





## FOR AGENCY USE ONLY

<b>Part B. TO BE COMPLETED BEFORE EXAMINATION BY APPOINTING OFFICER</b>			
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 <i>(If your answer is YES, explain fully to the physician performing the examination)</i>		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.  _____ <i>(Signature of applicant)</i>	

### 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  _____ <i>(signature)</i> _____ <i>(date)</i>
2. ADDRESS (including ZIP Code)	<b>IMPORTANT:</b> After signing, return the entire form intact in the pre-addressed "Confidential-Medical" envelope which the person you examined gave you.