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# Certificate of Medical Examination for Court Security Officers

*Date of Examination:* \_\_\_\_\_

*Purpose of Examination:*

- New Applicant Exam*  
 *Annual Medical Exam*

*Name:* \_\_\_\_\_

*District:* \_\_\_\_\_

## **SIGNATURE AND CERTIFICATION STATEMENT**

Read the following carefully before signing this certification. A false answer to any question in this statement may be grounds for disqualification and may be punishable by fine or imprisonment (U.S. Code Title 18, Section 1001).

I have completed this statement with the knowledge and understanding that any or all items contained herein may be subject to investigation and I consent to the release of information concerning my capacity and fitness by employers, educational institutions, law enforcement agencies, and other individuals and agencies, to duly accredited investigators, and other authorized employees of the Federal Government for that purpose.

**CERTIFICATION:** I certify that all of the statements made by me are true, complete, and correct to the best of my knowledge and belief, and are made in good faith.

\_\_\_\_\_  
Signature (sign in ink)

\_\_\_\_\_  
Date

*Medical Facility Completing Examination:* \_\_\_\_\_

## CSO-229 INSTRUCTIONS

### CSO (INCUMBENTS)/APPLICANTS:

- Nothing to eat or drink (except water) for 12 hours prior to examination appointment time. Regularly scheduled medications may be taken, as directed, unless you are a diabetic. Diabetics must contact their treating physician regarding the procedure they should follow for fasting before having laboratory tests performed.
- ALL *ITALICIZED* AREAS are to be completed in ink by contractor's employee/applicant and reviewed by Examining Physician. Use the Supplemental Information page (p. 8) if additional space is needed.
- Provide details where necessary. **Do not leave any question blank. Do not use "white out" or correction tape. Additional information must be documented on the attached "Supplemental Information" sheet.**
- **Eyeglass (including "over the counter" reading glasses) and contact lens wearers: you must wear or bring your glasses/contacts with you to the examination.**
- **Hearing aid wearers:** The hearing test must be performed **without** hearing aids.
- All certification statements **must** be signed and dated.

### EXAMINING CLINIC STAFF:

- Corrections/alterations to documentation must be legible and signed or initialed by staff member.
- **"White out"/correction tape must not be used.**
- All test results and report forms must be legible and clearly identified with the CSO's name and the date the test was performed.
- The designated physician must co-sign all examinations performed by Physician Assistants or Nurse Practitioners.

### CHECKLIST FOR CLINIC STAFF:

- Fasting Chemistry panel to include fasting glucose, electrolytes, liver & renal function tests.\*  
\* If specimen is hemolyzed, lab test must be repeated.
- Fasting Lipid Panel
- CBC with WBC differential & Platelet Count\*  
\* If specimen is hemolyzed, lab test must be repeated.
- Urinalysis (Test results for Specific Gravity, Glucose, Protein, & Blood in the urine must be documented)
- 12 lead resting EKG (Lead placement must be verified by physician)
- Hearing test - pure tone air conduction audiogram results (Attach printout or record results on page 10.)  
**CSO must be positioned in such a way that he is unable to visually detect the administration of tones during testing.**
- Vision test results

**PART I. COURT SECURITY OFFICER IDENTIFICATION**

NAME (Last, First, Middle-Type or print): \_\_\_\_\_ Soc. Sec. No.: \_\_\_\_\_ Sex:  M  F Date of Birth: \_\_\_\_\_

Circuit: \_\_\_\_\_ District: \_\_\_\_\_ Applicant  Incumbent  Years in Position: \_\_\_\_\_ Date of Exam: \_\_\_\_\_

**PART II. COURT SECURITY OFFICER MEDICAL RELEASE FORM**

I, \_\_\_\_\_, authorize my employer and an examining physician, \_\_\_\_\_, to release my medical examination records to the United States Marshals Service (USMS) for employment consideration as a Court Security Officer, with the stipulation that the released information be kept confidential and used solely for the purposes of determining my medical qualification. In addition, I hereby grant the USMS permission to release my medical records to the reviewing medical officials designated by the USMS.

\_\_\_\_\_  
SIGNATURE DATE

\_\_\_\_\_  
WITNESS DATE

**PART III. REPORT OF MEDICAL HISTORY**

**STATEMENT OF MEDICATIONS CURRENTLY USED:**

NOTE: CHECK HERE IF MEDICATIONS ARE NOT CURRENTLY USED .....   
(Use the supplemental information page located at the end of the exam form if additional space is needed)

Name of Medication	Diagnosis	Dosage	Taken Since

**STATEMENT OF HOSPITALIZATION HISTORY:**

NOTE: CHECK HERE IF NEVER HOSPITALIZED .....

Admission Date	Reason for Admission	Type of Treatment	Outcome

NAME (Last, First, Middle): \_\_\_\_\_

Social Security #: \_\_\_\_\_

**PART III. REPORT OF MEDICAL HISTORY, CONTINUED**

**STATEMENT OF SURGICAL HISTORY INCLUDING OUTPATIENT PROCEDURES:**

NOTE: CHECK HERE IF NO PRIOR HISTORY OF SURGERY .....

Date of Surgery	Diagnosis	Type of Procedure	Outcome

Check each of the following items YES or NO. Every item checked YES MUST be carefully explained in the blank space on the right. (Use the supplemental information page located at the end of the exam if additional space is needed)

	<u>YES</u>	<u>NO</u>	<u>EXPLANATION</u>
<b>I. Have you been refused employment or been unable to hold a job or stay in school because of:</b>			
A. Sensitivity to chemicals, dust, sunlight, etc.	<input type="checkbox"/>	<input type="checkbox"/>	_____
B. Inability to perform certain motions	<input type="checkbox"/>	<input type="checkbox"/>	_____
C. Inability to assume certain positions	<input type="checkbox"/>	<input type="checkbox"/>	_____
D. Other medical reasons (If yes, give reason)	<input type="checkbox"/>	<input type="checkbox"/>	_____
<b>II. Have you ever been denied life insurance? (Give reason for denial and details.)</b>	<input type="checkbox"/>	<input type="checkbox"/>	_____
<b>III. Have you been advised to have any operations not listed under "Surgical History" above? (Give type of procedure and when recommended.)</b>	<input type="checkbox"/>	<input type="checkbox"/>	_____
<b>IV. Have you ever been rejected for, or discharged from, military service because of physical, mental, or other reasons? (Give date, reason, type of discharge, if any.)</b>	<input type="checkbox"/>	<input type="checkbox"/>	_____
<b>V. Have you ever received or applied for disability compensation or disability pension? (If yes, specify what kind, granted by whom, amount, when and why.)</b>	<input type="checkbox"/>	<input type="checkbox"/>	_____

NAME (Last, First, Middle):

Social Security #:

**PART III. REPORT OF MEDICAL HISTORY, CONTINUED**

**PART IV. PHYSICAL EXAM**

**GENERAL CONDITION**

Contractor's employee/applicant **MUST PROVIDE** an explanation in the **Comments** section below for each YES (current or past) item checked below.

All *italicized* areas **MUST** be completed by the Contractor's employee/applicant.

Have you now or have you ever had (check one box for each item below):

	YES NOW	YES PAST	NO
1. <i>Recent gain/loss of weight</i>			
2. <i>Chronic or frequent colds</i>			
3. <i>Skin diseases</i>			
4. <i>Anemia</i>			
5. <i>Leg Cramps</i>			
6. <i>Adverse reaction to serum drug, or medicine</i>			
7. <i>Tumor (Specify type/location in the Comments section below)</i>			
8. <i>Growth (Specify type/location in the Comments section below)</i>			
9. <i>Cyst (Specify type/location in the Comments section below)</i>			
10. <i>Cancer (Specify type/location in the Comments section below)</i>			
11. <i>Diabetes or sugar in urine</i>			
12. <i>Stutter or stammer habitually</i>			
13. <i>Excessive bleeding after injury or surgery</i>			
14. <i>Do you wear glasses or contact lenses?</i>			
15. <i>Blindness in one eye</i>			
16. <i>Sleep apnea</i>			

**Doctor's Comments:** Doctor Comments: (Check one and explain as necessary for each organ system)

- No positive or pertinent negative findings were noted upon exam.
- The following positive and/or pertinent negative findings were noted:

**Contract Employee/Applicant Comments:** (Use the Supplemental information page located on page 8 if additional space is needed). **Contract Employee/Applicant MUST provide an explanation of all above YES answers.** (See example below.)

Item #	Diagnosis (if known)	Date of onset	Date of recovery (if resolved)	Doctor's Comments: Please review comments in the italicized area at left for completeness and add any additional clarifications in the unshaded area below.
3	<i>Eczema (EXAMPLE)</i>	1994	1994	

NAME (Last, First, Middle):

Social Security #:

**PART III. REPORT OF MEDICAL HISTORY, CONTINUED**

**PART IV. PHYSICAL EXAM**

YES YES  
NOW PAST NO

**HEAD, EYES, EARS, NOSE, THROAT (INCLUDING THYROID)**

17. Eye trouble or surgery (RK, PR, Lasik, or other)				
18. Ear, nose, throat, sinus trouble				
19. Hearing loss				
20. Severe tooth/gum trouble				
21. Hay Fever/Allergies				
22. Thyroid Trouble				
23. Wear a hearing aid <input type="checkbox"/> right ear <input type="checkbox"/> left ear				

**Doctor's Comments:** (Check one)

- No positive or pertinent negative findings were noted upon exam.
- The following positive and/or pertinent negative findings were noted:

**CARDIORESPIRATORY**

24. Scarlet or Rheumatic fever				
25. Tuberculosis				
26. Exposed to someone with Tuberculosis				
27. Coughed up blood				
28. Asthma/emphysema/shortness of breath				
29. Chest pain or pressure				
30. Chronic Cough/Bronchitis				
31. Palpitation/Pounding Heart				
32. Heart disease or trouble				
33. High or low blood pressure				
34. Disease of the arteries				
35. Abnormal chest X-ray				
36. Increased Cholesterol level				
37. Abnormal ECG or Stress test				

**Doctor's Comments:** (Check one)

- No positive or pertinent negative findings were noted upon exam.
- The following positive and/or pertinent negative findings were noted:

**GASTROINTESTINAL**

38. Frequent Indigestion/Reflux				
39. Gallbladder trouble/Stones				
40. Jaundice or hepatitis				
41. Hemorrhoids				
42. Stomach, Liver, intestinal trouble				

**Doctor's Comments:** (Check one)

- No positive or pertinent negative findings were noted upon exam.
- The following positive and/or pertinent negative findings were noted:

*Contract Employee/Applicant Comments: (Use the Supplemental information page located on page 8 if additional space is needed). Contract Employee/Applicant MUST provide an explanation of all above YES answers. (See example below.)*

Item #	Diagnosis (if known)	Date of onset	Date of recovery (if resolved)	Doctor's Comments: Please review comments in the italicized area at left for completeness and add any additional clarifications in the unshaded area below.
41	Hemorrhoids (EXAMPLE)	2001	2001	

NAME (Last, First, Middle):

Social Security #:

**PART III. REPORT OF MEDICAL HISTORY, CONTINUED**

**PART IV. PHYSICAL EXAM**

YES YES  
NOW PAST NO

**GENITOURINARY/HERNIAS**

43. Rupture/hernias			
44. Frequent or painful urination			
45. Kidney Stone or blood in urine			
46. Protein in urine			
47. Prostate trouble / surgery			

**Doctor's Comments:** (Check one)

- No positive or pertinent negative findings were noted upon exam.  
 The following positive and/or pertinent negative findings were noted:

**NERVOUS SYSTEM**

48. Frequent or severe headache			
49. Dizziness/vertigo			
50. Fainting Spells/Syncope			
51. Head injury			
52. Stroke			
53. Neuritis			
54. Paralysis			
55. Epilepsy or seizures			
56. Frequent trouble sleeping			
57. Depression, anxiety, excessive worry			
58. Loss of memory or amnesia			
59. Periods of unconsciousness			
60. Psychiatric counseling			
61. Learning disability			
62. Treatment for mental condition			
63. Attempted suicide			

**Doctor's Comments:** (Check one)

- No positive or pertinent negative findings were noted upon exam.  
 The following positive and/or pertinent negative findings were noted:

**MUSCULOSKELETAL**

64. Wear a brace or back support			
65. Swollen or painful joints			
66. Broken bones			
67. Arthritis, bursitis, tendonitis			
68. Bone/joint or other deformity			
69. Back pain / trouble			
70. Painful or "trick" shoulder/elbow			
71. "Trick" or locked Knee			
72. Gout			
73. Loss of finger or toe			
74. Foot pain or trouble			

**Doctor's Comments:** (Check one)

- No positive or pertinent negative findings were noted upon exam.  
 The following positive and/or pertinent negative findings were noted:

*Contract Employee/Applicant Comments: (Use the Supplemental information page located on page 8 if additional space is needed). Contract Employee/Applicant MUST provide an explanation of all above YES answers. (See example below.)*

Item #	Diagnosis (if known)	Date of onset	Date of recovery (if resolved)	Doctor's Comments: Please review comments in the italicized area at left for completeness and add any additional clarifications in the unshaded area below.
66	<i>Broken left arm (EXAMPLE)</i>	1994	1994	

NAME (Last, First, Middle):

Social Security #:





**PART III. REPORT OF MEDICAL HISTORY, CONTINUED**

Is there any other medical disorder or physical impairment that has not been documented above which could interfere with the full performance of the duties listed on page 11?

YES (Explain below)       NO

CERTIFICATION: I certify that all of the statements made by me are true, complete, and correct to the best of my knowledge and belief, and are made in good faith.

PRINT (INCUMBENT) APPLICANT NAME

SIGNATURE

DATE

**PART V. PHYSICAL MEASUREMENTS**

All un-italicized areas are to be completed by the Examining Physician or clinic staff.

**Vital signs**

Weight \_\_\_\_\_ Height \_\_\_Ft. \_\_\_In.      Blood Pressure \_\_\_/\_\_\_      Pulse \_\_\_\_\_

<b><u>Vision-Acuity:</u></b>	<u>Both</u>	<u>Right</u>	<u>Left</u>		<u>Both</u>	<u>Right</u>	<u>Left</u>
Uncorrected Near	20/____	20/____	20/____	Uncorrected Far	20/____	20/____	20/____
Corrected Near	20/____	20/____	20/____	Corrected Far	20/____	20/____	20/____

**Vision-Color:**

Testing MUST be done with Ishihara (or comparable) Pseudo-Isochromatic Plates. A MINIMUM OF FOURTEEN PLATES must be reported.

Type of test:     Ishihara     Other \_\_\_\_\_    # of plates correct: \_\_\_\_\_ # of plates tested \_\_\_\_\_

**Vision-Peripheral:**

Is the peripheral vision normal? (Check one)       YES       NO

**Vision-Depth Perception:**

Results must be recorded in seconds of arc.

Type of test: \_\_\_\_\_ Score: \_\_\_\_\_ Seconds of arc: \_\_\_\_\_

**Hearing Testing** must be done with an AUDIOMETER IN A SOUND CONTROLLED ROOM OR BOOTH. Each ear must be tested separately at 500, 1000, 2000, 3000, and 4000 Hz. **HEARING AIDS MAY NOT BE USED DURING TESTING.** Attach audiometer printout to this page.

<b>Results:</b>	500	1000	2000	3000	4000
Right ear					
Left ear					

NAME (Last, First, Middle):

Social Security #:

**PART VI. EXAMINATION SUMMARY**

**DOCTOR PLEASE NOTE:**

Please be advised that the COURT SECURITY OFFICER IS A WEAPONS BEARING SECURITY POSITION. The range of duties that the officer must be constantly prepared to perform include INTENSE PHYSICAL EXERTION, USE OF FIREARMS AND PHYSICAL CONFRONTATION. Emergency situations requiring such activities MAY ARISE WITHOUT WARNING and require maximum performance with no opportunity for preparation. Any condition that can subtly or suddenly compromise the CSO's ability to perform the full range of duties may result in INJURY or DEATH to the officer, co-workers or members of the public.

Detailed description of the essential job functions of the Court Security Officer position may be found on page 11.

(Use the supplemental information page if additional space is needed)

Problem List (past & present medical/surgical conditions):	Recommended Limitations (Essential job functions are listed on page 11.)

Are there any contraindications to the performance of aggressive security activities?  YES  NO  
Check if supplemental information page is used

Doctor, please affirm the three following statements with a check in the associated box and sign below. Thank you for your assistance in this important clearance process:

- I have reviewed and understand the available materials describing the requirements of the CSO position.
- I have reviewed the attached ECG for adequacy and proper lead placement.
- I have reviewed the currently available laboratory reports and other testing for adequacy and completeness.

EXAMINING PHYSICIAN'S NAME (Type or print)

SIGNATURE

ADDRESS (including ZIP code)

OFFICE TELEPHONE NUMBER

FACSIMILE NUMBER

The following must be attached to this exam form:

- Fasting Chemistry Panel to include liver and renal function tests, fasting glucose by venipuncture, and electrolytes.
- Fasting Lipid Panel
- CBC with WBC differential and platelet count.
- Urinalysis for specific gravity, Blood, Glucose and Protein.
- 12 Lead ECG (original) lead placement must be verified by the examiner.
- Audiometer Printout or results recorded on page if printout is not available.
- Vision test results (Test records may be attached to this form).

NAME (Last, First, Middle):

Social Security #:

## **COURT SECURITY OFFICER'S JOB FUNCTIONS**

The primary functions of the Court Security Officer include physical security for federal court facilities and perimeters, checkpoint security for court facilities and courtroom entry points, courtroom monitoring, and a rapid response to emergencies and alarms within facility where federal court proceedings are held.

**Essential duties require Court Security Officers to be able to:**

### **Work Environment**

1. Work extended hours
2. Work in adverse weather
3. Work alone while armed
4. Work under stress
5. Stop, question or detain individuals
6. Encounter individuals who display a violent or irrational temperament
7. Provide armed escort

### **Weapons**

8. Use handgun with weak (non-dominant) hand
9. Use handcuffs
10. Use handgun
11. Confiscate weapon from person in pat down

### **Cardiovascular and Musculoskeletal**

12. Must have the ability to physically subdue attacker(s)
13. Must have the ability to physically control violent or unruly crowds
14. Must have the ability to subdue after running in pursuit
15. Must have the ability to respond to emergency with unplanned strenuous physical activity
16. Must have the ability to climb stairs in pursuit or in emergency
17. Must have the ability to sit or stand in one position for at least 2 hours

### **Vision**

18. Use distant vision to monitor front checkpoint and to monitor courtroom
19. Use distant vision to monitor garage/vehicles
20. Use distant vision to detect if individual has weapon
21. Use near vision to read x-ray monitor
22. Recognize basic colors
23. Visually detect peripheral movement/ID threat

### **Hearing**

24. Comprehend speech during face-to-face conversations
25. Comprehend speech during telephone conversations
26. Comprehend speech during radio transmissions
27. Comprehend speech when you can't see another CSO
28. Hear sounds that require investigation
29. Determine location of sound