DEPARTMENT OF NONAPPROPRIATE		(Applicant	must supply ow to heavy i	information			see AR 215-3; the					
CERTIFICATE OF MEDICA			vrite or Print		proponen	t agency is	DC3, G1.					
1. NAME (CAPS) LAST - FIRST - MID		- MISS - MRS.	2. SEX	1	3. BIRTH	I DATE						
				MALE	(Мо.,	(Mo., day, year)						
		☐ FEMALE										
4. STREET ADDRESS AND APARTM	MENT NO.	5. CITY, STATE, AND ZIP CODE										
6. POSITION TITLE AND NUMBER			7. PAY F	PLAN AND	8. GRADE O	R LEVEL	9. SALARY					
			occı	JPATION CODE								
10. NAME AND LOCATION OF EMP	LOYING OFFICE											
11. (A) ARE YOU NOW EMPLOYED I	N POSITION SHOWN IN ITE	EM 7	(B) IF "YE	S" GIVE THE DA	TE OF YOUR	ORIGINAL	APPOINTMENT					
YES	NO		TO THIS	POSITION:								
13. (A) HAVE YOU ANY PHYSICAL E	DEFECT OR DISABILITY WH	IATSOEVER?	☐ YE	S NC) IF "Y	ES", GIVE	DETAILS.					
(B) DOES THE VETERANS ADMI (C) HAVE YOU EVER RECEIVED A NONAPPROPRIATED FUNI	DISABILITY RETIREMENT					YES	=					
Sign your name in INK as it appears on your physician for purpose of identification.	our application in the presence of	f the										
DOCTOR: All questions on both side beginning the examination, refer to it of the position to which the applicant	ems 13 and 14 on the Health	Qualification Pl	acement Re	ecord so that you	will have a kn	owledge of						
1. HEIGHT: FEET	INCHES	WE	IGHT:	POUND	s							
2. EYES:			20	_		_	20 20	_				
(A) DISTANT VISION (Snellen): (B) WHAT IS THE LONGEST AND PLICANT? TEST EACH EYE S		WHICH THE FO		SPECIMEN OF		TYPE CA	LEFT N BE READ BY THE SES, IF WORN:	E AP-				
		ь		N TO				181				
		R.	'	N. TO	IN. R		_ IN. TO	IN.				
		L.	1	N. TO	IN. L	·	_ IN. TO	IN.				
(C) EVIDENCE OF DISEASE OR I	NJURY: RIGH	т		LE	FT							
(D) COLOR VISION: IS COLOR V			ER COLOR			YES	□ NO					
IF NOT, CAN APPLICANT PAS	S LANTERN, YARN, OR OT	HER COMPARA	ABLE TEST	?	□ NO							
3. EARS: (CONSIDER DENOMINATO ORDINARY CONVERSAT		NORMAL. REC	ORD AS NU	MERATORS TH	E GREATEST	DISTANCE	HEARD)					
RIGHT EAR LE 20 FT.	FT EAR I 20 FT.	EVIDENCE OF I	DISEASE O	R INJURY: RIGH	IT EAR L	EFT EAR						
4. NOSE 5.	PARA NASAL SINUSES	6.	MOUTH A	ND THROAT								
7. GASTRO-INTESTINAL (A	A) HISTORY OF PEPTIC ULC HEALED HOW LONG? SYMPTOMS PRESENT, IF TREATMENT (Use space un	ANY (Severity,)	requency, etc	OATE OF LAST	ULCER: K-RAY	ACTIVE	QUIESCENT					
8. METABOLIC DISORDERS: (INDICATIVE PREMARKS.")												

9. HEART AND BLOOD VESSELS	(A) BLOOD PRESSURE: MM. HG. SYSTOLIC DIASTOLIC						
(B) IS ORGANIC HEART DISEASE PRESENT? YES NO	(C) IF ORGANIC HEART DISEASE IS PRESENT, IS IT FULLY COMPENSATED YES NO						
(D) PULSE RATE: SITTING IMMEDIATELY AFTER EXER TWO MINUTES AFTER EXERCISE CARD	NAC RESERVE						
	(GOOD, FAIR, OR POOR)						
10. LUNGS:							
RIGHT	LEFT						
	ONG HAS THE DISEASE BEEN ARRESTED?						
IF THERE IS HISTORY OF TUBERCULOSIS, IS ANY TYPE OF COLLAPSE TH FULL DETAILS UNDER "REMARKS." IS MEDICAL SUPERVISION NECESS (IF X-RAY IS MADE, GIVE REPORT UNDER "REMARKS.")	ERAPY BEING RECEIVED AT PRESENT? \square YES \square NO. IF "YES," GIVE ARY? \square YES \square NO						
11. HERNIA: YES NO. IF "YES", NAME VARIETY: INGUINAL, VE	NTRAL FEMORAL POST-OPERATIVE FTC :						
IF PRESENT, IS IT SUPPORTED BY A WELL-FITTING TRUSS?	NO						
12. VARICOSE VEINS: YES NO. IF "YES", STATE LOCATION A							
13. FEET: IS FLAT FOOT PRESENT? YES NO. IF "YES", STATE DE	GREE OF IMPAIRMENT OF FUNCTION						
14. DEFORMITIES, ATROPHIES, AND OTHER ABNORMALITIES, DISEASE NO	(NONE, SLIGHT, MODERATE, SEVERE)						
14. DEI OKMITIES, ATKOTTIES, AND OTTEK ADNOKMAETTES, DISEASE NO	T INCEUDED ABOVE						
15. SCARS OF SERIOUS INJURY OR DISEASE							
16. NERVOUS SYSTEM: (A) INCLUDE SYMPTOMS AND FULL HISTORY OF A SHEETS IF NECESSARY.):	NY MENTAL, NERVOUS OR EMOTIONAL ABNORMALITY (USE ADDITIONAL						
(B) HAS APPLICANT EVER BEEN HOSPITALIZED OR TREATED FOR A ME (C) WHERE (NAME AND LOCATION OF HOSPITAL):	ENTAL ILLNESS? YES NO						
(D) DATE OR DATES OF HOSPITALIZATION:							
(E) DESCRIBE ANY RESIDUALS OF PREVIOUS MENTAL OR NERVOUS IL	LNESS:						
(F) ANY HISTORY OF EPILEPSY OR FAINTING SPELLS? YES	NO 15 00 OWE DETAILS HADED IDEMARKS DELOW						
1,	NO. IF SO, GIVE DETAILS UNDER "REMARKS" BELOW.						
17. EVIDENCE OR HISTORY OF VENEREAL DISEASE: IF BLOOD SEROLOGY ("REMARKS.")R OTHER LABORATORY EXAMINATIONS ARE MADE, GIVE DETAILS UNDE						
18. URINALYSIS (IF INDICATED): OR OR	AL PUMEN						
18. URINALYSIS (IF INDICATED): SP. GR	ALBUMENSUGAR BLOOD PUS						
CASTS	BLOODP08						
I HAVE FOUND THE APPLICANT ABNORMAL UNDER THE FOLLOWING HEA	DINGS:						
REMARKS:							
19. SIGNATURE OF PHYSICIAN OR EXAMINER NAME TYPE	D OR PRINTED DATE						
13. SIGNATURE OF FITTSIONAL OR EXAMINER.	DATE						
20 ADDDESS OF EVAMINING BUYGIGIAN 477	A PO VOLUMANE EEDERAL REGIONATIONS TO VIEW						
20. ADDRESS OF EXAMINING PHYSICIAN (Typed or printed)	21. DO YOU HAVE FEDERAL DESIGNATION? YES NO IF "YES," SPECIFY						
	FULL TIME PART TIME FEE BASIS						

	HE	ALTH				PLACEME ATED FUN	ENT RECORD									
1. NAME (CAPS) LAST - FIRST - MIDDLE MR MISS - MRS.						2. SEX MALE (Mo., day, year)										
5. STREET ADDRESS AND APARTMENT NO.						6. CITY, STATE, AND ZIP CODE										
7. POSITION TITLE AND NUMBER						8. PAY P	PLAN AND JPATION CODE	9. GRADE OR LEVEL	10	0. S	SAL	ARY				
11. NAME AND LOCATION OF EMPLOYING OF	FICE															
12. (A) ARE YOU NOW EMPLOYED IN POSITION SHOWN IN ITEM 7 YES NO							S" GIVE THE DA S POSITION:	ATE OF YOUR ORIGINA	L AP	POI	NTI	MEN	Γ			
TO BE COM	PLET	ED I	BY AI	PPOIN	TING	OFFICE	R: SECTION	S 13 AND 14								
(A). BRIEF OUTLINE OF WHA' For the physician's use, set down in brief and employee does on this job, including environ climb, distance to rest room facilities, cafeter <i>Section 13 below.)</i>	simple mental	e tern l deta	ns wha ils suc	at the ch as sta	irs to	In Section	on 14 below, ell to the duties	AL DEMANDS OF neircle the number of of the position for what spaces may be used	thos	e fa	acto	rs w	hic nt is	being		
TO BE COMPLE INSTRUCTIONS: The items circled below requirements of the position for which this i Indicate the individual's physical capacities X in the appropriate column opposite the nu individual has any other physical limitations	indicandivid	ate th lual is s pos	e physical properties being sition library to the second s	sical g conside by placi	dered	requiren under "I capacity	nents not encir Remarks" on	4 THROUGH 20 cled or not covered by the reverse side. When the cated, explain under "	enev	er l	PA	RTL	٩L			
14. PHYSICAL REQUIREMENTS					MENT	AL FACTO	RS									
		CA	PACITY	<u> </u>							CA	PAC	TY			
	FULL	P	ARTIAL	NONE	1				FU	LL	1	ARTI	\neg	NONE		
1. OUTSIDE				\Box	+	WORKING A	ROUND MACHINE	RY WITH MOVING PARTS	П		T		\top			
2. OUTSIDE AND INSIDE					19.	MOVING OB.	JECTS OR VEHICL	.ES				\Box	1			
3. EXCESSIVE HEAT					20.	WORKING O	N LADDERS OR S	CAFFOLDING								
4. EXCESSIVE COLD					21.	WORKING B	ELOW GROUND									
5. EXCESSIVE HUMIDITY					22.	UNUSUAL FA	ATIGUE FACTORS	(Specify)		-						
6. EXCESSIVE DAMPNESS OR CHILLING																
7. DRY ATMOSPHERIC CONDITIONS					23.	WORKING W	TH HANDS IN WA	TER								
8. EXCESSIVE NOISE, INTERMITTENT					24.	EXPLOSIVES	3									
9. CONSTANT NOISE					25.	VIBRATION										
10. DUST					26.	WORKING C	LOSELY WITH OT	HERS								
11. SILICA, ASBESTOS, ETC.					27.	WORKS ALO	NE									
12. FUMES, SMOKE, OR GASES					28.	PROTRACTE	D OR IRREGULAR	R HOURS OF WORK								
13. SOLVENTS (Degreasing agents)					29.	SPECIAL FA	CTORS (Specify)			1		$\overline{\Box}$				
14. GREASES AND OILS					L				LL			Ш				
15. RADIANT ENERGY			ШΓ	\Box								\Box				
16. ELECTRICAL ENERGY				\coprod								Ш	\perp			
17. SLIPPERY OR UNEVEN WALKING SURFACES																

14. PHYSICAL REQUIREMENTS (Continued)						Fl	JNC	TIC	NAL FACTORS							
	CAPACIT		CITY													
		FULL PART		ART	TIAL		NONE			FULL			PARTIAL		NONE	
33. HEAVY LIFTING - 45 POUNDS AND OVER 34. MODERATE LIFTING - 15-44 POUNDS	H		-						54. ABILITY FOR RAPID MENTAL AND MUSCULAR COORDINATION SIMULTANEOUSLY							
35. LIGHT LIFTING - UNDER 15 POUNDS	H							П	55. ABILITY TO USE AND DESIRABILITY OF USING						$\overline{}$	
36. HEAVY CARRYING - 45 POUNDS AND OVER					П				FIREARMS	L						
37. MODERATE CARRYING - 15-44 POUNDS									56. NEAR VISION CORRECTIBLE AT 13 TO 16 INCHES TO							
38. LIGHT CARRYING - UNDER 15 POUNDS	L		_		Ш				(Jaeger 1 to 4)		ᆜ					
39. STRAIGHT PULLING (HOURS)	L								57. FAR VISION CORRECTIBLE TO 20/20 TO 20/40		\perp					
40. PULLING - HAND OVER HAND (HOURS)	L		_						58. FAR VISION CORRECTIBLE TO 20/50 TO 20/100	4	\perp					
41. PUSHING (HOURS)	L								59. SPECIFIC VISUAL REQUIREMENT (Specify)	L						
42. REACHING ABOVE SHOULDER	L															
43. USE OF FINGERS									60. BOTH EYES REQUIRED		\perp					
44. BOTH HANDS REQUIRED	L								61. DEPTH PERCEPTION			\perp				
45. WALKING (HOURS)									62. ABILITY TO DISTINGUISH BASIC COLORS							
46. STANDING (HOURS)									63. ABILITY TO DISTINGUISH SHADES OF COLORS							
47. CRAWLING (HOURS)									64. HEARING (Aid permitted)							
48. KNEELING (HOURS)	Г								65. HEARING WITHOUT AID		T	T				
49. REPEATED BENDING (HOURS)	Г				П				66. SPECIFIC HEARING REQUIREMENTS (Specify)		一				$\overline{}$	
50. CLIMBING - LEGS ONLY (HOURS)	T									L	\Box					
51. CLIMBING - USE OF LEGS AND ARMS	T				T				67.	T	\top	т	o			
52. BOTH LEGS REQUIRED	T								68.	1	\top	\top	\top	\Box		
	H	\vdash	т		,				69.	+	+	+	+			
53. OPERATION OF CRANE, TRUCK, TUG, TRACTOR, OR MOTOR VEHICLE					┚╽			┚	70.	1	\top	\dagger	+			
16. REMARKS AND RECOMMENDATIONS: 17. PHYSICAL HANDICAP CODE 18. SIGNATURE OF PHYSICIAN OR EXAMINER					N	ΑN	ME T	ГҮІ	PED OR PRINTED		1	DAT	 E			
									20. DO YOU HAVE FEDERAL DESIGNATION?	7 .			_			
19. ADDRESS OF EXAMINING PHYSICIAN (Typed or printed)							IF "YES," SPECIFY									
	_												B	ASIS	•	
TO BE COMPLETED BY SUPERVISOR 21. POSITION TO WHICH INDIVIDUAL WAS ASSIGNED																
21. FOSITION TO WINDINGS WAS ASS	,,,	SINED														
22. SIGNATURE OF SUPERVISOR			N	NAME TYPED OR PRINTED							DATE					

PHYSICAL HANDICAP CODE INSTRUCTIONS

If the person examined has or has had a handicap which is listed on the back of these instructions, enter the code number in Item No. 17 on the Health Qualification Placement Record.

If more than one handicap applies, enter the one you think most limiting. If none of the handicaps apply, enter the code "00."

Detach these instructions after entering Physical Handicap Code on the Health Qualification Placement Record.

PHYSICAL HANDICAP CODE

00	NO REPORTABLE HANDICAP
10	AMPUTATION - ONE EXTREMITY
11	AMPUTATION - TWO OR MORE EXTREMITIES
20	DEFORMITY OR IMPAIRED FUNCTION - UPPER EXTREMITY
21	DEFORMITY OR IMPAIRED FUNCTION - LOWER EXTREMITY OR BACK
30	VISION - BEST CORRECTED VISION OF POORER EYE NOT MORE THAN 20/200
31	VISION - BEST CORRECTED VISION OF BETTER EYE NOT MORE THAN 20/200
40	HEARING - SOME IN ONE EAR, NONE IN OTHER
41	HEARING - IN BOTH EARS BUT NOT MORE THAN 12/20 IN BETTER EAR WITHOUT USE OF A HEARING AID
42	HEARING - O/20 IN EACH EAR, INCLUDING SPEECH MALFUNCTION
50	TUBERCULOSIS - INACTIVE PULMONARY
51	ORGANIC HEART DISEASE (Compensated) - VALVULAR, ARRHYTHMIA, ARTERIOSCLEROSIS, HEALED CORONARY LESIONS
52	DIABETES - CONTROLLED
53	EPILEPSY - ADEQUATELY CONTROLLED
54	HISTORY OF EMOTIONAL OR BEHAVIORAL PROBLEMS REQUIRING SPECIAL PLACEMENT EFFORT
55	MENTALLY RETARDED (Diagnosis must be certified by appropriate State Office of Vocational Rehabilitation)