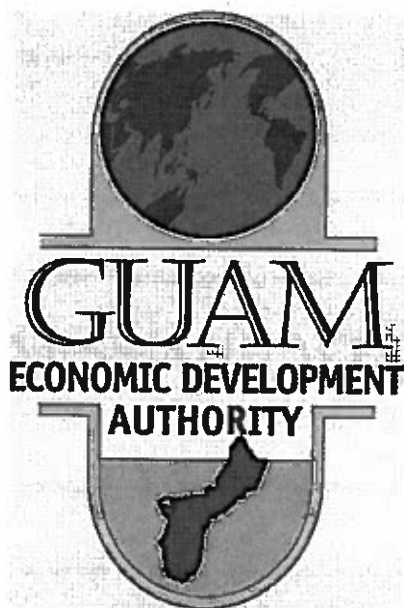


# PHYSICAL FITNESS AND WELLNESS PLAN



**August 2001**

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Industry Development Division

**Physical Fitness and Wellness Plan**

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**SECTION II – GENERAL PROCEDURES**

**A. Pre-participation Requirements**

Prior to participation, employees must complete the following:

1. Fitness and Wellness Program Registration (Appendix A)
2. Activity Sheet (Appendix B) Provide a schedule to his/her respective manager/supervisor including the time, date and place of program for the week. Once approved by the manager/supervisor, the employee shall forward a copy of the schedule to the designated Fitness Coordinator for GEDCA.
3. Statement of Medical Clearance/Medical Clearance Waiver Statement (Appendix C)
4. GEDCA Waiver of Liability. Each employee must sign the GEDCA Waiver of Liability and the GEDCA Statement of Medical Clearance form and a copy must also be forwarded to the Fitness Coordinator. (Appendix D)
5. Health Risk Questionnaire and Health Needs Assessment (Appendix E). A medical clearance and individual health risk questionnaire are requirements of the program guidelines and are integral components of physical fitness and wellness programs.

The health risk assessment must be filled out by the employee and, along with the medical clearance be provided to the Authority prior to partaking in the physical fitness and wellness program. **Every participating employee must complete the individual health risk assessment questionnaire regardless of medical clearance.**

**Medical clearance and questionnaires shall be forwarded through one's proper channels to the Physical Fitness and Wellness Coordinator. The Coordinator will file both documents with the employee's fitness records. All materials filed with the Coordinator will be kept CONFIDENTIAL. Unless authorized by the employee, no one may have access to the records maintained by the Physical Fitness and Wellness Coordinator.**

## **Physical Fitness and Wellness Plan**

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### **B. Program Participation**

Employees may participate in their fitness and wellness activities for a maximum of three days per week. The hours allowed for the fitness program will be between 11:00 a.m. and 2:00 p.m. or 4:00 p.m. to 5:00 p.m. Based on these time allocations, the options are:

#### **Option 1: (Lunchtime workout)**

(a) 11:00 a.m. - 12:00 p.m.      Fitness Program  
12:00 p.m. - 1:00 p.m.      Lunch

(b) 12:00 p.m. - 1:00 p.m.      Fitness Program  
1:00 p.m. - 2:00 p.m.      Lunch

#### **Option 2: (End of day workout)**

4:00 p.m. - 5:00 p.m.      Fitness Program

- Employee will leave work early and go directly to activity site.

#### **Option 3: (Morning workout)**

08:00 a.m. - 9:00 a.m.      Fitness Program

- Employee will arrive at work no later than 9:00 a.m.

An employee may participate in their activity if they have completed an entire day of work. Employees cannot be on annual or sick leave for half a day then participate in their fitness program. Employees must prioritize the Authority's daily operations before engaging in their respective fitness program.

Employees must time in and out when leaving the office for their fitness program. Since copies of schedules are filed with the Physical Fitness and Wellness Coordinator, the Coordinator will provide a report of participating employees to the Administrator. *Because only one (1) hour a day, three (3) times a week is allowed for the program, should discrepancies be found on a timesheet, the employee must either sign an for annual leave for the time used beyond the one (1) hour or if the time is unsubstantiated will be charged for leave without pay.*

It is important that the employee be at his/her scheduled place and time, performing physical fitness and wellness activities. Abuses of the program will result in the removal from the program, as well as the possibility for appropriate administrative action.

**Physical Fitness and Wellness Plan**

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**APPENDIX A**

**GUAM ECONOMIC DEVELOPMENT AUTHORITY  
PHYSICAL FITNESS PROGRAM**

**REGISTRATION FORM**

Date: \_\_\_\_\_  
Name of Employee: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Sex [ ]M [ ]F Age: \_\_\_\_\_ Ethnicity: \_\_\_\_\_  
Division: \_\_\_\_\_  
  
Division Manager: \_\_\_\_\_  
Approval of Supervisor: \_\_\_\_\_  
Signature: \_\_\_\_\_  
Date: \_\_\_\_\_

cc: Physical Fitness and Wellness Coordinator



**APPENDIX C**

**GUAM ECONOMIC DEVELOPMENT AUTHORITY  
STATEMENT OF MEDICAL CLEARANCE/  
MEDICAL CLEARANCE WAIVER STATEMENT**

Statement of Medical Clearance

I, \_\_\_\_\_ do not have any medical problems or conditions that would preclude me from participating in physical fitness and wellness activities, I understand that it is my responsibility to obtain medical clearance, at no cost to the government, before participating in physical fitness and wellness programs. Furthermore, should I incur any injury or injuries while performing physical fitness and wellness activities, Guam Economic Development Authority/Government of Guam will not be liable or responsible for the medical care and services provided to me.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

Medical Clearance Waiver Statement

I, \_\_\_\_\_ (Circle below where applicable)  
(PRINT FULL NAME)

- Elect to participate in physical fitness and wellness programs without medical clearance
- Do have medical problem(s) or condition(s) that would hinder my participation in fitness and wellness activities.

I understand that it is my responsibility to obtain medical clearance at no cost to the government, before participating in physical fitness and wellness programs. Furthermore, should I incur any injury or injuries while performing physical fitness and wellness activities, I understand and acknowledge that I am liable and responsible for the medical care and services provided to me.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

**APPENDIX D**

**GUAM ECONOMIC DEVELOPMENT AUTHORITY  
PHYSICAL FITNESS AND WELLNESS PROGRAM  
WAIVER OF LIABILITY**

I, \_\_\_\_\_, the undersigned employee of the Guam Economic Development Authority, acknowledge the following:

1. I have read GEDCA's physical fitness and wellness program and understand that it is offered as a benefit to me, and is an opportunity to increase my physical fitness and well being.
2. I may not engage in any dangerous activities during the program and I am free to choose the activity safest for me.

I hereby waive and release the Guam Economic Development Authority management and employees from all claims or liabilities of any kind brought forth by my participation in this program.

\_\_\_\_\_  
Print Name of Employee

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Employee

Acknowledged by:

\_\_\_\_\_  
Supervisor/Manager



**APPENDIX E**

**SEE ATTACHED**

- A. HEALTH RISK ASSESSMENT QUESTIONNAIRE**
- B. HEALTH NEEDS ASSESSMENT SURVEY**
- C. EXECUTIVE ORDER # 98-21**

# Physical Fitness and Wellness Plan

## PHYSICAL FITNESS AND WELLNESS PLAN HEALTH RISK ASSESSMENT QUESTIONNAIRE (APPENDIX E)

### Section A - Physical Fitness

Circle Y or N

- |    |  |   |   |
|----|--|---|---|
| 1. | Do you exercise or play a sport for at least thirty minutes, three or four times a week? | Y | N |
| 2. | Do you warm up and cool down by stretching before and after exercising?                  | Y | N |
| 3. | Do you fall into the appropriate weight category for someone your height and gender?     | Y | N |
| 4. | In general, are you please with the condition of your body?                              | Y | N |
| 5. | Are you satisfied with your current level of energy?                                     | Y | N |
| 6. | Do you use stairs rather than escalators or elevators whenever possible?                 | Y | N |

Add the Number of Answers in Each Column -----> [ ] [ ]

### Section B - Family History

Circle N or Y

- |    |  |   |   |
|----|--|---|---|
| 1. | Had a heart attack before age forty?         | N | Y |
| 2. | Had high blood pressure requiring treatment? | N | Y |
| 3. | Developed diabetes?                          | N | Y |
| 4. | Developed glaucoma?                          | N | Y |
| 5. | Developed gout?                              | N | Y |
| 6. | Developed breast cancer?                     | N | Y |

Add the Number of Answers in Each Column -----> [ ] [ ]

### Section C - Self-Care and Medical Care

Circle Y or N

- |    |   |   |   |
|----|---|---|---|
| 1. | Do you floss your teeth daily?  | Y | N |
| 2. | Do you have a dental checkup at least once a year?  | Y | N |
| 3. | Do you use sunscreen regularly and avoid extensive exposure to the sun?                               | Y | N |
| 4. | For women: Do you examine your breasts for unusual changes or lumps at least once a month?            | Y | N |
| 5. | For men: Do you examine your testicles for unusual changes or lumps at least once every three months? | Y | N |

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- |     |  |   |   |
|-----|--|---|---|
| 6.  | Do you usually know what to do in case of illness or injury?   | Y | N |
| 7.  | Do you avoid unnecessary X-rays?   | Y | N |
| 8.  | Do you normally get an adequate amount of sleep?   | Y | N |
| 9.  | Have you had your blood pressure check in the past year?   | Y | N |
| 10. | For women: Have you had a Pap smear within the last two years?   | Y | N |
| 11. | If you are over forty: Have you had a test for glaucoma within the last four years?  | Y | N |
| 12. | If you are over forty: Have you had a test for hidden blood in your stool within the last two years? If your are over fifty: within the last year? | Y | N |
| 13. | If your are over fifty: Have you had at least one endoscopic exam on the lower bowel?  | Y | N |

Add the Number of Answers in Each Column -----> [ ] [ ]

## Section D - Eating Habits

Circle Y or N

- |    |   |   |   |
|----|---|---|---|
| 1. | Do you drink enough fluids so that your urine is a pale yellow color?   | Y | N |
| 2. | Do you try special or fat diets?  | N | Y |
| 3. | Do you add salt to foods during cooking and at the table?   | N | Y |
| 4. | Do you minimize your intake of sweets, especially candy and soft drinks, and avoid adding sugar to food?                    | Y | N |
| 5. | Is your diet well-balanced (including vegetables, fruits, breads, cereals, dairy products and adequate sources of protein)? | Y | N |
| 6. | Do you limit your intake of saturated fats (butter, cheese, cream, fatty meals)?  | Y | N |
| 7. | Do you limit your intake of cholesterol (eggs, liver, meats)?   | Y | N |
| 8. | Do you eat fish and poultry more often than red meats?  | Y | N |
| 9. | Do you eat high fiber foods (vegetables, fruits, whole grain) several times a day?  | Y | N |

Add the Number of Answers in Each Column -----> [ ] [ ]

## Section E - Alcohol, Nicotine, and Other Drug Use

Circle Y or N

- |    |  |   |   |
|----|--|---|---|
| 1. | Do you smoke cigarettes, cigars, or a pipe, chew tobacco, or use other drugs?                                  | N | Y |
| 2. | Do you limit yourself to no more than two drinks a day?  | Y | N |
| 3. | Have family members or friends ever commented on or complained about your drinking or your use of other drug)? | N | Y |
| 4. | Have you been unable to recall things you did when your were drinking or using other drugs?                    | N | Y |
| 5. | Do you use alcohol or other drugs as a way of handling stressful situations or problems in your life?          | N | Y |

# Physical Fitness and Wellness Plan

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6. Do you read and follow the label directions when using prescribed and over-the-counter drugs? Y N  
Add the Number of Answers in Each Column -----> [ ] [ ]

## Section F - Accidents

- Circle Y or N
1. Do you drive after drinking alcohol or using other drugs, or ride with drivers who have been drinking or using other drugs? N Y  
2. Do you obey traffic rules and stay within the speed limit when you drive? Y N  
3. As a driver and passenger, do you wear a seat belt at all times? Y N  
4. Are the vehicles you drive well maintained? Y N  
5. Do you smoke in bed? N Y  
6. Are you informed and careful when using potentially harmful products or substances, such as a household cleaners, poisons, flammable, solvents, and electrical devices? Y N  
7. Do you own a gun? N Y

Add the Number of Answers in Each Column -----> [ ] [ ]

## Section G - Intellectual Life, Values, and Spirituality

- Circle Y or N
1. Are you interested in, and do you keep up to date on, social and political issues? Y N  
2. Are you satisfied with what you do for entertainment? Y N  
3. Do you engage in creative and stimulating activities as often as you would like? Y N  
4. Are you satisfied with the degree to which your work is consistent with your values? Y N  
5. Are you satisfied with the degree to which your leisure activities are consistent with your values? Y N  
6. Is it difficult for you to accept the values and lifestyles of others when they are different from your own? N Y  
7. Are you satisfied with your spiritual life? Y N

Add the Number of Answers in Each Column -----> [ ] [ ]

## Section H - Stress and Social Support

Check Mark Y or N

# Physical Fitness and Wellness Plan

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- |     |   |   |   |
|-----|---|---|---|
| 1.  | Are you satisfied with the amount of excitement in your life?   | Y | N |
| 2.  | Do you find it easy to laugh?   | Y | N |
| 3.  | Do you hold in your angry feelings without expressing them?   | N | Y |
| 4.  | Do you make decisions with minimum stress and worry?  | Y | N |
| 5.  | Do you include relaxation times as part of your daily routine?  | Y | N |
| 6.  | Do you anticipate and prepare for events or situation likely to be stressful? Y   | N |   |
| 7.  | Have you had to make difficult readjustments at home or work in the past year?  | N | Y |
| 8.  | Has a family member or close friend died, been seriously ill, or been injured within the past year?                         | N | Y |
| 9.  | Are you a chronic worrier, subject to guilt feelings or self-punishment?  | N | Y |
| 10. | Have your health, eating, or sleeping habits changed as a result of a stressful incident or situation during the past year? | N | Y |
| 11. | Are you able to fall asleep when you are ready and to sleep through the night uninterrupted?                                | Y | N |
| 12. | Do you wake up feeling rested?  | Y | N |
| 13. | Do you have one or more persons with whom you can discuss personal concerns, worries, or problems?                          | Y | N |
| 14. | Do they make you feel respected and/or admired?   | Y | N |
| 15. | Is there someone you can turn to if you need help, such as to lend you money?   | Y | N |
| 16. | Are you satisfied with the support you provide to others?   | Y | N |

Add the Number of Answers in Each Column -----> [ ] [ ]

## Section I - Sexuality

Circle Y or N

- |    |   |   |   |
|----|---|---|---|
| 1. | Are you satisfied with your level of sexual activity?                 | Y | N |
| 2. | Are you satisfied with your sexual relationship?                      | Y | N |
| 3. | Are you satisfied with your use (or nonuse) of contraceptives?        | Y | N |
| 4. | Are you satisfied with your use (or nonuse) of "safer sex" practices? | Y | N |

Add the Number of Answers in Each Column -----> [ ] [ ]

## Section J - Environment

Circle Y or N

- |    |   |   |   |
|----|---|---|---|
| 1. | Are you often in an environment that has significant air and/or noise pollution?  | N | Y |
| 2. | Are you often exposed to asbestos, vinyl chloride, formaldehyde, or other toxins? | N | Y |
| 3. | Do you miss many days at work due to illness or just not feeling up to it?        | N | Y |

# Physical Fitness and Wellness Plan

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("Work" refers to daily activities, including school or work in the home.)

- |    |  |   |   |
|----|--|---|---|
| 4. | Do you often sit for periods of an hour or more at a time?         | N | Y |
| 5. | Are you satisfied with your ability to plan your workload?         | Y | N |
| 6. | Do you receive adequate feedback to judge your performance?        | Y | N |
| 7. | Are you satisfied with your balance between work and leisure time? | Y | N |

Add the Number of Answers in Each Column -----> [ ] [ ]

# Physical Fitness and Wellness Plan

Are you interested in participating in the Department's Physical and Wellness Program?  Yes  No  
 If your answer is YES, proceed to item I. If your answer is No, stop here and submit your survey form to your supervisor.

## I. PERSONAL HISTORY

Name: \_\_\_\_\_ Date: \_\_\_\_\_  
 Section: \_\_\_\_\_ Job Title: \_\_\_\_\_  
 Ethnicity: \_\_\_\_\_ Tel. No.: \_\_\_\_\_

## II. MEDICAL HISTORY

- Yes  No 1. Have you ever been diagnosed with:
- Yes  No • Heart problem
  - Yes  No • Stroke
  - Yes  No • Diabetes
  - Yes  No • High blood pressure
  - Yes  No • High blood cholesterol
  - Yes  No • Other: \_\_\_\_\_ (specify)
- Yes  No 2. Are you on medications?  
 Yes  No 3. Have you undergone surgery? If YES, date: \_\_\_\_\_ What? \_\_\_\_\_  
 Yes  No 4. Have you ever experienced recurring back or neck pain?  
 Yes  No 5. At times, do you experience stress?  
 Yes  No 6. Have you ever attempted to lose weight?  
 Yes  No 7. Do you exercise?  
 Yes  No 8. Do you smoke?  
 Yes  No 9. Do you drink alcohol?  
 Yes  No 10. Do you eat 3 or more servings of fruits and vegetables a day?  
 11. When was the last time you had a complete physical examination?  
 Date: \_\_\_\_\_

## III. FITNESS ACTIVITIES

- Yes  No 1. Are you interested in individual exercise activities?  
 Yes  No 2. Are you interested in group exercise activities?  
 Please check the following activities you would like your agency or company to offer:
- |   |  |
|---|--|
| <input type="checkbox"/> Walk/Jog program | <input type="checkbox"/> Stationary exercise equipment |
| <input type="checkbox"/> Aerobic classes  | <input type="checkbox"/> Racquetball                   |
| <input type="checkbox"/> Basketball games | <input type="checkbox"/> Weight room                   |
| <input type="checkbox"/> Volleyball games | <input type="checkbox"/> Softball games                |
| <input type="checkbox"/> Swimming         | <input type="checkbox"/> Other: _____                  |

## IV. WELLNESS TOPICS

- |  |   |
|--|---|
| <input type="checkbox"/> Nutrition/Education                   | <input type="checkbox"/> Weight Management      |
| <input type="checkbox"/> Stress Management                     | <input type="checkbox"/> Smoking Cessation      |
| <input type="checkbox"/> High Blood Pressure Screening/Control | <input type="checkbox"/> First Aid/CPR          |
| <input type="checkbox"/> Cholesterol Reduction Education       | <input type="checkbox"/> Diabetes Education     |
| <input type="checkbox"/> Alcohol/Drug prevention Education     | <input type="checkbox"/> Other: _____ (specify) |

### PURPOSE

The purpose of this survey is to obtain information to identify your needs in reducing several risk factors associated with chronic diseases: such as coronary heart disease, stroke and diabetes which are common on our island. The information gathered will be used for research purposes: to design and evaluate programs.

### CONSENT

I hereby provide consent to the \_\_\_\_\_ to use this data as stated above, with the understanding that all personal information reported here will remain strictly confidential.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

# Physical Fitness and Wellness Plan

TERRITORY OF GUAM  
OFFICE OF THE GOVERNOR  
AGUAD, GUAM 96910  
U.S.A. 7



EXECUTIVE ORDER NO. 98-21

## RELATIVE TO IMPLEMENTING THE GOVERNMENT OF GUAM PHYSICAL FITNESS AND WELLNESS PROGRAM.

WHEREAS, the physical fitness and wellness of the employees and the citizens are of paramount importance; and

WHEREAS, statistics show that the health status of Guam's population continues to be affected each year due to lifestyle practices that result in increased stress levels; obesity; and medical conditions such as cardiovascular diseases and diabetes; and

WHEREAS, the Governor's Council on Physical Fitness and Sports aims to stimulate physical fitness and wellness programs and activities throughout the community, and has been tasked to raise the consciousness level concerning personal physical fitness; and

WHEREAS, the Council has implemented and completed the Physical Fitness and Wellness Pilot Program with the government of Guam employees and the results of the pilot program show that there are health benefits to be gained by participants of such a program; and

WHEREAS, the continuation of the Guam Physical Fitness and Wellness Program will benefit the government, its employees, and the community as a whole; and

NOW, THEREFORE, I, CARL T. C. GUTIERREZ, I Maga'lahaen Guåhan, Governor of Guam, by virtue of the authority vested in me by the Organic Act of Guam, as amended, and the laws of Guam, do order:

1. That the agency head of all departments and agencies of the government of Guam, both line and autonomous, establish a Physical Fitness and Wellness Program for their employees and adhere to the guidelines prescribed in the Guam Physical Fitness and Wellness Plan, as published by the Governor's Council on Physical Fitness and Sports, in support of the Vision 2001 objectives for health care.
2. Each agency head shall appoint a Wellness Coordinator for their respective agency, as stated in the Guam Physical Fitness and Wellness Plan, no later than August 15, 1996 and establish its program no later than September 15, 1996. Names of the Wellness Coordinators and established programs shall be submitted to the Division of Health Planning and Development of the Department of Integrated Services for Individuals with Disabilities.
3. That the Governor's Council on Physical Fitness and Sports continue to work with the Department of Public Health and Social Services, the Department of Parks and Recreation, and private sector fitness and wellness organizations to promote fitness and wellness within the community by collaborating with the village mayors to establish a physical fitness and wellness program within each village, henceforth to be called the "The Healthy Villages Program."
4. That the Division of Health Planning and Development of the Department of Integrated Services for Individuals with Disabilities serve as the liaison between the Department of Public Health and Social Services, the village mayors, and the Governor's Council on Physical Fitness and Sports in the implementation of The Healthy Villages Program, as well as in support of the government's Physical Fitness and Wellness Program.
5. That the Division of Health Planning and Development of the Department of Integrated Services for Individuals with Disabilities continue to monitor the physical fitness and wellness program with the government and serve as an information and resource center for departments and agencies in this endeavor.

SIGNED AND PROMULGATED at Hagåtña, Guam this 29th day of July, 1996.

  
CARL T. C. GUTIERREZ  
I Maga'lahaen Guåhan  
Governor of Guam

COUNTERSIGNED:

