



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.

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).

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.

DEMOGRAPHIC INFORMATION

Form section for demographic information including Name (Print), Address, Home Phone #, Work Phone #, Other Phone #, Best Time to Call, Social Security # (last 4 digits), Sex, Date of Birth, Height, and Weight.

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?
2. Have you ever been diagnosed or treated for a mental health condition?
3. Have you had, or have you been advised to have, any operations?
4. Have you been treated at any type of hospital in the last 10 years?
5. Have you ever had any illness, injury, or condition (including learning disability, attention deficit disorder, etc.) other than those already noted above?

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

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:

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):

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? 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 0 to 2 times per year	Occasionally 1 to 2 times per month	Frequently 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 0 to 2 times per year	Occasionally 1 to 2 times per month	Frequently 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 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 _____
<i>If yes, how long ago? _____</i> |
| 2. Seizures | 2. Yes _____ No _____ Don't Know _____
<i>If yes, how long ago? _____</i> |
| 3. Tremors or shakiness | 3. Yes _____ No _____ Don't Know _____
<i>If yes, how long ago? _____</i> |
| 4. Fainting or dizziness | 4. Yes _____ No _____
<i>If yes, how long ago? _____</i> |
| 5. Head injury | 5. Yes _____ No _____ Don't Know _____
<i>If yes, how long ago? _____</i> |
| 6. Wear a brace or back support | 6. Yes _____ No _____
<i>If yes, how long ago? _____</i> |
| 7. Frequent or severe headaches | 7. Yes _____ No _____
<i>If yes, how long ago? _____</i> |
| 8. Nerve injury | 8. Yes _____ No _____ Don't Know _____
<i>If yes, how long ago? _____</i> |
| 9. Paralysis | 9. Yes _____ No _____
<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 _____
<i>If yes, how long ago? _____</i> |
| 2. Episodes of depression | 2. Yes _____ No _____ Don't Know _____
<i>If yes, how long ago? _____</i> |
| 3. Periods of nervousness or anxiety | 3. Yes _____ No _____ Don't Know _____
<i>If yes, how long ago? _____</i> |
| 4. Prescribed medication for a mental health condition | 4. Yes _____ No _____ Don't Know _____
<i>If yes, how long ago? _____</i> |
| 5. History of alcoholism or alcohol use | 5. Yes _____ No _____ Don't Know _____
<i>If yes, how long ago? _____</i> |
| 6. History of substance or drug use | 6. Yes _____ No _____ Don't Know _____
<i>If yes, how long ago? _____</i> |
| 7. Suicide attempt or plans | 7. Yes _____ No _____
<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?
a. <i>Has it been surgically repaired?</i>
b. <i>Date of repair?</i> _____ | 4. Yes _____ No _____ Don't Know _____
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?
a. <i>Type of cancer?</i> _____
b. <i>Date of diagnosis?</i> _____
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 0 to 2 times per year	Occasionally 1 to 2 times per month	Frequently 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

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Candidate Signature

Date (mm/dd/yyyy)

FACILITY MEDICAL EXAMINER SIGNS HERE

REQUIRED

Print Name:

--

REQUIRED

Signature:

--

Facility Medical Examiner

Date (mm/dd/yyyy)

Print Name:

--

Signature:

--

Facility Medical Co-Signature (If required)

Date (mm/dd/yyyy)