

CERTIFICATE OF MEDICAL EXAMINATION
U.S. OFFICE OF PERSONNEL MANAGEMENT

Privacy Act Statement

Solicitation of this information is 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; and Section 3312 of Title 5 United States Code, regarding waiver of physical qualifications for preference eligibles. This form is used to collect medical information about individuals who are incumbents of positions in the Federal Government which require physical fitness testing and medical examinations, or individuals who have been selected for such a position contingent upon successful completion of physical fitness testing and medical examinations as a condition of their employment. The primary use of this information will be to determine the nature of a medical or physical condition that may affect safe and efficient performance of the work described. Additional potential routine uses of this information include using it to ensure fair and consistent treatment of employees and job applicants, to adjudicate requests to pass over preference eligibles, or to adjudicate claims of discrimination under the Rehabilitation Act of 1973, as amended. Completion of this form is voluntary; however, failure to complete the form may result in no further consideration of an applicant, or a determination that an employee is no longer qualified for his or her position. In addition, incomplete, misleading, or untruthful information provided on the form may result in delays in processing the form for employment, termination of employment, or criminal sanction.

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. Send comments regarding our estimate or any other aspect of this form, including suggestions for reducing completion time, to the U.S. Office of Personnel Management (OPM), Employee Services, Recruitment and Hiring, Hiring Policy, Attn: OMB Number (3206-0250), 1900 E Street, NW, Washington, D.C. 20415. The OMB number, 3206-0250, is currently valid. OPM may not collect this information, and you are not required to respond, unless this number is displayed.

Instructions

There are five parts in this form:

- Part A** - To be completed by applicant or employee. 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 B** - To be completed by the appointing officer before the medical examination: identifies the purpose of the examination; the position title, series and grade; generally describes the position; and shows the specific functional requirements and environmental factors that the work requires.
- Part C** - To be completed and signed by the examining physician, and returned to the employing agency in the pre-paid/pre-addressed "Confidential-Medical" envelope provided. Access to protected health information may be restricted to the agency medical officer in accordance with existing and applicable legal requirements.
- Part D** - To be completed by the agency medical officer who reviews the examination results and recommends action. Upon completion of Part D, an agency medical officer forwards Parts A, B, D and E to the agency human resources officer. A copy of the entire form, to include Part C, is retained in the medical record.
- Part E** - To be completed by the agency human resources officer in order to document the personnel action that is rendered. If the examining physician/physician assistant/nurse practitioner or reviewing agency medical officer requires additional space, he/she may add a page titled "See attached continuation with heading 'OF-178 Attachment: Worker Name _____; Date: _____'", and create the attachment.

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Part A. TO BE COMPLETED BY APPLICANT OR EMPLOYEE

1. Name (Last, First, Middle Initial)

2. Federal Employee Number

3. Sex

☐ Male

☐ Female

4. Birth Date (month, day, year)

5. Do you have any medical disorder or physical impairment which may interfere in any way with the full performance of duties shown in Part B, Number 3?

☐ Yes ☐ No

(If your answer is YES, explain in writing below, and verbally explain to the physician performing the examination)

6. Address (including City, State, Zip Code)

7. E-mail Address

8. Telephone Numbers (with Area Code)

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, 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 direct result of my examination.

10. Signature (Do not print)

11. Date (month, day, year)

Part B. TO BE COMPLETED BEFORE EXAMINATION BY APPOINTING OFFICER

1. Purpose of examination

☐ Pre-placement

☐ Other (Specify) _____

2. Position Title, Series, and Grade

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

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Part B. CONTINUED - TO BE COMPLETED BEFORE EXAMINATION BY APPOINTING OFFICER

4. Check the box for each functional requirement in section 4a and each environmental factor in section 4b essential to the duties of this position. List any additional essential factors in the blank spaces. Provide complete reference to applicable medical standards and requirements in Block 4a and ensure the examining physician/physician assistant/nurse practitioner has immediate and complete access to these materials when performing this assessment. If the position involves law enforcement, air traffic control, or firefighting, attach the specific medical standards for the information of the examining physician.

4a. Functional Requirements

- | | | |
|--|---|--|
| <input type="checkbox"/> Heavy lifting, 45 pounds and over | <input type="checkbox"/> Repeated bending (<u> 2 </u> hours) | <input type="checkbox"/> Both eyes required |
| <input type="checkbox"/> Moderate lifting, 15-44 pounds | <input type="checkbox"/> Climbing, legs only (<u> </u> hours) | <input type="checkbox"/> Depth perception |
| <input type="checkbox"/> Light lifting, under 15 pounds | <input type="checkbox"/> Climbing, use of legs and arms | <input type="checkbox"/> Ability to distinguish basic colors |
| <input type="checkbox"/> Heavy carrying, 45 pounds and over | <input type="checkbox"/> Both legs required | <input type="checkbox"/> Ability to distinguish shades of colors |
| <input type="checkbox"/> Moderate carrying, 15-44 pounds | <input type="checkbox"/> Operation of crane, truck, tractor, or motor vehicle | <input type="checkbox"/> Hearing (aid may be permitted) |
| <input type="checkbox"/> Light carrying, under 15 pounds | <input type="checkbox"/> Ability for rapid mental and muscular coordination simultaneously | <input type="checkbox"/> Hearing without aid |
| <input type="checkbox"/> Straight pulling (<u> 0 </u> hours) | <input type="checkbox"/> Ability to use and desirability of using firearms | <input type="checkbox"/> Specific hearing requirements (specify) |
| <input type="checkbox"/> Pulling hand over hand (<u> </u> hours) | <input type="checkbox"/> Near vision correctable at 13" to 16" to Jaeger 1 to 4 | Other (specify) |
| <input type="checkbox"/> Pushing (<u> 0 </u> hours) | <input type="checkbox"/> Far vision correctable in one eye to 20/20 and to 20/40 in the other | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Reaching above shoulder | <input type="checkbox"/> Specific visual requirement (specify) | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Use of fingers | | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Both hands required | | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Walking (<u> 3 </u> hours) | | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Standing (<u> 4 </u> hours) | | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Crawling (<u> 0 </u> hours) | | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Kneeling (<u> 0 </u> hours) | | <input type="checkbox"/> _____ |

4b. Environmental Factors

- | | | |
|---|---|--|
| <input type="checkbox"/> Outside | <input type="checkbox"/> Electrical energy | <input type="checkbox"/> Working alone |
| <input type="checkbox"/> Outside and inside | <input type="checkbox"/> Slippery or uneven walking surfaces | <input type="checkbox"/> Protracted or irregular hours of work |
| <input type="checkbox"/> Excessive heat | <input type="checkbox"/> Working around machinery with moving parts | Other (specify) |
| <input type="checkbox"/> Excessive cold | <input type="checkbox"/> Working around moving objects or vehicles | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Excessive humidity | <input type="checkbox"/> Working on ladders or scaffolding | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Excessive dampness or chilling | <input type="checkbox"/> Working below ground | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Dry atmospheric conditions | <input type="checkbox"/> Unusual fatigue factors (specify) | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Excessive noise, intermittent | | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Constant noise | <input type="checkbox"/> Working with hands in water | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Dust | <input type="checkbox"/> Explosives | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Silica, asbestos, etc. | <input type="checkbox"/> Vibration | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Fumes, smoke, or gases | <input type="checkbox"/> Working closely with others | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Solvents (degreasing agents) | | |
| <input type="checkbox"/> Grease and oils | | |
| <input type="checkbox"/> Radiant energy | | |

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Part C. TO BE COMPLETED BY EXAMINING PHYSICIAN/PHYSICIAN ASSISTANT/NURSE PRACTITIONER. Final examination results must be reviewed and certified by the Agency Medical Officer.

NOTE TO EXAMINING PHYSICIAN: The person you are about to examine will have to cope with the functional requirements and environmental factors checked in Part 4 of this form. Please take these, and the brief description of the job duties, into consideration as you make your examination and report your findings and conclusions.

1. Height _____ Feet, _____ Inches. Weight: _____ Pounds.

2. Eyes:

a. Distant vision (Snellen): without corrective lenses: right 20 left 20 ; with corrective lenses, if worn; right 20 left 20

b. Depth perception Type of test: _____
_____ Seconds of Arc

Number correct: _____ of _____ tested

Interpretation ☐ Normal ☐ Abnormal

c. Peripheral vision Right Nasal _____ degrees Temporal _____ degrees
Left Nasal _____ degrees Temporal _____ degrees

d. 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

The President may -

(1) prescribe such regulations for the admission of individuals into the civil service in the executive branch as will best promote the efficiency of that service; (2) ascertain the fitness of applicants as to age, health, character, knowledge, and ability for the employment sought; and (3) appoint and prescribe the duties of individuals to make inquiries for the purpose of this section.

(Title 5 U.S. Code 3301)

without corrective lenses:

L _____ in. to _____ in.

R _____ in. to _____ in.

with corrective lenses, if used:

L _____ in. to _____ in.

R _____ in. to _____ in.

e. Color vision:

Is color vision normal by Ishihara or other color plate test? ☐ Yes ☐ No

If not, can applicant pass lantern test? ☐ Yes ☐ No

Can see red/green/yellow? ☐ Yes ☐ No

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3. Ears: (Include certified audiogram results with the examination package).

Right Ear _____; Left Ear _____
20 ft. 20 ft.

4. Other Findings: Describe any abnormality (including diseases, scars, and disfigurements). Include brief pertinent history. If normal, so indicate.

- a. Eyes, ears, nose, and throat (including tooth and oral hygiene)
- b. Abdomen
- c. Head and back (including face, hair, and scalp)
- d. Peripheral blood vessels
- e. Speech (note any malfunction)
- f. Extremities (including strength, range of motion)
- g. 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)

- I. Neurological (including reflexes, sensation) and mental health

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5. Conclusions: Summarize below any medical findings that in your opinion, would limit this person's ability to perform these job duties or make them a hazard to themselves or others. If none, so indicate.

- ☐ No limiting conditions for this job
- ☐ Limiting conditions as follows:

6. Examining Physician's Name

7. E-Mail Address

8. Address (Including Street, City, State and ZIP Code)

9. Telephone Number

10. Signature of Examining Physician

11. Date (Month, Day, Year)

IMPORTANT: After signing, return the entire form intact in the pre-addressed "Confidential-Medical" envelope which the person you examined gave you.

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FOR AGENCY USE ONLY

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.

1. Recommendation:

- ☐ Medically Qualified
- ☐ Medically Qualified if restrictions accommodated (list restrictions)
- ☐ Medically Disqualified

2. Agency Medical Officer's Name	3. E-Mail Address
4. Address (Including Street, City, State and ZIP Code)	5. Telephone Number
6. Signature of Agency Medical Officer	7. Date (Month, Day, Year)

FOR AGENCY USE ONLY

Part E. TO BE COMPLETED BY AGENCY HUMAN RESOURCES OFFICER

1. Action Taken:

- ☐ Hired or Retained
- ☐ Non-Selected for Appointment, or Eligibility Objected To
- ☐ Action Taken to Separate

2. Agency Human Resources Officer's Name	3. E-Mail Address
4. Address (Including Street, City, State and ZIP Code)	5. Telephone Number
6. Signature of Agency Human Resources Officer	7. Date (Month, Day, Year)