Bechtel Nevada
Weapons of Mass Destruction Training Program
P.O. Box 98521
M/S: CF110
Las Vegas, NV 89193-8521

(Please print clearly or type application)

I am interested in attending the **WMD Radiological/Nuclear Course for HazMat Technicians**

Last Name_____**First Name**_____**MI**_____

Social Security Number:_____
(Student identification use only)

Commercial Driver's License # _____ **Expiration Date**_____

Department/Agency/Office Address **Email Address**

_____ _____

_____

_____

_____

Department/Agency/Office Telephone Number: **Department/Agency/Office Fax Number:**

_____ _____

Professional Experience:

My current job is: _____

Applicant's Signature:_____ Date_____

Supervisor's Signature:_____ Date_____

*State Coordinator:_____ Date _____

*Approval signature required.

Before mailing application ensure that you have filled in all requested information on the
1. Application
2. U.S. Dept. of Energy Security form
3. Bechtel Nevada Medical questionnaire

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

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.

Conference 2003 ❑ (please check if applicable)

(Older Versions Obsolete)
NV-205

09/2000

Information Required From Uncleared U.S. Citizens for Access to U.S. Department of Energy, Nevada Operations Office Facilities

WMD Group
Name of Group

Date of Visit

Name of Contact

Person Contact's Telephone (Include Area Code)

LAST Name **First** **Middle Initial (MI)**
(If no MI, write NMI)

Social Security Number

Date of Birth

Place of Birth (City and State)

Citizenship

Badge #: _____ **(If Applicable)**

Level of Clearance: _____ **(If Applicable)**

Purpose of Visit: _____

Company Name: _____

Job Title: _____

Business Street Address

Residence Street Address (No P.O. Boxes)

Business City, State, and ZIP Code

Residence City, State, and ZIP Code

Business Telephone (Include Area Code)

Residence Telephone (Include Area Code)

Badging Instructions (to be completed by the DOE/NV Visit Control Office):

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BECHTEL NEVADA-WMD TRAINING COURSE
RESPIRATOR MEDICAL EVALUATION QUESTIONNAIRE

Name _____SSN_____ Date _____

Employers Name and Address _____

Job Title _____ Sex _____ Age _____

Glove Size _____ Tyvek Suit Size _____ Height _____Weight _____ Boot Size _____

Are you trained to wear a respirator? _____ Yes _____ No

Are you trained to wear Self Contained Breathing Respirator (SCBA) _____ Yes _____ No

TO BE COMPLETED BY PHYSICIAN OR COMPANY MEDICAL REPRESENTATIVE

Does the patient now have or have they ever had any of the following:		**YES**	**NO**
1. Cardiovascular Disease	1.	____	____
2. Pulmonary Disease	2.	____	____
3. Smoke Tobacco	3.	____	____
4. Persistent Cough	4.	____	____
5. Heart Trouble	5.	____	____
6. Shortness of Breath	6.	____	____
7. History of Fainting or Seizures	7.	____	____
8. High Blood Pressure	8.	____	____
9. Diabetes	9.	____	____
10. Fear of Tight or Enclosed Places	10.	____	____
11. Sensation of Smothering	11.	____	____
12. Heat Exhaustion or Heat Stroke	12.	____	____
13. Ruptured Ear Drum	13.	____	____
14. Defective Vision	14.	____	____
15. Defective Hearing	15.	____	____
16. Contact lenses or glasses	16.	____	____
17. Taking Prescription Medication	17.	____	____
18. Problems wearing a respirator	18.	____	____
19. Other conditions that might interfere with respirator use or limit work ability	19.	____	____

Please explain any YES answers:

_____

_____

I approve/do not approve (circle one) the above named person to wear a respirator (50 lbs) and protective clothing (sealed impermeable suit) and engage in activities to include: walking in protective clothing, lifting equipment and casualties, conducting physical activities associated with emergency response operations, in a desert climate. **FOR TRAINING PURPOSES ONLY** for participation in the Bechtel Nevada WMD course.

Physician Signature: _____ License Number: _____
OR
Company Medical Representative:_____Title:_____Phone:_____

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