CERTIFICATE OF MEDICAL QUALIFICATION EXAMINATION

(Contains Controlled Unclassified Information and Confidential Medical Information)

Privacy Act Statement

AUTHORITY: 5 USC 3301, Civil service; generally; 5 USC 3312, Preference eligibles; physical qualifications; waiver; DoD Manual 6055.05, Occupational Medical Examinations: Medical Surveillance and Medical Qualification; 5 CFR 339.205, Medical evaluation programs.

PRINCIPAL PURPOSE(S): This form is used to collect preplacement and medical information about individuals who are incumbents of positions in the Department of Defense who require medical examination(s), or individuals who have been selected for such a position contingent upon successful completion of medical examination(s) as a condition of their employment.

ROUTINE USE(S): Disclosure of records are generally permitted under 5 U.S.C. 522a(b) of the Privacy Act of 1974, as amended. To disclose information to the Merit System Protection Board or the Office of the Special Counsel, the Federal Labor Relations Authority and its General Counsel, the Equal Employment Opportunity Commission, arbitrators, and hearing examiners to the extent necessary to carry out their authorized duties. Additional routine uses are listed in the applicable System of Records Notice, OPM/GOVT-10, Employee Medical File System Records at: https://www.opm.gov/information-management/privacy-policy/sorn/opm-sorn-govt-10-employee-medical-file-systems-records.pdf

DISCLOSURE: Voluntary; however, failure to complete this form may result in no further consideration as an application, or a determination that you are no longer qualified for your position. Additionally, incomplete, misleading, or untruthful information provided on this form may result in delays in employment processing.

Public Burden Statement

We estimate an average of two to three hours per response to complete, including the time for reviewing instructions, getting needed information, and reviewing the completed form.

Instructions

Part A To be completed by the requesting authority before the medical examination. It identifies the purpose of the examination, and the position title, series, and grade. It requires the attachment of the position description, and shows the specific functional requirements and environmental exposures or demands of the job. Attach any medical standards for the position.

Part B To be completed by applicant or employee. This includes an extensive medical history questionnaire. Signature of the applicant or employee certifies that the information provided is complete and accurate; and that the applicant or employee consents to the release of the examination results to the employing agency.

Part C To be completed by the examining medical provider. It includes findings from required exam elements and medical studies, if any, and from the examination applicable to the position to be completed. It is to be signed by the examiner (a licensed physician or practitioner).

Part D To be completed and signed by the examining medical provider. This is the examining medical provider's determination of the applicant's or employee's medical qualification for the job.

Part E To be completed by the Agency Medical Officer Reviewer (a licensed physician or other practitioner, who may also be the Examiner in Part C) to specify the medical disposition. After signing, ONLY Parts E and F are to be returned to the agency Human Resources officer, authorized requestor, or other designated authority by method in compliance with the Privacy Act of 1974 and according to the employing agency's procedures.

Part F To be completed by the agency human resources officer, authorized requestor, or other designated authority in order to document the personnel action that is rendered.

Examinee and Medical Department: Do not write below this line. For Human Resources Use Only.

Applicant/Employee Name	
Date of Birth *(Month, Day, Year)*	**DoD Identification Number**

Controlled by: OUSD(P&R)
CUI Category: PRVCY
Distribution/Dissemination Control: FEDCON
POC: osd.pentagon.ousd-p-r.mbx.forms@mail.mil

CERTIFICATE OF MEDICAL QUALIFICATION EXAMINATION

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Part A. TO BE COMPLETED BY APPOINTING OFFICER BEFORE MEDICAL EXAMINATION

1. Purpose of examination

- [X] Pre-placement *(Required: State the OPM Standard, the OPM-Approved Agency Standard, or None)*
- [ ] Review of documentation in follow-up of a previous exam performed _____ *(Required: Specify date of previous exam)*

2a. Position Title, Series and Grade

FCC Provider - Minot AFB, USAF -

2b. Attach position description (PD)#

N/A

3. Brief description of what the position requires the employee to do.

Employee is responsible for the successful implementation of all daily child care duties for children ages 2 weeks - 12 years of age.

4. Functional (Physical) requirements Identified by the Agency as essential to the duties of this position.

- [ ] Very heavy work. lifting objects greater than 100 pounds, frequent lifting or carrying objects greater than or equal to 50 pounds
- [ ] Heavy work. Heavy work lifting less than or equal to 100 pounds, frequent lifting or carrying objects weighing less than or equal 50 pounds
- [X] Medium work. Lifting less than or equal to 50 pounds, frequent lifting or carrying objects less than or equal to 25 pounds
- [ ] Light work. Lifting less than or equal to 20 pounds, frequent lifting or carrying objects less than or equal to 10 pounds
- [ ] Sedentary work. Lifting less than or equal to10 pounds, occasionally lifting or carrying articles like docket files, ledgers, and small tools
- [ ] Straight pulling (_____ *hours)*
- [ ] Pulling hand over hand (_____ *hours)*
- [ ] Pushing (_____ *hours)*
- [ ] Reaching above shoulder
- [X] Use of fingers
- [ ] Both hands required
- [X] Walking (_____ *hours)*
- [X] Standing (_____ *hours)*
- [ ] Crawling (_____ *hours)*
- [ ] Kneeling (_____ *hours)*
- [ ] Repeated bending (_____ *hours)*
- [ ] Climbing, legs only (_____ *hours)*
- [ ] Climbing, use of legs and arms
- [ ] Both legs required
- [ ] Operation of crane/weight handling equipment
- [ ] Operation of powered industrial truck/forklift/ material handling equipment
- [ ] Operation of motor vehicle *(not requiring commercial driver's license (CDL))*
- [ ] Operation of motor vehicle *(requiring commercial driver's license (CDL))*
- [ ] Arms, Ammunition, and Explosives handling
- [ ] Ability for rapid mental and muscular coordination simultaneously
- [ ] Ability to use firearms
- [ ] Near visual acuity correctable in one eye to 20/20 in and to 20/40 in the other eye
- [ ] Distant visual acuity correctable in one eye to 20/20 and to 20/40 in the other
- [ ] Other specific visual requirement _____
- [ ] Both eyes required
- [ ] Depth perception
- [ ] Ability to distinguish basic colors
- [ ] Ability to distinguish shades of colors
- [ ] Stereopsis
- [ ] Hearing *(aid permitted)*
- [ ] Hearing without aid
- [ ] Specific hearing requirements *(specify)* _____
- [ ] Use of respirator *(specify type(s))* _____
- [ ] Simultaneous rapid mental and muscular coordination

5. Environmental Factors (Environmental Exposures or Demands) expected while performing essential duties of this position.

- [ ] Outside
- [X] Outside and inside
- [ ] Indoors exclusively
- [ ] Reduced lighting
- [ ] Thermal stress (heat or cold)
- [ ] Excessive dampness or musty conditions
- [ ] Dry atmospheric conditions
- [ ] Excessive noise, intermittent
- [ ] Constant noise
- [ ] Dust *(specify:*

  mixed _____ *or specific dust* _____ *)*
- [ ] Silica
- [ ] Asbestos
- [ ] Fumes, smoke, or gases
- [ ] Solvents *(degreasing agents)*
- [ ] Grease and oils
- [ ] Radiant energy
- [ ] Electrical energy
- [ ] Slippery or uneven walking surfaces
- [ ] Working around machinery with moving parts
- [ ] Working around moving objects or vehicles
- [ ] Working at height or on ladders or scaffolding
- [ ] Working below ground
- [ ] Subject to unusual fatiguing factors *(specify)* _____
- [ ] Working with hands in water
- [ ] Explosives
- [ ] Vibration
- [ ] Working closely with others
- [ ] Working alone
- [ ] Protracted or irregular hours of work
- [ ] Cold stress
- [ ] High relative humidity

6. Specific functional requirements and environmental factors not listed above, if any

7. If the position involves specific medical standards such as law enforcement, air traffic control, or fire fighting, attach the specific medical standards for the information of the examining physician and mark here: [ ] Additional medical standards attached

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Applicant/Employee Name

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Part B. TO BE COMPLETED BY APPLICANT OR EMPLOYEE

8. If you are completing this questionnaire, it is because your job requires a level of health to perform assigned duties. The goal of these questions is to get an accurate idea of your ability to safely and effectively perform those duties. Certain health conditions may make performing the job dangerous to you or to those around you, or may make you unable to perform the job requirements. It is important that we identify those conditions and any limitations that would require job modification or special accommodation so that you and those around you are not put in danger. You are required to provide an accurate and complete medical history. The information will be kept confidential and will only be shared with the medical professionals involved in the pre-placement assessment process.

Have you ever had, do you now have or are you now being treated for any of the following:

YES	NO	Disease, symptom, diagnosis, or condition	Details, including whether resolved or not
		Eyes & Ears	
☐	☐	Vision problems	
☐	☐	Color blindness	
☐	☐	Glaucoma	
☐	☐	Recurrent conjunctivitis	
☐	☐	Object in an eye that required removal by a doctor	
☐	☐	Wear or used to wear glasses	
☐	☐	Use of used contact lenses	
☐	☐	Eye Surgery	
☐	☐	Any other vision problem	
☐	☐	Change or loss in hearing	
☐	☐	Any injury to your ears including ruptured ear drum	
☐	☐	Need to wear a hearing aid	
☐	☐	Ringing in the ear (tinnitus)	
☐	☐	Hearing Loss	
☐	☐	Chronic ear infection	
☐	☐	Any other hearing or eye problem	
		Respiratory	
☐	☐	Lung or respiratory disease (e.g., asthma, bronchitis, pneumonia, asbestosis, etc.)	
☐	☐	Shortness of breath, wheezing	
☐	☐	Pneumothorax (collapsed lung)	
☐	☐	Cough, other than with colds, flu or allergies	
☐	☐	Frequent colds	
☐	☐	Chronic sinusitis	
		Cardiac and Vascular	
☐	☐	Heart disease	
☐	☐	Chest Pain	
☐	☐	Shortness of breath	
☐	☐	Hypertension (high blood pressure)	
☐	☐	Circulation problem	
☐	☐	Blood problems or sickle disease	
		Gastrointestinal and Abdomen	
☐	☐	Hepatitis or jaundice	
☐	☐	Fatty liver	
☐	☐	Cirrhosis	
☐	☐	Frequent diarrhea	
☐	☐	Unexplained weight loss or gain	
☐	☐	Gall bladder problems, stones, or surgery	
☐	☐	Hernia	

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Have you ever had, do you now have or are you now being treated for any of the following: *(Continued)*

YES	NO	Disease, symptom, diagnosis, or condition	Details, including whether resolved or not
		Immunity and Infections	
☐	☐	Allergies (food/medicine/mold/dust)	
☐	☐	Tuberculosis (TB)	
☐	☐	Positive TB test	
☐	☐	Immune compromised condition	
		Urinary	
☐	☐	Kidney or bladder problems	
☐	☐	Blood in urine	
☐	☐	Frequent or painful urination	
☐	☐	Prostate problems	
		Musculoskeletal and Arthritis	
☐	☐	Muscle or joint problems, rheumatism, arthritis or bursitis	
☐	☐	Received a joint or tendon injection	
☐	☐	Cervical strain or whiplash	
☐	☐	Back pain or injury	
☐	☐	Back abnormality or scoliosis	
☐	☐	Disc disease, herniation, slipped disc, disc surgery	
☐	☐	Leg or arm problems	
☐	☐	Tendon or ligament problem	
☐	☐	Epicondylitis (tennis elbow)	
☐	☐	Carpal tunnel syndrome	
☐	☐	Leg cramps	
☐	☐	Foot problems, including flat feet, bunions, corns	
☐	☐	Gout	
☐	☐	Amputation	
☐	☐	Bone problems	
☐	☐	Use of any prostheses or medical devices such as artificial limbs, colostomy devices, braces	
		Neurological and Psychological	
☐	☐	Neurological disorder	
☐	☐	Stroke	
☐	☐	Epilepsy, seizures, fainting	
☐	☐	Dizziness, vertigo, or balance problem	
☐	☐	Problems with coordination or loss of coordination	
☐	☐	Frequent, unusual or sever headaches	
☐	☐	Memory loss	
☐	☐	Numbness or loss of sensation or feeling	
☐	☐	Paralysis	
☐	☐	Weakness (generalized or localized)	
☐	☐	Gait (walking) difficulty or change	
☐	☐	Breathing pauses while sleeping, sleep apnea, loud snoring	
☐	☐	Daytime sleepiness	
☐	☐	Mental or emotional illness	
☐	☐	Diagnosis of anxiety disorder or panic disorder	
☐	☐	Suicide attempt	

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Applicant/Employee Name

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Have you ever had, do you now have or are you now being treated for any of the following: *(Continued)*

YES	NO	Disease, symptom, diagnosis, or condition	Details, including whether resolved or not
		Neurological and Psychological *(continued)*	
☐	☐	Hospitalization for psychiatric condition	
☐	☐	Drug or alcohol abuse or treatment for drug or alcohol abuse	
		Skin	
☐	☐	Skin disease, rash, erosion, ulcer, eczema	
☐	☐	Hives or skin allergy	
☐	☐	Skin infection	
☐	☐	Skin cancer	
		Endocrine and Miscellaneous	
☐	☐	Thyroid disease (including heat and cold intolerance)	
☐	☐	Diabetes	
☐	☐	High cholesterol	
☐	☐	Cancer or tumor	
☐	☐	Multiple chemical sensitivity	
☐	☐	Are you currently receiving medical treatment for any condition?	
☐	☐	Other illness or medical condition not listed	
		Work and Occupational	
☐	☐	Do you have any concerns about your health as it relates to the job?	
☐	☐	Do you now receive, or have you ever received, compensation from a government agency for a service-related disability?	
☐	☐	Have you ever received Worker's Compensation for an injury or illness?	
☐	☐	Do you have a claim pending concerning Workers' Compensation?	
☐	☐	Have you ever lost time from work because of a job injury or illness?	
☐	☐	Do you have a permanent impairment or any activity restrictions?	
☐	☐	Have you ever had to leave a job due to a medical problem or due to permanent limitation or restriction?	
☐	☐	Are you unable to perform any particular motion or activity?	
☐	☐	Have you ever had surgery?	
		Medications and Treatments	
☐	☐	Are you currently taking any prescribed medications? *(list them)*	
☐	☐	Do you take any over the counter medications? *(list them)*	
☐	☐	Do you use marijuana or any marijuana-derived products? *(list them)*	

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In addition to or in consideration of the above, do you have any medical disorder or physical impairment which would interfere in any way with the full performance of the duties of the job you are being hired to do, including the applicable items in blocks 3-7?

YES ☐ NO ☐

If yes, describe how the disorder or impairment will interfere with the job duties.

9. Applicant or Employee Consent and Certification

I certify that all of the information I have provided on this form is complete and accurate to the best of my knowledge, and that submitting information that is incomplete, misleading, or untruthful may result in termination, non-selection, criminal sanctions, or delays in processing this form for employment. Furthermore, consistent with the Privacy Act Statement, I authorize the release to my employing agency of all information contained on this examination form and all other forms generated as a result of my examination.

10. Signature of Employee *(Do not print; certified electronic or handwritten signature only)*	11. Date *(Month, Day, Year)*

Part C. EXAMINATION

Only complete portions of examination applicable to the position.

Comments from review of Part B:

TO THE EXAMINING PHYSICIAN: The examinee will have to cope with the job duties, functional requirements, and environmental factors described in Sections 3-6 of this form, and, if box 7 is checked, meet the attached medical standards. Please take these and the medical history recorded in Part B into consideration as you make your examination and report your findings and conclusions. You are not required to examine all of the items listed below. Select and examine or test only those items which are necessary to determine whether the examinee can meet the requirements of the job.

12. Physical Examination Findings

Height	Weight	Blood Pressure	Pulse	Respiratory Rate
_____ Feet _____ Inches	_____ Pounds	_____ / _____ mm/Hg	_____ Beats per minute	_____ Breaths per min.

Temperature: _____ (oral) _____ (forehead) _____ (ear canal)

General appearance: _____

Vision

a. Distant Visual Acuity *(Snellen)*: without corrective lenses: Right (OD) 20 _____ Left (OS) 20 _____ Both (OU) 20 _____
with corrective lenses, if worn: Right (OD) _____ Left (OS) _____ Both (OU) _____

b. Stereopsis: Type of Test: _____ Seconds of Arc: _____ Number of correct: _____ of _____ tested

c. Depth perception: Type of test: _____
Seconds of Arc: _____
Number correct: _____ of _____ tested
Interpretation: ☐ Normal ☐ Abnormal

d. Field of Vision: Right: Nasal _____ degrees; Temporal _____ degrees
Left: Nasal _____ degrees; Temporal _____ degrees

e. Near Visual Acuity *(Snellen)*: without corrective lenses: Right (OD) 20 _____ Left (OS) 20 _____ Both (OU) 20 _____
with corrective lenses, if worn: Right (OD) _____ Left (OS) _____ Both (OU) _____

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Part C. EXAMINATION, Continued
Only complete portions of examination applicable to the position.

f. Color Vision: Is color vision normal: ☐ Yes ☐ No

Tested by:
- ☐ Cone Contrast Test
- ☐ Ishihara Color Plates: Number correct: _____ of _____ plates tested
- ☐ Other color vision test *(describe)* _____
- ☐ Limited color vision test:
  - Method *(describe)* _____
  - Result *(describe)* _____

Can distinguish between red, green, and yellow? ☐ Yes ☐ No

g. Intraocular Pressure: Right (OD): _____ mm HG Left (OS) _____ mm HG

Spirometry FVC _____ L _____ % Predicted FEV_1 _____ L _____ % Predicted FEV_1/FVC _____ % Predicted

h. Hearing

Right auricle, canal, Tympanic Membrane: ☐ Within normal limits ☐ Abnormal Comments: _____

Left auricle, canal Tympanic Membrane: ☐ Within normal limits ☐ Abnormal Comments: _____

Right Ear *(if tested)*: Audiometer reading in decibels *(dB)* for each frequency:

500 Hz	1000 Hz	2000 Hz	3000 Hz	4000 Hz	5000 Hz	6000 Hz

Left Ear *(if tested)*: Audiometer reading in decibels *(dB)* for each frequency:

500 Hz	1000 Hz	2000 Hz	3000 Hz	4000 Hz	5000 Hz	6000 Hz

Nose:	☐ Within normal limits	☐ Abnormal	Comments: _____
Throat:	☐ Within normal limits	☐ Abnormal	Comments: _____
Thyroid:	☐ Within normal limits	☐ Abnormal	Comments: _____
Blood vessels:	☐ Within normal limits	☐ Abnormal	Comments: _____
Chest:	☐ Within normal limits	☐ Abnormal	Comments: _____
Lungs:	☐ Within normal limits	☐ Abnormal	Comments: _____
Heart:	☐ Within normal limits	☐ Abnormal	Comments: _____
Abdomen:	☐ Within normal limits	☐ Abnormal	Comments: _____
Exposed skin:	☐ Within normal limits	☐ Abnormal	Comments: _____
Lymph nodes:	☐ Within normal limits	☐ Abnormal	Comments: _____
Mental status and Affect:	☐ Within normal limits	☐ Abnormal	Comments: _____
Gait:	☐ Within normal limits	☐ Abnormal	Comments: _____
Deep Tendon Reflexes:	☐ Within normal limits	☐ Abnormal	Comments: _____
Balance:	☐ Within normal limits	☐ Abnormal	Comments: _____
Grip Strength:	☐ Within normal limits	☐ Abnormal	Comments: _____
Light touch:	☐ Within normal limits	☐ Abnormal	Comments: _____
Upper extremities:	☐ Within normal limits	☐ Abnormal	Comments: _____
Lower extremities:	☐ Within normal limits	☐ Abnormal	Comments: _____
Neck:	☐ Within normal limits	☐ Abnormal	Comments: _____
Back:	☐ Within normal limits	☐ Abnormal	Comments: _____

Additional findings and required tests, if any, and results of findings:

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Part D. MEDICAL DISPOSITION
To be completed by examining medical provider

13. Determination: List the history and physical findings, if any, that, in your opinion, would limit this person's ability to perform the job duties under the conditions described in Sections 3-7 or would make the examinee a hazard to himself or to others, or that keep you from determining that the person can safely and effectively perform the job. If none, so indicate. (Do not list medical diagnoses. For example, if a job requires full arm range of motion but the examinee has limited elbow range of motion due to rheumatoid arthritis, state that the elbow does not have full range of motion; do not mention rheumatoid arthritis.)

☐ No medical limitations for this job
☐ Disqualified for this job
☐ Limiting or possibly disqualifying findings as follows:

☐ Information available at this time is insufficient to find this person medically qualified as follows:

14. Examining Medical Provider's Name *(Last, First Middle Initial)*	15. E-Mail Address
16. Office Address *(Including Street, City, State and Zip Code)*	17. Telephone Number
18. Signature of Examining Medical Provider	19. Date *(Month, Day, Year)*

After signing, copy the entire form and place or scan into the medical record. Release on request only to the DoD Component Medical Officer Reviewer. Return ALL PAGES plus all supplemental supporting documentation brought by the examinee in a pre-addressed envelope marked "Confidential-Medical" to the Agency/DoD Component Medical Officer Reviewer.

Part E. AGENCY DETERMINATION
To be completed by Agency/DoD Component Medical Officer Reviewer

20. Review the entire form (Parts A through D) obtained from the examining physician and make a determination as to whether the examinationand medical determination appear to be complete and consistent with Federal guidelines and requirements. You are not being asked to comment on the qualifications or competency of the medical examiner, unless it appears to be grossly inadequate.

☐ Examination, findings, and determination appear to be adequate and consistent with Federal guidelines.

☐ Examination, findings, and determination appear to be inadequate or inconsistent with Federal guidelines.

The following items require further description, investigation, or clarification:

☐ Examination, findings, and determination appear to be so inadequate or inconsistent with Federal guidelines that the medical examination and determination should be repeated.

21. Medical Officer Review Name *(Last, First, Middle Initial)*	22. Review Date *(Month, Day, Year)*	23. Phone Number

24. Signature of Agency/DoD Component Medical Officer Reviewer	
25. Address of Review *(Including Street, City, State, and Zip Code)*	26. E-Mail Address

After signing, place or scan the entire form into the medical record. Return ONLY THIS PAGE AND THE FOLLOWING PAGE to Human Resources.

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Part F. To be completed by Agency/DoD Component Human Resources Official

27. Action Taken:

- ☐ Hire
- ☐ Retain
- ☐ Non-Selected for Appointment, or Eligibility Objected To
- ☐ Separate

28. Comments and Notations

29. Human Resources Official Name *(Last, First, Middle Initial)*	30. Date *(Month, Day, Year)*
31. Signature of Human Resources Official	
30. Address *(Including Street, City, State, and Zip Code)*	
33. Telephone Number	34. E-Mail Address

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