

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: _____
 Audiometer (if given):

RIGHT EAR _____ ; LEFT EAR _____
 20 ft. 20 ft.

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 disfigurations). 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 (<i>last, first, middle</i>)	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 (<i>type or print</i>)	3. LOCATION (<i>city, State, ZIP Code</i>)	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 (<i>Type or print</i>)	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 (<i>compensated</i>)-Valvular, arrhythmia, arteriosclerosis, healed coronary lesions	
31 No usable vision		
1. EXAMINING PHYSICIAN'S NAME (<i>type or print</i>)	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.	