

Department of Health and Human Services
 Commissioned Corps of the U.S. Public Health Service
REPORT OF MEDICAL EXAMINATION
 (Please read Privacy Act Statement before completing this form.)

OMB No. xxxx-xxxx
 OMB approval expires
 xx/xx/xx

The public reporting burden for this collection of information is estimated to average 15 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing the burden, to the HHS/OS Reports Clearance Officer, 200 Independence Avenue, SW, Room 537-H, Washington, DC 20012 (PRA 0990-XXXX). Respondents should be aware that notwithstanding any other provision of law, no person shall be subject to any penalty for failing to comply with a collection of information if it does not display a currently valid OMB control number.

IMPORTANT INSTRUCTIONS: An applicant to the Commissioned Corps of the U.S. Public Health Service (Corps) must NOT have a medical examiner/physician complete this form until AFTER the applicant receives a personnel order calling the applicant to duty with the Corps.

RETURN COMPLETED FORM TO:

OFFICE OF COMMISSIONED CORPS OPERATIONS, ATTN: MEDICAL EVALUATIONS OFFICER, 1101 WOOTTON PARKWAY, SUITE 100, PLAZA LEVEL, ROCKVILLE, MD 20852, AND MARK ENVELOPE "TO BE OPENED BY MEDICAL PERSONNEL ONLY."

<p>AUTHORITY: 42 U.S.C. 202 et seq. and Executive Order 9397. RECORDS SYSTEM: 09-40-0002, "PHS Commissioned Corps Medical Records," HHS/PSC/HR. PRINCIPAL PURPOSE: To determine medical acceptability or update a medical file as part of the application process to the Commissioned Corps of the U.S. Public Health Service. ROUTINE USES: None. DISCLOSURE: Voluntary; however, failure to furnish the requested information will impede the selection process and hamper an applicant's candidacy. Use of the Social Security Number is used for positive identification of records.</p>	OCCO USE ONLY
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APPLICANT DATA

1. DATE OF EXAMINATION (MM/DD/YYYY)	2. NAME (Last, First, Middle Initial)	3. SOCIAL SECURITY NUMBER
4. DATE OF BIRTH (MM/DD/YYYY)	5. AGE	6. SEX
7. RACE (Ethnic Group)		
8. ADDRESS INFORMATION (If left blank will delay processing)		9. STATUS (X one)
a. Applicant Mailing Address (Include ZIP Code)		<input type="checkbox"/> Active Duty <input type="checkbox"/> Civilian <input type="checkbox"/> Reserve/Guard
b. ROTC Detachment Code (If applicable):		10. EXAMINER ADDRESS (Street, City, State and ZIP Code)

MEASUREMENTS

11. HEIGHT (to nearest 1/4 inch)	12. BLOOD PRESSURE	13. AUDIOMETER	14. READING ALOUD TEST																												
Standing Sitting	Systolic Diastolic	<table style="width:100%; border-collapse: collapse;"> <tr> <td style="width:10%;"></td> <td style="width:10%;">500</td> <td style="width:10%;">1000</td> <td style="width:10%;">2000</td> <td style="width:10%;">3000</td> <td style="width:10%;">4000</td> <td style="width:10%;">6000</td> <td style="width:10%;"></td> <td style="width:10%;">500</td> <td style="width:10%;">1000</td> <td style="width:10%;">2000</td> <td style="width:10%;">3000</td> <td style="width:10%;">4000</td> <td style="width:10%;">6000</td> </tr> <tr> <td style="text-align: center;">Right</td> <td></td><td></td><td></td><td></td><td></td><td></td> <td style="text-align: center;">Left</td> <td></td><td></td><td></td><td></td><td></td><td></td> </tr> </table>		500	1000	2000	3000	4000	6000		500	1000	2000	3000	4000	6000	Right							Left							<input type="checkbox"/> Satisfactory <input type="checkbox"/> Unsatisfactory (Explain in Item 57)
	500	1000	2000	3000	4000	6000		500	1000	2000	3000	4000	6000																		
Right							Left																								
15. PULSE	17. DISTANT VISION		18. REFRACTION																												
16. WEIGHT (to nearest pound)	Right 20/ Corr to 20/	SPH Cyl Axis	19. NEAR VISION																												
	Right 20/ Corr to 20/	SPH Cyl Axis	20/ Corr to 20/ By																												
20. HETEROPHORIA/TROPIA (Far only)		22. COLOR VISION																													
Eso ^Δ Exo ^Δ RH ^Δ LH ^Δ	21. COVER TEST		23. DEPTH PERCEPTION																												
<input type="checkbox"/> Pass (Non-Tropia) <input type="checkbox"/> Fail (Tropia)		<table style="width:100%; border-collapse: collapse;"> <tr> <th style="width:30%;">Test Used</th> <th style="width:40%;">Results</th> <th style="width:30%;">Score</th> </tr> <tr> <td><input type="checkbox"/> PIP</td> <td>No. Passed: No. Failed:</td> <td><input type="checkbox"/> VTA-ND/OVT/AFVT</td> </tr> <tr> <td><input type="checkbox"/> FALANT</td> <td>No. Passed: No. Failed:</td> <td><input type="checkbox"/> DPA-V</td> </tr> <tr> <td><input type="checkbox"/> Other (Specify)</td> <td></td> <td><input type="checkbox"/> Titmus/Stereo Fly (Arcs per second)</td> </tr> </table>	Test Used	Results	Score	<input type="checkbox"/> PIP	No. Passed: No. Failed:	<input type="checkbox"/> VTA-ND/OVT/AFVT	<input type="checkbox"/> FALANT	No. Passed: No. Failed:	<input type="checkbox"/> DPA-V	<input type="checkbox"/> Other (Specify)		<input type="checkbox"/> Titmus/Stereo Fly (Arcs per second)																	
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24. NEAR POINT OF CONVERGENCE		25. VIVID RED/GREEN (If fail Item 22)																													
		<input type="checkbox"/> Pass <input type="checkbox"/> Fail																													
26. OCULAR MOTILITY AND BINOCULARITY (RED LENS TEST)																															
<input type="checkbox"/> Pass <input type="checkbox"/> Fail If Failed: <input type="checkbox"/> Diplopia <input type="checkbox"/> Suppression																															

LABORATORY

27. URINALYSIS																															
Protein		Neg		T		1+		2+		3+		4+																			
Sugar		Neg		T		1+		2+		3+		4+																			
Blood		Neg		T		1+		2+		3+		4+																			
Leukocyte Esterase		Neg		T		1+		2+		3+		4+																			
28. OTHER REQUIRED TESTS (Specify type and results)																															
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PROOF

CLINICAL EVALUATION

Normal	(X each item in the appropriate column. Enter "NE" if not evaluated)	Abnormal	Normal	(X each item in the appropriate column. Enter "NE" if not evaluated)	Abnormal
	29. HEAD, FACE, NECK AND SCALP			43. ABDOMEN AN VISCERA (Include hernia)	
	30. NOSE			44. ENDOCRINE SYSTEM	
	31. SINUSES			45. SPINE, OTHER MUSCULOSKELETAL	
	32. MOUTH AND THROAT			46. UPPER EXTREMITIES (Strength, sensation, range of motion)	
	33. EARS – GENERAL (Internal and external canals) (Auditory acuity under item 13)			47. LOWER EXTREMITIES (Except feet) (Strength, sensation, range of motion)	
	34. DRUMS (Perforation)			48. FEET	
	35. VALSALVA			49. IDENTIFYING BODY MARKS, SCARS, TATTOOS	
	36. EYES – GENERAL (Visual acuity and refraction under items 17, 18, and 19)			50. SKIN, LYMPHATICS	
	37. PUPILS (Equality and reaction)			51. GU SYSTEM	
	38. OCULAR MOTILITY (Associated parallel movements, nystagmus)			52. ANUS AND RECTUM (Hemorrhoids, fistulae) (Prostrate if indicated) EXTERNAL EXAM	
	39. OPHTHALMOSCOPIC			53. FEMALE GU EXTERNAL VISUAL EXAM	
	40. LUNGS AND CHEST (Include breasts)			54. NEUROLOGIC	
	41. HEART (Thrust, size, rhythm, and sounds)			55. PSYCHIATRIC (Specify any personality deviation)	
	42. VASCULAR SYSTEM (Varicosities, etc.)				

56. REPEAT BP OR PULSE EXAM (SITTING) IF BP ≥ 140/90 OR PULSE ≥ 100

57. NOTES (Describe every abnormality in detail. Enter the item number before each comment.)

PROOF

58. EXAMINER (If performed by PA, PCNP, or FNP)

TYPED OR PRINTED NAME	RANK	CORPS OR DEGREE	SIGNATURE
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59. PHYSICIAN (MD/DO)

TYPED OR PRINTED NAME	RANK	DEGREE	SIGNATURE
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