Medical Surveillance Clearance by Outside Provider
Ordnance Handler (OH) / High Pressure (HP) / Crane Operator / Forklift

Employee Name:		**Examination Date:**
Date of Birth:	**Job Title:**	**Job Location and Employer**

I have personally seen and examined the patient in accordance with NASA Procedural Requirement NPR 1800.1E, NASA Occupational Health Program Procedures, Appendix C and reviewed my findings.

I certify that_____is medically cleared to work as an **(PLEASE CIRCLE); Ordnance Handler/ High Pressure/ Crane Operator/ Forklift.**

Provider Name and Degree (Printed):_____Phone:_____

Street Address:_____City_____State_____Zip Code_____

Provider's Signature*:_____ Date_____

*Only signatures of Doctor of Medicine, Doctor of Osteopathic, Nurse Practitioner, or Physician Assistant licensed to practice in the United States will be accepted. ***Please document your findings in the attached form in addition to your clinical note to ensure all requirements are met.***

Ordnance Handler (OH)		**High Pressure System Operator**	
Reference	NAVMED P-117, section 15-107 ANSI/AIAA G-095 29 CFR § 1910.119	Reference	Directive NO. GPR 8710.3D; 360-PG-8710.0.2A
Frequency	1. Baseline evaluation 2. Every 2 years evaluation (Biennial)	Frequency	1. Baseline evaluation 2. Every 2 years evaluation (Biennial)
Laboratory	1. Audiogram 2. Visual acuity 3. Depth perception 4. Color perception (as related to specific job) 5. Urinalysis (dipstick) 6. Discretionary tests a. ECG b. CBC c. Blood chemistry panel d. Chest X-ray e. Pulmonary function	Laboratory	1. Audiogram: Hearing loss in better ear less than 40dB at 500, 1,000, 2000, with or without a hearing aid 2. Visual Acuity: 20/40 with or without corrective lenses 3. Visual Fields at least 70 degrees in each eye 4. Discretionary Tests: a. ECG b. urinalysis (dipstick)
Physical Exam	1. Medical and occupational history to ascertain any condition that may cause any sudden incapacitation or inability to perform duties, tendencies to seizures, dizziness, claustrophobia, loss of physical control, or similar undesirable conditions. 2. Physical examination focusing on strength, endurance, agility, coordination, adequate visual acuity and hearing, and emotional stability.	Physical Exam	1. Occupational and Medical History 2. Physical Examination with focus on assessing any condition affecting vision and/or hearing that may cause any sudden incapacitation or inability to perform duties, tendencies to seizures, loss of physical control, or similar undesirable conditions.
Written Opinion	Job certification with any limitations	Written Opinion	Job Certification with any limitations or referrals for additional specialized clinical evaluation or testing
Employee Counseling	Counseling on evaluation results and conditions of increased risk.		

Medical Surveillance Clearance by Outside Provider

Crane Operator

Note: Includes ground floor, remote operation, high, cabin, pulpit cranes

Reference	NASA STD 8719.9 ASME B30.3 and B30.5 29 CFR § 1926.1427 29 CFR § 1910.178
Frequency	1. Baseline evaluation 2. Every 3 years evaluation
Laboratory	1. Audiogram: Hearing threshold average in better ear <40dB (500, 1000, 2000Hz) 2. Visual acuity: Minimum of 20/40 Snelling in each eye without correction or separately corrected to 20/40 Snellen in both eyes with or without corrective lenses 3. Depth perception 4. Field of Vision at least 70 degrees in horizontal median in each eye 5. Color vision: recognize and distinguish between red, yellow, and green. 6. Discretionary tests a. ECG b. Urinalysis (dipstick) c. Pulmonary function d. Hgb and Hct e. Hemoglobin A1c (HbA1c)
Physical Exam	Complete examination 1. History to ascertain any condition that may cause any sudden incapacitation or inability to perform duties. 2. Evaluation for reaction time, manual dexterity, and coordination 3. No tendencies to seizures, dizziness, claustrophobia, sudden incapacitation, loss of physical control, or similar undesirable conditions such as insulin-controlled diabetes 4. No evidence of physical defects, or emotional instability, that in the opinion of the examiner, would present a hazard to self or others
Written Opinion	1. Equipment/machinery operation certification with or without limitations or restrictions 2. The Center's evaluating provider will review: a. The examination and laboratory results b. Any required documentation from the employee's treating physician or referred specialist. i. Insulin-treated diabetics will provide documentation from their treating physician or provider describing their current condition severity and stability, treatment, and complications. ii. The required elements are detailed in the Insulin-Treated Diabetes Medical Assessment checklist (Medical Surveillance and Certification Examinations) and the information can be provided via the template or any documentation format. c. Any letters from the employee's supervisor 3. For persons not meeting medical certification requirements, OCHMO will review waiver requests.
Employee Counseling	Counseling on evaluation results and conditions of increased risk.

Medical Surveillance Clearance by Outside Provider

Forklift, Powered Industrial Truck, and High Lift Industrial Truck Operator

Note: Includes other devices (e.g., Mobile Elevated Work Platforms {MEWPs}) as referenced in NASA STD 8719.9, Section 10, unless otherwise covered by another certification exam (e.g., Crane, Table C3-4 or Motive (Heavy) Equipment, Table C3-12)

Reference	NASA STD 8719.9; 29 CFR 1910.67; 29 CFR 1910.178; Standard Interpretation of 1910.178, Disabled (vision impaired) forklift operators; Standard Interpretation of 1910.178(l)(1)(i), Disabled (hearing impaired) forklift operators; ANSI B56.1-1969
Frequency	1. Preplacement/Baseline evaluation 2. Every 2 years evaluation (Biennial))
Laboratory	1. Audiogram: Hearing threshold average <40 dB in better ear (at 500, 1000, 2000 Hz) 2. ECG: at baseline, then as clinically indicated. 3. Visual acuity: minimum of 20/40 in each eye without correction or separately corrected to 20/40 in each eye. 4. Depth Perception 5. Gross visual fields: minimum 70 degrees in each eye 6. Color vision: recognize and distinguish between red, yellow, and green. 7. Urine dipstick, to include glucose. 8. Additional tests, as clinically indicated. a. Chest x-ray b. Pulmonary function tests c. Blood chemistry panel d. CBC e. HbA1c
Physical Exam	1. Occupational and medical history 2. Physical exam with focus on assessing any condition affecting vision or hearing or that may cause any sudden incapacitation or inability to perform duties. 3. Evaluation of reaction time, manual dexterity, and coordination
Written Opinion	1. Equipment/machinery operation certification with or without limitations or restrictions 2. The Center's evaluating provider will review: a. The examination and laboratory results b. Any required documentation from the employee's treating physician or referred specialist. i. Insulin-treated diabetics will provide documentation from their treating physician or provider describing their current condition severity and stability, treatment, and complications. ii. The required elements are detailed in the Insulin-Treated Diabetes Medical Assessment checklist (Medical Surveillance and Certification Examinations) and the information can be provided via the template or any documentation format. c. Any letters from the employee's supervisor 3. For persons not meeting medical certification requirements, OCHMO will review waiver requests.
Employee Counseling	Counseling on evaluation results and conditions of increased risk.

Medical Surveillance Clearance by Outside Provider

Employee Instructions:

Please sign and complete pages 4 and 5 prior to your examination with your physician.

Privacy Act Notice

NASA Goddard GSFC and Wallops WFF Health Units

The collection of this information is authorized by 29 U.S.C. § 668. and 5 U.S.C. §7901. The primary use of this information is by NASA Health Unit Personnel for treatment and diagnostic services. Other routine uses of this information may be; to the Department of Labor for compensation claims regarding a job-related injury or illness; to a State unemployment compensation office regarding a claim; to Federal Life Insurance or Health Benefits carriers regarding a claim; to a Federal, State or local law enforcement agency when your agency becomes aware of a possible violation for civil or criminal law; to a Federal agency conducting an investigation on you for employment or security reasons; to respond to requests from a judicial or administrative body where this information is relevant to the subject matter involved in the pending judicial or administrative proceeding; and any other uses specified in the Office of Personnel Management's Employee Medical File System Records Notice published yearly in the Federal Register.

Your disclosure of the requested information including submissions of you Social Security number is voluntary. However, failure to supply all the requested information may affect the services provided to you. If the health services you request pertain to job- related clearances, and you decline to participate, you should consult with your supervisor. The absence of documented medical clearances in you file may impact your employer's authority to permit you to perform certain functions of your position.

Employee Printed Name_____

Signature_____Date _____

Medical Surveillance Clearance by Outside Provider

Employee Name:		**Today's Date:**
Date of Birth:	**Job Title:**	**Job Location, Employer**

Sex: ☐ Male ☐ Female

Check One: ☐ American Indian/AK Native ☐ White (non-Hispanic) ☐ Hispanic ☐ Black ☐ Asian ☐ Pacific Islander

Allergies:

Medications: List ALL medications (including prescription, non-prescription, vitamins, and herbal preparations) you are currently taken:

Social History: **Have you ever used tobacco?** ☐ Yes ☐ Currently ☐ No Vape/ Cigar/ chewing/ e-cig

Average Alcohol consumption per week_____drinks

Hospitalizations/ Surgeries; ☐ Yes (List year and Reason) ☐ No

Medical History: Which of the following conditions have you had?

☐ ☐Diabetes	☐ Migraines	☐ Chest Surgery	☐ Herniated Disc	☐ Silicosis
☐ Hepatitis	☐ Seizures	☐ Chronic Bronchitis	☐ High Blood Pressure	☐ Trouble Smelling Odors
☐ Claustrophobia	☐ kidney diseases	☐ Thyroid Condition	☐ Anemia	☐ Emphysema
☐ Pneumonia	☐ Asbestosis		☐ Head Injury	☐Positive TB Skin Test
☐ Asthma	☐Heart Attack	☐ Prostrate Problems	☐ Broken Bones	☐Heart Murmur ☐ Ruptured Ear Drum

☐ Loss of Consciousness ☐ Other (Specify)

Leisure Activities: In which of the following hobbies/activities do you participate?

☐ Painting ☐ Ceramics /Pottery ☐ Guns/ Hunting ☐ Aerobic Activity (List types and frequency) ☐ Gardening
☐ Refinishing ☐ Stained Glass ☐ Auto / Boat Repair ☐ Power Tool Usage ☐ Strength / Weight Training
☐ Yes ☐ Light ☐ Moderate ☐ Heavy Do you use safety equipment when you engage in these activities?
☐ Yes ☐ No Frequency_____times/week_____

Occupational History

Briefly describe the activities of your current job:
How long have you been doing this type of work?_____years
Have you ever been off work more than a day or been placed on limited or restricted duty because of work related illness or injury? ☐ Yes ☐ No
If yes, describe_____
Have you ever changed jobs due to health problems? ☐ Yes ☐ No
If yes describe_____
If this is your baseline examination list all outside and previous jobs starting with the one before your current job:
Company_____**Dates of Employment**_____**Job Duties Specific Hazards**_____

Current Physical Condition: Which have been a problem over the last year? I

General: ☐ Fever >100 ☐ **S**hivering/Chills ☐ Generalized Weakness ☐ Unexplained Weight Loss/gain ☐ Excessive Fatigue ☐ **S**wollen Glands ☐ Loss of appetite.

Eyes: ☐ **C**hange in Vision ☐ Itching ☐ Tearing

Ears, Nose, Throat: ☐ Difficulty Hearing ☐ Ringing/Buzzing ☐ Sinus Trouble ☐ Congestion ☐ Sneezing/runny Nose ☐ Nosebleeds ☐ Difficulty swallowing.

Heart / Lungs: ☐ Chest pain or pressure ☐ Irregular Heartbeat ☐ Palpitations/Skipped Beats ☐ New or changed cough ☐ Wheezing ☐ Shortness of breath.

Digestive System: ☐ Nausea / Vomiting ☐ Diarrhea / Constipation ☐ Yellow Jaundice ☐ Rectal Bleeding or Black Tarry Stools

Neurologic / Psychiatric: ☐ Headaches ☐ Dizziness / Passing out ☐ Depression ☐ Numbness or Tingling ☐ Excessive Anxiety ☐ Insomnia ☐ Loss of memory.

Skin/ Musculoskeletal: ☐ Rashes ☐ Moles that changed color/size ☐ Muscle/ Back /Neck Pain ☐ Weakness in Arms /leg ☐ Joint Pain

Genitourinary / Reproductive: ☐ Difficult or Painful Urination ☐ Blood in Urine ☐ Difficulty Having Children
Males: ☐ Lump in Testicle ☐ Impotence.
Females: ☐ Irregular Periods / Spotting ☐ Miscarriage or Stillborn Pregnancy ☐ Brest Lump / Discharge ☐ Pregnant

I certify that all the information I have provided on this page is complete and accurate to the best of my knowledge.

Signature of Employee:_____Date: _____

Medical Surveillance Clearance by Outside Provider

Employee Name:	Email:	Examination date:
Date of Birth:	**Job Title:**	**Job Location, Employer:**

*Medical Examination to be conducted NASA Procedural Requirement NPR 1800.1E, NASA Occupational Health Program Procedures, Appendix C (see page 1):

Occupational Physical Examination - please mark all areas evaluated and provide comments for any negative responses.

Purpose: ☐ Baseline Examination ☐ 1 yrs. (Annual) ☐ 2 yrs. (Biennial) ☐ 3 yrs. (Triennial)

Examination: (All test results must be listed)

1. **Vital Signs: Height_____(in) Weight_____(lbs.) Blood Pressure_____Pulse_____Temp_____BMI_____**

2. **Audiogram: (Left) 500 Hz:_____ 1000 Hz: _____ 2000 HZ: _____ (Right) 500 Hz: _____ 1000 Hz: _____ 2000Hz: _____**

3. **Best Vision: Testing Method: ☐ Screening Machine ☐ Wall/ Handheld Chart**

   ☐ Uncorrected ☐ With correction: ☐ Contacts ☐ Glasses

Near:	**OU (both) 20/_____**	**OU (both) 20/_____**
	OD (right) 20/_____	**OD (right) 20/_____**
	OS (left) 20/_____	**OS (left) 20/_____**
Far:	**OU (both) 20/_____**	**OU (both) 20/_____**
	OD (right) 20/_____	**OD (right) 20/_____**
	OS (left) 20/_____	**OS (left) 20/_____**

4. **Depth Perception: (test type and results)_____Seconds of arc: _____**

5. **Color Perception: (test used)_____Number correct:_____of_____tested Employee identify (Red/Green/Yellow) (☐ Yes / ☐ No)**

6. **Monocular vision: ☐ Yes / ☐ No**

7. **Field of Vision: Right Temporal ° ☐ _____Nasal ° ☐ _____ Left Temporal ° ☐ _____ Nasal ° ☐ _____**

8. **Urinalysis (dipstick): Specific gravity: _____ Protein _____ Glucose: _____ Blood: _____ Other: _____**

History and Physical Examination:

9. **Medical History:**
   History of seizures, sudden capacitation, dizziness, claustrophobia, loss of physical control, or similar undesirable conditions such as insulin-controlled diabetes, or emotional instability or physical defects or conditions, which in the opinion of the examiner could render the employee ineffective or a hazard to oneself, others, or the equipment operated: _____

10. **Examination:**
    Concerns regarding strength, endurance, agility, coordination, adequate visual acuity and hearing, emotional stability, dexterity, and react speed consistent with normal, healthy physiology and task at hand: _____

Discretionary Test:

- ECG: _____
- Complete Blood Count (CBC) _____
- Blood Chemistry Profile: _____
- Chest X-Ray: _____
- Pulmonary Function: _____
- Stress Test: _____

Job Limitations or Concerns:

EMPLOYEES - PLEASE RETURN COMPLETED FORM TO:

NASA WFF Health Unit
Code 250, Building F-160
34200 Fulton Street
Wallops Island, VA 23337
Phone: 757-824-1266
Fax 757-824-1497
Email: gsfc-WFFHealthUnit.mail.nasa.gov

NASA Goddard GSFC Health Unit
800 Greenbelt Rd, Building 97
Mail Stop code 250
Greenbelt, MD 20771
Phone: 301-286-6666
Fax: 202-256-9801
Email: gsfc-gbhealthunit@mail.nasa.gov