UNITED STATES DEPARTMENT OF AGRICULTURE
FOOD SAFETY AND INSPECTION SERVICE

CERTIFICATE OF MEDICAL EXAMINATION (with REPORT OF MEDICAL HISTORY)

(This information is for official and medically confidential use only and will not be released to unauthorized persons)

AUTHORITY: The Food Safety and Inspection Service is authorized by Title 5, Code of Federal Regulations, Part 339, Medical Qualification Determinations, to collect the information on this form. Solicitation of this information is also 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. The information you provide will be used to determine your medical qualifications for Federal employment.

PRINCIPAL PURPOSE(S): To obtain medical information from FSIS current and prospective employees to assist in making a determination of medical fitness for duty. Additional potential uses of this information include using it to ensure fair and consistent treatment of employees and job applicants and to adjudicate claims of discrimination under the Rehabilitation Act of 1973, as amended.

DISCLOSURE: Disclosure is voluntary. However, failure by a candidate to provide the information may result in a delay of appointment and/or withdrawal of tentative offer of employment. Failure of an employee to provide the information may result in removal from Agency duties and/or disciplinary actions, up to and including termination.

PRIVACY ACT STATEMENT: In accordance with the Privacy Act of 1974 (Public Law No. 93-579, 5 U.S.C. 552a), you are hereby notified that Section 3301 of Title 5 to the US Code authorizes collection of this information. The primary use of this information is to determine medical suitability of persons for service or assignments, report medical conditions required by law, and aid in preventive health care. The information becomes part of the Employee Medical Folder, which is maintained and protected in accordance with OPM regulations 5 CFR 293, Subpart E. These records are also protected by the Privacy Act of 1974, 5 U.S.C. 552a and are covered by OPM/GOVT-10, Employee Medical File System Records. The social security number is requested in order to more accurately identify and retrieve health care records of individuals. Providing the requested information is voluntary but failure to do so may result in the Agency's inability to process application for employment.

NON-DISCRIMINATION STATEMENT: The U.S. Department of Agriculture (USDA) prohibits discrimination in all its programs and activities on the bases of color, national origin, age, disability, sex, gender identity, religion, reprisal, and where applicable, political beliefs, marital status, familial or parental status, sexual orientation, if all or part of an individual's income is derived from any public assistance program, or protected genetic information. (Not all prohibited bases apply to all programs and/or employment activities.) Persons with disabilities who require alternative means for communication of program information (Braille, large print, audiotape, etc.) should contact USDA's TARGET Center at 202-720-2600 (voice and TDD). To file a complaint of discrimination, write to USDA, Director, Office of Civil Rights, 1400 Independence Avenue, S.W., Washington, D.C. 20250-9410, or call 800-795-3272 (voice) or 202-720-6382 (TDD). USDA is an equal opportunity provider and employer.

NOTE TO THE APPLICANT/EMPLOYEE:

Please complete Part A of this form (pages 1-8) and take it with you to your appointment for a medical physical examination. Please have your doctor(s) complete the medical exam portions (Parts B, C and D), sign and date each of the three parts to certify completion of the medical exam, and forward it directly to us in the postage paid envelope we have provided to you.

PART A. TO BE COMPLETED BY THE APPLICANT/EMPLOYEE

1. LAST NAME, FIRST NAME, MIDDLE NAME	2. SOCIAL SECURITY NUMBER	3. TODAY'S DATE *(mm/dd/yy)*

4a. HOME ADDRESS (Street, Apartment No., City, State and ZIP Code

4b. HOME TELEPHONE *(Include Area Code)*

4c. EMAIL ADDRESS

5a. Date of Birth _____ *(mm/dd/yy)*

5b. Sex: ☐ Male ☐ Female

6. CHECK ONE: ☐ APPLICANT ☐ EMPLOYEE

7. MEDICAL EXAMINATION LOCATION ADDRESS *(Include Zip Code),* AND TELEPHONE NUMBER

LAST NAME, FIRST NAME, MIDDLE INITIAL

8. CURRENT MEDICATIONS *(Prescription and over-the-counter)*

Please indicate the date when your prescription began. List your dosage amounts and identify reason for taking each medication and number of times taken during the day.

DATE	NAME OF MEDICATION	REASON FOR MEDICATION	DOSAGE	FREQUENCY	SIDE EFFECTS EXPERIENCED

9. ALLERGIES (Including environmental, medicine, latex or other substances)

10. HAVE YOU HAD SURGERY OR BEEN HOSPITALIZED IN THE LAST 10 YEARS? ☐ Yes ☐ No

(IF YES, PLEASE COMPLETE.)

Indicate Month/Year of Surgery/Hospitalization (make sure type of surgery is included)

Reason for Surgery/Hospitalization

11. HAVE YOU SEEN A DOCTOR IN THE PAST 12 MONTHS FOR ANY MEDICAL PROBLEM? ☐ Yes ☐ No

(IF YES, PLEASE DESCRIBE.)

LAST NAME, FIRST NAME, MIDDLE INITIAL

REVIEW OF SYSTEMS

Mark each item "YES" or "NO". Every item marked "YES" must be fully explained, including dates (mo/yr) and treatment.

12. MUSCULOSKELETAL

If "yes," please indicate dates (mo/yr), treatment and explanation

HAVE YOU EVER HAD:	Yes	No
a. Painful shoulder, elbow or wrist (e.g. pain, dislocation, etc.)	☐	☐
b. Recurrent back pain or any back problem	☐	☐
c. Numbness or tingling	☐	☐
d. Loss of finger or toe	☐	☐
e. Foot trouble (e.g., pain, corns, bunions, etc.)	☐	☐
f. Impaired use of arms, legs, hands, or feet	☐	☐
g. Swollen or painful joint(s)	☐	☐
h. Knee trouble (e.g., locking, giving out, pain or ligament injury, etc.)	☐	☐
i. Any knee, foot, hip, shoulder or wrist surgery	☐	☐
j. Any need to use corrective devices such as prosthetic devices, knee brace(s), back support(s), lifts or orthotics, etc.	☐	☐
k. Bone, joint, or other deformity	☐	☐
l. Plate(s), screw(s), rod(s) or pins(s) in any bone	☐	☐
m. Broken bone(s) (cracked or fractured)	☐	☐
n. Herniated disc	☐	☐
o. Repetitive motion symptoms (e.g., carpal tunnel, rotator cuff or tennis elbow)	☐	☐
p. Other musculoskeletal problems	☐	☐

13. RESPIRATORY

If "yes," please indicate dates (mo/yr), treatment and explanation

HAVE YOU EVER HAD:	Yes	No
a. Tuberculosis	☐	☐
b. Positive skin test for TB	☐	☐
c. Lived with someone who had tuberculosis	☐	☐
d. Coughed up blood	☐	☐
e. Asthma or any relating problem (indicate whether it is a current condition and/or childhood condition	☐	☐
f. Shortness of breath	☐	☐
g. Chronic bronchitis	☐	☐
h. Chronic wheezing or problems with wheezing	☐	☐
i. Been prescribed or used an inhaler	☐	☐
j. A chronic cough or cough at night	☐	☐
k. Chronic Sinusitis	☐	☐
l. Hay Fever	☐	☐
m. Chronic or frequent colds	☐	☐
n. Collapsed lung	☐	☐
o. Emphysema or chronic obstructive pulmonary disease	☐	☐
p. Other respiratory problems	☐	☐

LAST NAME, FIRST NAME, MIDDLE INITIAL

14. EYES

If "yes," please indicate dates (mo/yr), treatment and explanation

HAVE YOU EVER HAD:	Yes	No
a. Any indication that you are color blind	☐	☐
b. Glaucoma	☐	☐
c. Loss of vision in either eye	☐	☐
d. Cataracts	☐	☐
e. Detached retina, double vision and retinal hemorrhaging	☐	☐
f. Surgery to correct vision (RK, PRK, LASIK, etc.)	☐	☐
g. Other eye disorders	☐	☐

15. GENITOURINARY

If "yes," please indicate dates (mo/yr), treatment and explanation

HAVE YOU EVER HAD:	Yes	No
a. Frequent or painful urination	☐	☐
b Blood in urine	☐	☐
c. Sugar or protein in urine	☐	☐
d. Kidney disease	☐	☐
e. Prostate problems	☐	☐
f. Other genitourinary problems	☐	☐

16. NEUROLOGICAL AND MENTAL HEALTH

If "yes," please indicate dates (mo/yr), treatment and explanation

HAVE YOU EVER HAD:	Yes	No
a. Chronic headaches/migraines	☐	☐
b. Dizziness or fainting spells	☐	☐
c. A head injury, loss of memory, loss of consciousness or amnesia	☐	☐
d. Paralysis	☐	☐
e. Seizures, convulsions, epilepsy	☐	☐
f. Numbness or tingling	☐	☐
g. Meningitis, encephalitis, or other neurological problems	☐	☐
h. Depression	☐	☐
i. Bi Polar Disorder	☐	☐
j. Anxiety Disorder	☐	☐
k. Post Traumatic Stress Disorder (PTSD)	☐	☐
l. Traumatic Brain injury (TBI)	☐	☐
m. Alcohol/Drug dependency	☐	☐
n. Other mental health problems	☐	☐

LAST NAME, FIRST NAME, MIDDLE INITIAL

17. CARDIOVASCULAR

If "yes," please indicate dates (mo/yr), treatment and explanation

HAVE YOU EVER HAD:	Yes	No
a. Pain or pressure in the chest	☐	☐
b. Swelling or pain in legs or feet	☐	☐
c. Irregular heart beats	☐	☐
d. Palpitation/skipped heartbeats	☐	☐
e. Heart murmur	☐	☐
f. High or low blood pressure	☐	☐
g. Heart attack	☐	☐
h. Stroke	☐	☐
i. Other cardiovascular problems	☐	☐

18. GASTROINTESTINAL

If "yes," please indicate dates (mo/yr), treatment and explanation

HAVE YOU EVER HAD:	Yes	No
a. Persistent nausea or vomiting	☐	☐
b. Chronic diarrhea or constipation	☐	☐
c. Colitis, diverticulitis	☐	☐
d. Crohn's disease, irritable bowel syndrome	☐	☐
e. Liver cirrhosis, infection or jaundice	☐	☐
f. Rectal bleeding or black tarry stools	☐	☐
g. Severe or frequent heartburn/stomach pain	☐	☐
h. Stomach, liver, intestinal trouble or ulcer	☐	☐
i. Hepatitis	☐	☐
j. Other gastrointestinal problems	☐	☐

19. SKIN

If "yes," please indicate dates (mo/yr), treatment and explanation

HAVE YOU EVER HAD:	Yes	No
a. Recurrent skin conditions that require medical attention	☐	☐
b. Skin allergies/rashes (e.g. eczema, psoriasis or contact dermatitis)	☐	☐
c. Moles that have changed in size or color	☐	☐
d. Skin cancer	☐	☐
e. Latex allergy	☐	☐
f. Other skin problems	☐	☐

LAST NAME, FIRST NAME, MIDDLE INITIAL

20. EARS, NOSE AND THROAT

If "yes," please indicate dates (mo/yr), treatment and explanation

HAVE YOU EVER HAD:	Yes	No
a. Difficulty hearing	☐	☐
b. Ringing or buzzing in ears	☐	☐
c. Hearing aid	☐	☐
d. Chronic sinus trouble	☐	☐
e. Chronic nosebleeds	☐	☐
f. Chronic sneezing/running nose	☐	☐
g. Chronic sore throat	☐	☐
h. Difficulty swallowing	☐	☐
i. Ruptured ear drum	☐	☐
j. Other ear/nose/throat problems	☐	☐

21. OTHER SYMPTOMS AND DISEASES

If "yes," please indicate dates (mo/yr), treatment and explanation

HAVE YOU EVER HAD:	Yes	No
a. Unexplained weight loss or weight gain greater than 10 pounds	☐	☐
b. Hyperthyroidism	☐	☐
c. Hypothyroidism	☐	☐
d. Cancer	☐	☐
e. Chronic Anemia	☐	☐
f. Blood Disorder	☐	☐
g. Hypoglycemia or hyperglycemia (including frequency)	☐	☐
h. Diabetes (complete additional questions shown below)	☐	☐

Type 1 ☐ Type 2 ☐

Controlled by: Diet ☐ Exercise ☐ Medication ☐

Medication: Name and Dosage _____

Side Effects Experienced (if any) _____

Most recent Hemoglobin A1C results _____ Date _____ (must be performed within the past three months)

HAVE YOU EVER HAD:

	Yes	No	
i. Any additional symptoms or diseases not yet mentioned	☐	☐	If "yes," please indicate dates (mo/yr), treatment and explanation

LAST NAME, FIRST NAME, MIDDLE INITIAL

22. OCCUPATIONAL AND EXPOSURE HISTORY

	Yes	No	If "yes," please explain.
Have you ever been off work more than a day because of a work-related injury or illness?	☐	☐	
Have you ever had to wear respiratory protection for a workplace exposure (e.g. dust mask, half-face respirator)?	☐	☐	
Have you ever received disability compensation?	☐	☐	
Have you ever had a respiratory disease due to workplace exposures?	☐	☐	
Have you ever developed a sensibility due to workplace exposures (e.g. contact dermatitis, eye or upper respiratory irritation)?	☐	☐	
Have you ever changed jobs or duties due to health reasons?	☐	☐	
Have you ever been rejected by or discharged from the military for medical reasons?	☐	☐	
Are you a Veteran receiving compensation based on one or more medical conditions? (I*f yes, please list medical conditions for which you are being compensated.)*	☐	☐	

Please list all employment during the past 10 years. Include a brief description of job duties and the work environment, including any specific hazards, starting with your current position.

Agency/Company	Dates of Employment (From) - (To)	Job Duties/Activities	Specific Hazards*

*** Specific Hazards may include asbestos, chemicals, dust, fumes, gases, radiation, vibration, repetitive motion, intense light and loud noise. For any asbestos exposure, please indicate the year and place of first exposure.**

LAST NAME, FIRST NAME, MIDDLE INITIAL

POSITION TITLE:

POSITION REQUIREMENTS:

Functional Requirements:

- ☐ Moderate light lifting 30 pounds, with occasional lifting of up to 50 lbs.
- ☐ Repetitive motion of upper body and limbs (8 hours.)
- ☐ Reaching above shoulders.
- ☐ Use of fingers-dexterity and normal sensation required.
- ☐ Both hands required.
- ☐ Walking (8 hours.)
- ☐ Standing (8 hours), in limited space (2 feet by 4 feet.)
- ☐ Climbing stairs and vertical ladders.
- ☐ Both legs required (prosthesis acceptable with full range of mobility.)
- ☐ Near vision using appropriate vision screening device.
- ☐ Far vision correctable to 20/40.
- ☐ Normal depth perception.
- ☐ Normal peripheral vision (85 degrees temporarily in each eye.)
- ☐ Normal color vision.
- ☐ Normal hearing (Aid Permitted.)
- ☐ Ability to detect odors.
- ☐ Clear speech.
- ☐ Light lifting, 10 pounds.
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____

Environmental Factors:

- ☐ Working indoors and outdoors.
- ☐ Excessive heat.
- ☐ Excessive cold.
- ☐ Excessive humidity.
- ☐ Excessive dampness or chilling.
- ☐ Excessive noise, continuous.
- ☐ Slippery and uneven walking surfaces.
- ☐ Working around machinery with moving parts.
- ☐ Working around moving objects or vehicles.
- ☐ Working with hands in water.
- ☐ Working in close proximity to others.
- ☐ Protracted or irregular hours of work.
- ☐ Working with knives or other tools.
- ☐ Exposure to offensive odors such as manure, blood, etc.
- ☐ Possible exposure to noxious fumes.
- ☐ Will be required to wear appropriate safety protection.
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____

Do you have any medical disorder or physical impairment that would interfere in any way with the full performance of the duties as described in the position requirements, the functional requirements or the environmental factors?

☐ Yes ☐ No (If yes, explain fully and discuss fully with the physician performing the examination.)

I certify the information I have given is true, complete and correct to the best of my knowledge and belief. These statements are made in good faith. I understand that failure to self-report or knowingly provide a false answer to any question may be grounds for termination from the federal government. I also understand that a knowing and willful false statement on this form may be punished by fine or imprisonment or both.
(Section 1001 of Title 18, United States Code)

Name of Applicant/Employee (Print your name) **Signature** **Date**

LAST NAME, FIRST NAME, MIDDLE INITIAL

To the Physician/Examiner: The person you are about to examine will have to cope with the functional requirements, environmental factors and the general position requirements listed on the previous page. Please take them into consideration as you perform your examination and report your findings and conclusions. Please enter whether or not each system is within normal limits, and describe any abnormality (including diseases, scars, and disfigurements) if present. Include a brief medical history on an item, if pertinent.

PART B. EXAMINER HISTORY AND GENERAL PHYSICAL EXAM

1. HEIGHT: _____ Feet _____ Inches

2. WEIGHT: _____ Pounds

3. EYES, EARS, NOSE AND THROAT. (Including sense of smell) Any abnormalities? ☐ Yes ☐ No (If yes, please describe.)

Is conversational hearing normal at 15 feet? ☐ Yes ☐ No

4. SPEECH. Any malfunction? ☐ Yes ☐ No (If yes, please describe.)

5. HEAD. (Including face, hair, and scalp) Any abnormalities? ☐ Yes ☐ No (If yes, please describe.)

6. SKIN and LYMPH NODES. (Including thyroid glands) Any abnormalities? ☐ Yes ☐ No (If yes, please describe.)

Does the applicant/employee have chronic dermatitis of the hands? ☐ Yes ☐ No

Is the individual allergic to latex? ☐ Yes ☐ No

7. ABDOMEN. Any abnormalities? ☐ Yes ☐ No (If yes, please describe.)

LAST NAME, FIRST NAME, MIDDLE INITIAL

8. PERIPHERAL BLOOD VESSELS. Any abnormalities? ☐ Yes ☐ No (If yes, please describe.)

9. EXTREMITIES. (Including range of motion, flexibility, and strength) Any abnormalities? ☐ Yes ☐ No (If yes, please describe.)

10. MOTION TESTS. Please administer the following two motion tests and indicate findings.

Tinel's Test ☐ Positive ☐ Negative

Phalen's Test ☐ Positive ☐ Negative

Are there any symptoms of:

Carpal Tunnel Syndrome? ☐ Yes ☐ No (If yes, please explain your findings.)

Lateral Epicondylitis? ☐ Yes ☐ No (If yes, please explain your findings.)

Rotator Cuff Tear/Injury? ☐ Yes ☐ No (If yes, please explain your findings.)

11. URINALYSIS. ☐ Normal ☐ Abnormal (If abnormal, please explain your findings and any treatment prescribed.)

12. RESPIRATORY TRACT.

Any abnormal lung sounds? ☐ Yes ☐ No (If yes, please explain your findings.)

Are there any symptoms or history of Asthma? ☐ Yes ☐ No (If yes, please describer the asthma trigger, severity and treatment.)

LAST NAME, FIRST NAME, MIDDLE INITIAL

13. BLOOD PRESSURE/PULSE. Measure pulse and blood pressure.

If blood pressure readings show signs of hypertension as described in the agency's Medical Qualification Standards, it will be necessary to take three (3) additional readings.

BP Reading 1 _____ Date _____ Pulse Reading _____ Date _____

BP Reading 2 _____ Date _____ (Take this additional reading if systolic and/or diastolic are above established standards on Reading 1.)

BP Reading 3 _____ Date _____ (Take this additional reading if systolic and/or diastolic are above established standards on Reading 1.)

BP Reading 4 _____ Date _____ (Take this additional reading if systolic and/or diastolic are above established standards on Reading 1.)

Include any known history of high blood pressure or other related conditions.

14. HEART. Size, Rate, Rhythm, Function, Abnormal Sounds.

15. BACK. Include any known history of back ailments, extent of condition and prognosis.

16. COMMUNICABLE OR CONTAGIOUS DISEASE.

Please administer the following Tuberculin test: _____

Date administered: _____ Date read: _____ Induration: _____ (measurement in mm) _____

Other results: _____

Is there any evidence of any other communicable or contagious disease? ☐ Yes ☐ No

(If yes, please explain your findings.)

LAST NAME, FIRST NAME, MIDDLE INITIAL

17. NEUROLOGICAL AND MENTAL HEALTH. Is there any evidence of neurological or mental illness? (If yes, please explain your findings.)

18. MEDICAL HISTORY CONDITIONS. Any history of any other medical conditions that may affect the applicant's/employee's ability to perform the duties of the position? (If yes, please explain your findings.)

19. CONCLUSIONS.

Please comment on the medical history provided by the applicant/employee in Part A, and summarize below any medical findings from your examination which, in your opinion, would limit this person's performance of the job duties and/or would make the individual a hazard to themselves or others.

☐ **No Limiting Conditions for this Job**

☐ **Limiting Conditions, as follows:**

Physician's/Examiner's Name (type or print) _____

Physician's/Examiner's Signature _____

Date _____

Address _____

Telephone Number _____

Fax Number _____

PART C. VISION

LAST NAME, FIRST NAME, MIDDLE INITIAL

20. COLOR VISION TESTS. The applicant/employee must be tested using one of the "ACCEPTABLE" color plate tests listed below.

(Please check the box by the test used.)

- ☐ ISHIHARA (14 Plate Series)
- ☐ FARNSWORTH D-15
- ☐ TOYKO MEDICAL COLLEGE
- ☐ H-R-R (HARDY RAUD-RITTLER)
- ☐ DVORINE
- ☐ AMERICAN OPTICAL (ACO)
- ☐ _____
- ☐ _____
- ☐ _____

ABILITY TO DISTINGUISH COLORS

	CAPACITY		
	FULL	PARTIAL	NONE
PRIMARY COLORS			
SHADES OF COLORS			

→ **PLEASE INDICATE THE NUMBER OF PLATES MISSED.** _____

→ **PLEASE INDICATE THE TOTAL NUMBER OF PLATES USED.** _____

21. DISTANT VISION.

WHAT IS THE APPLICANT'S VISION WITHOUT GLASSES OR CONTACTS? LEFT 20/ _____ RIGHT 20/_____

WHAT IS THE APPLICANT'S VISION WITH GLASSES OR CONTACTS? LEFT 20/ _____ RIGHT 20/_____

22. NEAR VISION. [PLEASE NOTE: NEAR VISION MAY BE TESTED AT A DISTANCE OF 13 TO 16 INCHES WITH JAEGER TYPE 1 TO 4 LETTERS.]

WHAT IS THE APPLICANT'S VISION WITHOUT GLASSES OR CONTACTS? LEFT 20/ _____ RIGHT 20/ _____

WHAT IS THE APPLICANT'S VISION WITH GLASSES OR CONTACTS? LEFT 20/ _____ RIGHT 20/ _____

23. PERIPHERAL VISION. Any abnormalities? ☐ Yes ☐ No (If yes, please explain.)

Note peripheral visual fields: _____ degrees temporally _____ degrees nasally.

24. DEPTH PERCEPTION. Any abnormalities? ☐ Yes ☐ No (If yes, please explain.)

Physician's/Examiner's Name (type or print) _____

Physician's/Examiner's Signature _____

Date _____

Address (*include street, city, state and zip code)* _____

Telephone Number _____ Fax Number _____

PART D. BASELINE AUDIOGRAM TEST

LAST NAME, FIRST NAME, MIDDLE INITIAL

The Occupational Safety and Health (OSHA) requires the Baseline Audiogram Test sound pressure readings be in decibel indicators for 500, 1000, 2000, 3000, 4000, 6000 and 8000 Hertz. **Important Note:** If the test cannot be completed according to these guidelines, please refer the patient to a licensed or certified audiologist, otolaryngologist, physician or technician whose equipment meets these requirements.

IF A HEARING AID IS USED, THE TEST MUST BE CONDUCTED WITH THE HEARING AID AND WITHOUT THE HEARING AID

25. HEARING TEST. **PLEASE NOTE: ALL READINGS MUST BE IN DECIBELS AND MAKE SURE ALL HERTZ LEVELS ARE TESTED STARTING AT 0 DECIBELS.**

	EAR	500	1000	2000	3000	4000	6000	8000
WITHOUT HEARING AID	RIGHT							
	LEFT							

	EAR	500	1000	2000	3000	4000	6000	8000
WITH HEARING AID	RIGHT							
	LEFT							

DATE OF HEARING TEST: _____

CALIBRATION DATE OF AUDIOMETER: _____

(MUST HAVE BEEN CALIBRATED WITHIN ONE YEAR OF THIS EXAMINATION)

ADDITIONAL SPACE FOR COMMENTS (Specify item):

I certify the audiogram test administered to the above named individual complies with OSHA standards.

Physicians/Examiner's Name _____

Physician's/Examiner's Signature: _____

Address (Street, City, State and Zip Code: _____

_____

Telephone Number: _____

Fax Number: _____

PART E. AGENCY CERTIFICATION

THIS MEDICAL EXAMINATION FORM IS REVIEWED AND APPROVED.

FSIS OFFICIAL'S SIGNATURE: _____

TODAY'S DATE: _____