



**PAPERWORK REDUCTION ACT & PRIVACY ACT STATEMENT**

The Transportation Security Administration (TSA) requires physical/medical examinations prior to an individual's appointment to a TSA Security Officer position. TSA uses this form to obtain information relevant to an applicant's health status for purposes of making an employment decision. This is a mandatory collection of information if you wish to be considered for a TSA Security Officer position. It is estimated that the total average burden per response associated with this form is approximately 40 minutes. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a valid OMB control number.

**PRIVACY ACT STATEMENT:** AUTHORITY: 49 U.S.C. 44935 PRINCIPAL PURPOSE(S): This information will be used to determine your eligibility for employment as a Transportation Security Officer (TSO). ROUTINE USE(S): This information may be shared with contractors, grantees, or volunteers performing or working on a contract, service, grant, cooperative agreement, or job for the federal government, or for routine uses identified in the Office of Personnel Management's system of records notice, OPM/GOVT-10 Employee Medical File System Records (if hired) or OPM/GOVT-5 Recruiting, Examining, and Placement Records (if not hired). DISCLOSURE: Voluntary; failure to furnish the requested information may result in an inability to consider your application for employment.

**INSTRUCTIONS**

It is required that you complete each question or response in this questionnaire. After completing each page record your initials in the space provided at the bottom of each page. Your responses will be reviewed with you by a medical professional.

**DEMOGRAPHIC INFORMATION**

|                                                                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                       |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <p><b>Name (Print):</b> _____</p> <p><b>Address:</b> _____</p> <p><b>Home Phone #:</b> (____) _____ - _____</p> <p><b>Work Phone #:</b> (____) _____ - _____</p> <p><b>Other Phone #:</b> (____) _____ - _____</p> <p><b>Best Time to Call:</b> _____</p> | <p><b>Social Security # (last 4 digits):</b> ____ - ____ - ____ - ____</p> <p><b>Sex:</b> Male _____ Female _____</p> <p><b>Date of Birth:</b> ____ / ____ / ____<br/>(mm / dd / yyyy)</p> <p><b>Height:</b> ____ Feet ____ Inches</p> <p><b>Weight:</b> ____ lbs</p> |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|

**GENERAL INFORMATION**

1. Have you been refused employment, dismissed from a job, or unable to stay in school due to any medical condition or excessive absenteeism?      1. Yes \_\_\_\_\_ No \_\_\_\_\_  
*If yes*, please list each medical condition and record the year of the refusal:  
 \_\_\_\_\_  
 \_\_\_\_\_
2. Have you ever been diagnosed or treated for a mental health condition?      2. Yes \_\_\_\_\_ No \_\_\_\_\_  
*If yes*, specify the year for each mental health condition and provide details:  
 \_\_\_\_\_  
 \_\_\_\_\_
3. Have you had, or have you been advised to have, any operations?      3. Yes \_\_\_\_\_ No \_\_\_\_\_  
*If yes*, describe what type of operation and indicate date if appropriate  
 \_\_\_\_\_  
 \_\_\_\_\_
4. Have you been treated at any type of hospital in the last 10 years?      4. Yes \_\_\_\_\_ No \_\_\_\_\_  
*If yes*, specify when and reason for treatment  
 \_\_\_\_\_  
 \_\_\_\_\_
5. Have you ever had any illness, injury, or condition (including learning disability, attention deficit disorder, etc.) other than those already noted above?      5. Yes \_\_\_\_\_ No \_\_\_\_\_ Don't Know \_\_\_\_\_  
*If yes*, specify medical condition and when you were treated  
 \_\_\_\_\_  
 \_\_\_\_\_

**GENERAL INFORMATION (continued)**

6. Have you consulted or been treated by clinics, physicians, healers, or other practitioners within the past year for anything other than minor illnesses? 6. **Yes** \_\_\_\_\_ **No** \_\_\_\_\_  
**If yes**, provide an explanation and the name of doctor consulted and/or the hospital/clinic

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7. Have you ever been rejected for military service or law enforcement position(s) because of physical, mental, or other medical reasons? 7. **Yes** \_\_\_\_\_ **No** \_\_\_\_\_  
**If yes**, give date and reason for rejection:

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8. Have you ever been discharged from military service or a law enforcement position because of physical, mental, or other reasons? 8. **Yes** \_\_\_\_\_ **No** \_\_\_\_\_  
**If yes**, give date and reason. If military discharge, list type (e.g., honorable, other than honorable, for unfitness, unsuitability):

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9. Have you ever received a pension or compensation for a disability or work related injury or illness? 9. **Yes** \_\_\_\_\_ **No** \_\_\_\_\_  
**If yes**, complete the chart below for each occurrence:

| Disability | Year Disability Granted | Disability related to which body system?<br>Check one. |  | % Disability Granted | Duration of Disability (Years/Months) | Is disability permanent? (Yes/No) |
|------------|-------------------------|--------------------------------------------------------|--|----------------------|---------------------------------------|-----------------------------------|
|            |                         |                                                        |  |                      |                                       |                                   |
| 1          |                         | Musculoskeletal                                        |  |                      |                                       |                                   |
|            |                         | Mental Health                                          |  |                      |                                       |                                   |
|            |                         | Other                                                  |  |                      |                                       |                                   |
| 2          |                         | Musculoskeletal                                        |  |                      |                                       |                                   |
|            |                         | Mental Health                                          |  |                      |                                       |                                   |
|            |                         | Other                                                  |  |                      |                                       |                                   |
| 3          |                         | Musculoskeletal                                        |  |                      |                                       |                                   |
|            |                         | Mental Health                                          |  |                      |                                       |                                   |
|            |                         | Other                                                  |  |                      |                                       |                                   |

10. Do you have a valid driver's license? 10. **Yes** \_\_\_\_\_ **No** \_\_\_\_\_

11. Are you taking any prescription medications? 11. **Yes** \_\_\_\_\_ **No** \_\_\_\_\_  
**If yes**, list all current prescription medications and check the box that best describes how often you take each medication

| Name of Medication | Daily | Weekly | Monthly or Less |
|--------------------|-------|--------|-----------------|
|                    |       |        |                 |
|                    |       |        |                 |
|                    |       |        |                 |
|                    |       |        |                 |
|                    |       |        |                 |
|                    |       |        |                 |
|                    |       |        |                 |

**VISION:**

1. Do you have a total loss of vision in your right eye? 1. **Yes** \_\_\_\_\_ **No** \_\_\_\_\_  
 2. Do you have a total loss of vision in your left eye? 2. **Yes** \_\_\_\_\_ **No** \_\_\_\_\_  
 3. Have you had any type of eye surgery (such as Lasik, cataracts, etc.) in the past year? 3. **Yes** \_\_\_\_\_ **No** \_\_\_\_\_

**MEDICAL HISTORY**

**HEARING:**

- 1. Do you have a total loss of hearing in your right ear? 1. Yes \_\_\_\_\_ No \_\_\_\_\_ Don't Know \_\_\_\_\_
- 2. Do you have a total loss of hearing in your left ear? 2. Yes \_\_\_\_\_ No \_\_\_\_\_ Don't Know \_\_\_\_\_
- 3. Do you wear hearing aids?  
*If yes, is it a CROS style hearing aid?* 3. Yes \_\_\_\_\_ No \_\_\_\_\_  
Yes \_\_\_\_\_ No \_\_\_\_\_ Don't Know \_\_\_\_\_

**CARDIOVASCULAR: Have you EVER had or experienced any of the following?**

- 1. Chest pains 1. Yes \_\_\_\_\_ No \_\_\_\_\_  
*If yes, has your doctor prescribed heart medication for this?* Yes \_\_\_\_\_ No \_\_\_\_\_ Don't Know \_\_\_\_\_
- 2. Palpitations (rapid or skipped heart beat) 2. Yes \_\_\_\_\_ No \_\_\_\_\_ Don't Know \_\_\_\_\_  
*If yes, are you receiving treatment?* Yes \_\_\_\_\_ No \_\_\_\_\_ Don't Know \_\_\_\_\_
- 3. Heart murmur 3. Yes \_\_\_\_\_ No \_\_\_\_\_ Don't Know \_\_\_\_\_  
*If yes, has anyone ever recommended heart valve replacement?* Yes \_\_\_\_\_ No \_\_\_\_\_ Don't Know \_\_\_\_\_
- 4. Heart valve replacement 4. Yes \_\_\_\_\_ No \_\_\_\_\_
- 5. Past history or diagnosis of heart disease 5. Yes \_\_\_\_\_ No \_\_\_\_\_
- 6. Coronary bypass surgery or other heart surgery 6. Yes \_\_\_\_\_ No \_\_\_\_\_
- 7. Heart attack or stroke 7. Yes \_\_\_\_\_ No \_\_\_\_\_
- 8. Abnormal EKG or stress test result 8. Yes \_\_\_\_\_ No \_\_\_\_\_
- 9. Pacemaker or implanted defibrillator 9. Yes \_\_\_\_\_ No \_\_\_\_\_  
a. Pacemaker? a. Yes \_\_\_\_\_ No \_\_\_\_\_  
b. Implanted defibrillator? b. Yes \_\_\_\_\_ No \_\_\_\_\_
- 10. High blood pressure 10. Yes \_\_\_\_\_ No \_\_\_\_\_ Don't Know \_\_\_\_\_
- 11. Circulatory problems (e.g., Raynaud's disease, swelling of ankles, leg pains, numbness in feet or hands) 11. Yes \_\_\_\_\_ No \_\_\_\_\_ Don't Know \_\_\_\_\_
- 12. Cramps in legs 12. Yes \_\_\_\_\_ No \_\_\_\_\_
- 13. Phlebitis or blood clots 13. Yes \_\_\_\_\_ No \_\_\_\_\_ Don't Know \_\_\_\_\_

**RESPIRATORY: Have you EVER had or experienced any of the following?**

- 1. Problems breathing, wheezing, persistent cough or shortness of breath 1. Yes \_\_\_\_\_ No \_\_\_\_\_  
*If yes, how long ago?* \_\_\_\_\_
- 2. Bronchitis 2. Yes \_\_\_\_\_ No \_\_\_\_\_ Don't Know \_\_\_\_\_  
*If yes, how long ago?* \_\_\_\_\_
- 3. Blood in sputum or when coughing 3. Yes \_\_\_\_\_ No \_\_\_\_\_ Don't Know \_\_\_\_\_  
*If yes, how long ago?* \_\_\_\_\_
- 4. Past history or diagnosis of lung disease 4. Yes \_\_\_\_\_ No \_\_\_\_\_  
*If yes, how long ago?* \_\_\_\_\_
- 5. History of tuberculosis 5. Yes \_\_\_\_\_ No \_\_\_\_\_  
*If yes, how long ago?* \_\_\_\_\_
- 6. Positive TB test 6. Yes \_\_\_\_\_ No \_\_\_\_\_  
*If yes, how long ago?* \_\_\_\_\_
- 7. Asthma 7. Yes \_\_\_\_\_ No \_\_\_\_\_ Don't Know \_\_\_\_\_  
*If yes, how long ago?* \_\_\_\_\_

**GASTROINTESTINAL: Have you EVER had or experienced any of the following?**

- 1. Persistent stomach or abdominal pain 1. Yes \_\_\_\_\_ No \_\_\_\_\_  
*If yes, how long ago?* \_\_\_\_\_
- 2. Persistent diarrhea or constipation 2. Yes \_\_\_\_\_ No \_\_\_\_\_  
*If yes, how long ago?* \_\_\_\_\_
- 3. Blood in stool 3. Yes \_\_\_\_\_ No \_\_\_\_\_ Don't Know \_\_\_\_\_  
*If yes, how long ago?* \_\_\_\_\_

**HEPATIC: Have you EVER had or experienced any of the following?**

- 1. Liver disease, jaundice or history of cirrhosis 1. Yes \_\_\_\_\_ No \_\_\_\_\_ Don't Know \_\_\_\_\_  
*If yes, how long ago?* \_\_\_\_\_
- 2. Hepatitis 2. Yes \_\_\_\_\_ No \_\_\_\_\_ Don't Know \_\_\_\_\_  
*If yes, how long ago?* \_\_\_\_\_

**MEDICAL HISTORY (continued)**

**MUSCULOSKELETAL / ORTHOPEDIC:**

*Have you EVER had or experienced any of the following?*

- |                                                                              |                                                    |
|------------------------------------------------------------------------------|----------------------------------------------------|
| 1. Amputated hand or missing hand                                            | 1. Yes _____ No _____                              |
| 2. Any other amputation (e.g., leg, finger, toe)                             | 2. Yes _____ No _____                              |
| 3. Back pain                                                                 | 3. Yes _____ No _____                              |
| a. How often do you experience it?                                           | a. Frequently _____ Occasionally _____             |
| b. How often do you take medication for your pain?                           | b. Frequently _____ Occasionally _____ Never _____ |
| 4. Back surgery                                                              | 4. Yes _____ No _____                              |
| 5. Back injury                                                               | 5. Yes _____ No _____                              |
| 6. Joint pain or swelling                                                    | 6. Yes _____ No _____                              |
| 7. Loss of joint or limb movement                                            | 7. Yes _____ No _____                              |
| 8. Loss of strength or muscle weakness                                       | 8. Yes _____ No _____                              |
| 9. Difficulty walking                                                        | 9. Yes _____ No _____                              |
| 10. Difficulty bending, stooping or squatting                                | 10. Yes _____ No _____                             |
| 11. Difficulty reaching overhead, moving arms in all directions at shoulders | 11. Yes _____ No _____                             |
| 12. Arthritis, rheumatism, bursitis or gout                                  | 12. Yes _____ No _____ Don't Know _____            |
| 13. Bone, joint, or other deformity                                          | 13. Yes _____ No _____                             |
| 14. Foot problems (aching, pain when walking in bare feet)                   | 14. Yes _____ No _____                             |
| 15. Any orthopedic surgery within the past two years                         | 15. Yes _____ No _____                             |
| 16. Any neck (cervical spine) surgery                                        | 16. Yes _____ No _____                             |
| 17. Any neck (cervical spine) problems or disorder                           | 17. Yes _____ No _____                             |
| 18. Any fracture(s) with symptoms and/or abnormal range of motion            | 18. Yes _____ No _____ Don't Know _____            |
| 19. Plate, pin, or rod in any bone                                           | 19. Yes _____ No _____                             |

20. Check the statement below that best describes how long you can sit continuously without standing or walking:

***I am physically able to sit continuously without taking a break for a total of:***

- \_\_\_\_\_ Less than 1 hour in an 8-hour workday  
 \_\_\_\_\_ At least 1 to 2 hours in an 8-hour workday  
 \_\_\_\_\_ At least 3 to 4 hours in an 8-hour workday  
 \_\_\_\_\_ At least 5 to 6 hours in an 8-hour workday

21. Check the statement below that best describes how long you can stand and walk continuously without sitting or leaning against a table or wall:

***I am physically able to stand and walk continuously without taking a break for a total of:***

- \_\_\_\_\_ Less than 1 hour in an 8-hour workday  
 \_\_\_\_\_ At least 1 to 2 hours in an 8-hour workday  
 \_\_\_\_\_ At least 3 to 4 hours in an 8-hour workday  
 \_\_\_\_\_ At least 5 to 6 hours in an 8-hour workday

22. Do you have any lifting restrictions? 22. Yes \_\_\_\_\_ No \_\_\_\_\_  
*If yes, what is the maximum weight you are allowed to lift?* \_\_\_\_\_ pounds

23. Place a check next to the response that best describe how often you lift and/or carry objects for each weight category:

**Lift and/or carry (including upward pulling) a maximum of:**

| Weight    | Never / Rarely<br>0 to 2 times per year | Occasionally<br>1 to 2 times per month | Frequently<br>Once per week or more |
|-----------|-----------------------------------------|----------------------------------------|-------------------------------------|
| 30 pounds | Never or Rarely _____                   | Occasionally _____                     | Frequently _____                    |
| 50 pounds | Never or Rarely _____                   | Occasionally _____                     | Frequently _____                    |
| 70 pounds | Never or Rarely _____                   | Occasionally _____                     | Frequently _____                    |

24. ***How often*** do you participate in each of the following activities?

| Weight           | Never / Rarely<br>0 to 2 times per year | Occasionally<br>1 to 2 times per month | Frequently<br>Once per week or more |
|------------------|-----------------------------------------|----------------------------------------|-------------------------------------|
| Climb (Stairs)   | Never or Rarely _____                   | Occasionally _____                     | Frequently _____                    |
| Stoop/Bend/Squat | Never or Rarely _____                   | Occasionally _____                     | Frequently _____                    |
| Kneel            | Never or Rarely _____                   | Occasionally _____                     | Frequently _____                    |

25. **If you have a limitation performing any of the tasks listed below, place a check in the box (right, left) that corresponds to the side of your body with the limitation. Otherwise, check "No Limitations".**

- a. Can handle or pick up objects from a table with fingers  
 b. Can feel objects with fingers and hands (sensation)  
 c. Can touch finger tips to palm to make a fist  
 d. Can bend elbow and touch fingers to shoulder

| Limitations |      | No<br>Limitations |
|-------------|------|-------------------|
| Right       | Left |                   |
|             |      |                   |
|             |      |                   |
|             |      |                   |
|             |      |                   |

**MEDICAL HISTORY (continued)**

**ENDOCRINE:**

*Have you **EVER** had or experienced any of the following?*

- |                    |                                        |
|--------------------|----------------------------------------|
| 1. Diabetes        | 1. Yes _____ No _____ Don't Know _____ |
| 2. Thyroid disease | 2. Yes _____ No _____ Don't Know _____ |
| 3. Anemia          | 3. Yes _____ No _____ Don't Know _____ |
| 4. Blood disorder  | 4. Yes _____ No _____ Don't Know _____ |

**NEUROLOGICAL:**

*Have you **EVER** had or experienced any of the following?*

- |                                                                                         |                                                                              |
|-----------------------------------------------------------------------------------------|------------------------------------------------------------------------------|
| 1. Localized weakness, numbness, tingling, or loss of sensation in hands, legs, or feet | 1. Yes _____ No _____<br><i>If yes, how long ago?</i> _____                  |
| 2. Seizures                                                                             | 2. Yes _____ No _____ Don't Know _____<br><i>If yes, how long ago?</i> _____ |
| 3. Tremors or shakiness                                                                 | 3. Yes _____ No _____ Don't Know _____<br><i>If yes, how long ago?</i> _____ |
| 4. Fainting or dizziness                                                                | 4. Yes _____ No _____<br><i>If yes, how long ago?</i> _____                  |
| 5. Head injury                                                                          | 5. Yes _____ No _____ Don't Know _____<br><i>If yes, how long ago?</i> _____ |
| 6. Wear a brace or back support                                                         | 6. Yes _____ No _____<br><i>If yes, how long ago?</i> _____                  |
| 7. Frequent or severe headaches                                                         | 7. Yes _____ No _____<br><i>If yes, how long ago?</i> _____                  |
| 8. Nerve injury                                                                         | 8. Yes _____ No _____ Don't Know _____<br><i>If yes, how long ago?</i> _____ |
| 9. Paralysis                                                                            | 9. Yes _____ No _____<br><i>If yes, how long ago?</i> _____                  |

**PSYCHOLOGICAL:**

*Have you **EVER** had or experienced any of the following?*

- |                                                        |                                                                              |
|--------------------------------------------------------|------------------------------------------------------------------------------|
| 1. Counseling or psychiatric consultation              | 1. Yes _____ No _____<br><i>If yes, how long ago?</i> _____                  |
| 2. Episodes of depression                              | 2. Yes _____ No _____ Don't Know _____<br><i>If yes, how long ago?</i> _____ |
| 3. Periods of nervousness or anxiety                   | 3. Yes _____ No _____ Don't Know _____<br><i>If yes, how long ago?</i> _____ |
| 4. Prescribed medication for a mental health condition | 4. Yes _____ No _____ Don't Know _____<br><i>If yes, how long ago?</i> _____ |
| 5. History of alcoholism or alcohol use                | 5. Yes _____ No _____ Don't Know _____<br><i>If yes, how long ago?</i> _____ |
| 6. History of substance or drug use                    | 6. Yes _____ No _____ Don't Know _____<br><i>If yes, how long ago?</i> _____ |
| 7. Suicide attempt or plans                            | 7. Yes _____ No _____<br><i>If yes, how long ago?</i> _____                  |

**GENERAL HISTORY**

**Answer the following questions:**

- |                                                                                                                                                                         |                                                                 |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------|
| 1. Have you had an organ transplant?                                                                                                                                    | 1. Yes _____ No _____                                           |
| 2. Are you currently using, or have you in the past used, any narcotic medication or other prescription painkiller?                                                     | 2. Yes _____ No _____                                           |
| 3. Are you currently using, or have you in the past used, sedating medication or tranquilizers?                                                                         | 3. Yes _____ No _____ Don't Know _____                          |
| 4. Do you currently have or in the past had a hernia?<br>a. <i>Has it been surgically repaired?</i><br>b. <i>Date of repair?</i> _____                                  | 4. Yes _____ No _____ Don't Know _____<br>a. Yes _____ No _____ |
| 5. Do you have any skin problems/disease (e.g., urticaria, eczema, dermatitis, psoriasis)?                                                                              | 5. Yes _____ No _____ Don't Know _____                          |
| 6. Do you currently have or in the past had cancer?<br>a. <i>Type of cancer?</i> _____<br>b. <i>Date of diagnosis?</i> _____<br>c. <i>Date of last treatment?</i> _____ | 6. Yes _____ No _____                                           |
| 7. Do you have narcolepsy or a sleep disorder?                                                                                                                          | 7. Yes _____ No _____ Don't Know _____                          |
| 8. Do you use tobacco?                                                                                                                                                  | 8. Yes _____ No _____                                           |

**GENERAL HISTORY (continued)**

9. Check the statement below that best describes your ability to lift and carry:

***I affirm that I am physically able to pick up and carry a distance of 25 feet (for example, the distance to cross a two-lane street):***

\_\_\_\_\_ 30 lbs. (for example, 2 cases of 12oz. soft drinks -- 24 cans in each case)

\_\_\_\_\_ 50 lbs. (for example, 3 cases of 12oz. soft drinks -- 24 cans in each case)

\_\_\_\_\_ 70 lbs. (for example, 4 cases of 12oz. soft drinks -- 24 cans in each case)

10. **What is your present activity level?**

Check the level of activity listed below that best describes how often you participate in each of the activities:

| Activity                                                           | Never/Rarely<br>0 to 2 times per year | Occasionally<br>1 to 2 times per month | Frequently<br>Once per week or more |
|--------------------------------------------------------------------|---------------------------------------|----------------------------------------|-------------------------------------|
| Walk 2 miles continuously                                          | Never/Rarely _____                    | Occasionally _____                     | Frequently _____                    |
| Run 2 miles continuously                                           | Never/Rarely _____                    | Occasionally _____                     | Frequently _____                    |
| Weight training                                                    | Never/Rarely _____                    | Occasionally _____                     | Frequently _____                    |
| General fitness activities at gym                                  | Never/Rarely _____                    | Occasionally _____                     | Frequently _____                    |
| Basketball                                                         | Never/Rarely _____                    | Occasionally _____                     | Frequently _____                    |
| Tennis, racquetball, badminton                                     | Never/Rarely _____                    | Occasionally _____                     | Frequently _____                    |
| Soccer                                                             | Never/Rarely _____                    | Occasionally _____                     | Frequently _____                    |
| Gardening                                                          | Never/Rarely _____                    | Occasionally _____                     | Frequently _____                    |
| Golf                                                               | Never/Rarely _____                    | Occasionally _____                     | Frequently _____                    |
| Winter sports (cross country skiing, downhill skiing, ice skating) | Never/Rarely _____                    | Occasionally _____                     | Frequently _____                    |
| Other (list):                                                      | Never/Rarely _____                    | Occasionally _____                     | Frequently _____                    |

**CANDIDATE SIGNS HERE**

I certify that I have reviewed the foregoing information supplied by me and it is true and complete to the best of my knowledge. I authorize any of the doctors, hospitals, or clinics to furnish the Government a complete transcript of my medical record for purposes of processing my application. I have read the privacy statement at the beginning of this questionnaire and understand that falsification of information on Government forms is punishable by fine and/or imprisonment.

Sign your name and enter today's date in the space provided below:

**REQUIRED**

|  |  |
|--|--|
|  |  |
|--|--|

**Candidate Signature**

**Date (mm/dd/yyyy)**

**FACILITY MEDICAL EXAMINER SIGNS HERE**

**REQUIRED**

|                    |  |
|--------------------|--|
| <i>Print Name:</i> |  |
|--------------------|--|

**REQUIRED**

|                   |  |
|-------------------|--|
| <i>Signature:</i> |  |
|-------------------|--|

**Facility Medical Examiner**

**Date (mm/dd/yyyy)**

|                    |  |
|--------------------|--|
| <i>Print Name:</i> |  |
|--------------------|--|

|                   |  |
|-------------------|--|
| <i>Signature:</i> |  |
|-------------------|--|

**Facility Medical Co-Signature (If required)**

**Date (mm/dd/yyyy)**