NRC FORM 396 (MM-YYYY)
10 CFR 55.21, 55.23, 55.25, 55.27, 55.31 55.33, 55.53, 55.57.

U.S. NUCLEAR REGULATORY COMMISSION

CERTIFICATION OF MEDICAL EXAMINATION BY FACILITY LICENSEE

APPROVED BY OMB: NO. 3150-0024 EXPIRES: (MM/DD/YYYY)

Last Name	First Name	Middle Initial	Suffix	Applicant/Operator Docket Number	Facility

Full Address of Applicant/Operator	Date of Birth	Facility Docket Number (Separate multiple docket numbers by ";")
	Date of Most Recent Biennial Examination (MM/DD/YYYY) (See instructions)	☐ 050- ☐ 052-
		Applicant/Operator E-mail Address

A. MEDICAL EXAM INFORMATION

BASED ON THE RESULTS OF THE PHYSICAL EXAMINATION, INCLUDING INFORMATION FURNISHED BY THE APPLICANT/OPERATOR, I CERTIFY THAT THE ABOVE NAMED APPLICANT/OPERATOR HAS BEEN FOUND TO MEET THE MEDICAL REQUIREMENTS FOR LICENSED OPERATORS AT THIS FACILITY. I ALSO CERTIFY THAT IN REACHING THIS DETERMINATION, THE GUIDANCE CONTAINED IN THE ANSI STANDARD OR AN APPROVED NRC ALTERNATIVE METHOD WAS FOLLOWED AND THAT DOCUMENTATION IS AVAILABLE FOR REVIEW BY THE NRC.

GUIDANCE USED:

☐ ANSI/ANS 3.4 -- 1983 ☐ ANSI/ANS 3.4 -- 2013 ☐ ANSI/ANS 15.4 -- 2007 ☐ Other (Must specify below)

☐ ANSI/ANS 3.4 -- 1996 ☐ ANSI/ANS 15.4 -- 1988 ☐ ANSI/ANS 15.4 -- 2016

Typed or Printed Name of Physician	Physician's Certification Date (MM/DD/YYYY) (See Instructions)	State	License Number

BASED ON THE RECOMMENDATION OF THE PHYSICIAN, IT IS REQUESTED THAT THE APPLICANT/OPERATOR LICENSE BE CONDITIONED AS FOLLOWS: Check all that apply. ~~For each checked box in Nos. 4 though 11, PROVIDE EXPLANATION IN BOX AND ATTACH APPLICABLE SUPPORTING MEDICAL EVIDENCE AND MEDICAL EXAMINATION / TEST RESULTS (~~See form instructions for detail~~).~~

☐ 1. NO RESTRICTIONS.

☐ 2. CORRECTIVE LENSES SHALL BE WORN WHEN PERFORMING LICENSED DUTIES.

☐ 3. HEARING AID SHALL BE WORN WHEN PERFORMING LICENSED DUTIES. THIS DOES NOT APPLY TO CONDITIONS THAT REQUIRE PROTECTION IN HIGH NOISE AREAS.

☐ 4. SHALL TAKE MEDICATION AS PRESCRIBED TO MAINTAIN MEDICAL QUALIFICATIONS.

☐ 5. SHALL USE THERAPEUTIC DEVICE(S) AS PRESCRIBED TO MAINTAIN MEDICAL QUALIFICATIONS.

☐ 6. SOLO OPERATION IS NOT AUTHORIZED (Check one box). ☐ RO ☐ SRO ☐ LSRO

☐ 7. SHALL SUBMIT MEDICAL STATUS REPORT EVERY: (Check one box~~,~~. When "other" is checked, a specific time frame must be entered).

☐ 3 ☐ 6 ☐ 12 months, or ☐ Other

Enter the date that the medical status report requirement was added and/or removed (as applicable). (MM/DD/YYYY)	
Date Restriction Added:	Date Restriction Removed:

☐ 8. SHALL NOT PERFORM LICENSED DUTIES REQUIRING A RESPIRATOR.

☐ 9. OTHER RESTRICTIONS OR EXCEPTION ~~(*Required explanation on next page).~~

☐ 10. RESTRICTION CHANGE FROM PREVIOUS SUBMITTAL ~~(*Required explanation on next page).~~

☐ 11. INFORMATION ONLY

☐ 12. SUPPORTING DOCUMENTATION (Attach documentation in support of medical restrictions for new applicants~~).~~/operators.)

NRC FORM 396
(MM-YYYY)

U.S. NUCLEAR REGULATORY COMMISSION

CERTIFICATION OF MEDICAL EXAMINATION BY FACILITY LICENSEE (continued)

Last Name	First Name	Middle Initial	Suffix	Applicant/Operator Docket Number	Facility

Proposed Wording of Restriction ~~(*Required explanation from page 1).~~

Relationship of Restriction to Disqualifying Condition (Briefly indicate how restriction will ~~correct~~ address the disqualifying medical condition) ~~(*Required explanation from page 1).~~

Explanation(s) ~~(*Required explanation from page 1).~~

B. APPLICANT/OPERATOR'S SIGNATURE

I acknowledge the information in this certification and attachments as they apply to my licensure by the NRC. I authorize my facility to provide this certification and attachments to the NRC to use in the exercise of its authority over my licensure.

Signature and Date - Applicant / Operator

C. FACILITY CERTIFICATION

I CERTIFY UNDER PENALTY OF PERJURY THAT THE INFORMATION IN THIS DOCUMENT AND ATTACHMENTS IS TRUE AND CORRECT.

Printed Name and Title of Senior Management Representative

Signature and Date - Senior Management Representative

CERTIFICATION OF MEDICAL EXAMINATION BY FACILITY LICENSEE (Instructions)

Enter **NAME OF APPLICANT** as it appears on NRC Form 398 or **NAME OF OPERATOR** as it appears on the NRC issued License, **DOCKET NUMBER** and **DATE OF MOST RECENT BIENNIAL MEDICAL EXAMINATION.** If the time since the applicant's initial medical examination exceeds 24 months before an initial licensing action is completed, the applicant must be reexamined by a physician and a new NRC Form 396 must be submitted. If, during the term of the license, an operator develops a permanent physical or mental condition that causes the operator to fail to meet 10 CFR 55.21 that can be mitigated by requesting a license restriction, the facility licensee shall notify the NRC within 30 days of learning of the diagnosis by submitting an NRC Form 396. 10 CFR 55.25 requires a submission for only permanent conditions. Do not submit temporary conditions for which an operator is being administratively held by your facility. Per 10 CFR 55.55, NRC Operator license renewals (NRC Form 396 and NRC Form 398) shall be submitted at least 30 days prior to the license expiration date.

Enter **ADDRESS OF APPLICANT/OPERATOR**

Enter **Date of Birth OF APPLICANT/OPERATOR (MM/DD/YYYY)**

Enter **NAME OF FACILITY(IES)** and **FACILITY DOCKET NUMBER(S) -** Use Check Box to indicate 050-XXX or 052-XXX.

Enter **E-mail Address of the Applicant/Operator -** If you provide an e-mail address, you are electing to receive operator licensing correspondence from the NRC, electronically. If you do not provide an e-mail address, the NRC will correspond using mail to the address you provided.

Use **Check Box** to indicate which **Guidance Document** (ANSI 3.4, 15.4 or other) was used to determine the applicant's physical condition. If "other" is checked, include the title of the document.

SECTION A - MEDICAL EXAM INFORMATION - Enter **PHYSICIAN'S PRINTED NAME, PHYSICIAN'S CERTIFICATION DATE, LICENSE NUMBER, AND STATE OF LICENSURE**. (Indicate MD or DO following printed name). Physicians Certification Date = Date of physician's final certification of applicant/operator's medical suitability (including recommended license conditions) and/or the date of the physician's certification of a required medical status update (Check Box 7).

License Conditions - Check all the applicable boxes to request license condition(s). For each checked box in Nos. 4 through 11, provide supporting medical evidence that the requested license condition addresses the disqualifying medical condition. The supporting medical evidence shall consist of a brief narrative from the examining physician (provided either in the "Explanation" box or in an attached letter) addressing the pertinent medical history, objective findings (for example, blood pressure, HgA1C, and TSH), the diagnosis, and the recommended treatment (including name, dosing, and any adverse reactions), to demonstrate the efficacy of the proposed license condition.

Box 1 - NO RESTRICTIONS - Physical and mental condition and general health meet the minimum requirements, without exception.

Box 2 - CORRECTIVE LENSES SHALL BE WORN WHEN PERFORMING LICENSED DUTIES - Corrective lenses must be worn to meet the minimum requirements for vision.

Box 3 - HEARING AID SHALL BE WORN WHEN PERFORMING LICENSED DUITES - Hearing aid must be worn to meet the minimum requirements.

Box 4 - SHALL TAKE MEDICATION AS PRESCRIBED TO MAINTAIN MEDICAL QUALIFICATIONS - Meets the minimum medical requirements only by taking prescribed medication(s).

Box 5 - SHALL USE THERAPEUTIC DEVICE(S) AS PRESCRIBED TO MAINTAIN MEDICAL QUALIFICATIONS - Meets the minimum medical requirements only by using a therapeutic device (e.g., CPAP and Spinal Cord Stimulator).

Box 6 - SOLO OPERATION IS NOT AUTHORIZED - Another individual, capable of summoning help must be present when the operator is performing licensed duties. Check the applicant/operator's license type.

Box 7 - SHALL SUBMIT MEDICAL STATUS REPORT EVERY 3, 6 , 12 or Other Months - Medical condition that requires more frequent monitoring than the two (2) years required by 10 CFR 55.21. If "Other" is checked, include the requested time frame. ~~Indicate the date that the Medical Status Requirement was added or removed (MM/DD/YYYY).~~

Box 8 - SHALL NOT PERFORM LICENSED DUTIES REQUIRING A RESPIRATOR - Respiratory or integumentary (skin) condition.

Box 9 - OTHER RESTRICTIONS OR EXCEPTION - Other license condition(s) necessary to mitigate identified medical or psychological issue(s) that do not meet minimum medical requirements. Use **"Proposed Wording of Restriction" and "Relationship of Restriction to Disqualifying Condition"** boxes. ~~For Check Boxes 4-11, supporting **Medical Evidence must** include a narrative in the Explanation box or an attached letter from the examining physician outlining the condition, treatment and or medication (name, dose, timing & tolerance) and medical examination/test results (current blood pressure reading, A1C, TSH levels, etc.), for NRC review.~~ If an applicant or operator fails to meet a medical requirement but can demonstrate complete capacity to perform assigned duties, as proven by a ~~practical~~ test administered by the physician, the physician may recommend and justify a waiver of that portion of the applicable ANSI standard. For an applicant the waiver request must be made on the NRC Form 398, "Personal Qualification Statement - Licensee," by checking Box 12.c.3 and justifying the waiver/exception request in Box 25.

Box 10 - RESTRICTION CHANGE FROM PREVIOUS SUBMITTAL - Additional license condition request, modification of an existing condition or deletion of an existing condition. Must include an explanation in the **Explanation Box** and provide **Medical Evidence.**

Box 11 - INFORMATION ONLY - Check box if providing required established medical status updates that do not request new restrictions, removal of restrictions or change in status report frequency. Use for reporting any other medical situation you determine that needs to be reported to the NRC. Do not report temporary medical conditions for operators on administrative hold.

Box 12 - SUPPORTING DOCUMENTATION (Attach documentation in support of medical restrictions for new applicants).

SECTION B - SIGNATURE - Applicant/Operator

SECTION C - CERTIFICATION - Senior Management Representative

Detach these instructions prior to submittal. ~~and submit the Original NRC Form 396 with the NRC Form 398 for applicants or with a cover letter for operators who do not meet minimum requirements during licensure to the appropriate address.~~

In accordance with 10 CFR 55.5, this form shall be submitted to the appropriate NRC office electronically (for example by the EIE system or BOX) or by mail to:

REGIONAL ADMINISTRATOR, REGION I
U.S. NUCLEAR REGULATORY COMMISSION
2100 RENAISSANCE BOULEVARD, SUITE 100
KING OF PRUSSIA, PA 19406-2713

REGIONAL ADMINISTRATOR, REGION II
U.S. NUCLEAR REGULATORY COMMISSION
245 PEACHTREE CENTER AVENUE, NE., SUITE 1200
ATLANTA, GA 30303-1257

REGIONAL ADMINISTRATOR, REGION III
U.S. NUCLEAR REGULATORY COMMISSION
2443 WARRENVILLE ROAD, SUITE 210
LISLE, IL 60532-4352

REGIONAL ADMINISTRATOR, REGION IV
U.S. NUCLEAR REGULATORY COMMISSION
1600 E. LAMAR BOULEVARD
ARLINGTON, TX 76011-4511

U.S. NUCLEAR REGULATORY COMMISSION
RESEARCH AND TEST REACTORS
OVERSIGHT BRANCH
OFFICE OF NUCLEAR REACTOR REGULATION
WASHINGTON, DC 20555-0001