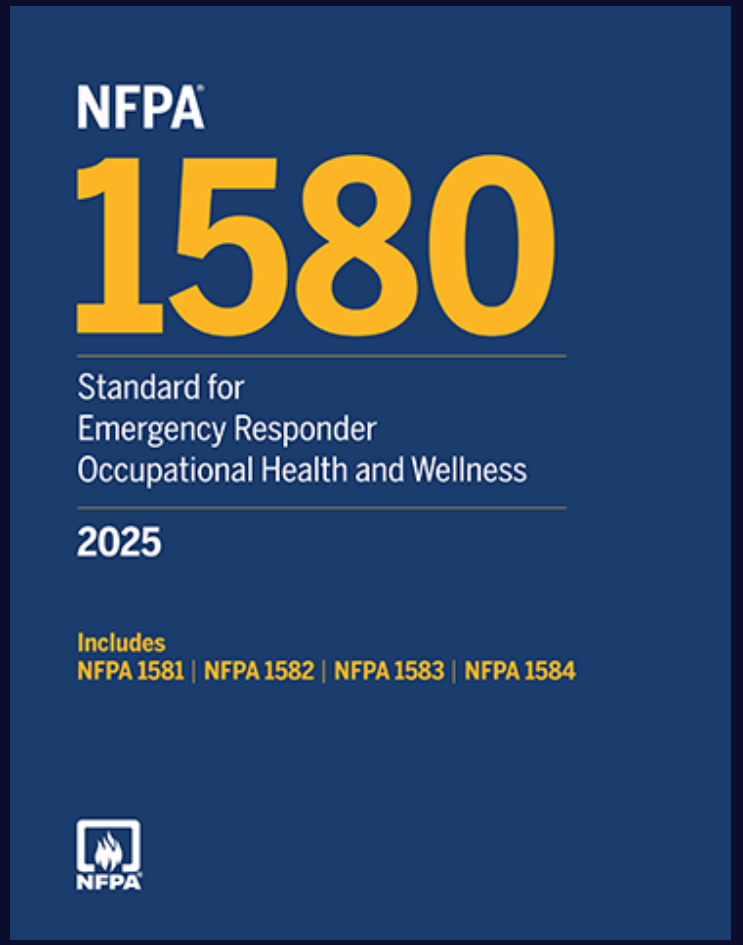
INTERNATIONAL ASSOCIATION OF FIRE FIGHTERS

NFPA 1580

WHAT THIS MEANS FOR YOUR DEPARTMENT



March 29, 2026

THE ORIGIN & EVOLUTION OF NFPA 1580/1582

NFPA 1582: EVOLUTION OF THE STANDARD

- NFPA 1001 (1974) - Mandatory medical evaluation of ‘candidates’
- NFPA 1500 (1987) - ‘Members’ evaluated annually by a physician
- NFPA 1582 (1992) – 1st edition
- 1997-2022 – Standard expands and evolves
  - updated medical criteria, EJT criteria, expanded screening, behavioral health
- 2019 – ERRS Consolidation Project
- 2023 – TIA consolidating candidate and member criteria and new criteria for cardiorespiratory fitness (CRF)
- 2025 – NFPA 1580 released

CONSOLIDATION OF CANDIDATES AND MEMBERS

- FEMA Challenge to separate requirements for candidates & members
  - Violation of ADA and Rehabilitation Act
  - No Exclusionary Conditions (Category A)
  - Individualized Assessment Required
- Required harmonization of chapters 6 & 9
- Removes outdated fitness disparities between candidates and incumbents
- Ensures firefighters are evaluated based on age- and sex-adjusted norms
- Addresses fairness, ADA compliance, and scientific accuracy

THE PROBLEM WITH CRF (PRE-2023)

- Separate requirements for:
  - Candidates: Must meet >12 METs
  - Incumbents (Members): Allowed <8 METs
- Elimination of CRF was a nonstarter for the docs

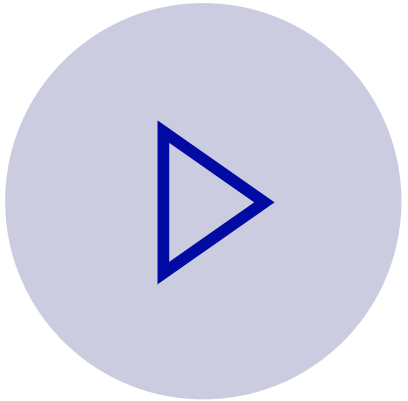
WE WERE DOING IT WRONG

- Inherently unfair
- Like the pulmonary function test, cardiopulmonary fitness varies with age and gender
- Decision made to follow the ACSM guidelines for exercise testing and prescription

NOW, LIKE BEFORE…

APPROPRIATE FITNESS = NO INTERVENTIONS

DEGRADED FITNESS = NO RESTRICTIONS, BUT PRESCRIBED FITNESS PROGRAM



POOR FITNESS = RESTRICTED FROM PERFORMING CERTAIN ESSENTIAL JOB TASKS

TECHNICAL COMMITTEE FOR

EMERGENCY RESPONDER OCCUPATIONAL HEALTH

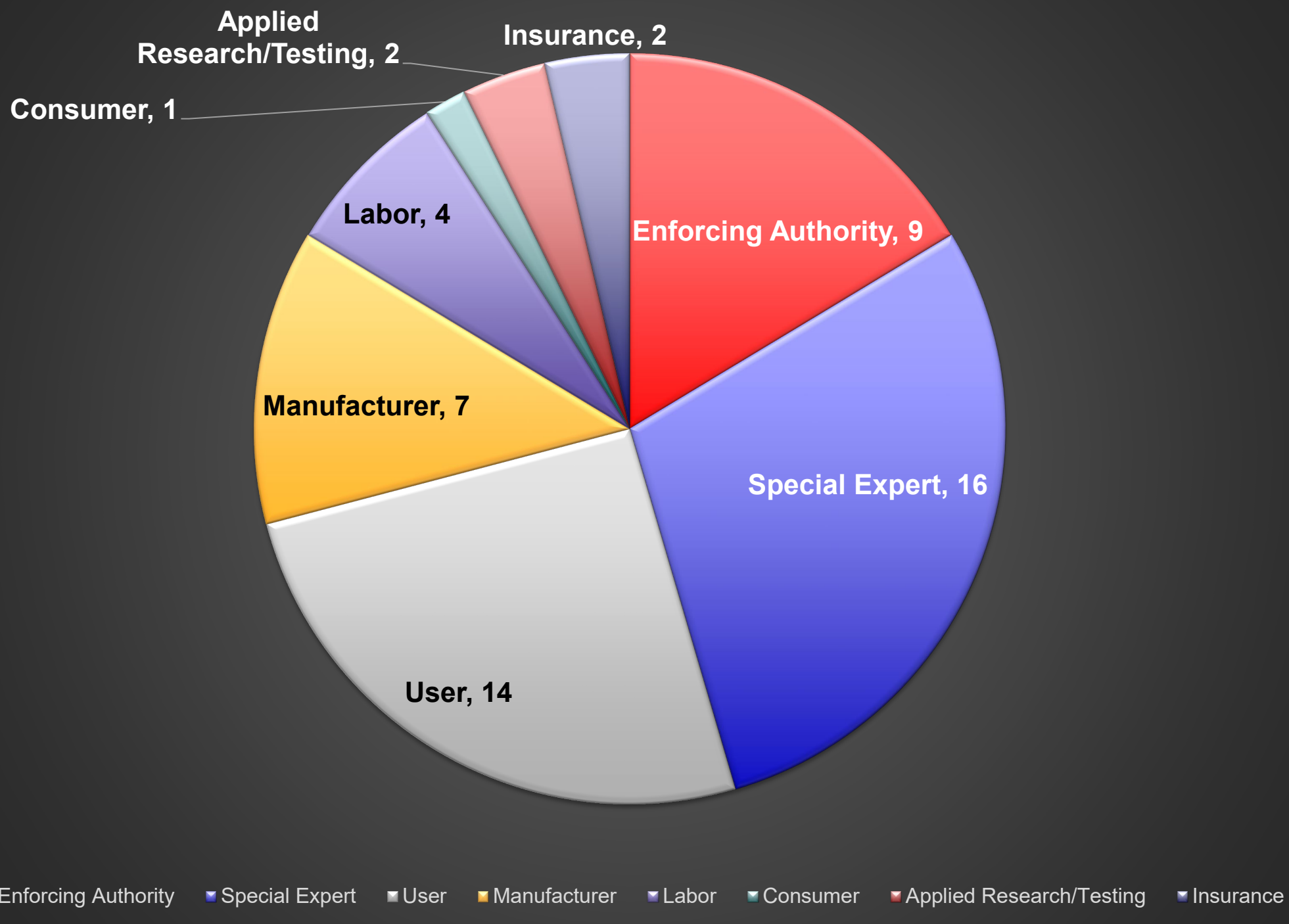
Randy Krause (Chair) – Port of Seattle FD

- Special Expert (SE) – 16
- User (U) – 14
- Enforcing Authority (E) – 9
- Manufacturer (M) – 7
- Labor (L) – 4
- Applied Research/Testing (A/T) – 2
- Insurance (I) – 2
- Consumer (C) - 1

55

Principal Members

Responsible for NFPA 1580 and NFPA 1585


Applied Research/Testing, 2
Insurance, 2
Consumer, 1
Labor, 4
Enforcing Authority, 9
Manufacturer, 7
Special Expert, 16
User, 14
Enforcing Authority
Special Expert
User
Manufacturer
Labor
Consumer
Applied Research/Testing
Insurance

ERRS CONSOLIDATION INITIATIVE (2019)

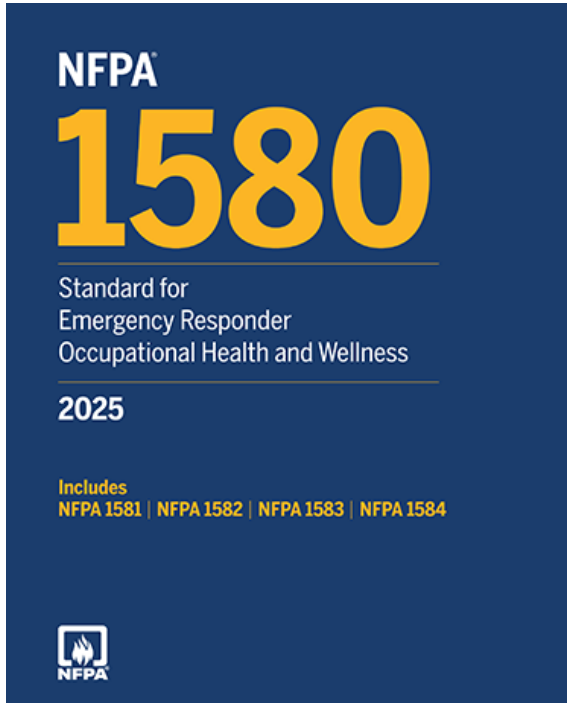
- NFPA Standards Council directed unification of Emergency Response & Responder Safety (ERRS) standards
- Objective: improve usability, reduce conflicts, and enhance overall standard quality
- Replaces multiple legacy standards with a unified framework
- Creation of NFPA 1580 (2025)
  - Establishes a single, comprehensive occupational health & wellness standard for emergency responders

NFPA 1580 – ORIGIN & DEVELOPMENT

- Standards Consolidated
  - NFPA 1581 (Infection Control)
  - NFPA 1582 (Comprehensive Occupational Medical Program)
  - NFPA 1583 (Fitness Programs)
  - NFPA 1584 (Rehabilitation)
- Standardized approach across health, fitness, medical, (and ‘rehabilitation’)

NFPA 1580 OVERVIEW

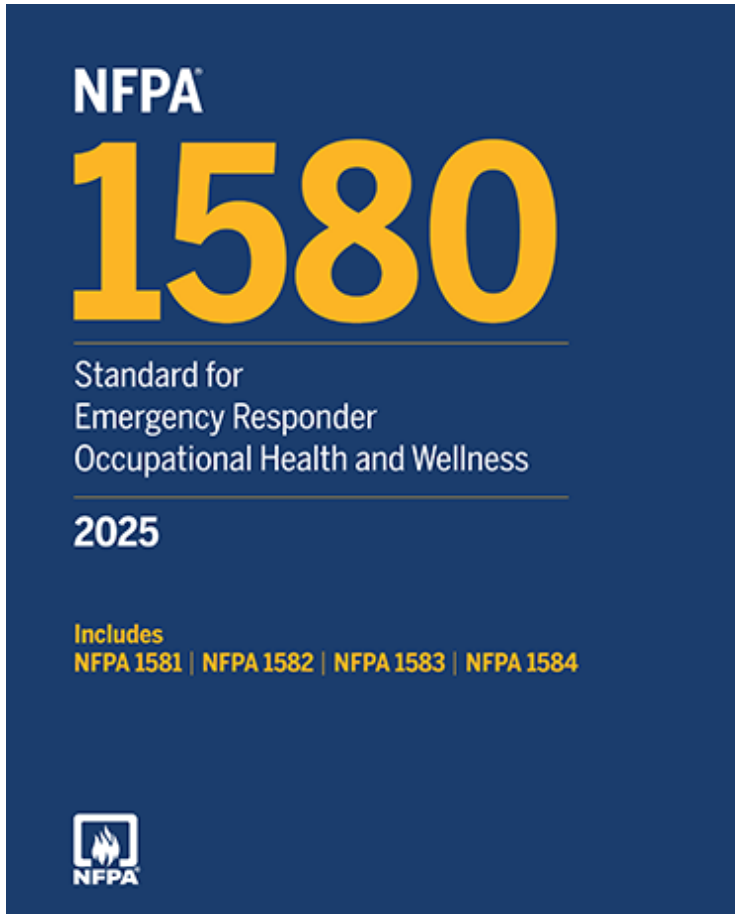
NFPA 1580 : SCOPE



This standard contains *minimum requirements* for:

- fire department infection control program;
- comprehensive occupational medical program for fire departments;
- the development, implementation, and management of a health-related fitness program (HRFP) for members of the fire department involved in emergency operations;
- developing and implementing processes for member prehabilitation, contamination control, rehabilitation, and recovery from incident scene operations and training exercises.

NFPA 1580



Chapters 1-3

1. Administration
2. Referenced Publications
3. Definitions

Annex A – Explanatory Material (*)

Annex B-K

NFPA 1580/1581: INFECTION CONTROL PROGRAM

Chapter 4: Program Components

Chapter 5: Fire Department Facilities

Chapter 6: Fire Department Emergency Vehicles

Chapter 7: Emergency Medical Service Operations

Chapter 8: Cleaning, Disinfecting, and Disposal

NFPA 1580/1582: OCCUPATIONAL MEDICAL EXAM

Comprehensive occupational medical program for fire departments

Chapter 9: Roles and Responsibilities

Chapter 10: Essential Job Tasks

Chapter 11: Evaluation of Members (The exam)

Chapter 12: Annual Fitness Evaluation of Members

Chapter 13: Medical Evaluation (The physician's role)

MEDICAL EVALUATION: TABLES ARE NEW IN 1582

13.9* Medical Conditions Involving the Gastrointestinal Tract and Abdominal Viscera.

The physician shall report any applicable job restrictions associated with the conditions in **Table 13.9** based on physician's evaluation of the individual's nutrition regimen and a propensity for symptomatic dehydration, anemia, chronic diarrhea, or incapacitating pain syndromes.

Table 13.9 Medical Conditions Involving the Gastrointestinal Tract and Abdominal Viscera

Condition	Special Criteria for Restriction	Special Provisions for No Restriction	Affected Essential Job Task(s)
(1)* Gastrointestinal disorders, including cholecystitis, gastritis, GI bleeding, inflammatory bowel disease or irritable bowel syndrome, intestinal obstruction, pancreatitis, diverticulitis, cirrhosis, or gastric or other GI ulcers, including Zollinger-Ellison syndrome	Has uncontrolled symptomatic dehydration, anemia, or incapacitating pain syndromes	Has symptoms under control without frequent acute flairs and without functional impairment, such as malnutrition, symptomatic dehydration, anemia, chronic diarrhea, or chronic pain syndrome	1, 5, 9, 13, 14
(2)* Gastrointestinal surgery (e.g., cholecystectomy, appendectomy, splenectomy), excluding transplant	–	Postoperatively, has healed without functional impairment, such as malnutrition, symptomatic dehydration, anemia, chronic diarrhea, or chronic pain syndrome	–
(3)* Abdominal wall, inguinal, or femoral hernia	Has high risk for incarceration and bowel strangulation during heavy exertion and lifting or for weakening of the abdominal wall musculature, as judged by the fire department physician	Has umbilical hernia that is small and asymptomatic or has abdominal wall hernia that has been surgically corrected and well-healed with surgeon's clearance for full lifting	1, 4, 6, 7, 13
(4) Liver transplant *(see Section 13.13 for antirejection medication)*	–	–	–
(5) Kidney disease	Has chronic, Stage 4 or greater kidney disease [glomerular filtration rate (GFR) < 30 ml/min]	–	9, 11, 13, 14, 15
(6) Hemodialysis or continuous ambulatory peritoneal dialysis	–	Meets the following provisions annually or at the frequency indicated:	9, 11, 13, 14, 15

NFPA 1580/1583: FITNESS

Health-related fitness program (HRFP) for members of the fire department involved in emergency operations

Chapter 14: Organization

Chapter 15: Health and Fitness Coordinator and Peer Fitness Trainers

Chapter 16: Assessment

Chapter 17: Exercise Training Program

Chapter 18: Health and Wellness Education

Chapter 19: Data Collection

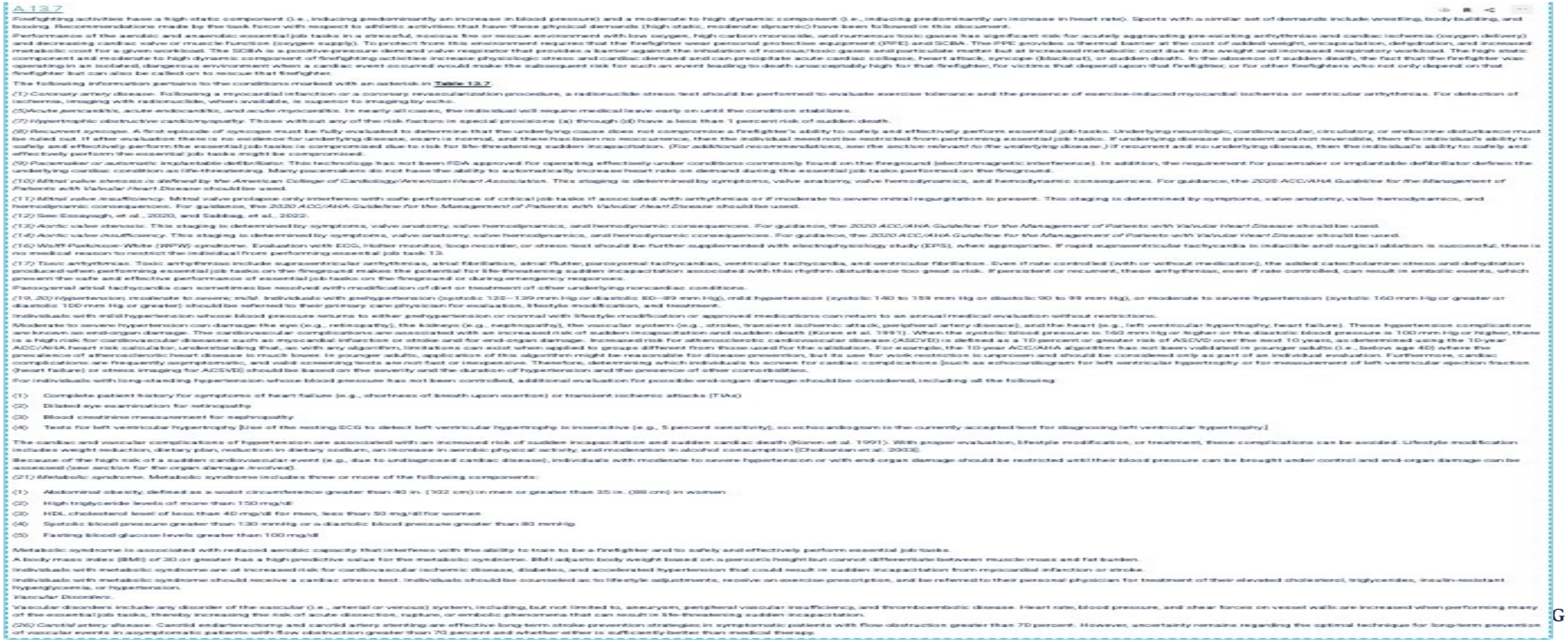
NFPA 1580/1584: REHABILITATION

Prehabilitation, contamination control, rehabilitation, and recovery from incident scene operations and training exercises

Chapter 20: Preparedness
Chapter 21: Preliminary Exposure Reduction
Chapter 22: Incident Scene and Training (Rehabilitation)
Chapter 23: Post-Incident Recovery

ANNEX A: EXPLANATORY MATERIAL

13.7* Medical Conditions Involving the Cardiovascular System.



A 13.7

Firefighting activities have a high static component (i.e., inducing predominantly an increase in blood pressure) and a moderate to high dynamic component (i.e., inducing predominantly an increase in heart rate). Sports with a similar set of demands include wrestling, body building, and bobsled. Recommendations made by the task force with respect to athletic activities that have these physical demands (high static, moderate dynamic) have been followed in this document.

Performance of the aerobic and anaerobic essential job tasks in a stressful, noxious fire or rescue environment with low oxygen, high carbon monoxide, and numerous toxic gases has significant risk for acutely aggravating pre-existing arrhythmias and cardiac ischemia (oxygen delivery) and decreasing cardiac valve or muscle function (oxygen supply). To protect from this environment requires that the firefighter wear personal protective equipment (PPE) and SCBA. The PPE provides a thermal barrier at the cost of added weight, encapsulation, dehydration, and increased metabolic cost for a given workload. The SCBA is a positive-pressure demand valve respirator that provides a barrier against the inhalation of noxious/toxic gases and particulate matter but at increased metabolic cost due to its weight and increased respiratory workload. The high static component and moderate to high dynamic component of firefighting activities increase physiologic stress and cardiac demand and can precipitate acute cardiac collapse, heart attack, syncope (blackout), or sudden death. In the absence of sudden death, the fact that the firefighter was operating in an isolated, dangerous environment when a cardiac event occurred would make the subsequent risk for such an event leading to death unacceptably high for that firefighter, for victims that depend upon that firefighter, or for other firefighters who not only depend on that firefighter but can also be called on to rescue that firefighter.

The following information pertains to the conditions marked with an asterisk in Table 13.7.

(1) *Coronary artery disease.* Following a myocardial infarction or a coronary revascularization procedure, a radionuclide stress test should be performed to evaluate exercise tolerance and the presence of exercise-induced myocardial ischemia or ventricular arrhythmias. For detection of ischemia, imaging with radionuclide, when available, is superior to imaging by echo.

(5) *Acute pericarditis, acute endocarditis, and acute myocarditis.* In nearly all cases, the individual will require medical leave early on until the condition stabilizes.

(7) *Hypertrophic obstructive cardiomyopathy.* Those without any of the risk factors in special provisions (a) through (d) have a less than 1 percent risk of sudden death.

(8) *Recurrent syncope.* A first episode of syncope must be fully evaluated to determine that the underlying cause does not compromise a firefighter's ability to safely and effectively perform essential job tasks. Underlying neurologic, cardiovascular, circulatory, or endocrine disturbance must be ruled out. If after evaluation there is no evidence for underlying disease, exam is normal, and there has been no reoccurrence, then the individual need not be restricted from performing essential job tasks. If underlying disease is present and not reversible, then the individual's ability to safely and effectively perform the essential job tasks is compromised due to risk for life-threatening sudden incapacitation. (For additional recommendations, see the section relevant to the underlying disease.) If recurrent and no underlying disease, then the individual's ability to safely and effectively perform the essential job tasks might be compromised.

(9) *Pacemaker or automatic implantable defibrillator.* This technology has not been FDA approved for operating effectively under conditions commonly found on the fireground (electromagnetic interference). In addition, the requirement for pacemaker or implantable defibrillator defines the underlying cardiac condition as life-threatening. Many pacemakers do not have the ability to automatically increase heart rate on demand during the essential job tasks performed on the fireground.

(10) *Mitral valve stenosis is defined by the American College of Cardiology/American Heart Association.* This staging is determined by symptoms, valve anatomy, valve hemodynamics, and hemodynamic consequences. For guidance, the 2020 ACC/AHA Guideline for the Management of Patients with Valvular Heart Disease should be used.

(11) *Mitral valve insufficiency.* Mitral valve prolapse only interferes with safe performance of critical job tasks if associated with arrhythmias or if moderate to severe mitral regurgitation is present. This staging is determined by symptoms, valve anatomy, valve hemodynamics, and hemodynamic consequences. For guidance, the 2020 *ACC/AHA Guideline for the Management of Patients with Valvular Heart Disease* should be used.

(12) See Essayagh, et al., 2020, and Sabbag, et al., 2022.

(13) *Aortic valve stenosis.* This staging is determined by symptoms, valve anatomy, valve hemodynamics, and hemodynamic consequences. For guidance, the 2020 *ACC/AHA Guideline for the Management of Patients with Valvular Heart Disease* should be used.

(14) *Aortic valve insufficiency.* This staging is determined by symptoms, valve anatomy, valve hemodynamics, and hemodynamic consequences. For guidance, the 2020 *ACC/AHA Guideline for the Management of Patients with Valvular Heart Disease* should be used.

(16) *Wolff-Parkinson-White (WPW) syndrome.* Evaluation with ECG, Holter monitor, loop recorder, or stress test should be further supplemented with electrophysiology study (EPS), when appropriate. If rapid supraventricular tachycardia is inducible and surgical ablation is successful, there is no medical reason to restrict the individual from performing essential job task 13.

(17) *Toxic arrhythmias.* Toxic arrhythmias include supraventricular arrhythmias, atrial fibrillation, atrial flutter, paroxysmal tachycardias, ventricular tachycardia, and ventricular fibrillation. Even if rate controlled (with or without medication), the added catecholamine stress and dehydration produced when performing essential job tasks on the fireground makes the potential for life-threatening sudden incapacitation associated with this rhythm disturbance too great a risk. If persistent or recurrent, these arrhythmias, even if rate controlled, can result in embolic events, which present the safe and effective performance of essential job tasks on the fireground or during emergency responses.

Paroxysmal atrial tachycardia can sometimes be resolved with modification of diet or treatment of other underlying noncardiac conditions.

(19, 20) *Hypertension, moderate to severe, mild.* Individuals with prehypertension (systolic 120—139 mm Hg or diastolic 80—89 mm Hg), mild hypertension (systolic 140 to 159 mm Hg or diastolic 90 to 99 mm Hg), or moderate to severe hypertension (systolic 160 mm Hg or greater or diastolic 100 mm Hg or greater) should be referred to their primary care physician for evaluation, lifestyle modification, and treatment.

Individuals with mild hypertension whose blood pressure returns to either prehypertension or normal with lifestyle modification or approved medications can return to an annual medical evaluation without restrictions.

Moderate to severe hypertension can damage the eye (e.g., retinopathy), the kidneys (e.g., nephropathy), the vascular system (e.g., stroke, transient ischemic attack, peripheral artery disease), and the heart (e.g., left ventricular hypertrophy, heart failure). These hypertension complications are known as end-organ damage. The cardiovascular complications are associated with an increased risk of sudden incapacitation and sudden death (Kones et al. 1991). When the systolic blood pressure is 160 mm Hg or higher or the diastolic blood pressure is 100 mm Hg or higher, there is a high risk for cardiovascular diseases such as myocardial infarction or stroke and for end-organ damage. Increased risk for atherosclerotic cardiovascular disease (ASCVD) is defined as a 10 percent or greater risk of ASCVD over the next 10 years, as determined using the 10-year ACC/AHA heart risk calculator, understanding that, as with any algorithm, limitations can exist when applied to groups different from those used for the validation. For example, the 10-year ACC/AHA algorithm has not been validated in younger adults (i.e., below age 40) where the prevalence of atherosclerotic heart disease is much lower. In younger adults, application of this algorithm might be reasonable for disease prevention, but its use for work restrictions is unproven and should be considered only as part of an individual evaluation. Furthermore, cardiac complications are frequently asymptomatic, and valid screening tests are not fast or inexpensive. Therefore, determining which individuals to screen for cardiac complications (such as echocardiogram for left ventricular hypertrophy or for measurement of left ventricular ejection fraction (heart failure) or stress imaging for ACSVD) should be based on the severity and the duration of hypertension and the presence of other comorbidities.

For individuals with long-standing hypertension whose blood pressure has not been controlled, additional evaluation for possible end-organ damage should be considered, including all the following:

(1) Complete patient history for symptoms of heart failure (e.g., shortness of breath upon exertion) or transient ischemic attacks (TIAs)
(2) Dilated eye examination for retinopathy
(3) Blood creatinine measurement for nephropathy
(4) Tests for left ventricular hypertrophy [Use of the resting ECG to detect left ventricular hypertrophy is insensitive (e.g., 5 percent sensitivity), so echocardiogram is the currently accepted test for diagnosing left ventricular hypertrophy.]

The cardiac and vascular complications of hypertension are associated with an increased risk of sudden incapacitation and sudden cardiac death (Kones et al. 1991). With proper evaluation, lifestyle modification, or treatment, these complications can be avoided. Lifestyle modification includes weight reduction, dietary plan, reduction in dietary sodium, an increase in aerobic physical activity, and moderation in alcohol consumption (Chobanian et al. 2003).

Because of the high risk of a sudden cardiovascular event (e.g., due to undiagnosed cardiac disease), individuals with moderate to severe hypertension or with end-organ damage should be restricted until their blood pressure can be brought under control and end-organ damage can be assessed (see section for the organ damage involved).

(21) *Metabolic syndrome.* Metabolic syndrome includes three or more of the following components:

(1) Abnormal obesity, defined as a waist circumference greater than 40 in. (102 cm) in men or greater than 35 in. (88 cm) in women
(2) High triglyceride levels of more than 150 mg/dl
(3) HDL cholesterol level of less than 40 mg/dl for men, less than 50 mg/dl for women
(4) Systolic blood pressure greater than 130 mmHg or a diastolic blood pressure greater than 80 mmHg
(5) Fasting blood glucose levels greater than 100 mg/dl

Metabolic syndrome is associated with reduced aerobic capacity that interferes with the ability to train to be a firefighter and to safely and effectively perform essential job tasks.

A body mass index (BMI) of 30 or greater has a high predictive value for the metabolic syndrome. BMI adjusts body weight based on a person's height but cannot differentiate between muscle mass and fat burden.

Individuals with metabolic syndrome are at increased risk for cardiovascular ischemic disease, diabetes, and accelerated hypertension that could result in sudden incapacitation from myocardial infarction or stroke.

Individuals with metabolic syndrome should receive a cardiac stress test. Individuals should be counseled as to lifestyle adjustments, receive an exercise prescription, and be referred to their personal physician for treatment of their elevated cholesterol, triglycerides, insulin-resistant hyperglycemia, or hypertension.

Vascular Disorders.

Vascular disorders include any disorder of the vascular (i.e., arterial or venous) system, including, but not limited to, aneurysm, peripheral vascular insufficiency, and thromboembolic disease. Heart rate, blood pressure, and shear forces on vessel walls are increased when performing many of the essential job tasks, thereby increasing the risk of acute dissection, rupture, or embolic phenomena that can result in life-threatening sudden incapacitation.

(26) *Carotid artery disease.* Carotid endarterectomy and carotid artery stenting are effective long-term stroke prevention strategies in symptomatic patients with flow obstruction greater than 70 percent. However, uncertainty remains regarding the optimal technique for long-term prevention of vascular events in asymptomatic patients with flow obstruction greater than 70 percent and whether either is sufficiently better than medical therapy.

NFPA 1580: NOTEWORTHY ANNEX MATERIAL

- **Annex D:** Guide for Fire Department Administrators (NFPA 1582)
  - Addresses reasonable accommodation requirements and limitations in ADA/ Rehab Act
- **Annex E:** Maternal and Child Health Considerations (NFPA 1582)
- **Annex G:** Behavioral Health (NFPA 1582)
- **Annex H:** Sample Fitness Plan (NFPA 1583)
- **Annex J:** Managing Heat Stress, Cold Stress, and Heat -Related Illness (NFPA 1584)

1580/1581

FIRE DEPARTMENT INFECTION CONTROL PROGRAM

INFECTION CONTROL OFFICER

- Responsible for maintaining a liaison with the fire department physician
- A confidential health data base shall be established
- This data base shall include:
  - Any occupational exposures
  - Vaccination status

EXPOSURE REPORTING

Exposure reports sent to Occ Health provider

- Blood or body fluids
- Airborne/droplet pathogens
- Needlesticks or sharps
- Contaminated PPE

Why reporting matters

- Early treatment
- Proper documentation
- Compliance and safety

What happens next

- Risk assessment
- Medical follow-up
- Confidential care

THE PROBLEM

CARDIAC RISK OF FIREFIGHTING

MMWR
Morbidity and Mortality Weekly Report
Weekly April 28, 2006 / Vol. 55 / No. 16

TABLE. Number and percentage of fatalities among career and volunteer firefighters, by cause/contributing cause — United States, 1994–2004

Cause/Contributing cause	Career No.	Career (%)	Volunteer No.	Volunteer (%)
Heart attack*	**142**	**(39)**	**306**	**(50)**
Stress/Overexertion	138	(97)	301	(98)
Other	4	(3)	5	(2)
Motor vehicle–related trauma	**44**	**(12)**	**160**	**(26)**
Vehicle collision/crash	30	(68)	116	(73)
Struck by vehicle	12	(27)	33	(20)
Other vehicle-related (e.g., crushed by or fell from a vehicle)	2	(5)	11	(7)
Asphyxiation	**74**	**(20)**	**45**	**(7)**
Caught/Trapped	56	(76)	31	(69)
Other (e.g., lost inside a structure or exposed to smoke)	18	(24)	14	(31)
All other†	**108**	**(29)**	**99**	**(16)**
Caught/Trapped	32	(30)	19	(19)
Fall	8	(7)	15	(15)
Exposure (e.g., to smoke)	9	(8)	14	(14)
Stress/Overexertion	16	(15)	14	(14)
Structure collapse	8	(7)	3	(3)
Other	35	(32)	34	(34)
Total	**368**		**610**	

* For example, myocardial infarction or arrhythmia.
† Includes deaths caused by burns, cerebral vascular accidents, drownings, electrocution, heat exhaustion, and trauma.

For every cardiac LODD, an estimated

17

non-fatal cardiac events occur on duty each year.

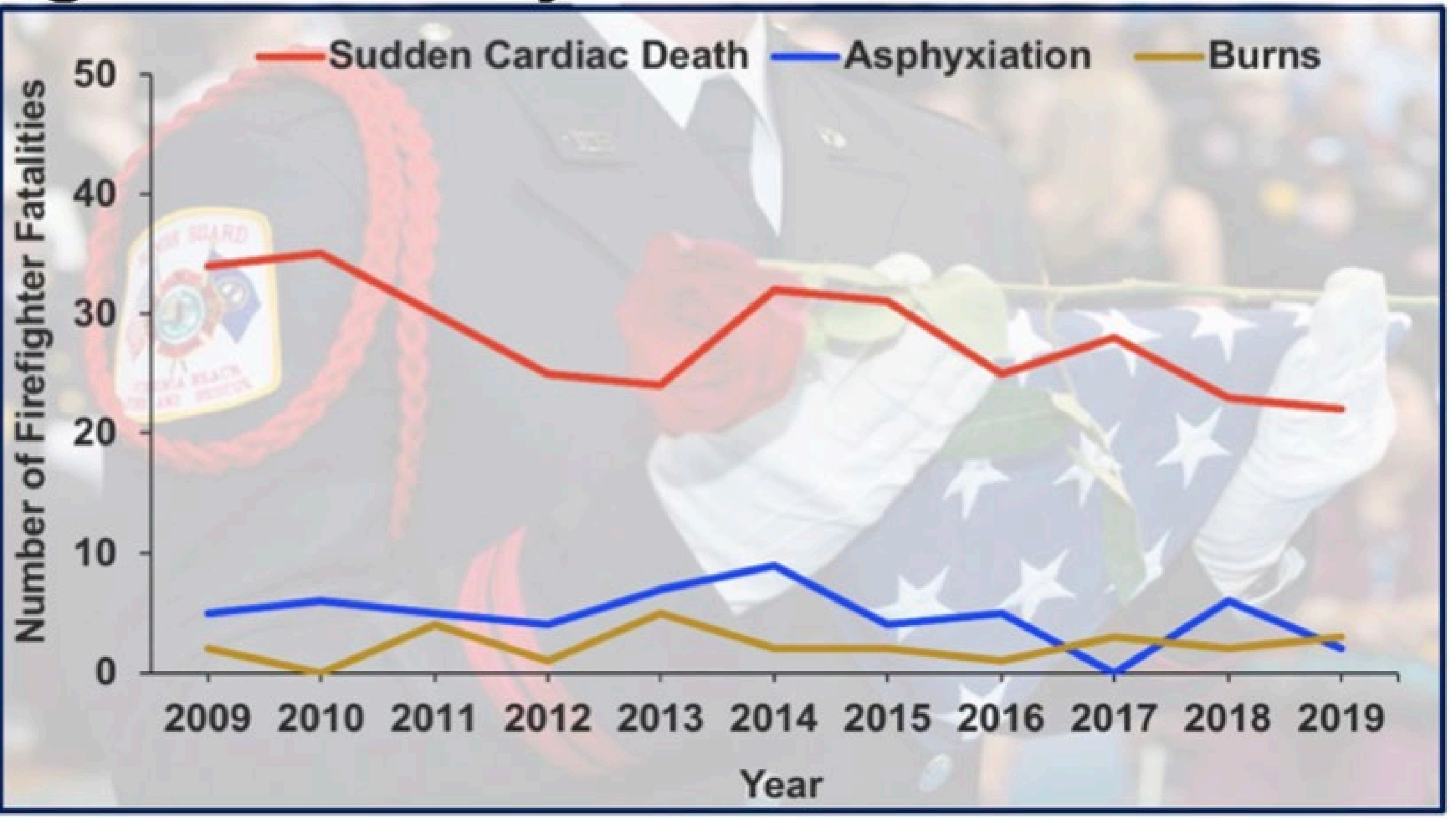
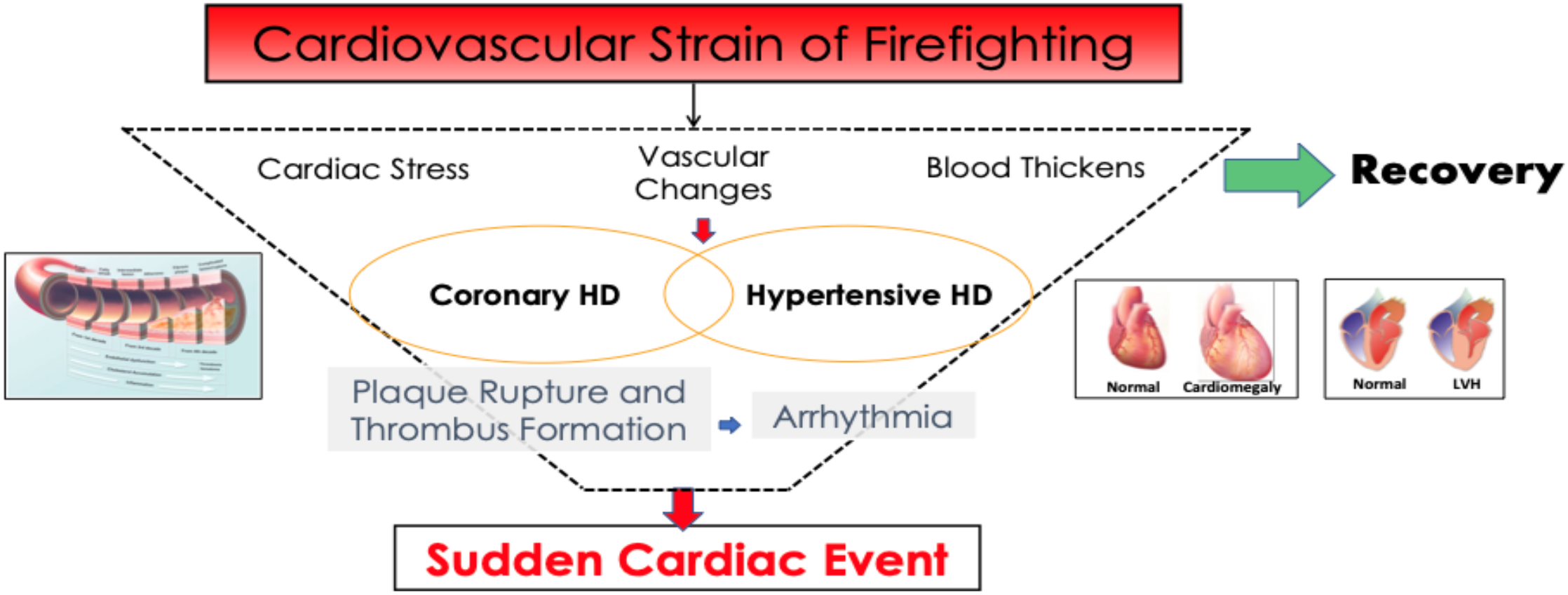

Sudden Cardiac Death
Asphyxiation
Burns
Number of Firefighter Fatalities
50
40
30
20
10
0
2009
2010
2011
2012
2013
2014
2015
2016
2017
2018
2019
Year

Table 1. Cardiovascular and metabolic responses during strenuous firefighting.

Variable	Rest	Firefighting
Heart rate (bpm)	70	192
Stroke volume (mL/beat)	85	130
Cardiac output (L/min)	5.7	25
Oxygen consumption (mL/kg/min)	3.5	45.5

INTEGRATION



Smith t al., 2013

Cardiovascular Disease Risk Factors in Fire Service

	Prevalence	
CVD Risk Factors	**Firefighters**	**General Population***
Hypertension (n=5063)+	**69%**	**29%**
High Cholesterol (n=4513)#	**20%**	**24%**
Low HDL (n=4513)#	**25%**	**18%**
Obesity (n=4513)#	**36%**	**40%**

+Khaja et al., 2021

International Journal of Environmental Research and Public Health

#Moffatt et al., 2021

PMR Preventive Medicine Reports

*About NCHS - NCHS Fact Sheets - National Health and Nutrition Examination Survey (cdc.gov)

WHY IS CRF IMPORTANT – MEDICAL EVIDENCE

CRF is an overall measure of Health

American Heart Association has proposed CRF as Vital Sign

1580/1582

COMPREHENSIVE OCCUPATIONAL MEDICAL PROGRAM FOR FIRE DEPARTMENTS

FIRE DEPARTMENT RESPONSIBILITIES

- Provide the fire department physician with a fire service overview, current job descriptions, and the essential job tasks
- The medical evaluations and any additional medical tests ordered by the fire department physician shall be provided at no cost to the members. (9.2.2)
- Where possible, the fire department shall provide alternate duty position for members when the fire department physician recommends temporary work restrictions.
- Education regarding reproductive health risks (13.14)

FIRE DEPARTMENT PHYSICIAN ROLE

- Individualized assessment…"there shall be no blanket exclusions"
- Status of the individual:
  - No restriction
  - Permanent restriction…due to a permanent or long-term medical condition
  - Temporary restriction
- Provide the AHJ a written statement that identifies the specific essential job task(s) the individual is restricted from performing
- The fire department physician shall not make a recommendation regarding the individual's employment in the fire department.

MEMBER RESPONSIBILITIES

- Cooperate, participate, and comply with the medical evaluation process *(don't be a jerk)*
- Provide complete and accurate information *(don't lie or conceal)*
- Report any occupational exposure
- Report to the fire department physician any medical condition that could interfere with the ability of the individual to safely perform essential job tasks
  - illness or injury
  - prescription or nonprescription medication
  - pregnancy

ESSENTIAL JOB TASKS

The fire department shall evaluate the essential job tasks

- against the types and levels of emergency services provided to the local community by the fire department,
- the types of structures and occupancies in the community,
- and the configuration of the fire department to determine which tasks apply to individuals

15 ESSENTIAL JOB TASKS

- Wearing PPE and SCBA
- Wearing a respirator
- Possible exposure to toxicants
- Climbing 6 flights in PPE/SCBA
- Risk of elevated core temp/dehydration
- Advancing hoselines
- Long and unpredictable periods of extreme exertion
- Ability to communicate while wearing PPE
- Functioning as an integral component of a team
- Shift work
- EMS Tasks

ESSENTIAL JOB TASKS

- *Not Necessarily All or Nothing*
- The fire department shall provide the fire department physician with the list of essential job tasks to be used in the medical evaluation of members and candidates.
- The FD can adapt the EJT to their locale, or add specialty EJT's

IMPLEMENTATION

When Chapters 9 through **13** are adopted by a jurisdiction, date(s) shall be set for individuals to achieve compliance by establishing a phase-in schedule for compliance with specific requirements, if needed.

CONFIDENTIALITY OF MEDICAL INFORMATION

- Specific information concerning medical diagnosis shall be released by the fire department physician only with written permission from the individual and/or as required by law.
- No fire department personnel, other than the fire department physician or appropriate medical staff, shall have access to another member's medical records without the express written consent of that member.

OCCUPATIONAL MEDICAL EVALUATION CHAPTER 11

- **Medical History**
- **Physical Exam**
- **Ancillary Tests** – *blood, vision, hearing, lung function, ECG, chest x-ray, risk stratification*
- **Screening** – *cancer, infectious disease, heavy metals*, behavioral health, sleep disturbance*
- **Consultation** – *occupational stress, hormone imbalance, CA risk*

TIMING OF THE ANNUAL OCCUPATIONAL EXAM

- All members shall receive a **baseline medical evaluation**
- The **annual evaluation** shall be completed every 12 months (±3 months).
- The interval requirements for performance of the annual occupational medical evaluation shall not preclude **more frequent medical evaluations of members for new or recurring conditions** when requested by the member, fire department physician, or AHJ.

RISK STRATIFICATION

- Members will be assessed using the ASCVD score
- Those at higher risk shall be further evaluated using symptom-limiting exercise stress testing (EST) with imaging.

NFPA 1582 CANCER SCREENING

- Colon
- Prostate
- Lung
- Bladder
- Oral
- Thyroid
- Skin
- Testicular
- Cervical
- Mammogram (>40)

ANNUAL FITNESS EVALUATION CHAPTER 12

- Weight & Body Composition
  - Surveillance only
- Aerobic Capacity
  - Above 50th percentile of general population
  - Between 35th and 50th percentile of general population
  - Below 35th percentile of general population
- Strength, Endurance, and Mobility
  - Surveillance only

THE BIG CHANGE
Cardiorespiratory Fitness

NOW, LIKE BEFORE…

Appropriate fitness =

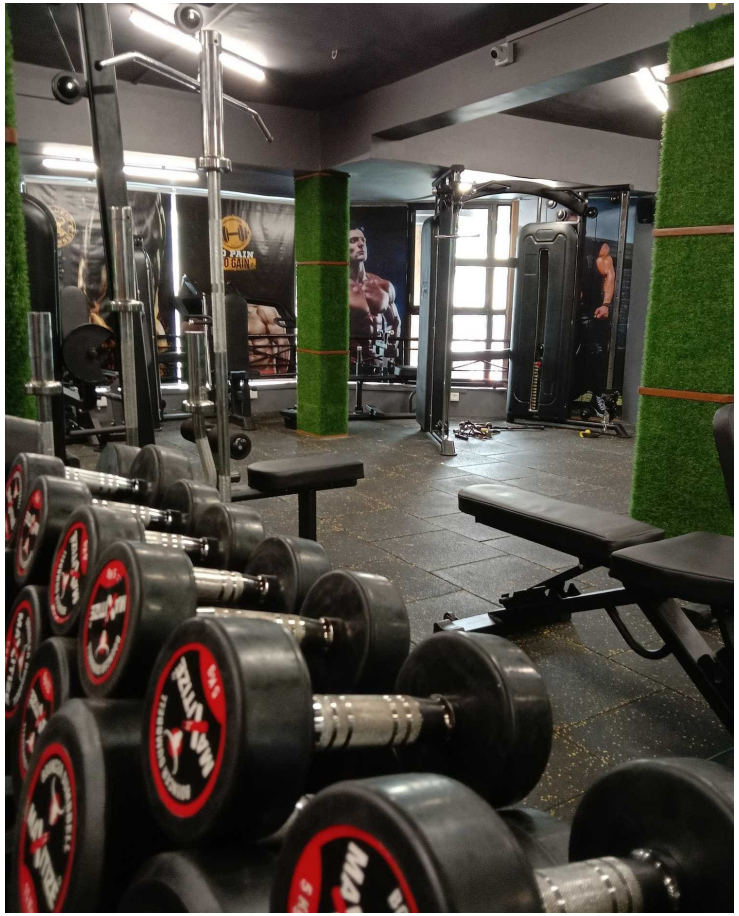
No interventions

Degraded Fitness =

No restrictions, but prescribed fitness program

Poor Fitness =

Restricted from performing certain essential job tasks



APPROPRIATE FITNESS WITH NO INTERVENTIONS

Cardiorespiratory fitness equal to the 50th percentile of the general population standardized for age and biological sex is an appropriate target level

"AN APPROPRIATE FITNESS LEVEL"

CARDIORESPIRATORY FITNESS AND AEROBIC CAPACITY STANDARD FOR FIREFIGHTERS, ADJUSTED FOR AGE AND BIOLOGICAL SEX OF THE INDIVIDUAL (50TH PERCENTILE)

	METs	
Age	**Male**	**Female**
20–29	**13.7**	**10.7**
30–39	**12.1**	**8.6**
40–49	**10.8**	**7.6**
50–59	**9.3**	**6.7**
60–69	**8.1**	**5.7**

NO RESTRICTIONS, BUT PRESCRIPTION

For an individual whose cardiorespiratory fitness levels are above the 35th percentile but below the 50th percentile **for the general population standardized by biological sex and age** the fire department physician shall require participation in a prescribed cardiorespiratory (aerobic) fitness program without job restrictions.

Earlier prescription than previous standard – proactive intervention

HIGH RISK = HIGHER BAR

Restriction is recommended for certain high risk medical conditions if the individuals cardiorespiratory fitness falls below the 50th percentile for age and sex.

- Certain cardiovascular, respiratory, and metabolic diseases
- This is actually an accommodation for conditions that in the past were disqualifying

RESTRICTION

For an individual whose cardiorespiratory fitness falls **below the 35th percentile for the general population standardized by biological sex and age**, the fire department physician shall do both of the following:

(1)Recommend to the AHJ that the individual be restricted from performing essential job tasks 1, 2, 4, 5, 6, 7, 8, 9, and 13

(2)Require the individual to participate in a prescribed cardiorespiratory (aerobic) fitness program

ESSENTIAL JOB TASKS NOT RESTRICTED FOR FITNESS BELOW 35TH%

(3) Exposure to toxic fumes, irritants, particulates, biological (i.e., infectious) and nonbiological hazards, or heated gases, despite the use of PPE and SCBA

(10) Operating fire apparatus or other vehicles in an emergency mode with emergency lights and sirens

(11) Critical, time-sensitive, complex problem solving during physical exertion in stressful, hazardous environments, including hot, dark, tightly enclosed spaces, that is further aggravated by fatigue, flashing lights, sirens, and other distractions

(12) Ability to communicate (i.e., give and comprehend written or verbal orders) while wearing PPE and respirators required by the jurisdiction under conditions of high background noise, poor visibility, and drenching from hose lines or fixed protection systems (e.g., sprinklers)

(14)Working in shifts, including during nighttime, that can extend beyond 12 hours

(15)Performing emergency medical service (EMS) tasks, such as cardiopulmonary resuscitation (CPR) or lifting or moving patients, while wearing PPE and respirators required by the jurisdiction

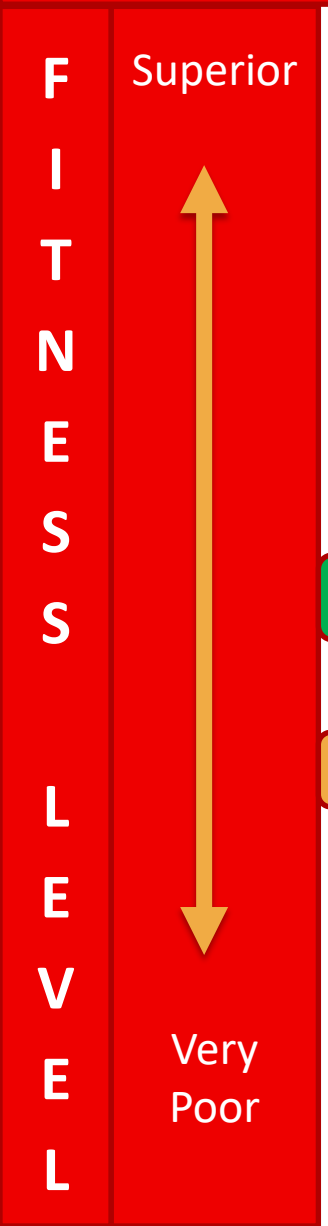
MINIMUM CARDIORESPIRATORY FITNESS

Cardiorespiratory Fitness and Aerobic Capacity Standard for Firefighters, Adjusted for Age and Biological Sex of the Individual (35th Percentile)		
Age	**METs**	
	Male	**Female**
20–29	12.4	9.6
30–39	11	7.8
40–49	9.9	6.9
50–59	8.4	6.1
60–69	7.3	5.3

Be prepared…

Incumbent firefighters who remained unrestricted at the previous 8 MET level, may now be restricted under NFPA 1582

Cardiorespiratory Fitness and Aerobic Capacity



20-29 years old

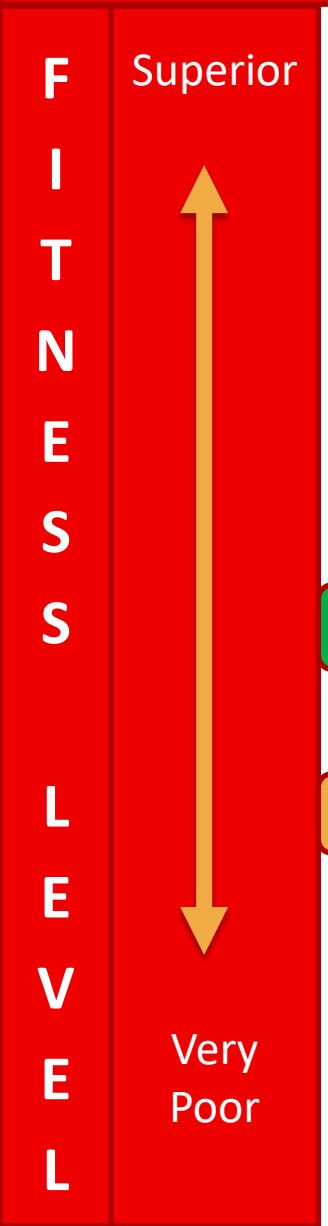
20-29 y/o Female
12.4 Mets = >80%
Very Good

50% Fair Fitness (20-29 y/o) 13.7 METs (Male) 10.7 METs (Female)

35% Poor Fitness (20-29 y/o) 12.4 METs (Male) 9.6 METs (Female)

20-29 y/o Male
9.6 Mets = >20%
Very Poor

Cardiorespiratory Fitness and Aerobic Capacity



30-39 years old

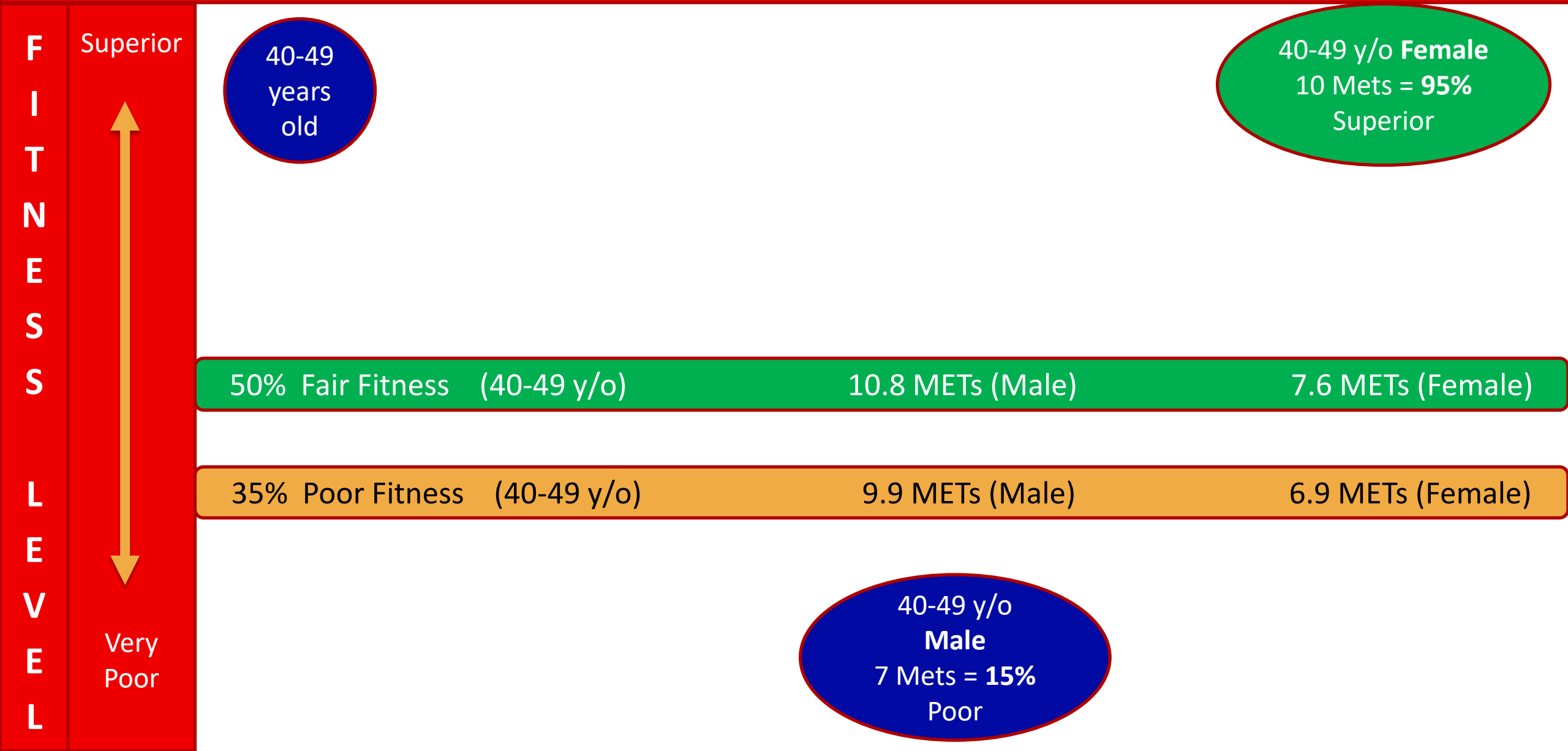
30-39 y/o Female
11 METs = 65%
Good

50% Fair Fitness (30-39 y/o) 12.1 METs (Male) 8.6 METs (Female)

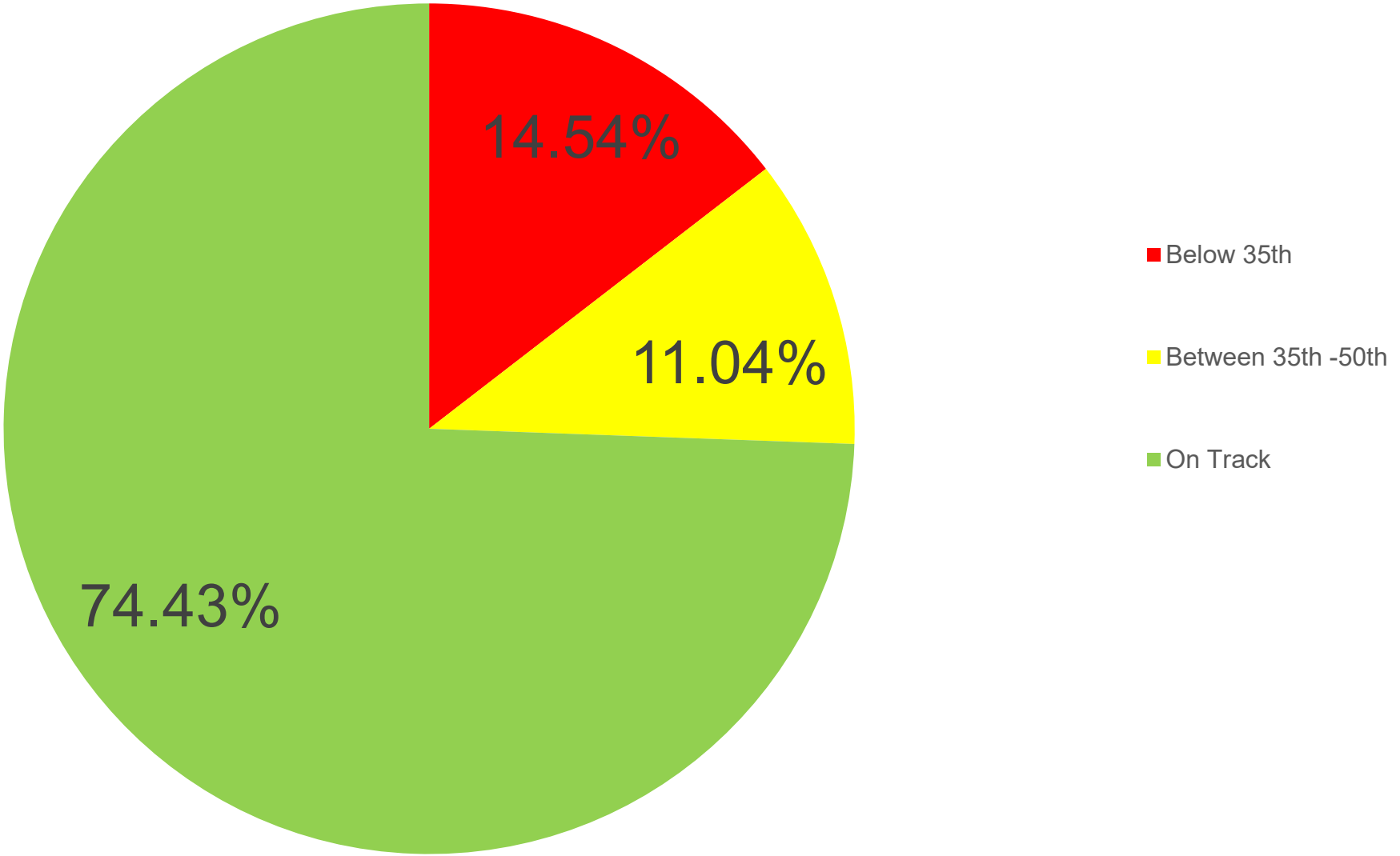
35% Poor Fitness (30-39 y/o) 11.0 METs (Male) 7.8 METs (Female)

30-39 y/o Male
7.8 METs = **15%**
Poor

Cardiorespiratory Fitness and Aerobic Capacity



Current MET Data



PRESCRIBED CRF/AEROBIC FITNESS PROGRAM

- The prescribed cardiorespiratory (aerobic) fitness program would be developed for the individual in consultation with the individual's personal doctor and/or the AHJ's health and wellness team.
- The individual would meet at a frequency identified during this consultation for appropriate follow-up and possible adjustment of the cardiorespiratory fitness program.

CRF: KEY TAKEAWAYS

- ✅ No more MET “one-size-fits-all” standard
- ✅ Age and sex now matter in fitness evaluation
- ✅ Focus on fairness, accuracy, and risk-based return-to-duty
- ✅ Proactive support replaces blanket restriction

EMPOWERMENT AND OWNERSHIP

- Your health is tactical readiness.
- Prevention = career longevity.
- This is not punishment — it’s protection.
- Wellness is not weakness.

CONTRACT LANGUAGE

CHALLENGES AND CONSIDERATIONS FOR FIRE DEPARTMENT PHYSICALS

THE CHALLENGES OF A OCC MEDICAL EXAM

- Is it fit for duty?
  - Medical evaluation of ability to safely perform essential job task
- What do you do with a member who has an Essential Job Task limiting condition?
- Contract Language Matters

BENEFITS OF AN ANNUAL COMPREHENSIVE MEDICAL EXAM

- High rate of occupational exposures and injuries
- Early detection of health problems leads to better outcomes
- Fitness is motivated and maintained
- Healthy workers, reduced injures, less time off
- Lower overall healthcare costs

ADDRESS EARLY ON…

- Implementation challenges
  - If you haven't had any expectations for 10+ years…
- How EJT restrictions will be addressed
  - Individualized Assessment
  - Reasonable Accommodation
  - Light Duty
  - Legal Considerations - See Annex B

CONFIDENTIALITY

- Don’t give this away!
- No fire department personnel, other than the fire department physician or appropriate medical staff, shall have access to another member’s medical records without the express written consent of that member.

ADDITIONAL CONSIDERATIONS

- Medical Record Retentional and Portability
- How is time off to handled when specialist clearance is required?

1580/1583

HEALTH-RELATED FITNESS PROGRAMS FOR FIRE DEPARTMENT MEMBERS

PROGRAM PARTICIPATION

- The fire department physician shall clear all members for participation in the exercise and fitness training program
- Prior to returning to full duty following an extended leave from an injury, illness, or other condition, a member shall be assessed to determine the need for an exercise program to ensure a safe transition back to work

1580/1584

MEMBER PREHABILITATION, CONTAMINATION CONTROL, REHABILITATION, AND RECOVERY FOR EMERGENCY OPERATIONS AND TRAINING

rehabilitate verb

re·ha·bil·i·tate | \ˌrē-ə-ˈbi-lə-ˌtāt, ˌrē-hə- \

rehabilitated; **rehabilitating**

Definition of *rehabilitate*

transitive verb

1 **a** : to restore to a former capacity : REINSTATE

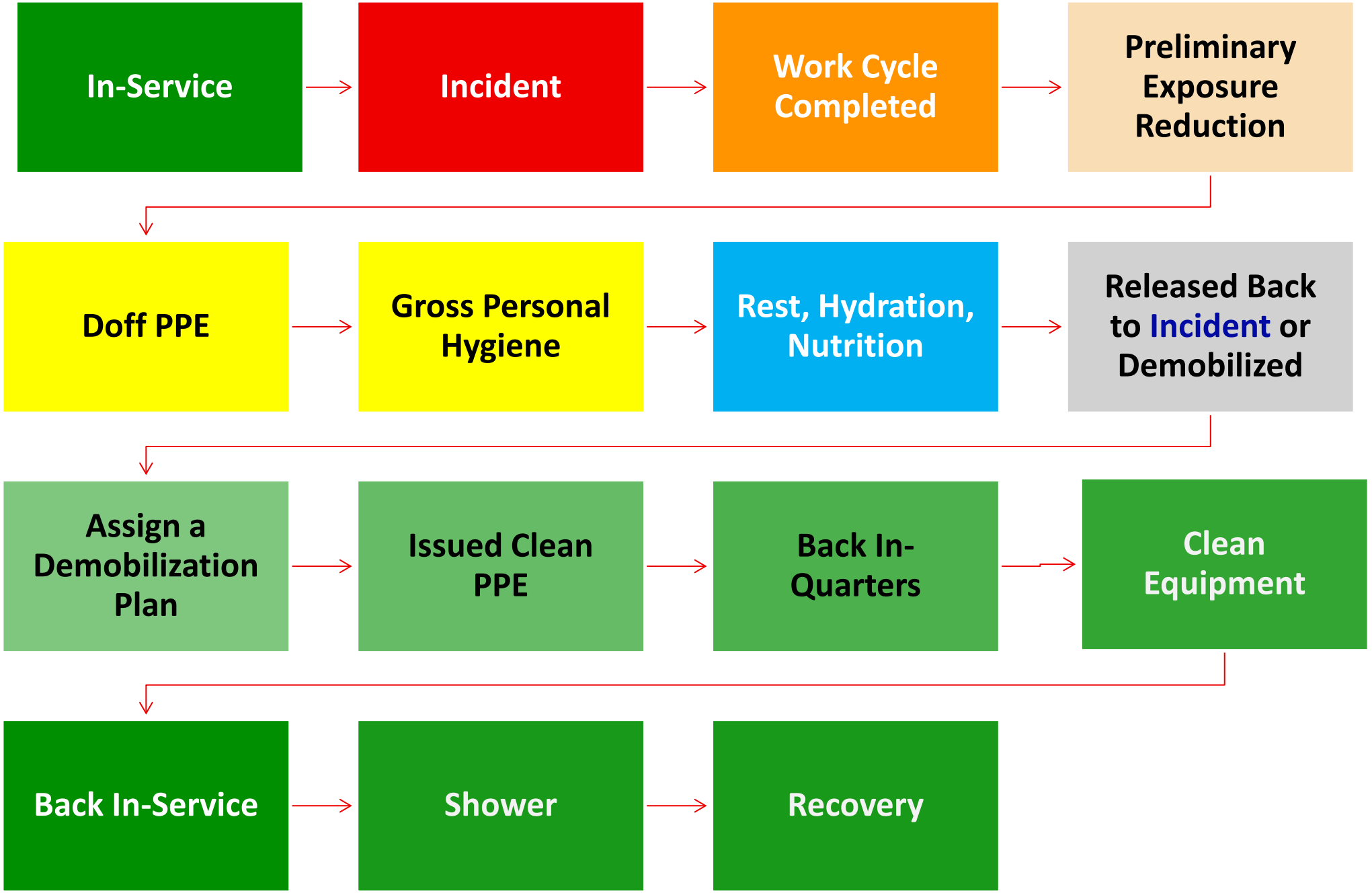
b : to restore to good repute : reestablish the good name of

2 **a** : to restore to a former state (as of efficiency, good management, or solvency)

// rehabilitate slum areas

b : to restore or bring to a condition of health or useful and constructive activity

Rehabilitation Process



PREPAREDNESS

- Organizational Policies & Procedures
- Member Education
  - Heat & Cold stress
  - Wind chill and heat index considerations
  - Impact of improper hydration, nutrition, and rest
  - Rhabdomyolysis
- Member Prehabilitation

Ensuring you're ready to take the run

PRELIMINARY EXPOSURE REDUCTION

- Completed prior to rehabilitation or demobilization from the incident
- Establishing hazard control zones
- Contamination reduction techniques
- On-Scene Personal Hygiene

MEMBER REHABILITATION

- Responsibilities of the member, supervisor, IC, rehab manager
- Location Characteristics
- Rest and recovery criteria
- Cooling and warming efforts
- Emergency medical care
  - No longer recommended to using vital sign criteria

EMS PERSONNEL SHALL BE ALERT FOR:

- Personnel complaining of chest pain, dizziness, shortness of breath, weakness, nausea, or headache
- General complaints, such as cramps, aches, and pains
- Symptoms of heat- or cold-related stress
- Changes in gait, speech, or behavior
- Alertness and orientation to person, place, and time of members
- Psychological or emotional distress resulting from exposure to potentially traumatic events

CRITERIA FOR MEMBER REHABILITATION

- *'…following the use of a single self-contained breathing apparatus (SCBA) cylinder with intensive work or after 40 minutes of intensive work without SCBA'*
- *May be adjusted in order to address incident-related life safety, rescue, and patient care.*

POST-INCIDENT RECOVERY

- Demobilization
- Post-incident Status
- Post-incident personal hygiene
- Station, Apparatus, Protective Clothing, and Equipment Decontamination.
- Potentially Traumatic Event Recognition
- Exposure Reporting

NEXT EDITION...

WORK STILL NEEDED…

- More emphasis on reproductive health education
- Implementation (of new/updated requirements)
- Not every finding may need immediate restriction
  - 30 to 90-day specialist follow-up
- What else??

A BEHAVIORAL HEALTH STANDARD??

Current BH Guidance

NFPA 1550: Emergency Responder Health and Safety

- Chapter 14: Behavioral Health and Wellness Programs
- Chapter 15: Occupational Exposure to Potentially Traumatic Event

NFPA 1580: Emergency Responder Occupational Health and Wellness

- Chapter 11: Behavioral Health Screening
- Annex G: Behavioral Health

NATIONAL FIREFIGHTER REGISTRY (NFR)

- Will help improve our understanding of occupational cancer
- Will lead to better prevention and mitigation
- Personal information will be kept confidential

LEARN MORE....

Cardiorespiratory Fitness (CRF) Assessment and Education

Today 2-4p

Session 3

Implementing a Total Wellness Program in your Department

Monday 8-10a

Session 4

Wellness Fitness Initiative: Igniting Change Updates

Tuesday 8-10a

Session 7

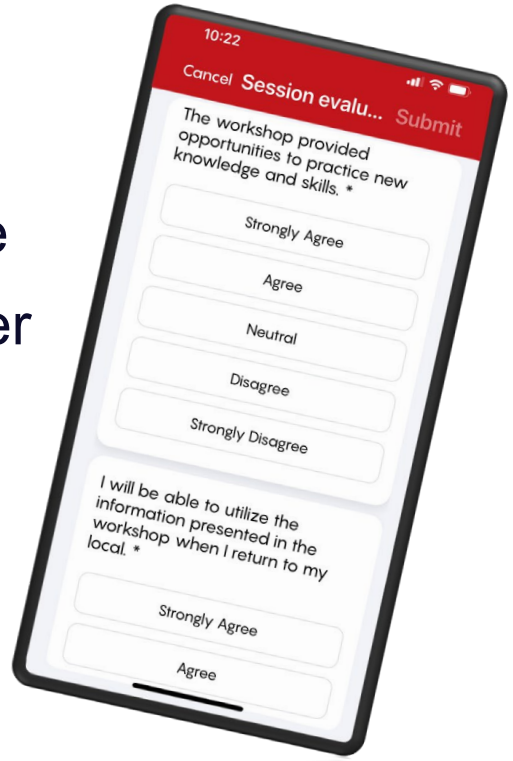
THANK YOU!
ANY QUESTIONS?

Kepra Jack
kepra@heartfitforduty.org

David Bernzweig
dbernzweig@oapff.org

EVALUATION AND WIN AN IPAD!

- **Submit your workshop and overall evaluations to be automatically entered in two drawings for a new iPad!**
- **Complete your evaluations using the IAFF app:**
  1. Download the IAFF app and sign in with your iaff.org username
  2. Tap the 2026 Strive for Excellence Summit event image to enter the event's dashboard
  3. Tap "Sessions" and tap on the workshops you attended
  4. Tap "Evaluation" and complete the evaluation
  5. Tap "Submit"



For the event's overall evaluation, follow steps 1 and 2, then tap "Event Evaluation" located in the event's Dashboard.