

UNITED STATES CIVIL SERVICE COMMISSION CERTIFICATE OF MEDICAL EXAMINATION

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

1. NAME (last, first, middle)	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 _____ (signature of applicant)	

Part B. TO BE COMPLETED BEFORE EXAMINATION BY APPOINTING OFFICER

1. PURPOSE OF EXAMINATION <input type="checkbox"/> PREAPPOINTMENT <input type="checkbox"/> OTHER (specify)	2. POSITION TITLE AIRCRAFT MECHANIC/INSPECTOR/ WORKER, WG-8852
3. BRIEF DESCRIPTION OF WHAT POSITION REQUIRES EMPLOYEE TO DO INSPECTS, REPAIRS AND MAINTAINS A VARIETY OF SYSTEMS SUCH AS HYDRAULIC, OIL, FUEL, AND PRESSURIZATION SYSTEMS, LANDING GEAR ASSEMBLIES, AILERONS AND FLAPS. PERFORMS THESE FUNCTIONS ON SINGLE ENGINE AIRCRAFT, BOTH FIXED AND ROTARY-WING.	

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

- | | | |
|--|--|--|
| <ul style="list-style-type: none">① Heavy lifting, 45 pounds and over② Moderate lifting, 15-44 pounds③ Light lifting, under 15 pounds④ Heavy carrying, 45 pounds and over⑤ Moderate carrying, 15-44 pounds⑥ Light carrying, under 15 pounds⑦ Straight pulling (hours)⑧ Pulling hand over hand (hours)⑨ Pushing (hours)⑩ Reaching above shoulder⑪ Use of fingers⑫ Both hands required⑬ Walking (hours)⑭ Standing (hours) | <ul style="list-style-type: none">⑮ Crawling (hours)⑯ Kneeling (hours)⑰ Repeated bending (hours)⑱ Climbing, legs only (hours)⑲ Climbing, use of legs and arms⑳ Both legs required21. Operation of crane, truck, tractor, or motor vehicle22. Ability for rapid mental and muscular coordination simultaneously23. Ability to use and desirability of using firearms24. Near vision correctable at 13" to 16" to Jaeger 1 to 4 | <ul style="list-style-type: none">25. Far vision correctable in one eye to 20/20 and to 20/40 in the other26. Far vision correctable in one eye to 20/50 and to 20/100 in the other27. Specific visual requirement (specify) *28. Both eyes required29. Depth perception30. Ability to distinguish basic colors31. Ability to distinguish shades of colors32. Hearing (aid permitted)33. Hearing without aid34. Specific hearing requirements (specify)35. Other (specify) * |
|--|--|--|

B. ENVIRONMENTAL FACTORS

- | | | |
|---|--|---|
| <ul style="list-style-type: none">① Outside② Outside and inside③ Excessive heat④ Excessive cold⑤ Excessive humidity⑥ Excessive dampness or chilling⑦ Dry atmospheric conditions⑧ Excessive noise, intermittent⑨ Constant noise⑩ Dust | <ul style="list-style-type: none">11. Silica, asbestos, etc.12. Fumes, smoke, or gases13. Solvents (degreasing agents)14. Grease and oils15. Radiant energy16. Electrical energy17. Slippery or uneven walking surfaces18. Working around machinery with moving parts19. Working around moving objects or vehicles | <ul style="list-style-type: none">20. Working on ladders or scaffolding21. Working below ground22. Unusual fatigue factors (specify)23. Working with hands in water24. Explosives25. Vibration26. Working closely with others27. Working alone28. Protracted or irregular hours of work29. Other (specify) |
|---|--|---|

Part C. TO BE COMPLETED BY EXAMINING PHYSICIAN

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.

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

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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
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2. ADDRESS <i>(including ZIP Code)</i>	IMPORTANT: After signing return <i>the entire form intact</i> in the pre-addressed "Confidential-Medical" envelope which the person you examined gave you.