DEPARTMENT OF HOMELAND SECURITY

FEDERAL LAW ENFORCEMENT TRAINING CENTERS

EMPLOYEE ON-DUTY FITNESS PROGRAM (EODFP) REGISTRATION

PRIVACY ACT STATEMENT

Authority	5, 10, and 14 United States Code; Executive Orders 12107, 12196, and 9397; 41 CFR 102-79.35; Privacy Act of 1974 (5 USC 552a); Section 7 of Pub. L. 93–579; 36 CFR Part 1220; 5 USC 293e; DHS Instruction 254-01-001; FLETC Directive 254-01; FLETC Manual 254-01.
Purpose	The primary purpose of the information collected is for use in the administration of the Employee Wellness Program to document participation in agency-sponsored health and wellness activities. This process facilitates and documents supervisor approval, health history, and evaluates the need for medical clearance for employees requesting participation in the FLETC Employee On-Duty Fitness Program. The SSN is required to identify and retrieve employee medical file system records.
Routine Uses	This information becomes a part of the Employee Medical Record of participants in the Employee Wellness Program, Employee On-Duty Fitness Program and is subject to all of the published routine uses of that system of records. This information is used to verify supervisor approval and to identify any medical condition which may modify or limit an employees ability to safely participate in an employer sponsored fitness program. Information may be released to authorized personnel involved in the Employee Wellness Program and/or FLETC Human Capitol Office. Possible uses for the Human Capitol Office include adjudicating claims and determining benefits related to workers compensation requests resulting from participation in the Employee On-Duty Fitness Program.
Disclosure	Voluntary. However, failure to furnish the requested information may delay participation, or prevent the requesting employee from participating, in the Employee On-Duty Fitness Program.

Instructions for Completing Employee On-Duty Fitness Program Registration

To minimize exposure of Sensitive Personally Identifiable Information (PII) and Protected Health Information (PHI), EODFP registration documents containing PII and PHI shall be emailed or mailed directly to the Employee Wellness Program by the requesting employee.

EMPLOYEE MEDICAL FILE SYSTEM RECORDS - EMPLOYEE MEDICAL FOLDER. All requesting employees must complete this form to establish the Employee Medical Folder with the Wellness Program. This is a one-time submission.

EMPLOYEE - SUPERVISOR AGREEMENT. To be completed by the requesting employee and their respective supervisor. This document must be resubmitted on an annual basis or at anytime there is a change in supervisor.

PHYSICAL ACTIVITY READINESS CERTIFICATION (PARC). To be completed by the requesting employee. This document must be resubmitted on an annual basis or at anytime there is an applicable change in the health status of the requesting employee. Questions yielding "Yes" responses require the requesting employee to submit the "Medical Clearance" document.

MEDICAL CLEARANCE. If you, the requesting employee, Vhoose not to complet the Physical Activity Readiness Certification (PARC), the Medical Clearance form must be completed by your health care provider and submitted with your EODFP registration packet.

The requesting employees shall forward completed forms to the Employee On-Duty Fitness Program Manager for final review. You will be contacted upon receipt/review of your registration packet.

Forms may be emailed to FLETC-Wellness@fletc.dhs.gov. It is strongly recommended you password-protect or encrypt any documents containing Sensitive PII/PHI you email

After the registration form is received and reviewed the requesting employee will receive a memorandum of approval if/when all requirements have been met (including required follow-up where applicable). The participation member shall maintain a copy of their approval letter. Verification of final approval shall be provided to supervisors upon request.

For additional information, or questions, please contact EODFP Manager at (912) 267-2262

EMPLOYEE MEDICAL FILE SYSTEM RECORDS NOTICE - Employee Medical Folder

The Office of Personnel Management (OPM) requires that records resulting from participation in agency-sponsored health promotion and wellness activities, including health risk appraisals, biometric testing, health coaching, disease management, behavioral management, preventive services, fitness programs, and any other activities that could be considered part of a comprehensive worksite health and wellness program be maintained in the Employee Medical Folder. The Employee On-Duty Fitness Program requests the last four digits of your Social Security Number (SSN) and your birth date for the purpose of establishing and maintaining your Employee Medical Folder as part of the wellness program. Please provide the information requested below.

Please provide the information requested below.

Last Name (including suffix, if applicable)	First Name	Middle Initial

SSN (Last Four)	Date of Birth (MM/DD/YYYY)

Employee Signature:

Reset Form

Employee Supervisor Agreement

Employee Last Name, First Name, Middle Initial (Please Print):	Directorate / Division / Branch, FLETC Training Site

I. Request Type: ☐ Initial ☐ Annual Renewal ☒ Change in Supervisor

II. Consent to Agreement

I understand that my participation in FLETC's Employee On-Duty Fitness Program is an extension of the employer/employee relationship and I must abide by all the conditions outlined in this agreement and FD/FM 254-01. I understand that any failure to adhere to the terms provided in this registration agreement, and those outlined in FD/FM 251-01, may result in the limitation, denial, or revocation of my participation in the program and/or other disciplinary action. I understand and/or agree that:

I have consulted my healthcare provider to discuss my suitability to safely participate in an employer sponsored fitness program. Furthermore, I will consult my physician, before continuing participation, at anytime there is a change in my health status that may affect my ability to safely participate in this program. Additionally, I will update my registration at any time there is a notable change to my medical status (e.g., musculoskeletal injury, surgical procedure, high blood pressure, etc.) and obtain physicians clearance prior to resuming participation.

In each pay period I must use WebTA (the time and attendance system) to submit Administrative Leave/Admin Wellness requests (documenting all hours of participation and activities w/location[s]) and receive supervisory approval prior to participation.

I will continue to perform any and all job duties, as required, without negative impact in work performance due to EODFP participation.

Employees with a current unsatisfactory performance evaluation, or who are operating under a Performance Improvement Plan, are prohibited from participation in the EODFP. Therefore, if a performance issue arises, my supervisor, at his/her discretion, may restrict, deny, or revoke my participation in the EODFP until performance or conduct issues have been satisfactorily resolved. Additionally, my supervisor may revoke my privileges if I abuse the program and fail to adhere to the guidelines.

I may be authorized up to a maximum of one (1) hour of Admin/Wellness leave for fitness related activities in a single day, not to exceed three (3) hours of Admin/Wellness leave during the week.

The time granted for purposes of physical fitness enhancement may be used at anytime during my scheduled workday including the first hour and last hour, pending supervisor approval.

Hours for engaging in fitness enhancing activities may not be used for any other purposes, unused hours cannot be carried forward to subsequent weeks, and all Admin/Wellness time must be spent during my normal 40 hour work week and cannot be the basis of overtime or other premium payment.

Fitness activities may be performed on site at FLETC locations, in a telework capacity, and/or (as applicable) off-site fitness and recreation facilities. I further understand the up to one (1) hour per day (not exceeding 3 hours in a week, nor 6 hours in a pay period) of admin/wellness time used for fitness activities includes travel to and from on-site and/or off-site facilities and no buffer time is awarded for travel

When permissible by the FLETC I may elect to use off-campus facilities for my personal benefit. I understand that this election may affect my ability to obtain Federal Employees Compensation Act ("FECA", commonly referred to as "worker's comp") benefits in the event that I am injured during my participation in the program, including during my travel to and from off-campus fitness facilities. However, this election is NOT a waiver of my right to file a FECA claim.

I maintain the right to withdraw from the program at any time, and if I withdraw from the program I will contact the EODFP Manager to update my participation status.

If I have a disability requiring reasonable accommodation to support participation in the EODFP, I must contact the Disability Program Manager for assistance.

III. Signature Block

Employee Signature:	Email:
First Line Supervisor Name - Please Print Legibly:	Email:

First Line Supervisor Signature:

Supervisor Comments (Please provide comments if EODFP request denied):

Health Services Contract Part 9, Attachment 11

Physical Activity Readiness Certification (PARC)

Employee Last Name, First Name, Middle Initial (Please Print):	Age:	Sex:
		Male ◯ Female ◯

I. Submission Type: ◯ **Initial** ◯ **Annual Renewal** ◉ **Change in Supervisor**

II. Risk Screen

Please read the questions below carefully and answer each one truthfully: Check Yes or No for each corresponding question.

1. Do you have a history of heart attack, stroke, cardiac arrest, other heart condition or high blood pressure; or are you currently under a physician's care for a heart condition or high blood pressure AND your physician stated you should only do physical activity/exercise recommended by a qualified health professional? ◯ Yes ◯ No
2. Do you feel pain in your chest at rest, during your daily activities of living or during/after physical activity/exercise? ◯ Yes ◯ No
3. In the past 12 months have you been treated for a bone, soft tissue (i.g., muscle, ligament, tendon) or joint problem limiting your activity level and/or could be made worse by exercise or has your healthcare provider instructed you to limit specific activities, exercises, or body movements? ◯ Yes ◯ No
4. Do you have any respiratory conditions (i.e., asthma, chronic bronchitis, emphysema, chronic obstructive pulmonary disease,etc.) and/or are you currently prescribed an inhaler? ◯ Yes ◯ No
5. Do you have a history of metabolic (e.g. diabetes) or renal disease; or are you currently under the care of a physician for metabolic or renal disease? ◯ Yes ◯ No
6. Do you have a history of experiencing loss of balance, lightheadedness, dizziness and/or you have nearly or completely lost consciousness during normal activities and/or exercise? ◯ Yes ◯ No
7. Are you taking any other medications/prescriptions not mentioned here or over the counter supplements, that may have an impact on your physiological/physical health and your ability to safely participate in an employer sponsored fitness program? ◯ Yes ◯ No

If you answered "YES" to ONE or MORE of the questions (1-7) above seek further advice from your physician for additional guidance and complete section III, IV, and V of the PARC. Additionally, tell your primary care provider to which questions you answered yes. After medical consultation, seek advice from your physician or a qualified exercise professional on what type of activity is suitable for your current health status.

If you answered "NO" to ALL of the above questions (1-7), skip section III and IV, and proceed to section V of the PARC.

III. Health History (Please Check All Conditions That Apply)

- ☐ Heart Attack
- ☐ Cardiac Arrest
- ☐ Cardiac Arrythmia
- ☐ (Known) Heart Murmur
- ☐ Heart Failure
- ☐ Congenital Heart Disease
- ☐ (Any) Heart Surgery
- ☐ Coronary Angioplasty
- ☐ Heart Palpitations
- ☐ Stroke
- ☐ Arteriosclerosis or Atherosclerosis
- ☐ Chest Pain with Mild Exertion
- ☐ Dizziness, Fainting, or Blackouts with Mild Exertion
- ☐ Unusual Fatigue or Shortness of Breath During Usual Activities
- ☐ Prescribed Heart Medication(s): _____
- ☐ High Blood Pressure
- ☐ Prescribed Blood Pressure Medication: _____
- ☐ Pre-Diabetes
- ☐ Diabetes Type I
- ☐ Diabetes Type II
- ☐ High Cholesterol
- ☐ Renal (Kidney) Disease
- ☐ Chronic Obstructive Pulmonary Disease
- ☐ Emphysema
- ☐ Bronchitis
- ☐ Asthma
- ☐ Prescribed Inhaler: _____
- ☐ Other Lung/Pulmonary Condition
- ☐ Bone/Joint/Tendon/Ligament Injury (Problems)
- ☐ Neck/Spine Injury/Pain (Problem)
- ☐ Shoulder Injury/Pain (Problem)
- ☐ Back/Spine Injury/Pain (Problem)
- ☐ Hip Injury/Pain (Problem)
- ☐ Knee Injury/Pain (Problem)
- ☐ Ankle/Foot Injury/Pain (Problem)
- ☐ Arthritis
- ☐ Cancer (Any Kind)
- ☐ Parkinson's Disease
- ☐ Multiple Sclerosis
- ☐ Other Neuromuscular Condition
- ☐ Eating Disorder
- ☐ Environmental Allergies or Pollutants
- ☐ Psychological Condition
- ☐ Monitored by a physician or qualified exercise professional
- ☐ Other Medication(s)/Supplements: _____
- ☐ Other Condition:

IV. Certification of Medical Clearance

Please read the questions below carefully and answer each one truthfully AND provide your initials.

	Initial	
1. Have you, in the past 12 months, consulted your physician regarding your suitability to safely participate in an employer sponsored fitness program? If "NO", complete #2 & #3 of this section. If "YES", skip to #3 of this section.	_____	◯ Yes ◉ No
2. I attest, under penalty of perjury, I will consult my physician regarding my suitability to safely participate in an employer sponsored fitness program.	_____	◯ Yes ◯ No

3. Please provide the date of your most recent medical examination (mm/dd/yy) _____

Continue to Section V of the PARC

V. Participant Declaration

I certify that I have answered the above questions (PARC) truthfully and accurately and I am not withholding any information regarding my health status that would place me at increased risk of injury and/or cardiovascular complications by participating in the EODFP. I understand withholding information/making false statements and not consulting my physician about my ability to safely take part in a fitness program may jeopardize my welfare and I may suffer physical harm to include injury or death. Subsequently, I attest I am of sufficient health, have consulted my physician regarding my health status, and/or have obtained the necessary medical clearance regarding any health conditions - this includes health related items identified during the questionnaire as well as others not listed - that may impact my ability to safely participate in the EODFP. Furthermore, I understand the PARC is valid for no greater than 12 months and I must update and re-submit the PARC and consult my physician annually, or at any time there is a change in my health status that may affect my ability to safely participate in the EODFP.

I recognize that during my participation in the EODFP, chosen physical activities may be strenuous in nature. Strenuous physical activity includes, but is not limited to, muscular strength and endurance training, aerobic and anaerobic conditioning activities, flexibility, dynamic movement activities, and various other fitness enhancing activities. I understand that there exists the possibility of certain adverse changes occurring during physical activity and exercise. These changes include, but are not limited to, abnormal blood pressure, fainting, dizziness, disordered heart rhythm (e.g., irregular, fast, slow), and in rare instances, heart attack, stroke, or death. I further understand there exists the risk of bodily injury including, but not limited to, injuries to the muscles, bones, ligaments, tendons, and joints of the body. I understand the risk of cardiovascular and orthopedic injuries is higher with higher-intensity exercise programs and when perceived fitness level is greater than actual fitness level.

I acknowledge that I bare the sole responsibility for ensuring the safety and suitability of my exercise program, to include consulting my physician or a qualified exercise professional for guidance as necessary. I attest I will wear proper footwear and proper attire for engaging in fitness enhancing activities. I attest my exercise program will adhere to sound principles of health, fitness and exercise, including but not limited to, a proper warm-up and cool-down, selecting an appropriate exercise intensity for my fitness level, and selecting appropriate exercise activities for my physical ability

I acknowledge that I am solely responsible for promptly addressing unusual health-related feelings/signs/symptoms associated with physical effort or the cessation thereof. Additionally, I attest if heart-related symptoms, illness, injury, or any other unusual health-related feelings (associated with physical effort) arise during my exercise program I will cease exercising, and promptly consult with my healthcare provider or other medical professional. Moreover, I attest if the signs/symptoms arising from participation in my exercise program are of severe nature, I will immediately call 911 to activate emergency medical aid.

I acknowledge I am responsible for ensuring the safety of any fitness equipment, facility, or public area I use while in a telework environment, including personally owned fitness equipment, parks, sidewalks, roadways, commercial fitness centers, etc.

I affirm my participation in FLETC's EODFP is completely voluntary, and is in no way mandated by the FLETC, the Department of Homeland Security, or its representatives.

Employee Signature:	Date:

EMPLOYEE ON-DUTY FITNESS PROGRAM MANAGER USE ONLY

FLETC EMPLOYEE ON-DUTY FITNESS PROGRAM MEDICAL CLEARANCE

Employee Name (Please Print) Last, First, MI	Date

Physician/Primary Care Provider Name (Please Print):	Address (Including City, State, and Zip)

Greetings Doctor, your patient wishes to take part in an exercise program and/or fitness assessment and requires a physicians clearance before participating. Please detail any recommendations or restrictions for your patient's participation in a fitness program below.

I have examined and find that he/she has:

☐ No evident health conditions/restriction that would interfere with his/her safely participating in an employer sponsored exercise program.

☐ The following **significant** health condition(s) which would interfere with his/her safe participation in an employer sponsored exercise program:

and therefore recommend the following:

☐ He/she may participate in a progressive exercise/physical activity program without restriction.

☐ An unsupervised (supervision by a fitness professional not required) physical activity/exercise program under the conditions outlined below:

☐ avoidance of:

☐ inclusion of:

☐ He/she should only participate in physical activity/exercise programs under the supervision of a certified fitness professional in conjunction with the conditions outlined below:

☐ avoidance of:

☐ inclusion of:

☐ He/she should NOT participate in the employer-sponsored exercise program at this time.

Physician/PCP Signature	Phone Number:	Date