



DEPARTMENT OF THE ARMY
INSTALLATION MANAGEMENT COMMAND
JOINT BASE LEWIS-MCCHORD YAKIMA TRAINING CENTER
970 FIRING CENTER ROAD
YAKIMA, WA 98901-9399

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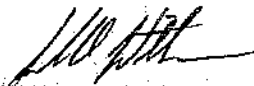
19 June 2020

MEMORANDUM SEE DISTRIBUTION

SUBJECT: Yakima Training Center (YTC) Policy Statement #16, Civilian Fitness and Wellness Program

1. In accordance with Army Regulation 600-63 (Army Health Promotion), 14 April 2015, Department of the Army Civilian Employees are encouraged to participate in the YTC Fitness Program. Participation in this program is voluntary and is subject to mission requirements. Supervisors may approve up to 3 hours of administrative leave per week (not to exceed 6 consecutive months) to participate in the fitness program, which includes physical fitness and health assessments.
2. To enroll in the program, employees must complete the Civilian Fitness Enrollment Packet (enclosure), which consists of an Initial Fitness Assessment Checklist, Health History Form, Informed Consent Form, Supervisor/Employee Participation Form, and a Physician Release Form.
3. This program does not apply to firefighters since these employees are in occupations that require physical strength and stamina for satisfactory performance. Subject to mission requirements, a physical exercise program is considered to be part of their jobs and may be conducted during duty hours.
4. Point of contact is the participating employee's supervisor.

Encl


LUKE A. WITTMER
LTC, SF
Commanding

Civilian Employee Fitness Enrollment Packet

Welcome to the Yakima Training Center Civilian Fitness Program! We appreciate your interest in the fitness program and hope to make the process of enrolling in the program as simple as possible. Please take a few minutes to acquaint yourself with the enrollment packet.

The enrollment packet is designed to assist DA Civilian employees with the enrollment process. It is important to note that you will not be enrolled in the program unless the packet is complete and you have received medical approval to start the program. When you are approved for the program, you will receive an approval form.

Congratulations for taking the first step to getting fit and staying fit!

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1. Initial Fitness Assessment Instructions and Checklist.
2. Health History Form.
3. Informed Consent.
4. Supervisor/Employee Participation Form.

If you have questions regarding the fitness program packet, please contact the Occupational Health Nurse.

HEALTH HISTORY FORM

Before engaging in a fitness program, certain medical or health issues need to be addressed. Occasionally, diseases are present, which the individual may not be aware of. This is often true in the beginning stages of cardiovascular (heart/blood vessel) disease; especially as an individual gets older. The undetected or "sub-clinical" diseases may cause problems when a fitness program is begun.

Name: _____ Age: _____

Person to Contact in an Emergency: _____

Relationship: _____ Phone Number: _____

Do you have or have you ever had any of the conditions, symptoms, or items listed below? Please mark all that apply.

- High blood pressure (hypertension)
- Heart attack
- Angina
- Heart failure
- Heart surgery
- Skipped or irregular heart beats
- Rhythm disturbance
- Coronary angioplasty (PTCA)
- Heart valve disease
- Cardiac catheterization
- Pacemaker
- Implantable cardiac defibrillator
- Congenital heart disease
- Heart transplantation
- Use medications for blood pressure or heart condition
- Been told by your health care provider you have a heart condition and should only do physical activity as recommended by him/her
- Any other heart condition (please specify)
- Stroke
- TIA
- Asthma
- Chronic obstructive pulmonary disease (COPD) or other lung disease
- Diabetes
- Seizures or Epilepsy
- Chest discomfort or pain with exertion or physical activity
- Chest pain in the last month when you were not doing physical activity
- Dizziness
- Loss of consciousness
- Fainting or blackouts
- Loss of balance
- Hypoglycemia
- Unreasonable breathlessness or short of breath with mild exercise
- Burning or cramping sensation in lower legs when walking short distances
- Musculoskeletal problems that limit your physical activity or could worsen with exercise

- You are pregnant
- Concerns about the safety of exercise
- You or your health care provider know of other reasons why you should not do physical activity without medical supervision
- Taking prescription medications
- You are a male older than 45 years
- You are a female older than 55 years or are post-menopausal or have had a hysterectomy
- You smoke or quit smoking in the last 6 months
- Your blood pressure is more than 140/90
- Your blood cholesterol level is more than 200
- You do not know you cholesterol level
- You have a close blood relative who had a heart attack or heart surgery before age 55 (father or brother) or age 65 (mother or sister)
- You are physically inactive and get less than 30 minutes of physical activity on at least 3 days per week
- You are more than 20 pounds overweight
- Recent surgery (last 6 months)

If you marked any of the above questions, you must have a doctor's release form from your primary care physician in order for you to start an exercise program.

Please list current medications and supplements:

I certify the above is accurate and complete to the best of my knowledge.

Participant's Signature	Date
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To be completed by Occupational Health Nurse Only:
 Comments (if any):

- Participant is: Medically approved to start the fitness program
- Referred to their primary care provider for additional medical screening

OCC Health Signature	Title	Date
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INFORMED CONSENT

I hereby give informed consent to engage in a series of health and medical evaluations including a Fitness Assessment conducted by the Occupational Health Nurse. The purpose of the assessment is to determine my physical fitness and health status. The assessment will include the following:

1. Blood Pressure and Pulse. A blood pressure cuff will determine blood pressure. Pulse will be determined by palpating the brachial artery in the wrist or other appropriate method.
2. Body Composition will be determined by:
 - a. Body Fat Percentage, which is determined by using the Omron Body Fat Analyzer to measure the percentage of body fat compared to lean muscle mass.
 - b. Body Mass Index (BMI), which is a measure that takes into account a person's weight and height to gauge total body fat in adults.
3. Cardio-respiratory Fitness will be determined by using a 3 minute Step Test. Cardio-respiratory fitness is defined as the ability of the heart and lungs to provide oxygen to the muscles. The Step Test involves measuring the heart rate in the recovery period following 3 minutes of stepping at 96 beats per minute (bpm) on a 12 inch bench. The recovery heart rate becomes lower in individuals who exercise regularly, indicating a more efficient heart.
4. The Sit and Reach Test measures flexibility of the muscles in the back of the legs and trunk. Flexibility is defined as the range of possible movement in a joint or group of joints.
5. There exists the possibility of certain changes occurring during the test. They include abnormal blood pressure, fainting, irregular heart rhythm, and in rare instances, heart attack, stroke, and death. Every effort will be made to minimize these risks by evaluation of preliminary information relating to your health and fitness and by observations during testing. Emergency equipment and trained personnel are available to deal with unusual situations that may arise. It is important that you inform the testing staff of any health conditions before completing the assessment so that the testing staff can decide which tests are appropriate for your fitness level.
6. Information you possess about your health status or previous experiences of unusual feelings with physical effort may affect the safety and value of your exercise test. Your prompt reporting of any discomfort during the exercise test is of great importance. You are responsible for fully disclosing such information when requested by the testing staff. Your permission to perform the exercise assessments are voluntary and you are free to stop the test at any point.
7. I desire such testing so that better advice regarding my proposed exercise program may be given to me, but I understand that the testing does not entirely eliminate risk in the proposed exercise program. I understand that I can withdraw my consent or discontinue participation in any aspect of the fitness testing or program at any time without penalty or prejudice toward me.
8. I have read all of the above explanations about the Health and Fitness Assessments. I voluntarily consent to participate in this program. I hereby give my permission for the aggregate data to be used for evaluation of this program. I understand that all information is kept confidential and no personal identifiers will be used when evaluating the program data results. My questions about this program have been answered to my satisfaction. I understand that if I have additional questions, I may contact the Occupational Health Nurse.

Signature of Participant

Date

Signature of Witness

Date

SUPERVISOR / EMPLOYEE PARTICIPATION FORM

Make a copy for your records and a copy for your supervisor. You are not enrolled until you receive the completed Enrollment Approval Form and give it to your supervisor.

Employee's

Name: _____

Employee's Phone

Employee's E-mail: _____

Worksite/Unit: _____

Work Phone: _____

Supervisor's

Supervisor's E-

Name: _____

mail: _____

AGREEMENT

1. We understand the above named employee will be participating in the command-sponsored Civilian Fitness Program, which permits up to 3 hours of administrative leave each week for 6 consecutive months beginning on _____ (Assessment Date) and ending on _____ (6 months after Assessment Date). We understand and agree that the exercise location on YTC will be a place of duty during authorized exercise periods. Ordinarily, exercise periods will be Monday, Wednesday, and Friday from _____ to _____.

2. We also understand and agree that:

- You have the opportunity to discontinue this program within 1 month from your official start date and keep your eligibility to enroll at a later time.
- Exercise sessions will start and finish on the Yakima Training Center.
- Exercise days and times may be amended only with prior approval of the supervisor and amendment of this agreement.
- Any costs associated with a physician's assessment will be paid by the employee.
- Unused exercise hours may not be carried forward to subsequent weeks.
- The program end date will not be extended to make up for missed exercise periods.
- No additional duty time is authorized for exercise preparation (e.g. changing clothes, cool down, personal hygiene, travel).
- Specified exercise periods may not be used for any non-duty purpose. Any period or portion not used in actual fitness training and exercise will be spent in the normal duty workplace accomplishing normal duties.
- Exercise periods are official duty time. Failure to appear, inappropriate use of exercise time, or misconduct during these periods would be considered as workplace infractions occurring during normal duty hours, and would be subject to the same disciplinary actions.
- Employee understands that if he or she chooses to use fitness classes, personal trainers, exercise gear, etc. that the cost is his or her responsibility.
- Failure to complete the final assessment may result in your supervisor requesting that all administrative leave used in connection with the program be replaced as annual leave.

3. As a participant, I will sign in at the gym prior to my exercise session. I understand that I must complete the final wellness assessment to complete the program. My supervisor and I understand that I am not authorized to start the Civilian Fitness Program until I receive my Enrollment Approval Form stating I have met all requirements to begin the program. I understand that this is a once in a career opportunity and will be documented in a Request for Personnel Action (NOT TRACKED VIA RPA). I certify that I have not been enrolled in the Civilian Fitness Program at any other location before.

Employee's Signature

Date

Supervisor's Signature

Date

Physician Release for Activity/Exercise Program

Dear Dr. _____

The following individual has indicated that you are his/her primary care physician. This individual has shown interest in beginning a moderate to vigorous activity/exercise program with the Civilian Fitness Program. Please provide us with your recommendations regarding activity/exercise prescription for this individual and any restrictions and/or limitations that would limit this individual's participation in an exercise program. Thank you for your cooperation.

Participant/Patient Name: _____

Physician's Recommendation

- _____ Patient may participate in unrestricted physical activity.
- _____ Patient may participate in light to moderate physical activity.
- _____ Patient should not participate in activity at this time.
- _____ Patient may participate in the following activities:

Please specify any restrictions or limitations you feel appropriate.

Physician's Name Telephone Number

Signature Date

FITNESS ASSESSMENT INSTRUCTIONS AND CHECKLIST

Step 1: Please follow the instructions carefully to ensure your file is set up properly. Please check the following blocks once each form is completed:

- Health History Form
- Informed Consent Form
- Supervisor / Employee Participation Form
- Physician Release for Activity/Exercise Program

Step 2: Create a folder to file your completed forms. Ensure your name is affixed to the folder and the forms are filed in the following order:

1. Fitness Assessment Instructions and Checklist
2. Supervisor / Employee Participation Form
3. Informed Consent Form
4. Health History Form
5. Physician Release for Activity/Exercise Form

Step 3: Schedule initial assessment with the Occupational Health Nurse and the MWR Supervisor. If you are feeling ill, reschedule the assessment.

Initial Assessment Date: _____

Height:	_____	Weight:	_____	Blood Pressure:	_____
Resting Pulse Rate:	_____	Body Fat %	_____	BMI:	_____
3 Minute Step Test HR:	_____	Sit & Reach:	_____		

Step 4: Schedule final assessment with the Occupational Health Nurse and the MWR Supervisor. The final assessment will occur 6 months after the initial assessment.

Final Assessment Date: _____

Height:	_____	Weight:	_____	Blood Pressure:	_____
Resting Pulse Rate:	_____	Body Fat %	_____	BMI:	_____
3 Minute Step Test HR:	_____	Sit & Reach:	_____		