

Ordnance Handler (OH) / Lifting Devices and Equipment Handler (LDE)/ High Pressure



Systems Operator (HP) Medical Surveillance Clearance by Outside Provider

Employee Name:		Examination Date:
Date of Birth:	Job Title:	Job Location:

I have personally seen and examined the patient in accordance with NASA Procedural Requirement NPR 1800.1, NASA Occupational Health Program Procedures, Appendix C (OH or LDE) or 500-PG-8710.3.1 (HP) and reviewed my findings.

I certify that _____ is medically cleared to work as an Ordnance Handler and or Lifting Devices and Equipment Operator (LDE) and or High Pressure Systems Operator (HP) (circle those that apply) and physically qualified to work.

Provider Signature*: _____ Date: _____

Providers Name and Degree (Print) : _____ Phone: _____

Street Address: _____ City _____ State _____ Zip code _____

*Only signatures of Doctor of Medicine, Doctor of Osteopathic Medicine, Nurse Practitioner, or Physician's Assistant licensed to practice in the United States will be accepted.

Lifting Devices and Equipment Handler (LDE)	
Source	NPR 1800.1, NASA Occupational Health Program Procedures, Appendix C, Crane Operators/Riggers Note: Includes ground floor, remote operation, high, cabin, pulpit
Frequency	1. Baseline Examination 2. Every 2 years
Laboratory	4. Audiogram: Hearing threshold average in better ear \leq 40 dB (500, 1,000, 2000 Hz) 5. Visual Acuity: Minimum of 20/40 Snellen in each eye without correction or separately corrected to 20/40 Snellen in both eyes with or without corrective lenses 6. Depth Perception 7. Field of Vision at least 70 degrees in the horizontal median in each eye 8. Color Vision 9. Discretionary Tests: a. ECG b. Urinalysis c. Pulmonary Function d. Hemoglobin (Hgb) and Hematocrit (Hct) e. HbA1C (discretionary)
Physical Exam	1. History to ascertain any condition that may cause any sudden incapacitation or inability to perform duties. 2. Evaluation of 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	Job Certification with any limitations or referral for further testing.

Ordnance Handler	
Source	NPR 1800.1, NASA Occupational Health Program Procedures, Appendix C, Ordnance Handler
Frequency	1. Baseline Examination 2. Every 2 years
Laboratory	1. Audiogram 2. Visual Acuity 3. Depth Perception 4. Color Perception (as related to specific job requirements) 5. Urinalysis (dipstick) 6. Discretionary Tests: • ECG • Complete Blood Count (CBC) • Blood Chemistry Profile • Chest X-ray • Pulmonary Function
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
Written Opinion	Job Certification with any limitations

High Pressure Systems Operator	
Source	500-PG-8710.3.1 High Pressure Systems Operator Certification
Frequency	1. Biennial
Laboratory	1. Audiogram: Hearing loss in better ear less than 40 dB 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
Written Opinion	Job Certification with any limitations

For WFF Health Unit Use

The results of the physical performed by the employee's medical provider has been reviewed in accordance with the most current version of NPR 1800.1 Appendix C

Stamp _____ Date _____

Ordnance Handler (OH) / Lifting Devices and Equipment Handler (LDE) /



High Pressure Systems Operator (HP) Physical by Outside Provider

Employee Instructions:

Please sign and complete pages 2 and 3 prior to your examination with your physician.

Privacy Act Notice NASA Wallops Health Unit

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 of 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 _____

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High Pressure Systems Operator (HP) Physical by Outside Provider

Employee Name: _____ Today's Date: _____

Date of Birth: _____ Job Title: _____ Job Location: _____

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

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

Social History: Have you ever used tobacco? Yes Currently No Average alcohol consumption per week _____ drinks

Hospitalizations and Surgeries: Yes (List year and Reason) No

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

<input type="checkbox"/> Allergies: (List) _____	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Migraines
<input type="checkbox"/> Anemia	<input type="checkbox"/> Emphysema	<input type="checkbox"/> Pneumonia
<input type="checkbox"/> Asbestosis	<input type="checkbox"/> Head Injury	<input type="checkbox"/> Positive TB Skin Test
<input type="checkbox"/> Asthma	<input type="checkbox"/> Heart Attack	<input type="checkbox"/> Prostrate Problems
<input type="checkbox"/> Broken Bones	<input type="checkbox"/> Heart Murmur	<input type="checkbox"/> Ruptured Ear Drum
<input type="checkbox"/> Cancer: (List) _____	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Seizures
<input type="checkbox"/> Chest Surgery	<input type="checkbox"/> Herniated Disc	<input type="checkbox"/> Silicosis
<input type="checkbox"/> Chronic Bronchitis	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Trouble Smelling Odors
<input type="checkbox"/> Claustrophobia	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Thyroid Condition
<input type="checkbox"/> Collapsed Lung	<input type="checkbox"/> Loss of Consciousness	<input type="checkbox"/> Other (Specify) _____
<input type="checkbox"/> Denture Use	<input type="checkbox"/> Mental Health Disorders	_____

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

<input type="checkbox"/> Painting	<input type="checkbox"/> Ceramics /Pottery	<input type="checkbox"/> Guns / Hunting	<input type="checkbox"/> Aerobic Activity (List types and frequency) _____
<input type="checkbox"/> Gardening	<input type="checkbox"/> Refinishing	<input type="checkbox"/> Stained Glass	_____
<input type="checkbox"/> Auto / Boat Repair	<input type="checkbox"/> Power Tool Usage	<input type="checkbox"/> Strength / Weight Training <input type="checkbox"/> Yes <input type="checkbox"/> Light <input type="checkbox"/> Moderate <input type="checkbox"/> Heavy	Frequency _____ times/week

Do you use safety equipment when you engage in these activities? Yes No

Occupational History:
Briefly descr be 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, descr be _____
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? In addition, circle problems which are severe or interfere with work activities.

General: Fever >100 Shivering/Chills Generalized Weakness Unexplained Weight Loss/gain Excessive Fatigue Swollen Glands Loss of Appetite

Eyes: Change 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 Heart Beat 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 /legs 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 of the information I have provided on this page is complete and accurate to the best of my knowledge
Signature of Employee: _____ Date: _____

Ordnance Handler (OH) / Lifting Devices and Equipment Handler (LDE) /



High Pressure Systems Operator (HP) Physical by Outside Provider

Employee Name:	SSN:	Examination Date:
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Date of Birth:	Job Title:	Job Location:
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*Medical Examination to be conducted NASA Procedural Requirement NPR 1800.1, 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 Annual (Ordnance) Biennial (HP) Biennial (LDE)

Examination:

- Vital Signs: Height _____ (in) Weight _____ (bs) Blood Pressure _____ Pulse _____ Temp _____ BMI _____
- Audiogram: _____
- Best Vision: Testing Method: Screening Machine Wall/ Hand Held Chart
 Uncorrected **With correction:** Contacts Glasses
Near: OU (both) 20/____
 OD (right) 20/____
 OS (left) 20/____
Far: OU (both) 20/____
 OD (right) 20/____
 OS (left) 20/____
Near: OU (both) 20/____
 OD (right) 20/____
 OS (left) 20/____
Far: OU (both) 20/____
 OD (right) 20/____
 OS (left) 20/____
- Depth Perception: (test type and results) _____ Seconds of arc: _____
- Color Perception: (test used) _____ Number correct: ____ of ____ tested Sees red/green yellow Yes No Monocular vision Yes No
- Field of Vision: **Right** Temporal _____ Nasal _____ Total _____ **Left** Temporal _____ Nasal _____ Total _____
- Urinalysis (dipstick): _____

History and Physical Examination :

- Medical History:
History of seizures, sudden incapacitation, dizziness, claustrophobia, sudden incapacitation, 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 being operated:

- Examination:
Concerns regarding strength, endurance, agility, coordination, adequate visual acuity and hearing, emotional stability, dexterity, and reaction speed consistent with normal, healthy physiology and the task at hand:

Discretionary Tests: Date: _____ Comments: _____
(Not required unless health or physical exam dictates.)

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

Job Limitations or Concerns:

Please return complete form (both sides) 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: larri.a.gentry@nasa.gov

