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 *(last, first, middle)*	2. SOCIAL SECURITY ACCOUNT NO.	3. SEX ☐ MALE ☐ 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?
☐ YES ☐ NO
(If your answer is YES' explain fully to the physician performing the examination)

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

(signature of applicant)

Part B. TO BE COMPLETED BEFORE EXAMINATION BY APPOINTING OFFICER

1. PURPOSE OF EXAMINATION
☒ PREAPPOINTMENT
☐ OTHER *(specify)*

2. POSITION TITLE
Heavy Mobile Equipment Repair Inspector,WG-5803

3. BRIEF DESCRIPTION OF WHAT POSITION REQUIRES EMPLOYEE TO DO
Performs operational, in-process and final inspection of work performed by others on a variety of construction, industrial, combat, tactical, and power generation equipment. Inspections include operational tests to ensure equipment is functioning properly.

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. 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
25. Far vision correctable in one eye to 20/20 and to 20/40 in the other
26. Far vision correctable in one eye to 20/50 and to 20/100 in the other
27. Specific visual requirement *(specify)*
28. Both eyes required
29. Depth perception
30. Ability to distinguish basic colors
31. Ability to distinguish shades of colors
32. Hearing *(aid permitted)*
33. Hearing without aid
34. Specific hearing requirements (specify)
35. Other *(specify)* Must meet the Physical requirements for entrance or retention in USAR.

B. ENVIRONMENTAL FACTORS

1. Outside
2. Outside and inside
3. Excessive heat
4. Excessive cold
5. Excessive humidity
6. Excessive dampness or chilling
7. Dry atmospheric conditions
8. Excessive noise, intermittent
9. Constant noise
10. Dust
11. Silica, asbestos, etc.
12. Fumes, smoke, or gases
13. Solvents *(degreasing agents)*
14. Grease and oils
15. Radiant energy
16. Electrical energy
17. Slippery or uneven walking surfaces
18. Working around machinery with moving parts
19. Working around moving objects or vehicles
20. Working on ladders or scaffolding
21. Working below ground
22. Unusual fatigue factors *(specify)*
23. Working with hands in water
24. Explosives
25. Vibration
26. Working closely with others
27. Working alone
28. Protracted or irregular hours of work
29. Other *(specify)*

Part C. TO BE COMPLETED BY EXAMINING PHYSICIAN

1. EXAMINING PHYSICIAN'S NAME *(type or print)*

2. ADDRESS *(including ZIP Code)*

3. SIGNATURE OF EXAMINING PHYSICIAN

(signature) *(date)*

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

STANDARD FORM NO. 78
OCTOBER 1969 (REVISION)
CIVIL SERVICE COMMISSION
FPM 339

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:

RIGHT EAR _____/20 ft.; LEFT EAR _____/20 ft.

Audiometer *(if given)*:

250	500	1000	2000	3000	4000	5000	6000	7000	8000

4. OTHER FINDINGS: In items a through l 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 and oral hygiene)*

b. Head and back *(including face, hair, and scalp)*

c. Speech *(note any malfunction)*

d. Skin and lymph nodes *(including thyroid gland)*

e. Abdomen

f. Peripheral blood vessels

g. Extremities

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

Part A. TO BE COMPLETED BY APPLICANT OR EMPLOYEE *(typewrite or print in ink)*

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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? ☐ YES ☐ NO *(If your answer is "YES" explain fully to the physician performing the examination)*	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 _____ *(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 LIMITATIONS, IF ANY, HERE.

☐ TAKE ACTION TO SEPARATE OR DO NOT HIRE. EXPLAIN WHY.

2. AGENCY MEDICAL OFFICER'S NAME *(type or print)*	3. LOCATION *(city, State, ZIP Code)*	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:

☐ HIRED OR RETAINED. ☐ NON-SELECTED FOR APPOINTMENT, OR ELIGIBILITY OBJECTED TO.

☐ ACTION TAKEN TO SEPARATE.

2. AGENCY PERSONNEL OFFICER'S NAME *(type or print)*	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 *(compensated)*—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 *(type or print)*	3. SIGNATURE OF EXAMINING PHYSICIAN _____ *(signature)* _____ *(date)*
2. ADDRESS *(including ZIP Code)*	IMPORTANT: After signing return *the entire form intact* in the pre-addressed "Confidential-Medical" envelope which the person you examined gave you.