OMB No. 1140-0056 (07/31/2007)

U.S. Department of Justice
Bureau of Alcohol, Tobacco, Firearms and Explosives

Special Agent Medical *(Preplacement/Incumbent)*

Part I - Demographic Data *(To be completed by special agent/applicant)*

1. Name *(Please print or type)*	2. Date of Birth	3. Date of Testing	4. Social Security Number	5. Sex ☐ Male ☐ Female

6. Home Address	7. Home Telephone Number	8. Work Telephone Number

9. Field Office	10. Field Office Mailing Address	11. Personal Telephone Number

12. Current Employer	13. Current Occupation	14. How Long in Current Position? *(Years/months)*

Part II - Medical History *(To be completed by special agent/applicant.* ***Please check each item yes or no. If yes, please explain****)*

15. Have you been refused employment or been unable to hold a job or stay in school due to any medical condition? ☐ Yes ☐ No

16. Have you ever been treated for any mental condition? ☐ Yes ☐ No

17. Have you ever been denied life or health insurance? *(If yes, state reason and provide details.)* ☐ Yes ☐ No

18. Have you had, or been advised to have, any operation? ☐ Yes ☐ No

19. Have you ever been a patient in any type of hospital? *(If yes, specify when, where and give details.)* ☐ Yes ☐ No

20. Have you ever had any illness or injury other than those already noted? *(including learning disabilities and Attention Deficit Disorder (ADD), etc. If yes, specify when, where and give details.)* ☐ Yes ☐ No

21. Have you consulted or been treated by clinics, physicians, healers, or other practitioners within the past 5 years for other than minor illness? *(If yes, give complete address of doctor, hospital, clinic, and give details.)* ☐ Yes ☐ No

22. **Females Only:** Are you currently pregnant? *(If yes, provide trimester. This question relates only to issue of the safe participation in training.)* ☐ Yes ☐ No

23. Have you ever been rejected or discharged from military service because of physical, mental condition, or for other reasons? *(If yes, give date, reason and type of discharge: whether honorable, other than honorable, for unfitness or unsuitability.)* ☐ Yes ☐ No

24. Have you ever received, is there pending, or have you applied for pension or compensation for existing disability? *(If yes, specify what kind, granted by whom, what amount, when, and why.)* ☐ Yes ☐ No

25. Have you had or are you currently experiencing any of the following? *(If yes, please explain)*

Blurred vision? ☐ Yes ☐ No

Color blindness? ☐ Yes ☐ No

Glaucoma? ☐ Yes ☐ No

26. Do You? *(If yes, please explain)*

Wear glasses or contact lenses? ☐ Yes ☐ No

Have cataracts? ☐ Yes ☐ No

Have you ever been diagnosed with any eye disease? *(If yes, please explain)* ☐ Yes ☐ No

Have you had any type of eye surgery *(i.e., RK, PRK, cataracts, etc.)*? *(If yes, please explain what specific surgery was performed and the date of surgery.)* ☐ Yes ☐ No

27. Have You Experienced Any of the Following? *(If yes, please explain below)*

Difficulty hearing	☐ Yes	☐ No	Loud, constant noise or music within the last 14 hours	☐ Yes	☐ No
Dizziness	☐ Yes	☐ No	Do you wear a hearing aid?	☐ Yes	☐ No
Loud, impact noise in past 14 hours	☐ Yes	☐ No	Do you use hearing protective equipment?	☐ Yes	☐ No
Are you in a hearing conservation program?	☐ Yes	☐ No	Ankles or feet swelling	☐ Yes	☐ No
Chest pains	☐ Yes	☐ No	Palpitations *(rapid or skipped heart beat)*	☐ Yes	☐ No
Leg pains	☐ Yes	☐ No	Past history or diagnosis of heart disease	☐ Yes	☐ No
Heart murmur	☐ Yes	☐ No	Heart attack or stroke	☐ Yes	☐ No
Coronary bypass surgery/other heart surgery	☐ Yes	☐ No	Abnormal treadmill	☐ Yes	☐ No
Abnormal EKG *(Resting)*	☐ Yes	☐ No	Cold hands or feet when others are comfortable in same room	☐ Yes	☐ No
Heart disease, stroke or heart attack in parents or siblings prior to age 55	☐ Yes	☐ No	High blood pressure	☐ Yes	☐ No
Numbness in feet/hands	☐ Yes	☐ No	Problems with breathing, wheezing, persistent cough, /shortness of breath	☐ Yes	☐ No
Phlebitis or blood clots	☐ Yes	☐ No			
Bronchitis, tuberculosis	☐ Yes	☐ No	Past history or diagnosis of lung disease or surgery	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	Diabetes	☐ Yes	☐ No
Heat/sun stroke	☐ Yes	☐ No	Pituitary gland problem	☐ Yes	☐ No
Thyroid disease	☐ Yes	☐ No	Anemia	☐ Yes	☐ No
Blood disorder	☐ Yes	☐ No	Back surgery	☐ Yes	☐ No
Back pain	☐ Yes	☐ No	Tingling in head/hands/legs	☐ Yes	☐ No
Joint pain or swelling	☐ Yes	☐ No	Epilepsy *(seizure)*	☐ Yes	☐ No
Lack of coordination	☐ Yes	☐ No	Loss of sensation	☐ Yes	☐ No
Tremors/shakiness	☐ Yes	☐ No	Stomach ulcers	☐ Yes	☐ No
Persistent stomach/abdominal pain	☐ Yes	☐ No	Trouble using hip/knee/shoulder	☐ Yes	☐ No
Vomiting blood	☐ Yes	☐ No	Loss of joint/limb movement	☐ Yes	☐ No
Trouble walking	☐ Yes	☐ No	Any limb or finger amputations	☐ Yes	☐ No
Loss of strength/muscle weakness	☐ Yes	☐ No	Gout	☐ Yes	☐ No
Arthritis	☐ Yes	☐ No	Urinary pain/infection/bleeding	☐ Yes	☐ No
Skin problems, urticaria	☐ Yes	☐ No	Localized weakness/numbness	☐ Yes	☐ No
Kidney disease	☐ Yes	☐ No	Are you right handed?	☐ Yes	☐ No
Are you left handed?	☐ Yes	☐ No	Blood in stool	☐ Yes	☐ No
Persistent diarrhea/constipation	☐ Yes	☐ No	Hepatitis	☐ Yes	☐ No
Liver disease	☐ Yes	☐ No	Hernia	☐ Yes	☐ No
Gall bladder problems	☐ Yes	☐ No	Feelings of depression	☐ Yes	☐ No
Psychiatric/psychologic consult	☐ Yes	☐ No	Fainting	☐ Yes	☐ No
Periods of nervousness	☐ Yes	☐ No	Syncope	☐ Yes	☐ No
Ringing or buzzing in ears	☐ Yes	☐ No			

Explanation:

28. Your Current Physical Activity or Exercise Program Intensity	29. Frequency of	30. Duration of	31. Activities
☐ Low ☐ Moderate ☐ High	_____ Days Per Week	_____ Minutes Per Session	

32. Medications *(List all medications (prescription and non-prescription) you are currently taking with dosage, frequency and reason.)*

33. Allergies *(Please check where applicable)*

☐ None

☐ Drugs *(Specify)* _____

☐ Pollens *(Specify)* _____

☐ Other *(Specify)* _____

☐ Dust or molds *(Specify)* _____

☐ Animals *(Specify)* _____

☐ Food *(Specify)* _____

Part III - Social History *(To be completed by special agent/applicant)*

34. Have You Ever Smoked?	35. If Yes, When?	36. Type
☐ Yes ☐ No	☐ CUrrently ☐ Past *(Number of years since you quit)* _____	☐ Cigarette ☐ Pipe ☐ Cigar

37. How Many Do or Did You Smoke Per Day?	38. For How Many Years?

39. What is Your Average Alcohol Consumption in a Week? *(1 drink = 12 oz. beer, 1 glass of wine, 1.5 oz. liquor)*

_____ Drinks

40. How Often Do You Drink Alcohol?

☐ Weekdays ☐ Weekends ☐ Both

Part IV - Family Medical History *(To be completed by special agent/applicant)*

41. Father ☐ Alive ☐ Deceased	Current Age	Current General Health ☐ Excellent ☐ Fair ☐ Unknown ☐ Good ☐ Poor	Age and Cause of Death or Reason for Poor Health
42. Mother ☐ Alive ☐ Deceased	Current Age	Current General Health ☐ Excellent ☐ Fair ☐ Unknown ☐ Good ☐ Poor	Age and Cause of Death or Reason For Poor Health
43. Number of Brothers	Age Range	Health Problems, If Any	Age and Cause of Death or Reason For Poor Health
44. Number of Sisters	Age Range	Health Problems, If Any	Age and Cause of Death or Reason For Poor Health

45. Familial Diseases *(Have any of your blood relatives, i.e. grandparents, parents, siblings)* Had Any of the Following:

☐ Stroke	☐ Heart Attacks or Strokes	☐ Migraine Headaches	☐ Goiter
☐ Cancer	☐ Heart Operations	☐ Back Trouble	☐ Hepatitis
☐ Emphysema	☐ Elevated Cholesterol	☐ Herpes	☐ Gall Bladder Disease
☐ Bleeding Tendencies	☐ Asthma	☐ Anemia	☐ Hernia
☐ Diabetes	☐ Hay Fever	☐ Glaucoma	☐ Obesity
☐ Epilepsy	☐ Nervous Breakdown	☐ Arthritis	☐ Syncope/Sudden Death
☐ Thyroid Disorder	☐ Gout	☐ Colitis	☐ Other *(Specify)* _____
☐ *Fainting Spells*	☐ *Leukemia*	☐ *Tuberculosis*	
☐ *High Blood Pressure*	☐ *Kidney Disease*	☐ *Alcohol/Drug Abuse*	
☐ *Heart Disease*	☐ *Mental Disorder*	☐ *Stomach Ulcers*	

I certify that I have reviewed the foregoing information supplied by me and that it is true and complete to the best of my knowledge. I authorize any of the doctors, hospitals, or clinics mentioned on these forms to furnish the Government a complete transcript of my medical record for purposes of processing my application for this employment or service. I authorize the release of all medical information to the Federal Occupational Health/Law Enforcement Medical Program and the Bureau of Alcohol, Tobacco, Firearms and Explosives point of contact.

Client's Signature	Date
Witness's Signature	Date

Part V - To Be Completed By Clinic *(Please print)*

Name of Clinic	Address/Location of Clinic	Telephone Number *(Include area code)*
RN	MD/DO	

Part VI - To Be Completed By Health Care Provider

Disclaimer: This examination does not substitute for a periodic health examination conducted by your private provider. It is being conducted for occupational purposes.

1. Preplacement Service:

Required Services *(Check when test is completed)*

- ☐ Labs *(blood & urine)*
- ☐ Blood Lead & ZPP
- ☐ Height, weight, vitals
- ☐ EKG *(12 lead with interpretation)*
- ☐ PPD Mantoux *(TB skin test)*
- ☐ Audiometry *(500 Hz - 8000 Hz)*
- ☐ Vision screening *(Near & Far; Corrected & Uncorrected)*
- ☐ Color vision *(14 plate Ishihara)*
- ☐ Peripheral vision *(nasal & temporal)*
- ☐ Tonometry
- ☐ Depth Perception *(seconds of arc)*
- ☐ General Physical Exam
- ☐ General Medical history
- ☐ Attach copies of all test results

Lab Components - Fasting Blood

- Cholesterol Total
- Triglycerides
- HDL - cholesterol
- LDL - cholesterol
- Chol/HDL
- Bilirubin
- Transferase
- GGT
- LDH, Total
- Alanine Transminase

Comprehensive Metabolic Panel

- Glucose
- Urea Nitrogen (BUN)
- Creatinine
- BUN/Creatinine
- Sodium
- Potassium
- Chloride
- Protein, Total
- Globulin
- Albumin/Globulin Ratio
- Alkaline Phosphatase
- AST (SGOT)

CBC *(included Diff/Plat)*

- White blood cell count
- Red blood cell count
- Hemaglobin
- Hematocrit
- MCV
- MCH
- RDW
- Platelet Count
- Neutrophils
- Lymphocytes
- Absolutes Monocytes
- Monocytes
- Absolute Eosinophils
- Eosinophils
- Absolute Basophils
- Basophils

Urinalysis

- Color
- Appearance
- Specific Gravity
- Glucose
- Ketones
- Occult Blood
- Protein
- Nitrite
- Leukocyte Esterase
- Microscopic if indicated

Part VII - Diagnosis and Physical Findings *(To be completed by Health Care Provider)*

2. Head and Neck

Normal	Abnormal	
☐	☐	Head, Face Neck *(thyroid)* Scalp
☐	☐	Nose/Sinuses
☐	☐	Mouth/Throat
☐	☐	Pupils Equal/Reactive
☐	☐	Ocular Motility
☐	☐	Ophthalmoscopic Findings

3. Color Vision *(Require documentation of:)*

Correct _____ of _____ Total Tested

Type Of Test

☐ Titmus
☐ Ishihara Plate
☐ Other *(Specify)* _____

4. Intraocular Pressure

Right _____ mm/hg Left _____ mm/hg

Type of Test: ☐ Puff ☐ Shiotz

Depth Perception *(Require documentation of:)*

Correct _____ of _____ Total Tested Arc

Type of Tester _____ _____ Seconds of Arc
_____ Shepard - Fry %

5. Peripheral Vision *(Require numerical values)*

Right Temporal Eye _____	Left Temporal Eye _____
Nasal _____	Nasal _____
Total _____	Total _____

6. Uncorrected Vision *(Snellen Units)*

Near: Both 20/_____ Right 20/_____ Left 20/_____
Far: Both 20/_____ Right 20/_____ Left 20/_____

7. Corrected Vision *(Snellen Units)*

Near: Both 20/_____ Right 20/_____ Left 20/_____
Far: Both 20/_____ Right 20/_____ Left 20/_____

8. Comment on Heent Abnormalities:

Part VIII - Audiology *(To be completed by Health Care Provider)*

9. **Frequency**	500 Hz	1000 Hz	2000 Hz	3000 Hz	4000 Hz	6000 Hz	8000 Hz
Right Ear							
Left Ear							

10. Audiogram: ☐ Baseline ☐ Annual ☐ Termination *(Attach current and baseline audiogram)*

Calibration Method: ☐ Oscar ☐ Biological Date _____

Review/Compare With Baseline: ☐ Change ☐ No Change ☐ Normal ☐ Abnormal

Right Ear

Canal/External Ear: ☐ Normal ☐ Abnormal
Tympanic Membrane: ☐ Normal ☐ Abnormal

Left Ear

Canal/External Ear: ☐ Normal ☐ Abnormal
Tympanic Membrane: ☐ Normal ☐ Abnormal

Comments: _____

11. Vital Signs:

Height	Weight	Blood Pressure	Pulse	Temperature *(If indicated)*
		_____ mm/hg *(sitting)*	_____ *(sitting)*	

Comments: _____

12. Tuberculosis

Date Administered	Date Read	Degrees of Induration	Date of Last Chest X-ray

Comments *(Chest X-rays, TB treatment/dates)*:

13. Cardio/Pulmonary:

EKG *(Attach with interpretation)*:	Lungs/Chest *(includes breast)*:	Heart *(murmur, palpitations, ectopic beats)*:	Vascular *(varicosities)*:
☐ Normal ☐ Abnormal	☐ Normal ☐ Abnormal	☐ Normal ☐ Abnormal	☐ Normal ☐ Abnormal

Comments: _____

14. Pulmonary Function Testing *(Attach copy)*:

% Predicted FVC	% Predicted FEV1	% Predicted FEV1/FVC	% Predicted FEF 25 - 75

Comments: _____

Part IX - Diagnosis and Physical Findings *(To be completed by Health Care Provider)*

15. Musculoskeletal

Upper Extremities *(strength)*:	Upper Extremities *(range of motion)*:	Lower Extremities *(strength)*:
☐ Normal ☐ Abnormal	☐ Normal ☐ Abnormal	☐ Normal ☐ Abnormal
Lower Extremities *(range of motion)*:	Feet	Spine
☐ Normal ☐ Abnormal	☐ Normal ☐ Abnormal	☐ Normal ☐ Abnormal
Flexibility	Deep Tendon Reflexes	Other Neurological
☐ Normal ☐ Abnormal	☐ Normal ☐ Abnormal	☐ Normal ☐ Abnormal

16. Can Applicant Participate in the Following:

Vigorous Aerobic Exercise Program 3 Hr/Wk *(minimum)* ☐ Yes ☐ No Push Ups ☐ Yes ☐ No

Pull Ups ☐ Yes ☐ No Sit Ups ☐ Yes ☐ No One and One Half Mile (1.5) Time Run ☐ Yes ☐ No

Comments: _____

17. Is Applicant Capable of the Following:

☐ Yes ☐ No Squat and rise without holding on to any object. Maintain squatting and kneeling for up to 45 seconds repeatedly.
☐ Yes ☐ No Kneel on one knee with arms extended in front of body at eye level for seven (7) seconds.
☐ Yes ☐ No Assume a one and two-knee kneeling position within two (2) seconds and be able to rise without assistance. Be able to repeat twice.
☐ Yes ☐ No Maintain a kneeing position for 2 - 3 minutes repeatedly.

Please Comment on "Cannot Participate" Responses: _____

☐ Normal ☐ Abnormal Mental/Emotional Affect *(describe if abnormal)* _____
☐ Normal ☐ Abnormal G -U System
☐ Normal ☐ Abnormal Abdomen, Viscera
☐ Normal ☐ Abnormal Rectal/Prostate
☐ Normal ☐ Abnormal Skin *(scar/unique markings)*
☐ Normal ☐ Abnormal Lymphatic
☐ Normal ☐ Abnormal Other _____

Comments: _____

Part X - Education and Referral *(To be completed by the Health Care Provider)*

18. Check the Topics Discussed During the Diagnosis Work-up or Physical Exam:

☐ Lipids	☐ Hypentension	☐ Exercise
☐ Obesity	☐ Smoking Cessation	☐ Alcohol Use
☐ Hearing Protection	☐ Vision Referral	☐ Other Personal Protective Equipment
☐ Job Stressors	☐ Referral(s)	☐ Immunizations

Part XI - Examining Physician's Summary of Significant Findings With Recommendations

Note: Please do not provide any official statement *(oral or written)* concerning the applicant's fitness or capability to perform the duties of any occupation. The Agency's Medical Review Officer will provide this statement.

Examining Physician's Name *(Print or type)*	Examining Physician's Signature	Date

When Exam is Complete, Fedex Within Two Days To:

Public Health Service
Division of Federal Occupational Health
Law Enforcement Medical Programs
Attn: P. Swan
Atlanta Federal Center, Suite 3R10
100 Alabama Street
Atlanta, GA 30303

ATF Use Only

Action Taken:

☐ Hired or Retained
☐ Non-selected For Appointment, or Eligibility Objected to
☐ Action Taken to Separate

Agency Personnel Officer's Name *(Print or type)*	Agency Personnel Officer's Signature	Date

Privacy Act Information

Executive Order, 9830 and 5 CFR 339.301 authorizes collection of this information. The primary use of this information is to determine medical suitability to qualify for a position that has specific medical standards, physical requirements, or is covered by a medical evaluation program established under these regulations. Furnishing this information is mandatory because such information is part of the basic qualifications for the position. If this information were not provided, the applicant would fail to meet the qualifications for the position.

Additional disclosures of this information may be: To the Department of Labor when processing a claim for compensation regarding a job connected injury or illness; to Federal Life Insurance or Health Benefits carriers regarding a claim; to another Federal agency; to a court, or a party in litigation before a court or in an administrative proceeding when the government is a party or when the agency deems it to be relevant and necessary to the litigation; to a Federal, State, or local law enforcement agency when such agency becomes aware of a violation or possible violation of civil or criminal law; to a Federal agency when conducting an investigation for employment or security reasons; to the General Services Administration in connection with responsibilities for records management.

Paperwork Reduction Act Notice

This information collection request is in accordance with The Paperwork Reduction Act of 1995. The purpose of this information is to determine whether or not an applicant is actually qualified for the position. The information will be initially used to make a recommendation on either hiring or not hiring an applicant or retaining an individual in a special agent position.

The estimated average burden associated with this collection of information is 45 minutes per respondent or recordkeeper, depending on individual circumstances. Comments concerning the accuracy of this burden estimate and suggestions for reducing this burden should be addressed to Reports Management Officer, Document Services Branch, Bureau of Alcohol, Tobacco, Firearms and Explosives, Washington, DC 20226.

An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number.