

TYPE OF DEPARTMENT/AGENCY(Bubble in the **ONE** item that is most similar to the agency/company you noted above. Completely fill in the bubble): Airport Authority (PO)

- | | | | |
|--|--|--|--|
| <input type="checkbox"/> Airport Authority (PO) | <input type="checkbox"/> National Guard (U) | <input type="checkbox"/> Ranger Station (N) | <input type="checkbox"/> Other Government Agency (G) |
| <input type="checkbox"/> Ambulance Service (A) | <input type="checkbox"/> Police Department (D) | <input type="checkbox"/> Rescue Squad (R) | <input type="checkbox"/> Local Level (LL) |
| <input type="checkbox"/> Emergency Management Agency (E) | <input type="checkbox"/> Port Authority (RT) | <input type="checkbox"/> Search and Rescue (C) | <input type="checkbox"/> Federal Level (FL) |
| <input type="checkbox"/> Emergency Medical/EMS (S) | <input type="checkbox"/> Private Industry/Sector (I) | <input type="checkbox"/> Sheriff's Office (FF) | <input type="checkbox"/> State Level (SL) |
| <input type="checkbox"/> Fire Department (F) | <input type="checkbox"/> Public Health (P) | <input type="checkbox"/> State Police (SP) | <input type="checkbox"/> University (UN) |
| <input type="checkbox"/> Hospital (H) | <input type="checkbox"/> Public Works (W) | <input type="checkbox"/> Volunteer Fire Department (V) | |

TYPE OF JURISDICTION:(Bubble in the **ONE** item best describing your agency's affiliation*):(Indicate additional jurisdiction information, Bubble **ONE** from the list below):

- | | | | | |
|--|---|---------------------------------------|--------------------------------------|---|
| <input type="checkbox"/> City/Township (C) | <input type="checkbox"/> District of Columbia (D) | <input type="checkbox"/> Region (G) | <input type="checkbox"/> Port (P) | <input type="checkbox"/> Tribal Territory (R) |
| <input type="checkbox"/> County/Parish (U) | <input type="checkbox"/> US Territory (T) | <input type="checkbox"/> Metro (M) | <input type="checkbox"/> Federal (F) | |
| <input type="checkbox"/> State (S) | <input type="checkbox"/> Private Sector (O) | <input type="checkbox"/> National (N) | <input type="checkbox"/> Airport (I) | |

NOTE: Military personnel should bubble "District of Columbia" in the first column and "Federal" in the second column*What is your primary job duty?**(Please bubble the **ONE** that most closely corresponds with your primary job duties; for example if you work for the Water Department, Bubble *Public Works*):

- | | | | |
|--|--|--|---|
| <input type="checkbox"/> Disaster Board Member (I) | <input type="checkbox"/> HazMat (H) | <input type="checkbox"/> Law Enforcement (L) | <input type="checkbox"/> Private Sector (V) |
| <input type="checkbox"/> Elected Official (B) | <input type="checkbox"/> Search & Rescue (R) | <input type="checkbox"/> Military (M) | <input type="checkbox"/> Public Health (P) |
| <input type="checkbox"/> Emergency Management (E) | <input type="checkbox"/> Hospital Administrator (Q) | <input type="checkbox"/> Nurse (N) | <input type="checkbox"/> Public Works (W) |
| <input type="checkbox"/> EMS (S) | <input type="checkbox"/> Hospital Planner (Z) | <input type="checkbox"/> Airport Operations (A) | <input type="checkbox"/> Safety Officer (Y) |
| <input type="checkbox"/> Explosive Ordnance Disposal (X) | <input type="checkbox"/> Governmental/Administrative (G) | <input type="checkbox"/> Other Health Care (Non-EMS) (C) | <input type="checkbox"/> Campus (U) |
| <input type="checkbox"/> Fire Suppression (F) | <input type="checkbox"/> Lab Technician (T) | <input type="checkbox"/> Physician (D) | <input type="checkbox"/> Public Safety Communications (J) |

Professional Background(Bubble the **ONE** item which best describes your background):

- Agency Head (AH) Emergency Responder (ER) Senior Management (SM) Elected Official (EO) Line Supervisor (LS) Volunteer (VO)

Years of Experience(Bubble only **ONE** from each column):**Experience as Trainer**

(If you've had experience as a trainer, please bubble in below):

- | | | | |
|---|---|---|--|
| In Profession
<input type="checkbox"/> 0 - 3 Years
<input type="checkbox"/> 4 - 6 Years
<input type="checkbox"/> 7 - 9 Years
<input type="checkbox"/> 10 - 12 Years
<input type="checkbox"/> 13 - 15 Years
<input type="checkbox"/> 16 or more Years | In Agency
<input type="checkbox"/> 0 - 3 Years
<input type="checkbox"/> 4 - 6 Years
<input type="checkbox"/> 7 - 9 Years
<input type="checkbox"/> 10 - 12 Years
<input type="checkbox"/> 13 - 15 Years
<input type="checkbox"/> 16 or more Years | <input type="checkbox"/> Yes
<input type="checkbox"/> No | <input type="checkbox"/> Conduct Training for other Departments/Agencies
<input type="checkbox"/> Conduct Training within Department/Agency |
|---|---|---|--|

WMD Background(Bubble in **ALL** items below which best describe your background):

- | | | | |
|---|---|--|---|
| <input type="checkbox"/> No prior training/experience | <input type="checkbox"/> At state level | <input type="checkbox"/> Extensive training (5+ courses) | <input type="checkbox"/> Several courses (2-4 courses) |
| <input type="checkbox"/> At federal level | <input type="checkbox"/> Awareness training | <input type="checkbox"/> Involved in development of agency/jurisdiction WMD plan | <input type="checkbox"/> Work in specialized HazMat or explosive ordnance disposal unit |
| <input type="checkbox"/> At local level | <input type="checkbox"/> Expert (SME) | <input type="checkbox"/> Serve on WMD Task Force | |

Privacy Act Statement

The information requested on this form is protected by the Privacy Act of 1974. The purpose for requesting this information is to enable proper processing of your information for access to the U.S. Department of Energy, Nevada Operations training facilities. Failure to provide the requested information may preclude processing your training request.



Respirator Medical Evaluation Questionnaire/Waiver Form

Sex: (M/F) Age: Height: ' " Weight: (lbs.) Boot Size:

- Trained to wear a respirator
- Trained to wear a Self Contained Breathing Respirator (SCBA)

Medical Conditions

(Bubble in ALL items below that you have now or have ever had)

- | | | | |
|--|---|--|---|
| <input type="checkbox"/> Cardiovascular Disease | <input type="checkbox"/> Pulmonary Disease | <input type="checkbox"/> Smoke Tobacco | <input type="checkbox"/> Persistent Cough |
| <input type="checkbox"/> Heart Trouble | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> History of Fainting or Seizures | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Defective Vision | <input type="checkbox"/> Sensation of Smothering | <input type="checkbox"/> Heat Exhaustion |
| <input type="checkbox"/> Ruptured Ear Drum | <input type="checkbox"/> Defective Hearing | <input type="checkbox"/> Contact Lenses or Glasses | <input type="checkbox"/> Taking Prescriptions |
| <input type="checkbox"/> Problems wearing a respirator | <input type="checkbox"/> Fear of Tight or Enclosed Places | <input type="checkbox"/> Other Conditions that might interfere with respirator use or limit work ability | |

 Please explain any item check:

I verify that I have been seen by a physician/company medical professional and been approved to wear a respirator FOR TRAINING PURPOSES ONLY for participation in the Bechtel Nevada WMD Training exercises at the Nevada Test Site.

I will take full responsibility in doing so and release Bechtel Nevada from any responsibility.

Student or Medical Representative/Company

Medical Rep. Signature: X _____ Date: ____/____/____
 License # _____ Title: _____ Phone: _____
 Student Signature: X _____ Date: ____/____/____

Forward application to your state Emergency Management Coordinator. If you have any questions you may call: 702-295-3224.

Applicant's Signature: X _____ Date: ____/____/____
 Department Head Signature: X _____ Date: ____/____/____
 State Coordinator's Signature: X _____ Date: ____/____/____

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