TO BE GIVEN TO PERSON EXAMINED WITH A PRE-ADDRESSED "CONFIDENTIAL-MEDICAL" ENVELOPE

UNITED STATES CIVIL SERVICE COMMISION CERTIFICATE OF MEDICAL EXAMINATION

Form Approved Budget Bureau No. 50-R0073

		BE CC	MPLETED BY A		NT OR EMPLOYEE (typ							
1. N	AME (last, first, middle)			2. SOCIA	L SECURITY ACCOUNT I	NO.	3. SEX	4. DATE OF BIRTH				
							☐ MALE					
							☐ FEMALE					
5. DO YOU HAVE ANY MEDICAL DISORDER OR PHYSICAL IMPAIRMENT WHICH WOULD INTERFERE IN ANY WAY WITH THE FULL PERFORMANCE OF THE DUTIES SHOWN BELOW?					6. I CERTIFY THAT ALL THE INFORMATION GIVEN BY ME IN CONNECTION WITH THIS EXAMINATION IS CORRECT TO THE BEST OF MY KNOWLEDGE AND BELIEF.							
	☐ YES ☐ No	0										
	our answer is "YES" explain fully to the pination)	physicia	n performing the	(signature of applicant)								
	Part B T	O BF (OMPLETED BE	 FORE EXAMINATION BY APPOINTING OFFICER								
1. Pl	JRPOSE OF EXAMINATION			2. POSITIO								
	☐ PREAPPOINTMENT											
	OTHER (specify)											
	RIEF DESCRIPTION OF WHAT POSITION R	EQUIR	ES EMPLOYEE TO	DO								
S. D. ALL. DESSAM TIGHT OF WHAT I CONTOURNE QUINCE LIVE EGTEE TO DO												
4. Check the number preceding each functional requirement and each professional factor according to the duties of this profile.												
4. Check the number preceding each functional requirement and each environmental factor essential to the duties of this position. List any additional essential factors in the blank spaces. Also, if the position involves law enforcement, air traffic control, or firefighting, attach the specific												
medical standards for the information of the examining physician.												
			A. FUNC	TIONAL	REQUIREMENTS							
	1. Heavy lifting, 50 pounds and over		15. Crawling (hours)			25. Far vision correctabl	e in one eve to 20/20				
	2. Moderate lifting, 15-44 pounds		16. Kneeling (hour)			and to 20/40 in the other					
	3. Light lifting, under 15 pounds		17. Repeated bend	,	hours)		26. Far vision correctabl to 20/100 in the other	e in one eye to 20/50 and				
	4. Heavy carrying, 50 pounds & over		18. Climbing, legs	only (hours)		27. Specific visual requir	ement (specify) Have				
	, , ,				•		sight					
	5. Moderate carrying, 15-44 pounds		19. Climbing, use20. Both legs requ	arms		28. Both eyes required29. Depth perception						
	6. Light carrying, under 15 pounds		21. Operation of c		tractor or motor		29. Depth perception					
	7. Straight pulling (hours)		vehicle	iane, nuck	, tractor, or motor		30. Ability to distinguish	basic colors				
	8. Pulling hand over hand (hours) 9. Pushing (hours)		22. Ability for rapid simultaneously	d mental ar	nd muscular coordination		31. Ability to distinguish shades of colors32. Hearing (aid permitted)					
	10. Reaching above shoulder		,		Г		33. Hearing without aid					
	11. Use of fingers	_	23. Ability to use a	and desirab	ility of using firearms		34. Specific hearing requirements (specify)					
	12. Both hands required		24. Near vision co	rrectable a	t 13" to 16" to	_						
	13. Walking (hours)	_	Jaeger 1 to 4									
	14. Standing (hours)		ouege to .	Total Hours:								
_			B. ENVI	RONMF	NTAL FACTORS							
	1. Outside		11. Silica, asbesto				20. Working on ladders	or scaffolding				
	Outside and Inside		12. Fumes, smoke				21. Working below groun					
	Excessive heat		13. Solvents (deg	. •			22. Unusual fatigue facto					
	4. Excessive cold		14. Grease and oi		o,		23. Working with hands					
	5. Excessive humidity		15. Radiant energ				24. Explosives					
	Excessive dampness or chilling		16. Electrical ener	-			25. Vibration					
	7. Dry atmospheric conditions		17. Slippery or un		na surfaces		26. Working closely with	others				
	Excessive noise, intermittent		18. Working arour		=		27. Working alone	5510				
	Constant noise	_	parts	ia maomin	ary with moving		28. Protracted or irregula	ar hours of work				
					objects or vehicles		29. Other (specify)					
	5401 (5510/0)				ETED BY PHYSICIAN		_c. card (specify)					
1. EX	KAMINING PHYSICIAN'S NAME (type or prin	t)			3. SIGNATURE OF EXA	MINING	PHYSICIAN					
	, , ,											
2. A	DDRESS (including ZIP code)				(signat	ure)		(date)				
					IMPORTANT ASS		and the second of the second					
					IMPORTANT: After signing, return the entire form intact in the pre-addressed "Confidential-Medical" envelope, which the person you examined gave you							

on the		orm. Please take th	ou are about to exam em and the brief des												
1. <u>H</u>	EIGHT:	_ FEET,	INCHES					WEIG	HT:		_ POUN	IDS			
2. EYES: <u>20</u>					<u>20</u>					<u>20</u> <u>20</u>					
(A) Distant vision (Snellen): without glasses: right left ; with glasses, if worn: right Left (B) What is the longest and shortest distance at which the following specimen of Jaeger No. 2 type can be read by applicant? Test Each eye separately															
Jaeger No. 2 Type Employees in the Federal classified service as may be										Ū	ses, if us				
	Requested by the Civil Service Commission or its				۲ 	in. to in.			K L.		_ in. to in. to		_ in. in.		
	Order September		e 18, 1923 (Executive												
			en Ishihara or other or other comparable					YES	□NO						
	RS: (Consider den dinary conversation		here as normal. Re				ors the gre	eatest di	stance he	ard.)					
RIGH [*]	T EAR	; LEFT EAR 20	ft.	250	50	0	1000	2000	3000	4000	5000	6000	7000	8000	
	HER FINDINGS: Ir ent. If normal, so in		riefly describe any a	bnormal	lity (in	nclud	ding disea	ses, sca	rs, and di	sfiguratio	ons). Inc	lude brie	f history	, if	
a. Ey	es, ears, nose, and	throat (including too	oth and oral hygiene))		e. Abdomen									
b. He	ad and neck (includ	ding face, hair, and s	scalp)			f. Peripheral blood vessels									
c. Sp	eech (note any mal	function)				g. Extremities									
d. Sk	in and lymph nodes	(including thyroid g	land)			h. Urinalysis (if indicated) Sp. Gr Sugar Blood									
						Albumen Casts Pus									
i. Res	spiratory tract <i>(X-ra</i>)	/ if indicated)													
j. Hea	art (size, rate, rhythi	m, function)													
Bloc	od pressure														
	e														
	G (if indicated)														
k. Ba	ck (special considei	ration for positions ii	nvolving heavy lifting	and oth	ner str	renu	ious dutie:	s)							
I. Neu	urological and ment	al health													
CONCLUSIONS: Summarize below any medical findings, which, in your opinion, would limit this person's performance of the job duties and/or would make him a hazard to himself or others. If none, so indicate.															
□ No limiting conditions for this job □ Limiting conditions as follows:															
	Ţ .														

FOR AGENCY USE ONLY

Part A. TO BE COMPLETED BY APPLICANT OR EMPLOYEE (typewrite or print in ink)											
NAME (last, first, middle)			ECURITY ACC			3. SEX	4. DATE OF BIRTH				
, , , ,							☐ MALE				
						☐ FEMALE					
5. DO YOU HAVE ANY MEDICAL DISORDER OR F IMPAIRMENT WHICH WOULD INTERFERE IN AI WITH THE FULL PERFORMANCE OF THE DUTI	6. I CERTIFY THAT ALL THE IFNORMATION GIVEN BY ME IN CONNECTION WITH THIS EXAMINATIN IS CORRECT TO THE BEST OF MY KNOWLEDGE AND BELIEF.										
☐ YES ☐ NO)										
(If your answer is "YES" explain full to the phys	sical performing the										
examination)		(signature of applicant)									
Part D. TO	(signature of applicant) AGENCY MEDICAL OFFICER (if one is available)										
NOTE: Review the attached certificate of medical examination and make your recommendations in item 1 below. If the medical examination was done for pre-appointment purposes, circle the appropriate handicap code in part F.											
1. RECOMMENDATION:	10110 IE 4111/ LIEDE										
HIRE OR RETAIN DESCRIBE LIMITAT	IONS, IF ANY, HERE.										
_											
TAKE ACTION TO SEPARATE OR DO	NOT HIRE, EXPLAIN WHY	Υ.									
AGENCY MEDICAL OFFICER'S NAME (type of the control of the con	or print) 3.	LOCATION	ON (city	, State, ZIP Co	4. DATE						
Part	E. TO BE COMPLETE	D BY A	GENC	Y PERSONN	IEL OI	FFICE	R	I.			
NOTE: Enter the action taken below. If this form is u											
Chapter 293, Subchapter 3; FPM Chapter 339 and F 1. ACTION TAKEN:	PM Supplement 339-31 for	dispositio	on and/c	or filing of both	parts c	of this fo	orm, either separately	or together.			
HIRE OR RETAINED.		NON	I-SELEC	CTED FOR AP	POINT	MENT.	OR ELIGIBILITY OB.	JECTED TO			
ACTION TAKEN TO SEPARATE.						,					
AGENCY PERSONNEL OFFICER'S NAME (ty	SIGNAT	SIGNATURE 4. DATE									
	HANDICAP CODE (to b							one handisan applies			
If the person examined has or had a handicap circle the one considered most limiting. If none					5 10 111	iat HaH	ulcap. Il more mar	Tone nandicap applies,			
00 No handicap of the type listed	40 Hearing aid require	ed				5 2	Diabetes controlled				
10 Amputation – one major extremity	41 No usable hearing 5 3 Epilepsy – adequately co						controlled				
11 Amputation – two or more major extremities	42 No usable hearing,	with spe	ech mal	function		5	History of emotional behavioral problems				
20 Deformity or impaired function upper	43 Normal hearing, with	th speech	n malfun	ction		-	equiring special placer	ment efforts			
extremity	50 Tuberculosis – inac	•				5 5 Mentally retarded					
21 Deformity or impaired f unction lower	51 Organic heart disea	ase (comi	pensate	d)		5	Mentally restored				
extremity or back	· ·										
30 Vision – one eye only					10001010010,						
31 No usable vision		- *									
1. EXAMINING PHYSICIAN'S NAME (type or print)		3. SIGNATURE OF EXAMINING PHYSICIAN									
2. ADDRESS (including ZIP code)		(signature) (date)									
2. AUDINESS (molading ZIF 6006)			IMPORTANT: After signing, return the entire form intact in the pre-								
			addressed "Confidential-Medical" envelope, which the person you examined gave you.								