

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 (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"/> REAPPOINTMENT <input type="checkbox"/> OTHER (specify)	2. POSITION TITLE AUTOMOTIVE WORKER FOREMAN/ SUPERVISOR, WS-5823	
3. BRIEF DESCRIPTION OF WHAT POSITION REQUIRES EMPLOYEE TO DO EXERCISES SUPERVISORY RESPONSIBILITY OVER THE WORK OPERATIONS OF APPROXIMATELY 13-30 AUTOMOTIVE WORKERS. PLANS WEEKLY AND MONTHLY WORK ASSIGNMENTS. RE-VIEWS WORK IN PROGRESS OR ON COMPLETION. ASSURES THAT MATERIALS ARE ORDERED AND DELIVERED.		
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 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) 	<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 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 	<ul style="list-style-type: none"> 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) *
B. ENVIRONMENTAL FACTORS		
<ul style="list-style-type: none"> 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 	<ul style="list-style-type: none"> 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 	<ul style="list-style-type: none"> 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)
* MUST MEET THE PHYSICAL REQUIREMENTS FOR ENTRANCE OR RETENTION IN USAR.		

Part C. TO BE COMPLETED BY EXAMINING PHYSICIAN

1. EXAMINING PHYSICIAN'S NAME (type or print)	3. SIGNATURE OF EXAMINING PHYSICIAN
2. ADDRESS (including ZIP Code)	_____ (signature) _____ (date) 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

Part A. TO BE COMPLETED BY APPLICANT OR EMPLOYEE <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>	IMPORTANT: After signing return <i>the entire form intact</i> in the pre-addressed "Confidential-Medical" envelope which the person you examined gave you.