TO BE GIVEN TO PERSON EXAMINED WITH A PRE-ADDRESSED "CONFIDEN-TIAL-MEDICAL" ENVELOPE.

2. ADDRESS (including ZIP Code)

UNITED STATES CIVIL SERVICE COMMISSION

CERTIFICATE OF MEDICAL EXAMINATION

Form Approved Budget Bureau No. 50-R0073

Part A	A. TO BE COM	MPLETE	D BY APP	LICANT OR E	EMPLO	YEE	
1. NAME (last, first, middle)		2. SOCIA	L SECURITY A	ACCOUNT NO.	3. SEX		4. DATE OF BIRTH
			ı	I		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							
(If your answer is "YES" explain fully to the physician performin examination)	g the	(signature of applicant)					
Part B. TO BE	COMPLETED	BEFORE	EXAMIN	ATION BY AP	POINT	TING OFFICER	
1. PURPOSE OF EXAMINATION		2. POSITI	ON TITLE				
PREAPPOINTMENT							
OTHER (specify)							
3. BRIEF DESCRIPTION OF WHAT POSITION REQUIRES EMP	LOYEE TO DO						
4. Circle 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 fire fighting, attach the specific medical standards for the information of the examining physician. A. FUNCTIONAL REQUIREMENTS							
1. Heavy lifting, 45 pounds and over 2. Moderate lifting, 15-44 pounds 3. Light lifting, under 15 pounds 4. Heavy carrying, 45 pounds and over 5. Moderate carrying, 15-44 pounds 6. Light carrying, under 15 pounds 7. Straight pulling (hours) 8. Pulling hand over hand (hours) 9. Pushing (hours) 10. Reaching above shoulder 11. Use of fingers 12. Both hands required 13. Walking (hours) 14. Standing (hours) 15. Coutside 26. Outside 27. Outside 28. Outside and inside 39. Excessive heat 40. Excessive cold 50. Excessive humidity	 15. Crawling (hours) 16. Kneeling (hours) 17. Repeated bending (hours) 18. Climbing, legs only (hours) 19. Climbing, use of legs and arms 20. Both legs required 21. Operation of crane, truck, tractor, or motor vehicle 22. Ability for rapid mental and muscular coordination simultaneously 23. Ability to use and desirability of using firearms 24. Near vision correctable at 13" to 16" to Jaeger 1 to 4 B. ENVIRONMENTAL FACTORS 11. Silica, asbestos, etc. 12. Fumes, smoke, or gases 13. Solvents (degreasing agents) 14. Grease and oils 15. Radiant energy 				and to 20/40 in the 26. Far vision correcta to 20/100 in the ot 27. Specific visual req 28. Both eyes require 29. Depth perception 30. Ability to distinguis 31. Ability to distinguis 32. Hearing (aid perm 33. Hearing without ai 34. Specific hearing re 35. Other (specify) 20. Working on ladder 21. Working below gro 22. Unusual fatigue fa 23. Working with hand 24. Explosives	able in one eye to 20/50 and her uirement (specify) d sh basic colors sh shades of colors itted) d equirements (specify)	
Excessive dampness or chilling Dry atmospheric conditions Excessive noise, intermittent Constant noise Dust	18. Working parts	pery or uneven walking surfaces 26. Working a 27. Working a 28. Protracte 29. Other (sp			25. Vibration26. Working closely w27. Working alone28. Protracted or irreg29. Other (specify)		
Pai	rt C. TO BE CO	OMPLET	ED BY EX	AMINING PH	YSICIA	AN	
1. EXAMINING PHYSICIAN'S NAME (type or print)			3. SIGNATUI	RE OF EXAMINING	G PHYSI	CIAN	

IMPORTANT: After signing, return *the entire form intact* in the preaddressed "Confidential-Medical" envelope which the person you examined gave you.

STANDARD FORM 78 (Rev. 10-69) Page 2

ciro rep	NOTE TO EXAMINING PHYSICIAN: The person you are about to examine will have to cope with the functional requirements and environmental factors circled on page 1 of this form. Please take them, and the brief description of job duties above them, into consideration as you make your examination and report your findings and conclusions.					
1.	HEIGHT: FEET, INCHES.	WEIGHT: POUNDS.				
	EYES (A) Distant vision (Snellen): without glasses: right le (B) What is the longest and shortest distance at which the following					
	supplement the Executive Orders of May 29 and June 18, 1923 (Executive	without glasses: with glasses, if used: in. to in. R in. to in. in. to in. L in. to in.				
	(C). Color vision: Is color vision normal when Ishihara or other color If not, can applicant pass lantern, yarn, or other comparable test					
3.	EARS: (Consider denominators indicated here as normal. Record a RIGHT EAR ; LEFT EAR 20 ft.	as numerators the greatest distance heard.) Audiometer (if given): 250 500 1000 2000 3000 4000 5000 6000 7000 8000				
4.		nality (including diseases, scars, and disfigurations). Include brief history, if				
	a. Eyes, ears, nose, and throat (including tooth and oral hygiene)	e. Abdomen				
	b. Head and back (including face, hair, and scalp)	f. Peripheral blood vessels				
	c. Speech (note any malfunction)	g. Extremities				
	d. Skin and lymph nodes (including thyroid gland)	h. Urinalysis (if indicated) Sp. gr Sugar Blood Albumen Casts Pus				
	i. Respiratory tract (X-ray if indicated)					
	j. Heart (size, rate, rhythm, function) Blood Pressure Pulse EKG (if indicated)					
	k. Back (special consideration for positions involving heavy lifting and other strenuous duties)					
	I. Neurological and mental health					
	ONCLUSIONS: Summarize below any medical findings which, in your na hazard to himself or others. If none, so indicate. No limiting conditions for this job Limiting conditions as follows:	opinion, would limit this person's performance of the job duties and/or would make				

FOR AGENCY USE ONLY

Part A. TO BE COMPLETED BY APPLICANT OR EMPLOYEE					
1. NAME (last, first, middle)	2. SOCIAL SECURITY ACCOUNT 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 PREVIOUSLY NOTED?	6. I CERTIFY THAT ALL THE INFORMA EXAMINATION IS CORRECT TO TH				
☐ YES ☐ NO					
(If your answer is "YES' explain fully to the physician performing the examination)					
	(signature of applicant)				
		·	·		

1. EXAMINING PHYSICIAN'S NAME (type or print)	3. SIGNATURE OF EXAMINING PHYSICIAN				
2. ADDRESS (including ZIP Code)	(signature)	(date)			
	IMPORTANT: After signing, return the entire form addressed "Confidential-Medical" envelope which examined gave you.				