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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. This form is only used to collect medical information about applicants during the post-offer phase of hiring or to collect medical information about employees when job-related and consistent with business necessity.

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 employment activities on the bases of race; color; religion; national origin; age; sex; disability; political beliefs; marital, familial or parental status; or reprisal. Persons with disabilities who require alternative means for communication (Braille, large print, audiotape, etc.) should contact USDA's TARGET Center at 202-720-2600 (voice and TDD). To initiate a complaint of employment discrimination, contact the Food Safety and Inspection Service Civil Rights Staff within 45 days from the day the discrimination occurred, at USDA, FSIS, Office of the Administrator, Civil Rights Staff, 5601 Sunnyside Avenue, Building 1, Room 2260, Mail Stop 5261, Beltsville, Maryland 20705, 1 (800) 269-6912 (toll free) or (301) 504-7755 (Voice and TDD). Employment complaints can also be initiated electronically at: <https://usda-efile.icomplaints.com/efile-usda-prod/login/>. 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.

Waiver of medical standards may be considered in conjunction with a complete health and safety review. Please contact the hiring agency/employing agency directly if you wish to request reasonable accommodation. A reasonable accommodation is any change to a job, the work environment, or the way things are usually done that enables an individual with a disability to apply for a job, perform job duties or receive equal access to job benefits.

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)
<input type="text"/>	<input type="text"/>	<input type="text"/>

4a. HOME ADDRESS (Street, Apartment No., City, State and ZIP Code)	4b. HOME TELEPHONE (Include Area Code)
<input type="text"/>	<input type="text"/>
	4c. EMAIL ADDRESS
	<input type="text"/>

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
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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.)

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.)	<input type="checkbox"/>	<input type="checkbox"/>
b. Recurrent back pain or any back problem	<input type="checkbox"/>	<input type="checkbox"/>
c. Numbness or tingling	<input type="checkbox"/>	<input type="checkbox"/>
d. Loss of finger or toe	<input type="checkbox"/>	<input type="checkbox"/>
e. Foot trouble (e.g., pain, corns, bunions, etc.)	<input type="checkbox"/>	<input type="checkbox"/>
f. Impaired use of arms, legs, hands, or feet	<input type="checkbox"/>	<input type="checkbox"/>
g. Swollen or painful joint(s)	<input type="checkbox"/>	<input type="checkbox"/>
h. Knee trouble (e.g., locking, giving out, pain or ligament injury, etc.)	<input type="checkbox"/>	<input type="checkbox"/>
i. Any knee, foot, hip, shoulder or wrist surgery	<input type="checkbox"/>	<input type="checkbox"/>
j. Any need to use corrective devices such as prosthetic devices, knee brace(s), back support(s), lifts or orthotics, etc.	<input type="checkbox"/>	<input type="checkbox"/>
k. Bone, joint, or other deformity	<input type="checkbox"/>	<input type="checkbox"/>
l. Plate(s), screw(s), rod(s) or pins(s) in any bone	<input type="checkbox"/>	<input type="checkbox"/>
m. Broken bone(s) (cracked or fractured)	<input type="checkbox"/>	<input type="checkbox"/>
n. Herniated disc	<input type="checkbox"/>	<input type="checkbox"/>
o. Repetitive motion symptoms (e.g., carpal tunnel, rotator cuff or tennis elbow)	<input type="checkbox"/>	<input type="checkbox"/>
p. Other musculoskeletal problems	<input type="checkbox"/>	<input type="checkbox"/>

13. RESPIRATORY

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

HAVE YOU EVER HAD:

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

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 Yes No
- b. Glaucoma Yes No
- c. Loss of vision in either eye Yes No
- d. Cataracts Yes No
- e. Detached retina, double vision and retinal hemorrhaging Yes No
- f. Surgery to correct vision (RK, PRK, LASIK, etc.) Yes No
- g. Other eye disorders Yes No

15. GENITOURINARY

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

HAVE YOU EVER HAD:

Yes No

- a. Frequent or painful urination Yes No
- b. Blood in urine Yes No
- c. Sugar or protein in urine Yes No
- d. Kidney disease Yes No
- e. Prostate problems Yes No
- f. Other genitourinary problems Yes No

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 Yes No
- b. Dizziness or fainting spells Yes No
- c. A head injury, loss of memory, loss of consciousness or amnesia Yes No
- d. Paralysis Yes No
- e. Seizures, convulsions or epilepsy Yes No
- f. Numbness or tingling Yes No
- g. Meningitis, encephalitis, or other neurological problems Yes No
- h. Depression Yes No
- i. Bipolar Disorder Yes No
- j. Anxiety Disorder Yes No
- k. Post Traumatic Stress Disorder (PTSD) Yes No
- l. Traumatic Brain Injury (TBI) Yes No
- m. Alcohol/Drug dependency Yes No
- n. Other mental health problems Yes No

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 | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Swelling or pain in legs or feet | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Irregular heart beats | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Palpitation/skipped heartbeats | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Heart murmur | <input type="checkbox"/> | <input type="checkbox"/> |
| f. High or low blood pressure | <input type="checkbox"/> | <input type="checkbox"/> |
| g. Heart attack | <input type="checkbox"/> | <input type="checkbox"/> |
| h. Stroke | <input type="checkbox"/> | <input type="checkbox"/> |
| i. Other cardiovascular problems | <input type="checkbox"/> | <input type="checkbox"/> |

18. GASTROINTESTINAL

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

HAVE YOU EVER HAD:

Yes No

- | | | |
|--|--------------------------|--------------------------|
| a. Persistent nausea or vomiting | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Chronic diarrhea or constipation | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Colitis or diverticulitis | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Crohn's disease or irritable bowel syndrome | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Liver cirrhosis, infection or jaundice | <input type="checkbox"/> | <input type="checkbox"/> |
| f. Rectal bleeding or black tarry stools | <input type="checkbox"/> | <input type="checkbox"/> |
| g. Severe or frequent heartburn/stomach pain | <input type="checkbox"/> | <input type="checkbox"/> |
| h. Stomach, liver, intestinal trouble or ulcer | <input type="checkbox"/> | <input type="checkbox"/> |
| i. Hepatitis | <input type="checkbox"/> | <input type="checkbox"/> |
| j. Other gastrointestinal problems | <input type="checkbox"/> | <input type="checkbox"/> |

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 | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Skin allergies/rashes (e.g. eczema, psoriasis or contact dermatitis) | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Moles that have changed in size or color | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Skin cancer | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Latex allergy | <input type="checkbox"/> | <input type="checkbox"/> |
| f. Other skin problems | <input type="checkbox"/> | <input type="checkbox"/> |

20. EARS, NOSE AND THROAT

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

HAVE YOU EVER HAD:

	Yes	No
a. Difficulty hearing	<input type="checkbox"/>	<input type="checkbox"/>
b. Ringing or buzzing in ears	<input type="checkbox"/>	<input type="checkbox"/>
c. Hearing aid	<input type="checkbox"/>	<input type="checkbox"/>
d. Chronic sinus trouble	<input type="checkbox"/>	<input type="checkbox"/>
e. Chronic nosebleeds	<input type="checkbox"/>	<input type="checkbox"/>
f. Chronic sneezing/running nose	<input type="checkbox"/>	<input type="checkbox"/>
g. Chronic sore throat	<input type="checkbox"/>	<input type="checkbox"/>
h. Difficulty swallowing	<input type="checkbox"/>	<input type="checkbox"/>
i. Ruptured ear drum	<input type="checkbox"/>	<input type="checkbox"/>
j. Other ear/nose/throat problems	<input type="checkbox"/>	<input type="checkbox"/>

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	<input type="checkbox"/>	<input type="checkbox"/>
b. Hyperthyroidism	<input type="checkbox"/>	<input type="checkbox"/>
c. Hypothyroidism	<input type="checkbox"/>	<input type="checkbox"/>
d. Cancer	<input type="checkbox"/>	<input type="checkbox"/>
e. Chronic Anemia	<input type="checkbox"/>	<input type="checkbox"/>
f. Blood Disorder	<input type="checkbox"/>	<input type="checkbox"/>
g. Sleep Apnea	<input type="checkbox"/>	<input type="checkbox"/>
h. Hypoglycemia or hyperglycemia (including frequency)	<input type="checkbox"/>	<input type="checkbox"/>
i. Diabetes (complete additional questions shown below)	<input type="checkbox"/>	<input type="checkbox"/>

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	
j. Any additional symptoms or diseases not yet mentioned	<input type="checkbox"/>	<input type="checkbox"/>	If "yes," please indicate dates (mo/yr), treatment and explanation

22. OCCUPATIONAL AND EXPOSURE HISTORY

If "yes," please explain.

Yes No

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 sensitivity 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? *(If 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

Job Duties/Activities

Specific Hazards*

(From) - (To)

* 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: Public Health Veterinarian / Food Inspector / Consumer Safety Inspector

POSITION REQUIREMENTS:

Public Health Veterinarians (PHVs), Food Inspectors (FIs) and Consumer Safety Inspectors (CSIs) are involved in ante-mortem inspection of livestock or poultry and post-mortem inspection of red meat or poultry. This inspection activity is performed in a noisy industrial environment with large moving machinery that cannot be stopped instantly. Workstations and walkways can be extremely narrow and slippery. Excellent stability and balance is required. Frequent physical activities such as walking, climbing, standing, and kneeling are required, including climbing and walking on catwalks.

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 Hearing
- Ability to detect odors.
- Clear speech.
- Light lifting, 10 pounds.
- Ability to palpate organs & note product differences.
- Color vision allowing identification of subtle shades.

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.
- Sub-freezing temperatures.
- Summertime temperatures at 80 to 90 degrees.
- Rapid, constant repetitive motion with hands/wrists.

* Failure to fully meet a functional requirement is not automatically disqualifying. Please contact the hiring agency/employing agency directly if you wish to request reasonable accommodation in connection with the functional requirements, environmental factors or other general position requirements. FSIS responds to reasonable accommodation requests based on the facts of each case, conducting an individualized assessment to evaluate each request on its own merits.

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.

Please also note that applicants/employees may request reasonable accommodation for assistance in coping with the functional requirements, environmental factors and other general position requirements listed on this form.

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 describe the asthma trigger, severity and treatment.)

LAST NAME, FIRST NAME, MIDDLE INITIAL

13. BLOOD PRESSURE/PULSE.

Measure pulse and blood pressure. Agency Medical Qualification Standards indicate that systolic blood pressure greater than **155** and/or diastolic blood pressure greater than **95** may be disqualifying.

BP Reading 1 _____ Date _____ Pulse Reading _____ Date _____

If blood pressure readings show signs of hypertension as described in the agency's Medical Qualification Standards, please take three (3) additional, serial readings on three (3) different days

BP Reading 2 _____ Date _____ (Take this additional reading if systolic and/or diastolic are above 155/95 on Reading 1.)

BP Reading 3 _____ Date _____ (Take this additional reading if systolic and/or diastolic are above 155/95 on Reading 1.)

BP Reading 4 _____ Date _____ (Take this additional reading if systolic and/or diastolic are above 155/95 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.

Administer a Tuberculin test and show results below.

[NOTE: If there is any history of TB, including a positive skin test for TB or a BCG vaccination, please also perform an X-ray to determine if the individual has active TB or residual damage from TB, and note results below.]

Name of Tubercullin administered: _____

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.)

- | | |
|---|--|
| <input type="checkbox"/> ISHIHARA (14 Plate Series)
<input type="checkbox"/> FARNSWORTH D-15
<input type="checkbox"/> TOKYO MEDICAL COLLEGE | <input type="checkbox"/> H-R-R (HARDY RAUD-RITTLER)
<input type="checkbox"/> DVORINE
<input type="checkbox"/> AMERICAN OPTICAL (ACO) |
|---|--|

ABILITY TO DISTINGUISH COLORS. Please enter applicant's capacity to distinguish primary colors and shades of color by checking full, partial or none.

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. Please measure peripheral visual fields. Degrees temporally: _____ Degrees nasally: _____

Any abnormalities? Yes No (If yes, please explain.)

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.

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

WITH HEARING AID	EAR	500	1000	2000	3000	4000	6000	8000
	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: _____