in constant daylight or darkness. Your clinical assessment will be used to determine the person's physical qualifications for deployment to the Polar Regions.

Conduct the following tests and provide the results to the participant:

Standard Panel

- Tuberculin Skin Test (PPD)
- Influenza vaccine

Additional

- Tetanus Toxoid (good for 10 years) Year: _____
- Medical Self History (pages 1-5 of this form)
- Polar Physical Examination (pages 8-9 of this form)
- EKG (new participants; every five years if aged 40-49, and yearly if 50+) Year: _____
- Exercise Stress Test with MD Interpretation Year: _____
(must complete 9 minutes, stage 3, 85% max heart rate)
- Pulmonary Function Test, Pre/Post Bronchodilator (with history of asthma or emphysema, or if job requires respiratory wear)
- Guaiac Stool Test (age 50+)
- Pap Smear Cytology Report with Endocervical Cell Reporting (yearly for all women < 65)
- Mammogram Radiology Report (Baseline for women at age 35, then every two years aged 40-49, then yearly if 50+) Year: _____
- Chest X-ray (every five years if Participant has a smoking history > 15 years; or if wintering over; or if there is a history of a positive PPD; or current symptoms of pulmonary disease) Year: _____
- Gallbladder Ultrasound (South Pole and McMurdo winter over Participants)
- Psychological testing (South Pole and McMurdo winter over Participants)

Prescription medications (type and quantity) are limited at all Polar medical facilities. Participants are required to bring a sufficient supply of medications for the duration of their deployment or make the necessary arrangements for shipment of medication in accordance with provided guidelines found within the Polar Physical Qualification Important Information attachment.

After the examination, return the Medical History, Polar Physical Examination Form and ALL results to the Participant so they can include it with this packet. It's the responsibility of the Participant to return all results to UTMB.

For additional questions, please contact UTMB at polmedpq@utmb.edu or 1-855-300-9704 (toll free).

Thank you,

University of Texas Medical Branch – Center for Polar Medical Operations

~~(medical processor for NSF/GEO/Polar sponsored contractors)~~

NSF Form 1700 (rev MAR 2014)

Polar Physical Qualification (PQ) Packet

OMB CONTROL NUMBER: 3145-0177

Expires: APR 2017 (Previous versions not authorized.) Applicants: Please retain one copy for your records



PIPELINE #

PARTICIPANT NAME:

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PIPELINE # _____

PARTICIPANT NAME: _____

**POLAR PHYSICAL EXAMINATION
MUST BE COMPLETED BY M.D., D.O., P.A., OR N.P.**

Name: _____	Date of Birth: _____	Blood Type: _____
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New Government regulations require that you be informed of the following:

“The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information.

‘Genetic information’ as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.”

Therefore, you should not forward any information related to the patient’s family’s medical history and only submit answers to those questions regarding this patient’s personal/individual history.

VITAL SIGNS		VISION			
Height: _____	Weight: _____	Without Correction		With Correction	
		DIST	NEAR	DIST	NEAR
BP: _____ / _____	Pulse: _____	R		R	_____
BMI: _____		L		L	_____

Finding	Normal	Abnormal	Finding	Normal	Abnormal
General appearance			Inguinal, include hernia		
Head and neck			Genitalia		
Eyes			Rectal		
Ears			Spine		
Nose			Upper extremities		
Mouth			Lower extremities		
Thyroid			Skin (include body)		
Lymph nodes			Vascular		
Chest and lungs			Neurologic		
Breasts			Emotional Status		
Heart			Pelvic exam		
Abdomen			Prostate exam (age > 40)		
Guaic Test (annually, age > 50): _____ <div style="text-align:right;">Result/Date</div>			Influenza Vaccination (annually): (Mandatory for Antarctic deployment) (Recommended for Arctic deployment) _____ <div style="text-align:right;">Date</div>		
TB Skin test (annually): _____ <div style="text-align:right;">Result/Date</div>			Tetanus Vaccination (every 10 years): _____ <div style="text-align:right;">Date</div>		



PIPELINE # _____

PARTICIPANT NAME: _____

Examiner – Comment on all abnormal findings

Examiner – Comment on overall fitness and health conditions that might interfere with the Participant’s ability to participate in a remote polar deployment.

Examiner’s Name: _____ Signature: _____ Date: _____

Examiner Street Address: _____

City: _____ State: _____ Zip Code: _____

Office Phone: _____ Office Fax: _____

Return the completed examination form and results of the requested tests to the Participant.



PIPELINE #

PARTICIPANT NAME:

Dear Dentist:

This Participant is being considered for participation in the NSF/GEO/Polar Programs). The Polar Regions are isolated and lack dental facilities so the state of the candidate’s dental health is important. Participants must be free of dental disease and we recommend that all treatment be completed three weeks before deployment. There must be no caries, active periodontal disease, potential endodontic disease, prosthetic deficiencies, potentially symptomatic wisdom teeth, or any uncompleted treatment. Additional treatment or procedures may be required before this person can deploy to the Polar Regions. All dental work must be completed, documented and all results are to be given to the Participant so they can return the results to UTMB.

Following the dental exam, the candidate should provide documentation of:

I. DENTAL EXAM	Chart all existing restorations, missing teeth, and endodontically treated teeth only on the Dental Examination Form . The treating dentist must sign the Dental Examination Form and document all completed work.
II. THIRD MOLARS	Treatment <u>must be completed three weeks prior to deployment</u> in order for the dental condition to stabilize before deployment. Third molars must be extracted only if they are symptomatic or any of the following are present: <ol style="list-style-type: none"> 1. Periodontal probe can contact the crown of an interrupted third molar 2. Bleeding or poor hygiene is evident in the third molar area 3. Pseudo pockets, bony pockets are present 4. Soft tissue extends onto the occlusal surface of the third molar
III. RADIOGRAPHS	ORIGINAL MOUNTED RADIOGRAPHS must be included with the Dental Examination Form. Copies or poor quality radiographs will not be accepted. Digital radiographs can be sent in high-resolution JPEG format or printed in high resolution on glossy photographic paper . Radiographs become a part of the participant’s USAP record and WILL NOT BE RETURNED to you or the participant, so you may wish to use a double film pack to retain original radiographs for yourself. Necessary radiographs include: <ol style="list-style-type: none"> 1. Set of four ORIGINAL bitewing x-rays mounted – showing crestal bone and all posterior teeth and contacts clearly. These films must be taken within six months of the winter over deployment date and 12 months of the Summer deployment date and must accompany the completed examination form. 2. Panoramic and/or mounted full mouth survey – Must have been taken within five years of deployment date and updated every five years. 3. A periapical (PA) film of all endodontic work, crowns, and extensive restorations
IV. ORTHODONTICS	Candidates with fixed orthodontic appliances or undergoing any active treatment may be considered for short deployments, but only with written approval from the attending provider and approval from the ASC Dental Reviewer. <ol style="list-style-type: none"> 1. Unrestricted Clearance – Fixed or removable orthodontic retainer only, with no active appliance. 2. Restricted Clearance for deployments up to six months – Candidates undergoing orthodontic treatment who do not require treatment for the period of deployment and who have not had active treatment for two months prior to deployment. <p>In view of the fact that there will be no orthodontic care, and in most cases, no dental care available consideration should be given to placing the candidate in passive appliances or passive retention for the period of deployment.</p>

After the examination, return the Medical History, Polar Dental Examination Form, X-rays and ALL results to the Participant so they can include it with this packet. It’s the responsibility of the Participant to return all results to UTMB.

For additional questions, contact UTMB at polmedpq@utmb.edu or 1-855-300-9704 (toll free).

Thank you,
University of Texas Medical Branch – Center for Polar Medical Operations
(medical processor for NSF/GEO/Polar sponsored contractors)



PIPELINE #

PARTICIPANT NAME:

UNITED STATES ANTARCTIC PROGRAM DEPLOYMENT CONSENT/AUTHORIZATION DOCUMENTS

IMPORTANT NOTICE FOR PARTICIPANTS IN THE UNITED STATES ANTARCTIC PROGRAM

Participants in the United States Antarctic Program (USAP) are expected to comport themselves in such a manner that their activities and demeanor reflect credit on themselves and their sponsoring organizations. The special circumstances and conditions prevailing in Antarctica require high standards of conduct.

The potential for mishap in Antarctica is a constant threat. Your ability to deal effectively with a mishap is reduced if you are under the influence of alcohol or other drugs. The National Science Foundation (NSF) will not condone abuse of alcohol or controlled substances in Antarctica. Unauthorized or excessive use of such substances will not be tolerated.

The laws of the United States prohibit the possession, shipping, or mailing of illegal drugs. In addition, governments in New Zealand and South American countries have strict laws forbidding the possession or transportation through their country of firearms, knives, pornographic materials, marijuana or non-prescription drugs. These laws are strictly enforced and penalties for violation are severe. For example, in New Zealand the importation of illegal drugs, including marijuana, is punishable by up to 14 years imprisonment. Letter mail, parcels, and cargo being sent to Antarctica are subject to examination and opening by United States and foreign authorities. All incoming and outgoing mail for McMurdo station transits New Zealand and is subject to interdiction by New Zealand Customs Service through the use of narcotics detection dogs and other direct-inspection procedures. Like any traveler, you must abide by applicable foreign law. If you are found in violation thereof, you are subject to prosecution in the courts of that country. Association with the USAP affords neither preferential treatment nor immunity from prosecution. The New Zealand and Chilean Governments have expressly stated their intention to vigorously prosecute violators.

Conviction for any criminal action under the laws of the United States or foreign countries may result in your removal from the USAP.

_____ I have read and understand this *Important Notice for Participants in the United States Antarctic Program*.
Initials

MEDICAL RISKS FOR NSF-SPONSORED PERSONNEL TRAVELING TO ANTARCTICA

Travel to Antarctica imparts certain risks to the traveler, because of harsh environmental conditions encountered, limitations in the medical care available in Antarctica, and difficulties during emergencies with providing timely evacuation to tertiary medical care facilities in New Zealand, South America, or in the United States. USAP participants should consider these risks before deciding to deploy to Antarctica.

Virtually all medical care to USAP participants is provided through the USAP medical care system. Medical clinics operate at all three year-round stations (McMurdo, South Pole, and Palmer Stations). Emergency medical technicians and dispensary operations are available on the two oceanographic research vessels. First-aid/first responders support larger seasonal remote field camps. The three clinics are comparable to a small community hospital emergency room and ambulatory care facility, but without secondary or tertiary care facilities nearby for patient referral or specialist support. Radiography (X-rays) and selected laboratory tests are available in the clinics, but more sophisticated imaging procedures and diagnostic tests are not. Operating room surgical suites are not available at the stations, although each clinic has a triage/trauma room. The USAP does not maintain a frozen blood supply at each station, relying instead on a "walking blood bank" (where individual donors would provide fresh blood if transfusions were needed and blood types matched). The evacuation of critically ill or injured patients from Antarctic sites to sophisticated medical care off the continent (to New Zealand, South America, or the United States) is difficult during the austral summer and may be impossible during the austral winter (February through August). Partly because of these limitations, NSF requires medical and dental screening of personnel prior to deployment to Antarctica. These medical screening examinations are necessary to determine the presence of medical conditions that could threaten the health or safety of the individual while in Antarctica. They are also necessary to determine whether medical conditions exist that cannot be effectively managed while the individual is in Antarctica. Persons who fail to meet these medical/dental screening criteria will be notified of the specific reason(s) for their disqualification. Disqualified individuals may request reconsideration by completing a waiver request package (obtained from the University of Texas Medical Branch).



PIPELINE #

PARTICIPANT NAME:

Pre-deployment screening can identify existing medical conditions that may be difficult or impossible to treat effectively in Antarctica. USAP participants should realize that serious accidents or injuries might challenge the medical care system in Antarctica as well. Therefore, individuals should recognize the limitations in the medical care system in Antarctica before they engage in any risk-taking behaviors (whether on-the-job or during recreational pursuits) that may result in accidents or injuries.

Data collected as a result of this medical screening requirement are maintained in accordance with the Privacy Act (5 USC552a) and protected against unauthorized release, as described in the appended Privacy Notice found in the USAP PQ Important Information attachment. The collection of this information must display a currently valid OMB control number. You are not required to respond to the collection of this information unless it displays a currently valid OMB control number.

I have read and understand the *Medical Risks for NSF-Sponsored Personnel Traveling to Antarctica*.
Initials

MEDICAL SCREENING FOR BLOOD-BORNE PATHOGENS

As described above, USAP medical clinics at the three U.S. research stations do not maintain supplies of frozen blood. NSF research stations in the Arctic do not have readily available blood supplies. In the event of the need for a transfusion, other individuals at the research station with matching blood types would be asked to donate fresh whole blood for the patient. In order to maintain a viable donor pool, the NSF requests that USAP and Arctic participants during the austral summer season voluntarily submit to testing for Human Immunodeficiency Virus (HIV) along with the required Hepatitis virus B and C as part of their medical screening process. Please note that HIV testing is required for candidates intending to spend the winter in Antarctica or in the Arctic. In addition, consent to HIV testing does not guarantee that it will be performed.

CONSENT FOR HIV ANTIBODY BLOOD TEST

I have been informed that my blood will be tested for Human Immunodeficiency Virus (HIV) antibodies, the causative agent of Acquired Immune Deficiency Syndrome (AIDS). I understand that the testing involves the withdrawal of a small amount of my blood by venipuncture and subsequent testing of that blood sample via ELISA (Enzyme-Linked Immuno-Sorbent Assay) and Western Blot methods.

I understand that if I have any questions regarding the testing procedure or interpretation of results, I should discuss them with my health care provider. I understand that my examining physician will receive a copy of these test results and may be required, under State law, to report positive test results to state health department authorities, and I consent to these disclosures.

I understand that the results of this blood test will be incorporated into my USAP medical file. All information in that file is maintained in accordance with the Privacy Act (5 USC 552a) and protected against unauthorized release, as described in the appended Privacy Notice found in the Polar Physical Qualification Information Packet.

I volunteer for the Walking Blood Bank, should a medical emergency develop while I am on station that requires a blood donation to help save a human life. Yes No

I have read and understand the above *Medical Screening for Blood-Borne Pathogens information*.
Initials

Having read and understood the above statements, I hereby GIVE DO NOT GIVE
my consent to the collection and testing of my blood to determine the presence of HIV antibodies if required.
Initials

I have read and understand the
NSF/GEO Polar Programs Deployment Consent/Authorization Documents.
Signature



PIPELINE #

PARTICIPANT NAME:

1. Applicant Statement and Release of Liability

Applicant Statement

I, [name], am a candidate for deployment to the Polar Regions under the auspices of the Geosciences Division of Polar Programs as a [position/company] OR under [grant number].

I was advised that I am not physically qualified for deployment to the Polar Regions.

I am aware that the Physical Qualification (PQ) process is designed to identify personnel who are physically qualified and, for Antarctic winter-over candidates, psychologically adapted for assignment in Antarctica. [initial]

I understand that the PQ process is necessary to identify the presence of any physical or psychological condition that would threaten the health or safety of myself or of other Polar Programs participants, that could not be effectively treated by the limited medical care capabilities in the Polar Regions (in addition, transportation to Polar medical facilities or from the Arctic or Antarctic to higher level health care facilities may be limited), or that otherwise pose a risk that would jeopardize accomplishment of NSF Polar Programs objectives. [initial]

I understand that also important during any season, summer or winter, are the costs of lost productivity and the diversion of limited resources that results when deployed personnel are unable to perform their assigned function. [initial]

I understand that medical care capabilities may be quite distant from work locations and research sites; that work may be required at terrestrial elevations as high as 12,000 feet (3,600 meters); that ambient temperatures may reach -123 degrees Fahrenheit (-86 degrees Celsius) or lower; that my assignment may involve complete isolation for up to nine months in groups of two to 200 people. [initial]

I understand that I may be required to have further medical examinations or to furnish additional medical documentation in support of my Application for Reconsideration. [initial]

I understand that I will not be reimbursed for the cost of any additional examinations or documentation. [initial]

I understand that my employer has a responsibility to provide a physically qualified work force and therefore it may elect to hire an alternate at any time during this process. [initial]

In the event that the National Science Foundation approves my application subject to certain limitations and restrictions, I agree that if I choose to deploy I will abide by any limitations and restrictions imposed by the National Science Foundation. [initial]

I understand that the National Science Foundation's decision on my Application for Waiver is final. [initial]



PIPELINE # _____

PARTICIPANT NAME: _____

For and in consideration of the National Science Foundation waiving the Medical Clearance Criteria as they pertain to a condition for which I, _____ [applicant], a candidate for employment in the Polar Regions with _____ [organization], was found to be "not physically qualified" and thereby authorizing my deployment under the auspices of the NSF/GEO Polar Programs, for and on behalf of myself, my personal representatives, heirs and assigns, hereby release and discharge the U.S., its agents, servants and employees, including but not limited to the National Science Foundation, the Department of Defense and its agencies, agents, servants or employees, whether military or civilian and, where applicable, the Lockheed Martin Antarctic Support Contractor, its subcontractors, agents, servants, and employees from any and all claims for property damage, personal illness or injury, or death resulting directly or indirectly from waiver of the Medical Clearance Criteria and authorization to deploy.

Printed Name

Signature

Date

State of _____, County of _____

On _____, before me personally appeared _____,
[date] [applicant's name]

who proved to me on the basis of satisfactory evidence to be the person named herein and who acknowledged to me that he/she executed this application in his/her authorized capacity, and that by his/her signature on the instrument the person executed the instrument.

I certify under PENALTY OF PERJURY under the laws of the State of _____ that the foregoing is true and correct.

WITNESS my hand and official seal.

Notary Public Signature

Notary Public Seal



PIPELINE # PARTICIPANT NAME:

2. Employer Endorsement and Release of Liability

Employer Endorsement

Complete this form and obtain the signature of the Authorized Representative for your Organization as noted below.

Applicant's Name:

Position:

Organization	Authorized Representative
Lockheed Martin, Partners, Subcontractors	Project Director
NSF-Funded Research Grants	Authorized Organizational Representative

The National Science Foundation, as manager of the U.S. Antarctic Program and lead federal agency for US Arctic Programs, requires all candidates for deployment to the Polar Regions under the auspices of National Science Foundation Division of Polar Programs to undergo and pass a Physical Qualification (PQ) process. The PQ process is designed to identify personnel that are physically qualified and, for Antarctic winter-over candidates only, psychologically adapted for assignment in Antarctica. The PQ process is necessary to identify the presence of any physical or psychological condition that would threaten the health or safety of the candidate or of other Polar Programs participants, that could not be effectively treated by the limited medical care capabilities in the Polar Regions (in addition, transportation to Polar medical facilities or from the Arctic or Antarctic to higher level health care facilities may be limited), or that otherwise pose a risk that would jeopardize accomplishment of NSF/GEO Polar Programs objectives. Also important during any season, summer or winter, are the costs of lost productivity and the diversion of limited resources that results when deployed personnel are unable to perform their assigned functions. For these reasons, all documentation is reviewed against a rigorous set of Medical Clearance Criteria that were established and are regularly reviewed by qualified medical personnel with extensive experience with conditions in the Polar Regions. The National Science Foundation's physical qualification process is outlined at 45 CFR 675.

The above-named applicant has been found "not physically qualified" for deployment to the Polar Regions under the auspices of the NSF/GEO/Division of Polar Programs due to _____ [insert condition]

The National Science Foundation provides a process whereby eligibility for deployment to the Arctic or Antarctic may be reconsidered. In order to be reconsidered, the applicant submits an application consisting of an Applicant Statement, an Applicant Release of Liability, an Employer Endorsement, and an Employer Release of Liability. The National Science Foundation's subcontracted medical processor (UTMB Health Center for Polar Medical Operations) reviews the application, provides a medical recommendation, and submits the documentation to the National Science Foundation for reconsideration.

The reconsideration process takes approximately six to eight weeks to complete once the application has been submitted. Be advised that applicants may be required to have further medical examinations or to furnish additional medical documentation in support of their application. Costs incurred as a result of these requirements are not reimbursable by the National Science Foundation and must be borne by the applicant or his/her employing organization. In addition, the employer may find it necessary to hire an alternate at any time during this process in order to ensure it is able to perform its responsibilities in the Polar Regions.

If the National Science Foundation rules favorably on the application, the Medical Clearance Criteria as they pertain to the condition for which the applicant was found to be "not physically qualified" will be waived and the applicant will be authorized to deploy. The National Science Foundation may approve the application subject to certain limitations and restrictions. For example, the applicant could be restricted to certain operating locations or required to undergo monitoring of his/her condition by on-site medical providers. The National Science Foundation's decision on the application is final.

As the Authorized Organizational Representative, you are asked to review the below Employer Endorsement in support of the above-named individual's application. If you support the individual's application and agree to the statements contained therein, initial as indicated and sign the Employer Endorsement and the Employer Release of Liability on behalf of your Organization.



PIPELINE # _____

PARTICIPANT NAME: _____

_____, is a candidate for deployment to the Arctic or Antarctic under the auspices of the [applicant's name] NSF/GEO/Division of Polar Programs as an employee of _____ [organization].

We were advised that the applicant is "not physically qualified" for deployment to the Polar Regions. _____ [initial]

We are aware that the Physical Qualification (PQ) process is designed to identify personnel that are physically qualified and, for Antarctic winter-over candidates only, psychologically adapted for assignment in Antarctica. _____ [initial]

We understand that the PQ process is necessary to identify the presence of any physical or psychological condition that would threaten the health or safety of the applicant or of other Polar Programs participants, that could not be effectively treated by the limited medical care capabilities in the Polar Regions (in addition, transportation to Polar medical facilities or from the Arctic or Antarctic to higher level health care facilities may be limited), or that otherwise pose a risk that would jeopardize accomplishment of NSF/GEO Polar Programs objectives. _____ [initial]

We understand that also important during any season, summer or winter, are the costs of lost productivity and the diversion of limited resources that results when deployed personnel are unable to perform their assigned function. _____ [initial]

We understand that medical care capabilities may be quite distant from work locations and research sites; that work may be required at terrestrial elevations as high as 12,000 feet (3,600 meters); that ambient temperatures may reach -123 degrees Fahrenheit (-86 degrees Celsius) or lower; that his/her assignment may involve complete isolation for up to nine months in groups of two to 200 people. _____ [initial]

We understand that the applicant may be required to have further medical examinations or to furnish additional medical documentation in support of his/her application. _____ [initial]

We agree that we will not seek reimbursement of the costs of further medical examinations or additional medical documentation by the National Science Foundation through contracts, cooperative agreements, or grants funded by the National Science Foundation. _____ [initial]

We understand our responsibility to provide a physically qualified work force and therefore that we may elect to hire an alternate at any time during this process. _____ [initial]

We understand that the National Science Foundation may approve the application subject to certain limitations and restrictions which could affect the applicant's ability to perform his/her duties. _____ [initial]

We are aware of the potential impacts that the applicant's deployment may have on our organization, including the potential impact of the applicant being unable to perform his or her job while in the Arctic or Antarctic. _____ [initial]



PIPELINE #

PARTICIPANT NAME:

By my signature as the Authorized Organizational Representative, I acknowledge the risks associated with [applicant's name] deploying to the Polar Regions with his/her medical condition, and I support his/her Application for Waiver to the National Science Foundation on behalf of the Organization.

Employer Release of Liability

For and in consideration of the National Science Foundation waiving the Medical Clearance Criteria as they pertain to a condition for which [applicant], a candidate for employment in the Polar Regions with [organization], was found to be "not physically qualified" and thereby authorizing his/her deployment under the auspices of the NSF/GEO/Division of Polar Programs, for and on behalf of the Organization, we release and discharge the U.S., its agents, servants and employees, including but not limited to the National Science Foundation, the Department of Defense and its agencies, agents, servants or employees, whether military or civilian and, where applicable, the Antarctic Support Contractor, its subcontractors, agents, servants, and employees from any and all claims for property damage, personal illness or injury, or death resulting directly or indirectly from waiver of the Medical Clearance Criteria and authorization to deploy.

Organization

Print Title, Authorized Organizational Representative

Print Name, Authorized Organizational Representative

Authorized Organizational Representative Signature

Date



PIPELINE #

PARTICIPANT NAME:

DIVISION OF POLAR PROGRAMS ARCTIC PROGRAM DEPLOYMENT CONSENT/AUTHORIZATION DOCUMENTS

Arctic Program Physical Qualification Important Information

IMPORTANT NOTICE FOR PARTICIPANTS IN THE NSF/GEOSCIENCES DIVISION OF POLAR PROGRAMS

Participants in the Arctic Program under the auspices of the US National Science Foundation Geosciences Directorate Division of Polar Programs (herein after referred to as the NSF Polar Regions – North) are expected to comport themselves in such a manner that their activities and demeanor reflect credit on themselves and their sponsoring organizations. The special circumstances and conditions prevailing in the Arctic require high standards of conduct.

The potential for mishap in the Arctic is a constant threat. Your ability to deal effectively with a mishap is reduced if you are under the influence of alcohol or other drugs. The National Science Foundation (NSF) will not condone abuse of alcohol or controlled substances in its Arctic research stations. Unauthorized or excessive use of such substances will not be tolerated.

The laws of the United States prohibit the possession, shipping, or mailing of illegal drugs. In addition, governments in other Arctic countries have strict laws forbidding the possession or transportation through their country of firearms, knives, pornographic materials, marijuana or non-prescription drugs. These laws are strictly enforced and penalties for violation are severe.

Conviction for any criminal action under the laws of the United States or foreign countries may result in your removal from the Arctic Program.

Initials

I have read and understand this Important Notice for Participants in the NSF Polar Regions – North.

Medical Risks for Personnel Traveling to the NSF Polar Regions - North

Travel to the NSF Polar Regions - North imparts certain risks to the traveler. You may experience extremely cold (subzero) temperatures, high altitude and other environmental conditions that put you at risk for cold-related injuries. The limitations in the medical care available and difficulties, in emergencies, of providing timely evacuation to tertiary medical care facilities in the U.S. or other countries in the Arctic increase your risk of serious complications from exposure or lack of immediate medical care. Extremes of daylight and darkness can impact sleep or other behaviors. Living in close quarters increases the likelihood of exposure to communicable diseases. United States polar programs participants should consider these risks before deciding to deploy to the NSF Polar Regions - North.

Therefore, it is imperative that each individual deploying to the NSF Polar Regions – North, recognize these limitations in medical care while they are deployed. It is, in part, because of these limitations, that the NSF requires medical and dental screening of personnel prior to deployment to the NSF Polar Regions - North. These medical screening examinations are necessary to determine the presence of medical conditions that could threaten the health or safety of the individual while deployed. Each person who fails to meet these medical/dental screening criteria will be notified of the specific reasons for the disqualification. Disqualified individuals may request reconsideration by completing a waiver request package (obtained from the designated NSF point of contact).

Prior to deploying, you should familiarize yourself with the conditions and available healthcare at the location to which you are traveling and ensure that you have medical evacuation insurance. Medevac insurance is an allowable grant cost.



PIPELINE #

PARTICIPANT NAME:

Pre-deployment screening can identify existing medical conditions that may be difficult or impossible to treat effectively in the Polar Regions. Participants should realize that serious accidents or injuries might challenge the medical care system, as well. Therefore, individuals should understand the limitations in the medical care system before they engage in any risk-taking behaviors (whether on-the-job or during recreational pursuits) that may result in accidents or injuries.

Data collected as a result of this medical screening requirement are maintained in accordance with the Privacy Act (5 USC 552a) of 1974 and protected against unauthorized release, as described in the appended Privacy Notice.

I have read and understand this information sheet.

Print Name Signature and Date