AMERICAN FEDERATION OF GOVERNMENT EMPLOYEES
NATIONAL VETERANS AFFAIRS COUNCIL #53
Affiliated with the AFL - CIO
Mid-Term Bargaining Committee

Oscar L. Williams Jr., Chair
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29 Lake Street
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Willie Haywood, Member
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17705 Garden Blvd.
Cleveland, OH 44128

Tinita Cole, Member
NVAC Nat., Rep.
VAMC Dayton
Dayton, OH 54528

February 24, 2023

Anthony Colon, Acting Director
VA Northern Indiana, HCS
2121 Lake Avenue
Fort Wayne, In 46805

Subject: VISN 10 – VA Northern Indiana, HCS, EOH 345 Evaluation Program
(AFGE Local l020 and AFGE Local 1384)

Dear Mr. Colon:

In accordance with Article 47 Section 4 B, of the Master Agreement the National VA Council #53 is formally demanding to bargain on VA NIHCS, EOH 345 Evaluation Program as cited above in VISN 10 within the Department. Ms. Alma L. Lee, President of the National VA Council #53, will be naming the Union's Chief Negotiator and team members. Please provide the named bargaining team with all information and/or data related to the cited subject. The negotiation of this matter should normally begin no later than twenty (20) workdays after the Management's Chief Negotiator receives our demand to bargain.

Please cease and desist any implementation until the bargaining obligation has been met. The named bargaining team my request a briefing over the cited subject above, before sending any proposals. If you have any questions, please contact me at (217) 554-4979.

Sincerely,

Oscar L. Williams, Jr.
Chairperson, Mid-Term Bargaining Committee
2nd Executive Vice President
National VA Council #53

cc: Alma L. Lee, President National VA Council #53
Willie E. Haywood Jr., 6th District Representative, NVAC

AFGE: Good Government We Are Ready

EOH 345 Evaluation
Employee Occupational Health (EOH) Program

PHYSICAL FITNESS INQUIRY FOR INCIDENTAL DRIVERS

1. Name (Last, First, MI)	1a. Last Four of Security Number	2. Date of Birth (MM/DD/YYYY)	3. Title of Position

4. Home Address (Number, Street, City, State & Zip) & Phone Number	5. Employing Agency
	5.a. Name of Supervisor

6. Have you ever had any of the following or do you now have any of the following?

Yes	No		Yes	No	
☐	☐	a.Poor vision even with glasses or contacts	☐	☐	n.Seizures or epilepsy
☐	☐	b.Eye problems (except glasses or contacts)	☐	☐	o.Sleep apnea, sleep disorders, daytime sleepiness
☐	☐	c.Ear and/or hearing problems	☐	☐	p. Use of a continuous Positive Airway Pressure (CPAP) machine
☐	☐	d.High or low blood pressure	☐	☐	q.Severe arthritis, rheumatism that affects driving
☐	☐	e.Heart disease, heart attack, bypass or other problems	☐	☐	r.Missing or limited use of arm, hand, finger, leg, or foot
☐	☐	f.Pacemaker, defibrillator, or other implantable device	☐	☐	s.Nervious or mental illness requiring medications
☐	☐	g.Sugar or albumin in urine	☐	☐	t.Excessive alcohol use
☐	☐	h.Diabetes	☐	☐	u.Arrested for driving under the influence (DUI)/DUI
☐	☐	i.Frequent or severe headaches	☐	☐	v.Use of an illegal substance within the last two years
☐	☐	j.Loss of Consciousness (LOC), dizziness or fainting spells	☐	☐	w.Drug use, alcohol use or addiction
☐	☐	k.Head/brain injury or illness, concussion	☐	☐	x.Chronic use of a controlled medication or narcotic
☐	☐	l.Stroke, Transient Ischemic Attack, (TIA), paralysis, weakness	☐	☐	y.Any medical condition that affects your ability to drive
☐	☐	m.Blood clots or bleeding problems	☐	☐	z.Any restrictions listed on driver's license (i.e. glasses)

7. Explain all "Yes" responses below. List any restrictions on driver's license (i.e. glasses). Example: 6a. Blind in one eye. No treatment. No activity limitations, valid driver's license.

Certification: I certify that my answers to the above are full and true. False statement(s) or responses may be grounds for cancellation of eligibility or dismissal from driving.	Driver's Signature	Date (MM/DD/YYYY)

8. Physician or other licensed health care professional (PLHCP): Review, Summarize, and make an overall determination on Page 2.

Comments: Considered does not meet:

MANAGEMENT AND EMPLOYEE REPORT OF PHYSICAL FITNESS INQUIRY FOR INCIDENTAL DRIVERS

1. Name (Last, First, MI)	2. Date of Birth (MM/DD/YYYY)	3. Title of Position

REVIEW AND CERTIFICATION BY DESIGNATED OFFICIAL

I certify that I have reviewed this Physical Fitness Inquiry for Incidental Drivers form and other available information regarding the physical condition of the individual, and I have made the following determination:

☐	**Medically cleared** to operate a motor vehicle. Renewal Date:
☐	**NOT** medically cleared to operate a motor vehicle.
☐	An appointment in EOH is **required** for further evaluation and prior to medical clearance determination.

Name of Supervisor

Signature of PLHCP	Name and Title of PLHCP	Date (MM/DD/YYYY)

PAGE 1 & 2: Employee Medical Folder (EMF)
ONLY PAGE 2 (copy): Volunteer, Employee, Employer, Supervisor

PRINT ☐ RESET FORM ☐

Non-Printing note to provider: enter your title, name, and date before electronically signing (form will lock for editing after PIV signature is entered).