To be given to the individual examined with a pre-addressed envelope marked "Confidential - Medical".

CERTIFICATE OF MEDICAL EXAMINATION

U.S. OFFICE OF PERSONNEL MANAGEMENT

Form Approved
OMB No. 3206 - 0250

Privacy Act Statement

Solicitation of this information is authorized by Section 552a of Title 5, United States Code, regarding records maintained on individuals; Section 3301 of Title 5, United States Code, regarding determination as to an individual's fitness for employment with regard to age, health, character, knowledge and ability; and Section 3312 of Title 5 United States Code, regarding waiver of physical qualifications for preference eligibles. This form is used to collect medical information about individuals who are incumbents of positions in the Federal Government which require physical fitness testing and medical examinations, or individuals who have been selected for such a position contingent upon successful completion of physical fitness testing and medical examinations as a condition of their employment. The primary use of this information will be to determine the nature of a medical or physical condition that may affect safe and efficient performance of the work described. Additional potential routine uses of this information include using it to ensure fair and consistent treatment of employees and job applicants, to adjudicate requests to pass over preference eligibles, or to adjudicate claims of discrimination under the Rehabilitation Act of 1973, as amended. Completion of this form is voluntary; however, failure to complete the form may result in no further consideration of an applicant, or a determination that an employee is no longer qualified for his or her position. In addition, incomplete, misleading, or untruthful information provided on the form may result in delays in processing the form for employment, termination of employment, or criminal sanction.

Public Burden Statement

We estimate an average of two to three hours per response to complete, including the time for reviewing instructions, getting needed information, and reviewing the completed form. Send comments regarding our estimate or any other aspect of this form, including suggestions for reducing completion time, to the U.S. Office of Personnel Management (OPM), Strategic Human Resources Policy, Medical Policy and Programs Division, Attn: OMB Number (3206-0250), 1900 E Street, NW, Washington, D.C. 20415. The OMB number, 3206-0250, is currently valid. OPM may not collect this information, and you are not required to respond, unless this number is displayed.

Instructions

There are five parts in this form:

Part A - To be completed by applicant or employee. Signature of the applicant or employee certifies that the information provided is complete and accurate; and that the applicant or employee consents to the release of the examination results to the employing agency.

Part B - To be completed by the appointing officer before the medical examination: identifies the purpose of the examination; the position title, series and grade; generally describes the position; and shows the specific functional requirements and environmental factors that the work requires.

Part C - To be completed and signed by the examining physician, and returned to the employing agency in the pre-paid/ pre-addressed "Confidential-Medical" envelope provided.

Part D - To be completed by the agency medical officer who reviews the examination results and recommends action.

Part E - To be completed by the agency human resources officer in order to document the personnel action that is rendered.

To be given to the individual examined with a pre-addressed envelope marked "Confidential - Medical".

CERTIFICATE OF MEDICAL EXAMINATION

U.S. OFFICE OF PERSONNEL MANAGEMENT

Form Approved
OMB No. 3206 - 0250

Part A. TO BE COMPLETED BY APPLICANT OR EMPLOYEE

1. Name (Last, First, Middle Initial)

2. Federal Employee Number	3. Sex ☐ Male ☐ Female	4. Birth Date *(month, day, year)*

5. Do you have any medical disorder or physical impairment which would interfere in any way with the full performance of the duties shown in Part B, No. 3?

☐ Yes ☐ No

(If your answer is YES, explain fully to the physician performing the examination)

6. Address (including City, State, Zip Code)

7. E-mail Address	8. Telephone Numbers (with Area Code)

9. Applicant or Employee Consent and Certification

I certify that all of the information I have provided on this form is complete and accurate to the best of my knowledge, and that submitting information that is incomplete, misleading, or untruthful may result in termination, criminal sanctions, or delays in processing this form for employment. Furthermore, consistent with the Privacy Act Statement, I authorize the release to my employing agency of all information contained on this examination form and all other forms generated as a direct result of my examination.

10. Signature (Do not print)	11. Date *(month, day, year)*

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. 'Genetic information' as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services. (29 C.F.R. 1635.8(b)(1)(i)(B))

To be given to the individual examined with a pre-addressed envelope marked "Confidential - Medical".

CERTIFICATE OF MEDICAL EXAMINATION

U.S. OFFICE OF PERSONNEL MANAGEMENT

Form Approved
OMB No. 3206 - 0250

Part B. TO BE COMPLETED BEFORE EXAMINATION BY APPOINTING OFFICER

1. Purpose of examination	2. Position Title, Series, and Grade
☐ Pre-placement ☐ Other (Specify)_____	AIRCRAFT ORDINANCE INSPECTOR, WG-6652

3. Brief description of what the position requires the employee to do.

Performs on-site inspection of aircraft weapons systems in an Aviation Support Facility (ASF) engaged in AVUM and AVIM level maintenance, repair, modification, and overhaul of fixed and rotary wing aircraft, their major assemblies, to include articulating pylons, tow launchers, electronic components optical sighting systems, on-board fire control computers, helmet sight systems, heads up display units and guns. Makes initial, interim, and final inspection. Performs a variety of visual operational inspections, using testing equipment and determines serviceability and repairs required to aircraft armament systems.

Reviews work orders and maintenance records to ensure that required repairs have been made, and that the initials of mechanic and foreman appear on maintenance records. After completion of final inspection, signs inspection report certifying that aircraft armament systems in satisfactory operation condition, or rejects aircraft and returns to ordnance shop of correction of repair defects noted.

To be given to the individual examined with a pre-addressed envelope marked "Confidential - Medical".

CERTIFICATE OF MEDICAL EXAMINATION

U.S. OFFICE OF PERSONNEL MANAGEMENT

Form Approved
OMB No. 3206 - 0250

Part B. CONTINUED - TO BE COMPLETED BEFORE EXAMINATION BY APPOINTING OFFICER

4. Check the box for each functional requirement in section 4a and each environmental factor in section 4b 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.

4a. Functional Requirements

- [x] Heavy lifting, 45 pounds and over
- [x] Moderate lifting, 15-44 pounds
- [ ] Light lifting, under 15 pounds
- [ ] Heavy carrying, 45 pounds and over
- [ ] Moderate carrying, 15-44 pounds
- [ ] Light carrying, under 15 pounds
- [ ] Straight pulling (_____ hours)
- [ ] Pulling hand over hand (_____ hours)
- [ ] Pushing (_____ hours)
- [x] Reaching above shoulder
- [ ] Use of fingers
- [ ] Both hands required
- [ ] Walking (_____ hours)
- [x] Standing (1/2 hours)
- [x] Crawling (1/2 hours)
- [x] Kneeling (1/2 hours)
- [ ] Repeated bending (_____ hours)
- [ ] Climbing, legs only (_____ hours)
- [x] Climbing, use of legs and arms
- [ ] Both legs required
- [ ] Operation of crane, truck, tractor, or motor vehicle
- [ ] Ability for rapid mental and muscular coordination simultaneously
- [ ] Ability to use and desirability of using firearms
- [ ] Near vision correctable at 13" to 16" to Jaeger 1 to 4
- [ ] Far vision correctable in one eye to 20/20 and to 20/40 in the other
- [ ] Specific visual requirement (specify)
- [ ] Both eyes required
- [ ] Depth perception
- [ ] Ability to distinguish basic colors
- [ ] Ability to distinguish shades of colors
- [ ] Hearing (aid permitted)
- [ ] Hearing without aid
- [ ] Specific hearing requirements (specify)

Other (specify)

4b. Environmental Factors

- [ ] Outside
- [x] Outside and inside
- [ ] Excessive heat
- [ ] Excessive cold
- [ ] Excessive humidity
- [ ] Excessive dampness or chilling
- [ ] Dry atmospheric conditions
- [x] Excessive noise, intermittent
- [ ] Constant noise
- [x] Dust
- [ ] Silica, asbestos, etc.
- [ ] Fumes, smoke, or gases
- [ ] Solvents (degreasing agents)
- [x] Grease and oils
- [ ] Radiant energy
- [x] Electrical energy
- [x] Slippery or uneven walking surfaces
- [ ] Working around machinery with moving parts
- [ ] Working around moving objects or vehicles
- [ ] Working on ladders or scaffolding
- [ ] Working below ground
- [ ] Unusual fatigue factors (specify)
- [ ] Working with hands in water
- [ ] Explosives
- [ ] Vibration
- [ ] Working closely with others
- [ ] Working alone
- [ ] Protracted or irregular hours of work

Other (specify)

- [x] Working in confined spaces

To be given to the individual examined with a pre-addressed envelope marked "Confidential - Medical".

CERTIFICATE OF MEDICAL EXAMINATION

U.S. OFFICE OF PERSONNEL MANAGEMENT

Form Approved
OMB No. 3206 - 0250

Part C. TO BE COMPLETED BY EXAMINING PHYSICIAN

NOTE TO EXAMINING PHYSICIAN: The person you are about to examine will have to cope with the functional requirements and environmental factors checked in Part 4 of this form. Please take these, and the brief description of the job duties, 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 corrective lenses: right ____ 20 left ____ 20; with corrective lenses, if worn; right ____ 20 left ____ 20

b. Depth perception

Type of test: _____

_____ Seconds of Arc

Number correct: _____ of _____ tested

Interpretation ☐ Normal ☐ Abnormal

c. Peripheral vision

Right Nasal _____ degrees Temporal _____ degrees

Left Nasal _____ degrees Temporal _____ degrees

d. 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

The President may -
(1) prescribe such regulations for the admission of individuals into the civil service in the executive branch as will best promote the efficiency of that service; (2) ascertain the fitness of applicants as to age, health, character, knowledge, and ability for the employment sought; and (3) appoint and prescribe the duties of individuals to make inquiries for the purpose of this section.
(Title 5 U.S. Code 3301)

	without corrective lenses:	with corrective lenses, if used:
	L _____ in. to _____ in.	L _____ in. to _____ in.
	R _____ in. to _____ in.	R _____ in. to _____ in.

e. Color vision: Is color vision normal by Ishihara or other color plate test? ☐ Yes ☐ No

If not, can applicant pass lantern test? ☐ Yes ☐ No

Can see red/green/yellow? ☐ Yes ☐ No

Part C. CONTINUED - TO BE COMPLETED BY EXAMINING PHYSICIAN

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 in dB (if given) for Right Ear:									
250	500	1000	2000	3000	4000	5000	6000	7000	8000

Audiometer in dB (if given) for Left Ear:									
250	500	1000	2000	3000	4000	5000	6000	7000	8000

4. Other Findings: Describe any abnormality (including diseases, scars, and disfigurations). Include brief pertinent history. If normal, so indicate.

a. Eyes, ears, nose, and throat (including tooth and oral hygiene)

b. Abdomen

c. Head and back (including face, hair, and scalp)

d. Peripheral blood vessels

e. Speech (note any malfunction)

f. Extremities (including strength, range of motion)

g. 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 (including reflexes, sensation) and mental health

To be given to the individual examined with a pre-addressed envelope marked "Confidential - Medical".

CERTIFICATE OF MEDICAL EXAMINATION

U.S. OFFICE OF PERSONNEL MANAGEMENT

Form Approved
OMB No. 3206 - 0250

Part C. CONTINUED - TO BE COMPLETED BY EXAMINING PHYSICIAN

5. Conclusions: Summarize below any medical findings that in your opinion, would limit this person's ability to perform these job duties or make them a hazard to themselves or others. If none, so indicate.

☐ No limiting conditions for this job

☐ Limiting conditions as follows:

6. Examining Physician's Name	7. E-Mail Address
8. Address (Including Street, City, State and ZIP Code)	9. Telephone Number
10. Signature of Examining Physician	11. Date (Month, Day, Year)

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

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. 'Genetic information' as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services. (29 C.F.R. 1635.8(b)(1)(i)(B))

To be given to the individual examined with a pre-addressed envelope marked "Confidential - Medical".

CERTIFICATE OF MEDICAL EXAMINATION

U.S. OFFICE OF PERSONNEL MANAGEMENT

Form Approved
OMB No. 3206 - 0250

FOR AGENCY USE ONLY

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.

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	3. E-Mail Address
4. Address (Including Street, City, State and ZIP Code)	5. Telephone Number
6. Signature of Agency Medical Officer	7. Date (Month, Day, Year)

FOR AGENCY USE ONLY

Part E. TO BE COMPLETED BY AGENCY HUMAN RESOURCES OFFICER

1. Action Taken:

☐ Hired or Retained

☐ Non-Selected for Appointment, or Eligibility Objected To

☐ Action Taken to Separate

2. Agency Human Resources Officer's Name	3. E-Mail Address
4. Address (Including Street, City, State and ZIP Code)	5. Telephone Number
6. Signature of Agency Human Resources Officer	7. Date (Month, Day, Year)