# Medical Surveillance Clearance by Outside Provider

## NASA NPR 1800.1E

| 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_____under the NASA 1800.1E requirements.

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.***

### 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:**

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