

NOAA Form 57-03-52
(01-23)
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U.S. DEPARTMENT OF COMMERCE
NATIONAL OCEANIC AND ATMOSPHERIC ADMINISTRATION

REPORT OF EXAMINATION AND MEDICAL HISTORY - DIVER

INSTRUCTIONS: The NOAA Diving Physical report consists of three parts. Page one contains contact information, checklists of required medical tests, attestation by the diver and approval by the NOAA DMO. Pages 2-3 are the diver's self-reported medical history. Examiner, please review pages 1-3, summarize the diver's medical condition, and then fill out items 88 and 89, "Examiner Review". Pages 4-6 contain the results of the medical exam and tests, as well as the signature of the medical professional conducting the exam. The Examiner must be either a Medical Doctor (MD), Doctor of Osteopathy (DO), Nurse Practitioner (NP), or Physician's Assistant (PA). Submission instructions are on the final page.

All tests must be completed within the last 12 months, unless otherwise indicated in the checklist below.

LAST NAME	FIRST NAME	MIDDLE NAME	DATE of BIRTH
BEST CONTACT PHONE NUMBER	WORK E-MAIL ADDRESS	DIVE UNIT	
UNIT DIVING SUPERVISOR'S NAME		UNIT DIVING SUPERVISOR'S E-MAIL ADDRESS	
DUTY STATION ADDRESS			

MEDICAL EVALUATION PACKET CHECKLIST

REQUIRED FOR ALL EXAMINATIONS

	NOAA Form 57-03-52 Report of Physical Examination and Medical History– Diver
	Complete Blood Count (CBC)
	Complete urinalysis
	Near and distant vision tests – results

DEPENDING ON YOUR AGE, HABITS, OR WHETHER THIS IS AN INITIAL OR PERIODIC EXAM, THE FOLLOWING TESTS MAY ALSO BE REQUIRED:

All INITIAL EXAMINATIONS must include these additional test results	
	Spirometry test – results and interpretation
	Audiogram – results and interpretation
	Chest X-ray interpretation within the past 24 months (no films)

All 40 and OLDER EXAMINATIONS must include these additional test results	
	12-Lead resting EKG – results and interpretation
	Lipid screening – total cholesterol, HDL, LDL, and triglycerides
	Hemoglobin (HgA1c) or fasting glucose screening

All PERIODIC EXAMINATIONS must include this additional test (SMOKERS ONLY)	
	Spirometry test – results and interpretation

APPLICANT CERTIFICATION (initial each item and sign below):

_____ I have reviewed the attached medical information and consider the application package to be complete and accurate.		
_____ I acknowledge that it is my responsibility to notify the NOAA Diving Medical Officer of any medical condition, illness, injury, medical treatments, and/or surgeries, or any changes to the above, as they occur.		
_____ I acknowledge it is my responsibility to also notify my UDS and the DM/LD of any conditions or restrictions that will affect my diving on any given day. Failure to do so could compromise the mission and endanger myself or my fellow divers.		
I certify that the attached medical information in the package is complete and true to the best of my knowledge:		
APPLICANT NAME	APPLICANT SIGNATURE	DATE

NOAA DIVING OFFICER APPROVAL

Final determination of the diver's medical suitability for NOAA diving will be made by the NOAA Diving Medical Officer.		
I have reviewed the attached medical information and have found the applicant named above to be:		
<input type="checkbox"/> Medically cleared for NOAA diving duty <input type="checkbox"/> Not medically cleared for NOAA diving duty		
DIVING MEDICAL OFFICER NAME	DIVING MEDICAL OFFICER SIGNATURE	DATE

REPORT OF MEDICAL HISTORY - DIVER

The diver should fill out this page and give the completed page to the Examiner for review.

1a. LAST NAME		1b. FIRST NAME		1c. MIDDLE NAME		2. DATE of BIRTH			
3. AGE		4. GENDER		5. HEIGHT (inches)		6. WEIGHT (pounds)		7. DATE	
8. STATEMENT OF PRESENT HEALTH						9. ALLERGIES <i>List all allergies: insect bites, stings, foods, and medicines</i>			
						10. Do you carry an Epi-Pen? YES NO			

PAST MEDICAL HISTORY: Have you ever had the following? Check each item.

	YES	NO		YES	NO
12. Adverse reaction to medication			24. Pain or pressure in the chest		
13. Tuberculosis or positive TB test			25. Palpitation, pounding heart, or abnormal heartbeat		
14. Exposed to someone who had tuberculosis			26. Heart murmur or other disorder		
15. Asthma or any breathing difficulty			27. Heart or blood vessel surgery		
16. Used or have been prescribed an inhaler			28. Abnormal heart anatomy or patent foramen ovale		
17. Plates, screws, rods, or pins in any bone			29. Diabetes		
18. High or low blood sugar			30. High cholesterol		
19. Sugar, albumin, or blood in the urine			31. Stroke		
20. Tumor, growth, cyst, or cancer			32. Heart disease		
21. Aneurysm, frequent or severe headaches			33. Parent or sibling with condition indicated in 29-32		
22. Seizures, convulsions, epilepsy, or fits			34. Treated in a decompression chamber		
23. Other neurological disorder or injury			35. Medical disqualification for diving duty		

PAST MEDICAL HISTORY: Have you had the following in the last ten years? Check each item.

	YES	NO		YES	NO
36. Thyroid trouble or goiter			51. Rectal disease, hemorrhoids, bleeding from rectum		
37. Eye disorder or trouble			52. Shortness of breath or wheezing		
38. Surgery to correct vision (i.e. RK, PRK, LASIK)			53. Sinusitis, bronchitis, or frequent colds		
39. Recurrent back pain or any back problem			54. Kidney, bladder, or urination problems		
40. Nerve injury, numbness, tingling, or sensitive areas			55. Head injury, memory loss, or amnesia		
41. Loss of finger or toe			56. Concussion or period of unconsciousness		
42. Knee trouble (locking, giving out, pain, injury)			57. Dizziness or fainting spells		
43. Leg cramps			58. Prolonged bleeding, blood clot, or embolism		
44. Painful or swollen joints			59. High or low blood pressure		
45. Arthritis, rheumatism, tendinitis, or bursitis			60. Depression, anxiety, or claustrophobia		
46. Artificial joint or other deformity			61. Received counseling of any type		
47. Bone fracture or deformity			62. Been evaluated or treated for a mental condition		
48. Stomach or intestinal trouble			63. Attempted or planned suicide		
49. Jaundice, hepatitis, or liver disease			64. Inability to focus or pay attention		
50. Hernia or rupture			65. Ear infection		

CURRENT MEDICAL HISTORY: Do you currently have any of the following? Check each item.

	YES	NO		YES	NO
66. Severe tooth or gum trouble			74. Use of prosthetic / corrective devices or braces		
67. Wear glasses or contact lenses			75. Frequent indigestion or heartburn		
68. Lack of vision in either eye			76. Skin disease (i.e. acne, eczema, psoriasis)		
69. Hay fever or allergic rhinitis			77. Recent unexplained weight loss or gain		
70. Ear, nose or throat trouble			78. Motion sickness (kinetosis)		
71. Hearing loss or wear a hearing aid			79. Difficulty distinguishing colors or seeing at night		
72. Impaired use of arms, hand, legs or feet			80. Difficulty performing moderate to heavy exercise		
73. Foot problems			81. Currently pregnant/may be pregnant (women only)		

REPORT OF MEDICAL HISTORY - DIVER

The diver should fill out this page and give to the Examiner. Examiner, please review pages 2-3 and then fill out items 88 and 89 below.

LAST NAME	FIRST NAME	MIDDLE NAME	DATE
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82. Indicate the type and frequency of use for the following:

a. Alcohol	b. Tobacco	c. Recreational drugs
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PAST DIVE MEDICAL HISTORY: Have you ever had the following as a result of diving? Check each item.

	YES	NO		YES	NO
83a. Ear or sinus squeeze			g. Near drowning		
b. Inability to equalize middle ear pressure			h. Arterial gas embolism (AGE)		
c. Ruptured ear drum			i. Oxygen (O ₂) toxicity		
d. Vertigo (dizziness)			j. Carbon dioxide (CO ₂) toxicity		
e. Loss of consciousness or asphyxia			k. Type I DCS (pain only, itching, rash, swelling)		
f. Lung squeeze or collapsed lung (pneumothorax)			l. Type II DCS		

84. Indicate any other medical conditions not listed above.

85. Indicate date, location, and reason for each hospitalization and surgery had or advised to have within the last ten years. Indicate reasons for any declined surgery.

86. Provide a detailed explanation for each item checked "YES" in either Medical History section. Add additional pages if necessary.

APPLICANT CERTIFICATION

87. I certify that I have reviewed the medical information provided by me. It is true and complete to the best of my knowledge. I understand that falsification of information on a Government form is punishable by fine and/or imprisonment and that incomplete information may delay or prevent my qualification for dive duty.

a. APPLICANT NAME	b. APPLICANT SIGNATURE	c. DATE
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EXAMINER REVIEW

88. EXAMINER SUMMARY of DEFECTS

89a. EXAMINER NAME and TITLE	b. EXAMINER SIGNATURE	c. DATE
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REPORT OF PHYSICAL EXAMINATION - DIVER

1a. APPLICANT LAST NAME	1b. FIRST NAME	1c. MIDDLE NAME	2. DATE of BIRTH	3. DATE of EXAM
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Instructions to the Examiner:

The person requesting this physical examination is an applicant for training or currently participates in diving activities with self-contained underwater breathing apparatus (SCUBA) or other similar equipment. Your opinion of the applicant's medical fitness for diving is requested. The Medical History and Physical Examination forms focus on conditions that may put a diver at increased risk for injuries or other conditions that could lead to decompression sickness (DCS) or drowning. The diver must be able to withstand some degree of cold stress, high pressures of up to six (6) atmospheres, the physiologic effects of immersion, the optical effects of water, and have sufficient physical and mental reserves to deal with underwater emergencies. Final determination for fitness for diving will be made by the NOAA Diving Program.

The Examiner should review pages 2-3, complete fields 88 and 89 on page 3, complete a comprehensive physical examination of the diver, and complete this page and all following pages. All tests and examinations must be completed in the last 12 months (except for the chest X-ray, which should be completed within the last 24 months). The additional tests that must be completed are on page 1 of this form. If you conduct other laboratory tests or diagnostic studies as part of this physical examination, include copies of these results with the submission of the other required documentation. Submission instructions for this form and all test results are on the last page of this form.

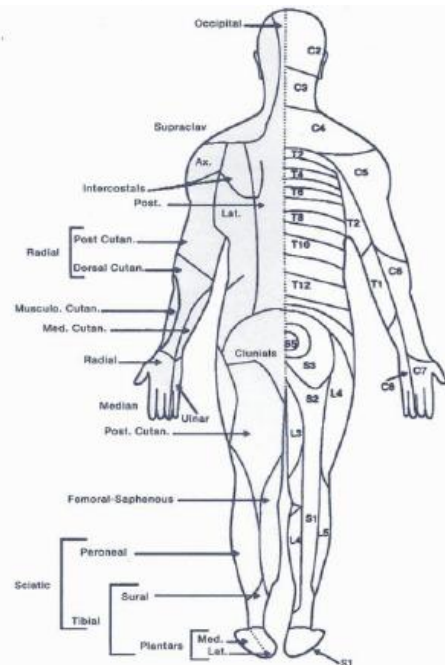
For questions, please contact the NOAA Diving Medical Officer at (206) 526-6474.

5. EXAM TYPE <input type="checkbox"/> Initial <input type="checkbox"/> Periodic	6. AGE	7. GENDER	8. HEIGHT (inches)	9. WEIGHT (pounds)
10. TEMP. (°F)	11. PULSE	12. BLOOD PRESSURE	2 nd BP (if needed)	3 rd BP (if needed)
13. VISION CORRECTABLE TO 20/20? Right eye Distant ____ (Y/N) Near ____ (Y/N) Left eye Distant ____ (Y/N) Near ____ (Y/N)		14. NEED CONTACT LENS USE WHILE DIVING OR PRESCRIPTION DIVING MASK? <input type="checkbox"/> YES <input type="checkbox"/> NO	15. NEAR VISION Right eye 20 / ____ Corrected to 20 / ____ Left eye 20 / ____ Corrected to 20 / ____	

GENERAL CLINICAL EVALUATION: Check each item.	Normal	Abnormal	Description of abnormality
16. Head, face and scalp			
17. Neck			
18. Eyes			
19. Fundus			
20. Ears (external / external canals)			
21. Eustachian tube function, can perform Val Salva			
22. Tympanic membranes			
23. Nose (septal alignment)			
24. Sinuses			
25. Mouth and throat			
26. Dental (loose or decayed teeth)			
27. Lungs and chest (including breasts)			
28. Heart (thrust, size, rhythm, sounds)			
29. Pulses (equality, etc.)			
30. Vascular system (varicosities, etc.)			
31. Abdomen and viscera			
32. Hernia (all types)			
33. Feet (arch, pes cavus / planus)			
34. Spine			
35. Skin, lymphatics			

1a. LAST NAME	1b. FIRST NAME	1c. MIDDLE NAME	3. DATE of EXAM
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44. Sensation (sharp dull, two-point discrimination) Diagram and label areas of altered sensations, and surgical and traumatic scars.



REPORT OF PHYSICAL EXAMINATION - DIVER

1a. LAST NAME	1b. FIRST NAME	1c. MIDDLE NAME	3. DATE of EXAM
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45. Summary of Laboratory/ancillary data. Transcribe results below or attach official laboratory report. Tests below are representative of standard analyses, yours may not list every test. Submit all test results provided.

COMPLETE URINALYSIS		METABOLIC DATA		AUDIOMETRY (Only for initial physical)																																																		
Spec. Gravity		Glucose		HZ	500	1000	2000	3000	4000	6000																																												
Ph		BUN		Left																																																		
Color		Creatinine		Right																																																		
Clarity		eGFR		<table border="1"><tr><td colspan="2">CBC DATA</td><td colspan="2">LIPID PROFILE</td></tr><tr><td>Leuk Esterase</td><td></td><td colspan="2">Total</td><td></td></tr><tr><td>Protein</td><td></td><td colspan="2">Triglycerides</td><td></td></tr><tr><td>Glucose</td><td></td><td colspan="2">HDL</td><td></td></tr><tr><td>Ketones</td><td></td><td colspan="2">LDL</td><td></td></tr><tr><td>Occult Blood</td><td></td><td colspan="2">VLDL</td><td></td></tr><tr><td>Bilirubin</td><td></td><td colspan="2">LDL/HDL Ratio</td><td></td></tr><tr><td>Urobilirubin</td><td></td><td colspan="2"></td><td></td></tr><tr><td>Nitrite</td><td></td><td colspan="2"></td><td></td></tr></table>							CBC DATA		LIPID PROFILE		Leuk Esterase		Total			Protein		Triglycerides			Glucose		HDL			Ketones		LDL			Occult Blood		VLDL			Bilirubin		LDL/HDL Ratio			Urobilirubin					Nitrite				
CBC DATA		LIPID PROFILE																																																				
Leuk Esterase		Total																																																				
Protein		Triglycerides																																																				
Glucose		HDL																																																				
Ketones		LDL																																																				
Occult Blood		VLDL																																																				
Bilirubin		LDL/HDL Ratio																																																				
Urobilirubin																																																						
Nitrite																																																						
BUN/Cr																																																						
Sodium																																																						
Potassium																																																						
Chloride																																																						
CO ₂																																																						
Calcium																																																						
HgA1C																																																						

46. All abnormal physical findings must be described in detail here by number. Add additional pages if necessary.

47. Although the NOAA Diving Medical Officer will make the final determination regarding fitness for duty as a diver, are there any further concerns to this applicant's fitness for diving?

48. EXAMINATION LOCATION NAME and ADDRESS	49a. EXAMINER NAME	49b. PHONE NUMBER
	49c. EXAMINER TITLE	
	49d. EXAMINER SIGNATURE	49e. DATE

SUBMISSION INSTRUCTIONS

This form must be sent via a secured file transfer method such as a password-protected PDF, or Accellion (Kiteworks) File Transfer. Files sent from a NOAA.GOV email address to the DMO@NOAA.GOV email address are secure and do not need to be encrypted further. Email is the preferred submission method.

Email to: DMO@NOAA.GOV
Subject: "Report of Physical Exam - Diver (last name)"

Or, mail to:
NOAA Diving Medical Officer (DMO)
NOAA Diving Program
7600 Sand Point Way NE
Seattle, WA 98115

PRA Public Burden Statement

A Federal agency may not conduct or sponsor, and a person is not required to respond to, nor shall a person be subject to a penalty for failure to comply with an information collection subject to the requirements of the Paperwork Reduction Act of 1995 unless the information collection has a currently valid OMB Control Number. The approved OMB Control Number for this information collection is 0648-XXXX. Without this approval, we could not conduct this information collection. Public reporting for this information collection is estimated to be approximately 2 hours per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the information collection. All responses to this information collection are required to obtain benefits. Send comments regarding this burden estimate or any other aspect of this information collection, including suggestions for reducing this burden to the NOAA Diving Center Executive Officer, NOAA Diving Program, 7600 Sand Point Way NE, Building 8, Seattle, WA 98115, 206-526-6460.

Privacy Act Statement

Authority: The collection of this information is authorized under 29 CFR 1910, Subpart T, Commercial Diving Operations. Additional authorities include 29 U.S.C. 653, 655, 657; 40 U.S.C. 333; 33 U.S.C. 941; Secretary of Labor's Order No. 8-76 (41 FR 25059), 9-83 (48 FR 35736), 1-90 (55 FR 9033), 6-96 (62 FR 111), 3-2000 (65 FR 50017), 5-2002 (67 FR 65008), 5-2007 (72 FR 31160), or 4-2010 (75 FR 55355) as applicable, and 29 CFR 1911.

Purpose: NOAA is collecting this information to assess an individual's medical fitness to dive, proficiency, and further training. Information will also be used to ensure diving equipment is safe and well maintained and that all policies are being adhered to for safety reasons. Aggregate data is used for annual reports and other leadership documents.

Routine Uses: NOAA will use this information in the determination of an individual's medical fitness to dive. Disclosure of this information is permitted under the Privacy Act of 1974 (5 U.S.C. Section 552a) to be shared among Department staff for work-related purposes. Disclosure of this information is also subject to all of the published routine uses as identified in the Privacy Act System of Records Notice NOAA-10, NOAA Diving Program.

Disclosure: Furnishing this information is voluntary. However, the failure to provide complete and accurate information will exclude the individual from NOAA's Diving Program.