

All Equipment Operators

TO BE GIVEN TO PERSON EXAMINED WITH A PRE-ADDRESSED "CONFIDENTIAL-MEDICAL" ENVELOPE.

UNITED STATES CIVIL SERVICE COMMISSION CERTIFICATE OF MEDICAL EXAMINATION

Form Approved Budget Bureau No. 50-R0073

Part A. TO BE COMPLETED BY APPLICANT OR EMPLOYEE (typewrite or print in ink)

1. NAME (last, first, middle) 2. SOCIAL SECURITY ACCOUNT NO. 3. SEX MALE FEMALE 4. DATE OF BIRTH 5. DO YOU HAVE ANY MEDICAL DISORDER OR PHYSICAL IMPAIRMENT WHICH WOULD INTERFERE IN ANY WAY WITH THE FULL PERFORMANCE OF THE DUTIES SHOWN BELOW? 6. I CERTIFY THAT ALL THE INFORMATION GIVEN BY ME IN CONNECTION WITH THIS EXAMINATION IS CORRECT TO THE BEST OF MY KNOWLEDGE AND BELIEF.

Part B. TO BE COMPLETED BEFORE EXAMINATION BY APPOINTING OFFICER

1. PURPOSE OF EXAMINATION PREAPPOINTMENT OTHER (Specify) 2. POSITION TITLE Engineering Equipment Operator, WB-5716 3. BRIEF DESCRIPTION OF WHAT POSITION REQUIRES EMPLOYEE TO DO Operates a variety of heavy construction and maintenance of equipment... 4. Circle the number preceding each functional requirement and each environmental factor essential to the duties of this position. A. FUNCTIONAL REQUIREMENTS B. ENVIRONMENTAL FACTORS

Part C. TO BE COMPLETED BY EXAMINING PHYSICIAN

1. EXAMINING PHYSICIAN'S NAME (Type or print) 2. ADDRESS (Including ZIP Code) 3. SIGNATURE OF EXAMINING PHYSICIAN IMPORTANT: After signing, return the entire form intact in the pre-addressed "Confidential-Medical" envelope which the person you examined gave you.

ORIGINAL

NOTE TO EXAMINING PHYSICIAN: The person you are about to examine will have to cope with the functional requirements and environmental factors circled on the other side of this form. Please take these, and the brief description of the job duties above them, into consideration as you make your examination and report your findings and conclusions.

1. HEIGHT: _____ FEET, _____ INCHES. WEIGHT: _____ POUNDS.

1. EYES: 20 20 20 20
 (A) Distant vision (Snellen): without glasses: right _____ left _____ ; with glasses, if worn; right _____ left _____
 (B) What is the longest and shortest distance at which the following specimen of Jaeger No. 2 type can be read by the applicant?
 Test each eye separately.

Jaeger No. 2 Type
 employees in the Federal classified service as may be required by the Civil Service Commission or its authorized representative. This order will supplement the Executive Orders of May 29 and June 18, 1923 (Executive Order, September 4, 1924).

without glasses: { L _____ in. to _____ in. R _____ in. to _____ in.
 with glasses, if used: L _____ in. to _____ in. R _____ in. to _____ in.

(B) Color vision: Is color vision normal when Ishihara or other color plate test is used? YES NO
 If not, can applicant pass lantern, yarn, or other comparable test? YES NO

3. EARS: (Consider denominators indicated here as normal. Record as numerators the greatest distance heard.)
 Ordinary conversation: _____
 RIGHT EAR _____ ; LEFT EAR _____
 20 ft. 20 ft.
 Audiometer (if given):

250	500	1000	2000	3000	4000	5000	6000	7000	8000

4. OTHER FINDINGS: In items a through l briefly describe any abnormality (including diseases, scars, and disfigurements). Include brief history, if pertinent. If normal, so indicate.

- | | |
|--|--|
| a. Eyes, ears, nose, and throat (including tooth and oral hygiene) | e. Abdomen |
| b. Head and back (including face, hair, and scalp) | f. Peripheral blood vessels |
| c. Speech (note any malfunction) | g. Extremities |
| d. Skin and lymph nodes (including thyroid gland) | h. Urinalysis (if indicated)
Sp. gr. _____ Sugar _____ Blood _____
Albumen _____ Casts _____ Pus _____ |
| i. Respiratory tract (X-ray if indicated) | |
| j. Heart (size, rate, rhythm, function)
Blood pressure _____
Pulse _____
EKG (if indicated) _____ | |
| k. Back (special consideration for positions involving heavy lifting and other strenuous duties) | |
| l. Neurological and mental Health | |

Jaeger No. 2 Type

Conclusions: Summarize below any medical findings which, in your opinion, would limit this person's performance of the job duties and/or would make him a hazard to himself or others. If none, so indicate.

- No limiting conditions for this job
 Limiting conditions as follows

FOR AGENCY USE ONLY

Part B. TO BE COMPLETED BEFORE EXAMINATION BY APPOINTING OFFICER			
1. NAME (last, first, middle)	2. SOCIAL SECURITY ACCOUNT NO.	3. SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	4. DATE OF BIRTH
5. DO YOU HAVE ANY MEDICAL DISORDER OR PHYSICAL IMPAIRMENT WHICH WOULD INTERFERE IN ANY WAY WITH THE FULL PERFORMANCE OF THE DUTIES SHOWN BELOW? <input type="checkbox"/> YES <input type="checkbox"/> NO <small>(If your answer is YES, explain fully to the physician performing the examination)</small>		6. I CERTIFY THAT ALL THE INFORMATION GIVEN BY ME IN CONNECTION WITH THIS EXAMINATION IS CORRECT TO THE BEST OF MY KNOWLEDGE AND BELIEF. _____ (Signature of applicant)	

Part D. TO BE COMPLETED BY AGENCY MEDICAL OFFICER (if one is available)

NOTE: Review the attached certificate of medical examination and make your recommendations in item 1 below. If the medical examination was done for pre-appointment purposes, circle the appropriate handicap code in part F.

1. RECOMMENDATION: <input type="checkbox"/> HIRE OR RETAIN, DESCRIBE LIMITATIONS, IF ANY, HERE. <input type="checkbox"/> TAKE ACTION TO SEPARATE OR DO NOT HIRE, EXPLAIN WHY		
2. AGENCY MEDICAL OFFICER'S NAME (type or print)	3. LOCATION (city, State, ZIP Code)	4. DATE

Part E. TO BE COMPLETED BY AGENCY PERSONNEL OFFICER

NOTE: Enter the action taken below. If this form is used for pre-appointment purposes, be sure the appropriate handicap code in part F is circled. **IMPORTANT:** See FPM Chapter 293, Subchapter 3; FPM Chapter 339; and FPM Supplement 339-31 for disposition and/or filing of both parts of this form, either separately or together.

1. ACTION TAKEN: <input type="checkbox"/> HIRED OR RETAINED <input type="checkbox"/> NON-SELECTED FOR APPOINTMENT, OR ELIGIBILITY OBJECTED TO. <input type="checkbox"/> ACTION TAKEN TO SEPARATE		
2. AGENCY PERSONNEL OFFICER'S NAME (Type or print)	3. SIGNATURE	4. DATE

Part F. HANDICAP CODE (to be completed only in pre-appointment cases)

If the person examined has or had a handicap listed below, circle the code number which pertains to that handicap. If more than one handicap applies, circle the one considered most limiting. If none of the handicap codes apply, circle code "00".

- | | | |
|---|--|--|
| 00 No handicap of the type listed | 40 Hearing aid required | 52 Diabetes-controlled |
| 10 Amputations-one major extremity | 41 No usable hearing | 53 Epilepsy-adequately controlled |
| 11 Amputation-two or more major extremities | 42 No usable hearing, with speech malfunction | 54 History of emotional behavioral problems requiring special placement effort |
| 20 Deformity or impaired function-upper extremity | 43 Normal hearing, with speech malfunction | 55 Mentally retarded |
| 21 Deformity or impaired function-lower extremity or back | 50 Tuberculosis-inactive pulmonary | 56 Mentally restored |
| 30 Vision-one eye only | 51 Organic heart disease (compensated)-Valvular, arrhythmia, arteriosclerosis, healed coronary lesions | |
| 31 No usable vision | | |

1. EXAMINING PHYSICIAN'S NAME (type or print)	3. SIGNATURE OF EXAMINING PHYSICIAN _____ (signature) _____ (date)
2. ADDRESS (including ZIP Code)	IMPORTANT: After signing, return the entire form intact in the pre-addressed "Confidential-Medical" envelope which the person you examined gave you.