



TRANSPORTATION SECURITY OFFICER MEDICAL QUESTIONNAIRE

OMB control number 1652-0032

Expiration 10/31/2026

Public Burden and Privacy Act Statements. Instructions

TRANSPORTATION SECURITY OFFICER MEDICAL QUESTIONNAIRE

PUBLIC BURDEN STATEMENT: TSA is collecting this information to determine suitability to serve as a Transportation Security Officer (TSO). This is a voluntary collection of information; however, failure to furnish the requested information may result in an inability to consider your eligibility for employment as a TSO. TSA estimates that the total average burden per response associated with this collection is approximately 0.50 hours, including the time for reviewing instructions and getting needed information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a valid OMB control number. The OMB number control number assigned to this collection of information is 1652-0032, which expires on 10/31/2026. Send comments regarding our estimate or any other aspect of this form, including suggestions for reducing burden, to DHS/TSA, TSAPRA@tsa.dhs.gov or TSA-11, Transportation Security Administration, 6595 Springfield Center Drive, Springfield, Virginia 20598-6011. Attn: PRA 1652-0032 Transportation Security Officer Medical Questionnaire.

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). ROUTINE USE(S): This information may be shared with contractors, grantees, or volunteers performing or working on a contract, service, grant, cooperative agreement, or job for the federal government, or for routine uses identified in the Office of Personnel Management's system of records notice, OPM/GOVT-10 Employee Medical File System Records (if hired) or OPM/GOVT-5 Recruiting, Examining, and Placement Records (if not hired). DISCLOSURE: Voluntary; failure to furnish the requested information may result in an inability to consider your application for employment.

When you submit this form, it will not automatically collect your details like name and email address unless you provide it yourself.

Instructions

It is required that you personally complete each question or response in this questionnaire in one session. Information will not be saved if the questionnaire is closed prior to submission. It can take up to 30 minutes (0.50 hours) to complete the questionnaire.

To learn more about the medical requirements of the Transportation Security Officer (TSO) position, it is recommended that you review the TSO Medical Guidelines that can be found at https://jobs.tsa.gov/Resources/TSO_Medical_Guidelines.pdf.

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Health Care Provider Information

TRANSPORTATION SECURITY OFFICER MEDICAL QUESTIONNAIRE

* Required

Health Care Provider Information

1. Please type the full name of the licensed health care provider who completed or is anticipated to complete your medical clearance form. *

2. Please type the phone number of the health care provider listed above *

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Demographic Information

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* Required

Demographic information

3. Please select the date you start this questionnaire. *

Please input date (M/d/yyyy)

4. Enter your Email Address *

Please enter an email

5. Name (as listed on your application; First, M.I., Last, suffix) *

Enter your answer

6. Address *

Enter your answer

7. City, State, Zip *

Enter your answer

8. Primary Phone # *

Enter your answer

9. Last 4 of Social Security Number *

Please enter at most 4 characters

10. Sex *

Male

Female

11. Date of Birth *

Please input date (M/d/yyyy)

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General Information

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* Required

General Information

12. Have you been refused employment, dismissed from a job, or unable to stay in school due to any medical condition or excessive absenteeism? (Please note: This may not automatically disqualify you from TSA employment.) *

Yes

No

13. Have you had any operations and/or medical procedures? *

Yes

No

14. Have you had a visit to a clinic, physician, chiropractor, ER, urgent care, outpatient facility physical therapist, healer, acupuncturist, or any other practitioner within the past year? *

Yes

No

15. Are you currently taking any prescription medications? *

Yes

No

16. Are you currently taking any non-prescription OTC medications/herbs/supplements? *

Yes

No

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Vision and Hearing

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* Required

Vision and Hearing

17. Do you have known uncorrectable vision loss or a total loss of vision in either eye? *

Yes

No

18. Have you had any type of refractive eye surgery such as LASIK, PRK, etc.? *

Yes

No

19. Do you use a hearing aid for either ear? *

Yes

No

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Respiratory

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* Required

Respiratory

20. Do you have asthma or chronic obstructive pulmonary disease (COPD)? *

Yes

No

21. Have you EVER had active tuberculosis (not just a positive skin test)? *

Yes

No

22. Have you ever had any other lung disease? *

Yes

No

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Cardiovascular

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* Required

Cardiovascular

23. Have you ever had or experienced hypertension? *

- Yes
 No

24. Have you had a treadmill exercise stress test? *

- Yes
 No

25. Have you ever had or experienced coronary artery disease, heart attack, open heart surgery, stent, or angioplasty? *

- Yes
 No

26. Have you ever experienced heart failure or cardiomyopathy? *

- Yes
 No

27. Have you experienced atrial fibrillation, atrial flutter, supraventricular tachycardia, Wolff-Parkinson-White Syndrome or ventricular tachycardia? *

- Yes
 No

28. Have you experienced ventricular fibrillation? *

- Yes
 No

Cardiovascular

2 of 2

29. Have you experienced unexplained syncope (fainting or passing out)? *

Yes

No

30. Do you have a pacemaker? *

Yes

No

31. Have you experienced valvular heart disease? *

Yes

No

32. Do you have an automatic implantable cardiac defibrillator (AICD)? *

Yes

No

33. Have you experienced peripheral vascular disease that causes pain with walking? *

Yes

No

34. Have you experienced thoracic or abdominal aortic aneurysm? *

Yes

No

35. Have you experienced other cardiac condition(s) not previously mentioned? *

Yes

No

Abdominal Organs and Renal

TRANSPORTATION SECURITY OFFICER MEDICAL QUESTIONNAIRE

* Required

Abdominal Organs and Renal

36. Have you had or do you currently have a hernia? *

- Yes
 No

37. Do you have chronic kidney disease (CKD)? *

- Yes
 No

38. Are you being treated with hemodialysis or peritoneal dialysis? *

- Yes
 No

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Musculoskeletal

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* Required

Musculoskeletal

39. Have you ever had an amputation or congenitally absent body part? *

- Yes
 No

40. Do you use any ambulatory aids (crutches, cane, walker, etc.)? *

- Yes
 No

41. Have you ever experienced an upper extremity condition (hand, wrist, forearm, elbow, upper arm, shoulder)? *

- Yes
 No

42. Have you ever experienced a lower extremity condition (foot, ankle, lower leg, knee, upper leg, hip)? *

- Yes
 No

43. Have you ever experienced a spine condition (back, neck, surgery)? *

- Yes
 No

44. Have you ever experienced a joint replacement surgery? *

- Yes
 No

Neurological

1 of 2

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* Required

Neurological

45. Have you ever had or experienced a cerebrovascular accident (CVA, stroke, brain bleed, or TIA)? *

- Yes
 No

46. Have you ever had or experienced seizures or epilepsy? *

- Yes
 No

47. Have you ever had or experienced vertigo? *

- Yes
 No

48. Have you had Meniere's disease? *

- Yes
 No

49. Have you had or experienced the paralysis of a limb? *

- Yes
 No

50. Have you had or experienced the complete loss of touch sensation in the upper extremity? *

- Yes
 No

Neurological 2 of 2

51. Have you had or experienced cognitive impairment (ongoing memory loss, dementia)? *

Yes

No

52. Have you had or experienced malignancy of the spinal cord or brain? *

Yes

No

53. Have you had or experienced amyotrophic lateral sclerosis? *

Yes

No

54. Have you had or experienced multiple sclerosis? *

Yes

No

55. Have you had or experienced Parkinson's? *

Yes

No

56. Have you had or experienced other neurologic disorders not previously noted? *

Yes

No

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Endocrine

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* Required

Endocrine

57. Do you have diabetes? *

Yes

No

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Sleep Disorders

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* Required

Sleep Disorders

58. Have you ever had or experienced narcolepsy? *

Yes

No

59. Have you ever had or experienced obstructive sleep apnea? *

Yes

No

60. Have you ever had or experienced shift work disorder? *

Yes

No

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Psychological 1 of 2

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* Required

Psychological

61. Have you ever had or experienced anxiety disorder? *

- Yes
 No

62. Have you ever had or experienced a panic attack? *

- Yes
 No

63. Have you ever had or experienced attention deficit/hyperactivity disorder (ADHD)? *

- Yes
 No

64. Have you ever had or experienced bipolar disorder? *

- Yes
 No

65. Have you ever had or experienced a depressive disorder? *

- Yes
 No

66. Have you ever had or experienced a personality disorder? *

- Yes
 No

Psychological 2 of 2

67. Have you had or experienced a post-traumatic stress disorder (PTSD)? *

Yes

No

68. Have you had or experienced psychosis or psychotic features? *

Yes

No

69. Have you had or experienced a substance abuse disorder? *

Yes

No

70. Are you being treated for a mental health condition? *

Yes

No

71. Have you attempted suicide? *

Yes

No

72. Have you had or experienced electroconvulsive therapy? *

Yes

No

73. Have you had or experienced schizophrenia, schizoaffective, or schizophreniform disorder? *

Yes

No

74. Have you had or experienced other mental health disorders not previously noted? *

Yes

No

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Activity 1 of 2

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* Required

Activity

75. Are you able to frequently lift and carry passenger baggage weighing up to 50 pounds without assistance? *

- Able
 Unable

76. Are you able to frequently squat, bend and stoop? *

- Able
 Unable

77. Are you able to frequently reach overhead with each arm? *

- Able
 Unable

78. Are you able to stand continuously for up to 4 hours without a break? *

- Able
 Unable

79. Are you able to walk for up to 3 miles during a shift? *

- Able
 Unable

80. Are you able to feel and manipulate small objects with both hands? *

- Able
 Unable

81. Are you able to open/close zippers, snaps, and buckles on baggage, backpacks and briefcases? *

- Able
 Unable

82. How often do you walk 2 miles continuously? *

- Never/Rarely (0 to 2 times per year)
 Occasionally (1 to 2 times per month)
 Frequently (Once per week or more)

Activity 2 of 2

83. How often do you run 2 miles continuously? *

- Never/Rarely (0 to 2 times per year)
- Occasionally (1 to 2 times per week)
- Frequently (Once per week or more)

84. How often do you weight train or perform general fitness activities at a gym? *

- Never/Rarely (0 to 2 times per year)
- Occasionally (1 to 2 times per week)
- Frequently (Once per week or more)

85. How often do you participate in other physical activities (e.g. sports)? *

- Never/Rarely (0 to 2 times per year)
- Occasionally (1 to 2 times per week)
- Frequently (Once per week or more)

86. Do you have any restrictions or limitations on your activity or function? *

- Yes
- No

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