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

Part A. TO BE COMPLETED BY APPLICANT OR EMPLOYEE (typewrite or print in ink)										
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 O	R PHYS	ICAL	6. I CER	RTIFY THAT ALL THE IN	NFORMATI	ON GIVEN BY ME IN CON	NECTION WITH			
IMPAIRMENT WHICH WOULD INTERFERE II	N ANY V	VAY	-			THE BEST OF MY KNOWL				
WITH THE FULL PERFORMANCE OF THE D BELOW?	UTIES S	SHOWN								
YES □	NO									
// wave analysis "VES" avalain fully to the	mbumla	ian manfannina 46a								
(If your answer is "YES" explain fully to the examination)	pnysic	ian performing the			(signa	ature of applicant)				
Dowt D	TO DE	COMPLETED D	FEODE I	FORE EXAMINATION BY APPOINTING OFFICER						
	IO BE				APPOINTI	NG OFFICER				
1. PURPOSE OF EXAMINATION			2. POSITIO	2. POSITION TITLE						
☐ PREAPPOINTMENT					Firefigh	ter (Light Level)				
☐ OTHER (specify)										
3. BRIEF DESCRIPTION OF WHAT POSITION F										
Duties mainly involve office type work with o and long hours of work, as well as some ben	ccasion	nal exertion requiri	ng basic (	good health. Activities	s may inclu	ide climbing stairs, stand	ing, operating a vehicle			
Unusual Fatigue Factors: Work is performed										
vegetation, etc.						, , , , , , , , , , , , , , , , , , , ,				
4. Circle (shaded) the number preceding e	achfur	nctional requireme	ent and e	ach environmental fa	actor esse	ntial to the duties of this	position. List any			
additional essential factors in the blank										
medical standards for the information of	the exa	amining physiciar	٦.				•			
		A. FUN	CTIONAL	L REQUIREMENTS						
Heavy lifting, 50 pounds and over	15.	Crawling (	hours)		25.	Far vision correctable	in one eye to 20/20			
Moderate lifting, 15-44 pounds	16.	Kneeling (	hour)			and to 20/40 in the oth	ner			
3. Light lifting, under 15 pounds	17.	Repeated bendi	ng (	hours)	26.	Far vision correctable to 20/100 in the other	in one eye to 20/50 and			
4. Heavy carrying, 50 pounds & over	18.	Climbing, legs o	nlv (0.5 h	nours)	27.		ment (specify) Have sight			
5. Moderate carrying, 15-44 pounds	19.	Climbing, use of			28.	Both eyes required	(			
6. Light carrying, under 15 pounds	20.	Both legs requir	-		29.	Depth perception				
g , g, ,		• .		, tractor, or motor						
7. Straight pulling ( hours)	21.	vehicle	,	,	30.	Ability to distinguish ba	asic colors			
8. Pulling hand over hand (8 hours)	22.	Ability for rapid i			31.	Ability to distinguish sh	nades of colors			
9. Pushing ( hours)		coordination sim	ıultaneou	sly	32.	Hearing (aid permitted	))			
10. Reaching above shoulder	23.	Ability to use on	d dooirah	ility of using firearms	33.	Hearing without aid				
11. Use of fingers		Ability to use an	u uesiiab	niity of using meanns	34.	Specific hearing requir	rements (specify)			
12. Both hands required	24.	Near vision corr	ectable a	nt 13" to 16" to						
13. Walking ( hours)		Jaeger 1 to 4								
14. Standing ( hours)										
		B. EN	<b>VIRONME</b>	ENTAL FACTORS						
1. Outside	11.	Silica, asbestos	s, etc.		20.	Working on ladders or	scaffolding			
Outside and Inside	12.	Fumes, smoke,	or gases	3	21.	Working below ground	l			
Excessive heat	13.	Solvents (degre	easing ag	ents)	22.	Unusual fatigue factor	s (specify) See B.3 above			
Excessive cold	14.	Grease and oils	3		23.	Working with hands in	water			
<ol><li>Excessive humidity</li></ol>	15.	Radiant energy			24.	Explosives				
Excessive dampness or chilling	16.	Electrical energ	-		25.	Vibration				
<ol><li>7. Dry atmospheric conditions</li></ol>	17.	Slippery or une		-	26.	Working closely with o	thers			
Excessive noise, intermittent	18.	Working around	d machine	ery with moving	27.	Working alone				
Constant noise		parts			28.	Protracted or irregular	hours of work			
10. Dust (Severe)	19.			objects or vehicles	29.	Other (specify)				
		Part C. TO E	BE COMF	PLETED BY PHYSIC	IAN					
1. EXAMINING PHYSICIAN'S NAME (type or print)  3. SIGNATURE OF EXAMINING PHYSICIAN										

1. EXAMINING PHYSICIAN'S NAME (type or print)	3. SIGNATURE OF EXAMINING PHYSICIAN	
2. ADDRESS (including ZIP code)	(signature)	(date)
	<b>IMPORTANT:</b> After signing, return the entire to "Confidential-Medical" envelope, which the person y	

Note to Examining Physician: The person you are a on the other side of this form. Please take them and report your findings and conclusions.											
1. HEIGHT: FEET,	INCHES			W	EIGHT:			POUNE	os		
2. EYES:	<u>20</u>		<u>20</u>	; wit	h glasse	s, if wor	n:	2	0		<u>20</u>
(A) Distant vision (Snellen): without glasses:  (B) What is the longest and shortest distance at viseparately .	right which the followi	left ing specim	en of Ja	eger No	o. 2 type	can be r	_	jht applican		Left Each eye	ı
Jaeger No. 2 Type Employees in the Federal classified service as	may ha	without (	ut glasses: with glasses, if used:						l:		
Requested by the Civil Service Commission or its autho Representative. This order will supplement the Executi Orders of May 29 and June 18, 1923 (Executive Order September 4, 1924)										n. to n. to	
(C) Color vision: Is color vision normal when Ishihara or other color plate test is used? ☐ YES ☐ NO If not, can applicant pass lantern, yarn, or other comparable test? ☐ YES ☐ NO											
EARS: (Consider denominators indicated here a Ordinary conversation:		ord as num Audiome			itest dist	ance hea	ard.)				
RIGHT EAR; LEFT EAR 20 ft. 20 ft.	<u>-</u> ·	250	500	1000	2000	3000	4000	5000	6000	7000	8000
4. OTHER FINDINGS: In items a through I briefly describe any abnormality (including diseases, scars, and disfigurations). Include brief history, if pertinent. If normal, so indicate.											
a. Eyes, ears, nose, and throat (including tooth a	nd oral hygiene)	)	e. Abo	domen							
b. Head and neck (including face, hair, and scalp)			f. Peripheral blood vessels								
c. Speech (note any malfunction)			g. Ext	remities							
d. Skin and lymph nodes (including thyroid gland)			h. Urinalysis (if indicated) Sp. Gr Sugar Blood								
			Alb	oumen _		Cas	ts		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 involv	ring heavy lifting	and other	r strenud	ous dutie	es)						
Neurological and mental health											
CONCLUSIONS: Summarize below any medical make him a hazard to himself or others. If none,		, in your op	oinion, w	ould lim	it this pe	erson's p	erforma	ince of th	ne job d	uties and/	or would
☐ No limiting conditions for this job☐ Limiting conditions as follows:											

## FOR AGENCY USE ONLY

Part A. TO BE COMPLETED BY APPLICANT OR EMPLOYEE (typewrite or print in ink)								
		2. SOCIAL SECURITY A	, , ,	3. SEX	4. DATE OF BIRTH			
NAME (last, first, middle)		Z. SOCIAL SECURITY A	I I		4. DATE OF BIRTH			
				☐ MALE				
				FEMALE				
5. DO YOU HAVE ANY MEDICAL DISORDER OR F IMPAIRMENT WHICH WOULD INTERFERE IN A WITH THE FULL PERFORMANCE OF THE DUT	6. I CERTIFY THAT ALL THIS EXAMINATIN IS			CONNECTION WITH WLEDGE AND BELIEF.				
☐ YES ☐ NO								
(If your answer is "YES" explain full to the phy								
examination)								
	(signature of applicant)							
Part D. TO BE COMPLETED BY 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:								
☐ HIRE OR RETAIN DESCRIBE LIMITAT	TIONS, IF ANY, HERE.							
☐ TAKE ACTION TO SEPARATE OR DO	NOT HIRE, EXPLAIN WHY	<b>'</b> .						
2. AGENCY MEDICAL OFFICER'S NAME (type	or print) 3.	LOCATION (city, State, ZIP	4. DATE					
Part	E. TO BE COMPLETE	D BY AGENCY PERSON	INEL OFFICER					
NOTE: Enter the action taken below. If this form is a Chapter 293, Subchapter 3; FPM Chapter 339 and F								
1. ACTION TAKEN:	_	NON OF FOTER FOR	A DDOINTMENT OF	EL LOIDII ITV OD I	-0755 70			
HIRE OR RETAINED.		NON-SELECTED FOR A	APPOINTMENT, OR I	ELIGIBILITY OBJE	ECTED TO			
ACTION TAKEN TO SEPARATE.								
2. AGENCY PERSONNEL OFFICER'S NAME (type or print) 3. SIGNATURE					4. DATE			
Part F.	HANDICAP CODE (to b	e completed only in pre-	appointment cases	s)				
If the person examined has or had a handicap	listed below, circle the c	ode number, which perts	ains to that handica	np. If more than	one handican applies			
circle the one considered most limiting. If none			and to that harrand	p. II more alam	one nanaleap applies,			
00 No handicap of the type listed	52 Diabete	52 Diabetes controlled						
10 Amputation – one major extremity	41 No usable hearing	53 Epilepsy	53 Epilepsy – adequately controlled					
11 Amputation – two or more major extremities	42 No usable hearing, w	54 History	54 History of emotional behavioral problems					
20 Deformity or impaired function upper	1			requiring special placement efforts				
extremity				55 Mentally retarded				
21 Deformity or impaired f unction lower	51 Organic heart disease	56 Mentally	56 Mentally restored					
extremity or back	valvular, arrhythmia,							
30 Vision – one eye only	healed coronary lesio							
31 No usable vision	, , , , , , , , , , , , , , , , , , , ,							
		3 CICNATURE OF	EXAMINING PHYSI	ICIAN				
1. EXAMINING PHYSICIAN'S NAME (type or print)		J. SIGNATURE OF	LAAMINING PHISI	CIAN				
2. ADDRESS (including ZIP code)		1.	signature)		(date)			
3 (		IMPORTANT:	After signing, retu		form intact in the pre-			
		addressed "Confidential-Medical" envelope, which the person you examined gave you.						