

CERTIFICATE OF MEDICAL EXAMINATION
U.S. OFFICE OF PERSONNEL MANAGEMENT

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".

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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 <input type="checkbox"/> Male <input type="checkbox"/> Female	4. Birth Date (<i>month, day, year</i>)
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? <input type="checkbox"/> Yes <input type="checkbox"/> 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 (<i>month, day, year</i>)	

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))

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Part B. TO BE COMPLETED BEFORE EXAMINATION BY APPOINTING OFFICER

<p>1. Purpose of examination</p> <p><input type="checkbox"/> Pre-placement</p> <p><input type="checkbox"/> Other (Specify) _____</p>	<p>2. Position Title, Series, and Grade</p> <p>MOBILE EQUIPMENT SERVICER, WG-5806-06</p>
<p>3. Brief description of what the position requires the employee to do.</p> <p>Services a wide variety of automotive, heavy mobile, and powered support equipment. Completes preventive maintenance and work order services such as checking fluid levels, replacing fluids, cleaning battery boxes, flushing radiators, lubricating fittings and oil can points, etc. Performs these duties independently or while working as a helper to assist employees of higher grade in the completion of more complex repairs; removes, cleans or replaces spark plugs, hydraulic fluids, filters, tail pipes, batteries, air cleaners, light bulbs, and other similar items. Also obtains tools and parts as directed; cleans and lubricates parts and components; holds components in place, tightens bolts, etc. Removes, repairs, and replaces tires of all sizes.</p> <p>Takes oil samples in accordance with Army Oil Analysis Program procedures. In doing so, operates a variety of equipment and vehicles, only to bring the equipment or vehicle being sampled to proper temperature for sampling. Equipment being sampled is not operated under normal rated load but for the minimum time required to obtain a proper sample. Properly prepares and posts required documentation for AOAP. Prepares oil samples for shipment.</p> <p>May occasionally operate vehicles to bring them indoors for repair or service. Also, may occasionally drive other type and size vehicles for which qualified and licensed as determined by work load. Vehicles and equipment are not operated off the installation, at highway speeds or for their intended purpose (e.g. , with a load of equipment or personnel), but only for service or oil sampling.</p>	

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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

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

4b. Environmental Factors

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

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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:

L _____ in. to _____ in.

R _____ in. to _____ in.

with corrective lenses, if used:

L _____ 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

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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 disfigurements). 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

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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.	

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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: <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	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: <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 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)