

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

## UNITED STATES CIVIL SERVICE COMMISSION 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 <i>(last, first, middle)</i>	2. SOCIAL SECURITY ACCOUNT NO.	3. SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	4. DATE OF BIRTH
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? <input type="checkbox"/> YES <input type="checkbox"/> NO  <i>(If your answer is "YES" explain fully to the physician performing the examination)</i>		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  _____ <i>(signature of applicant)</i>	

### Part B. TO BE COMPLETED BEFORE EXAMINATION BY APPOINTING OFFICER

1. PURPOSE OF EXAMINATION <input type="checkbox"/> PREAPPOINTMENT <input type="checkbox"/> OTHER <i>(specify)</i>	2. POSITION TITLE <b>MARINE MACHINERY MECHANIC</b> <b>WG-5334</b>	
3. BRIEF DESCRIPTION OF WHAT POSITION REQUIRES EMPLOYEE TO DO <b>PERFORMS MAINTENANCE AND REPAIR ON ALL TYPES OF MARINE EQUIPMENT. THIS INCLUDES INSTALLING, MAINTAINING AND REPAIRING MARINE MACHINERY AND EQUIPMENT SUCH AS CARGO HANDLING MACHINERY, FORCED DRAFT BLOWERS, ANCHOR HANDLING GEAR, AND OTHER EQUIPMENT OF SIMILAR COMPLEXITY. TROUBLESHOOTS ON DIESEL ENGINES, AIR COMPRESSORS, CAPSTANS, WINDLASSES, WINCHES, SEWAGE EJECTORS, PORTABLE WATER EQUIPMENT, SALT WATER COOLING SYSTEMS, AS WELL AS FIRE, FUEL, REFRIGERATION, HEATING AND VENTILATING SYSTEMS.</b>		
4. Circle the number preceding <i>each</i> functional requirement and <i>each</i> 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.		
<b>A. FUNCTIONAL REQUIREMENTS</b>		
<ul style="list-style-type: none"> <li><input checked="" type="checkbox"/> 1. Heavy lifting, 45 pounds and over</li> <li><input type="checkbox"/> 2. Moderate lifting, 15-44 pounds</li> <li><input type="checkbox"/> 3. Light lifting, under 15 pounds</li> <li><input type="checkbox"/> 4. Heavy carrying, 45 pounds and over</li> <li><input type="checkbox"/> 5. Moderate carrying, 15-44 pounds</li> <li><input type="checkbox"/> 6. Light carrying, under 15 pounds</li> <li><input checked="" type="checkbox"/> 7. Straight pulling (      hours)</li> <li><input type="checkbox"/> 8. Pulling hand over hand (      hours)</li> <li><input type="checkbox"/> 9. Pushing (      hours)</li> <li><input type="checkbox"/> 10. Reaching above shoulder</li> <li><input type="checkbox"/> 11. Use of fingers</li> <li><input type="checkbox"/> 12. Both hands required</li> <li><input type="checkbox"/> 13. Walking (      hours)</li> <li><input checked="" type="checkbox"/> 14. Standing (      hours)</li> </ul>	<ul style="list-style-type: none"> <li><input checked="" type="checkbox"/> 15. Crawling (      hours)</li> <li><input type="checkbox"/> 16. Kneeling (      hours)</li> <li><input type="checkbox"/> 17. Repeated bending (      hours)</li> <li><input type="checkbox"/> 18. Climbing, legs only (      hours)</li> <li><input type="checkbox"/> 19. Climbing, use of legs and arms</li> <li><input type="checkbox"/> 20. Both legs required</li> <li><input type="checkbox"/> 21. Operation of crane, truck, tractor, or motor vehicle</li> <li><input type="checkbox"/> 22. Ability for rapid mental and muscular coordination simultaneously</li> <li><input type="checkbox"/> 23. Ability to use and desirability of using firearms</li> <li><input checked="" type="checkbox"/> 24. Near vision correctable at 13" to 16" to Jaeger 1 to 4</li> </ul>	<ul style="list-style-type: none"> <li><input type="checkbox"/> 25. Far vision correctable in one eye to 20/20 and to 20/40 in the other</li> <li><input type="checkbox"/> 26. Far vision correctable in one eye to 20/50 and to 20/100 in the other</li> <li><input type="checkbox"/> 27. Specific visual requirement <i>(specify)</i></li> <li><input checked="" type="checkbox"/> 28. Both eyes required</li> <li><input type="checkbox"/> 29. Depth perception</li> <li><input type="checkbox"/> 30. Ability to distinguish basic colors</li> <li><input type="checkbox"/> 31. Ability to distinguish shades of colors</li> <li><input checked="" type="checkbox"/> 32. Hearing <i>(aid permitted)</i></li> <li><input type="checkbox"/> 33. Hearing without aid</li> <li><input type="checkbox"/> 34. Specific hearing requirements <i>(specify)</i></li> <li><input type="checkbox"/> 35. Other <i>(specify)</i></li> </ul>
<b>B. ENVIRONMENTAL FACTORS</b>		
<ul style="list-style-type: none"> <li><input type="checkbox"/> 1. Outside</li> <li><input checked="" type="checkbox"/> 2. Outside and inside</li> <li><input type="checkbox"/> 3. Excessive heat</li> <li><input type="checkbox"/> 4. Excessive cold</li> <li><input type="checkbox"/> 5. Excessive humidity</li> <li><input type="checkbox"/> 6. Excessive dampness or chilling</li> <li><input checked="" type="checkbox"/> 7. Dry atmospheric conditions</li> <li><input type="checkbox"/> 8. Excessive noise, intermittent</li> <li><input type="checkbox"/> 9. Constant noise</li> <li><input checked="" type="checkbox"/> 10. Dust</li> </ul>	<ul style="list-style-type: none"> <li><input type="checkbox"/> 11. Silica, asbestos, etc.</li> <li><input checked="" type="checkbox"/> 12. Fumes, smoke, or gases</li> <li><input type="checkbox"/> 13. Solvents (degreasing agents)</li> <li><input checked="" type="checkbox"/> 14. Grease and oils</li> <li><input type="checkbox"/> 15. Radiant energy</li> <li><input type="checkbox"/> 16. Electrical energy</li> <li><input checked="" type="checkbox"/> 17. Slippery or uneven walking surfaces</li> <li><input type="checkbox"/> 18. Working around machinery with moving parts</li> <li><input checked="" type="checkbox"/> 19. Working around moving objects or vehicles</li> </ul>	<ul style="list-style-type: none"> <li><input checked="" type="checkbox"/> 20. Working on ladders or scaffolding</li> <li><input type="checkbox"/> 21. Working below ground</li> <li><input type="checkbox"/> 22. Unusual fatigue factors <i>(specify)</i></li> <li><input checked="" type="checkbox"/> 23. Working with hands in water</li> <li><input type="checkbox"/> 24. Explosives</li> <li><input type="checkbox"/> 25. Vibration</li> <li><input checked="" type="checkbox"/> 26. Working closely with others</li> <li><input checked="" type="checkbox"/> 27. Working alone</li> <li><input type="checkbox"/> 28. Protracted or irregular hours of work</li> <li><input type="checkbox"/> 29. Other <i>(specify)</i></li> </ul>
<b>* MUST MEET THE PHYSICAL REQUIREMENTS FOR ENTRANCE OR RETENTION IN USAR.</b>		

### Part C. TO BE COMPLETED BY EXAMINING PHYSICIAN

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

**NOTE TO EXAMINING PHYSICIAN:** The person you are about to examine will have to cope with the functional requirements and environmental factors circled on the other side 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.

2. EYES:

(A) Distant vision (Snellen): without glasses: right 20 left 20 ; with glasses, if worn: right 20 left 20

(B) What is the longest and shortest distance at which the following specimen of Jaeger No. 2 type can be read by the applicant? Test each eye separately.

Jaeger No. 2 Type \_\_\_\_\_  
 employees in the Federal classified service as may be requested by the Civil Service Commission or its authorized representative. This order will supplement the Executive Orders of May 29 and June 18, 1923 (Executive Order, September 4, 1924).

without glasses:

with glasses, if used:

R. \_\_\_\_\_ in. to \_\_\_\_\_ in.

R. \_\_\_\_\_ in. to \_\_\_\_\_ in.

L. \_\_\_\_\_ in. to \_\_\_\_\_ in.

L. \_\_\_\_\_ in. to \_\_\_\_\_ in.

(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

3. EARS: (Consider denominators indicated here as normal. Record as numerators the greatest distance heard.)  
 Ordinary conversation;

Audiometer (if given):

250	500	1000	2000	3000	4000	5000	6000	7000	8000

RIGHT EAR \_\_\_\_\_; LEFT EAR \_\_\_\_\_  
 20 ft. 20 ft.

4. OTHER FINDINGS: In items a through l briefly describe any abnormality (including diseases, scars, and disfigurements). Include brief history, if pertinent. If normal, so indicate.

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)

l. Neurological and mental 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:

## FOR AGENCY USE ONLY

<b>Part A. TO BE COMPLETED BY APPLICANT OR EMPLOYEE</b> <i>(typewrite or print in ink)</i>			
1. NAME <i>(last, first, middle)</i>	2. SOCIAL SECURITY ACCOUNT NO.	3. SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	4. DATE OF BIRTH
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? <input type="checkbox"/> YES <input type="checkbox"/> NO <i>(If your answer is "YES" explain fully to the physician performing the examination)</i>		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  _____ <i>(signature of applicant)</i>	

### 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: <input type="checkbox"/> HIRE OR RETAIN. DESCRIBE LIMITATIONS, IF ANY, HERE.    <input type="checkbox"/> TAKE ACTION TO SEPARATE OR DO NOT HIRE. EXPLAIN WHY.		
2. AGENCY MEDICAL OFFICER'S NAME <i>(type or print)</i>	3. LOCATION <i>(city, State, ZIP Code)</i>	4. DATE

### Part E. TO BE COMPLETED BY AGENCY PERSONNEL OFFICER

NOTE: Enter the action taken below. If this form is used for pre-appointment purposes, be sure the appropriate handicap code in Part F is circled. **IMPORTANT:** See FPM Chapter 293, Subchapter 3; FPM Chapter 339 and FPM Supplement 339-31 for disposition and/or filing of both parts of this form, either separately or together.

1. ACTION TAKEN: <input type="checkbox"/> HIRED OR RETAINED. <input type="checkbox"/> NON-SELECTED FOR APPOINTMENT, OR ELIGIBILITY OBJECTED TO. <input type="checkbox"/> ACTION TAKEN TO SEPARATE.		
2. AGENCY PERSONNEL OFFICER'S NAME <i>(type or print)</i>	3. SIGNATURE	4. DATE

### Part F. HANDICAP CODE *(to be completed only in pre-appointment cases)*

If the person examined has or had a handicap listed below, circle the code number which pertains to that handicap. If more than one handicap applies, circle the one considered most limiting. If none of the handicap codes apply, circle code "00".

00 No handicap of the type listed 10 Amputation—one major extremity 11 Amputation—two or more major extremities 20 Deformity or impaired function—upper extremity 21 Deformity or impaired function—lower extremity or back 30 Vision—one eye only 31 No usable vision	40 Hearing aid required 41 No usable hearing 42 No usable hearing, with speech malfunction 43 Normal hearing, with speech malfunction 50 Tuberculosis—inactive pulmonary 51 Organic heart disease <i>(compensated)</i> —valvular, arrhythmia, arteriosclerosis, healed coronary lesions	52 Diabetes—controlled 53 Epilepsy—adequately controlled 54 History of emotional behavioral problems requiring special placement effort 55 Mentally retarded 56 Mentally restored
--	--	---

1. EXAMINING PHYSICIAN'S NAME <i>(type or print)</i>	3. SIGNATURE OF EXAMINING PHYSICIAN  _____ <i>(signature)</i> _____ <i>(date)</i>
2. ADDRESS <i>(including ZIP Code)</i>	<p style="text-align: center; margin: 0;">IMPORTANT: After signing return <i>the entire form intact</i> in the pre-addressed "Confidential-Medical" envelope which the person you examined gave you.</p>