

**Special Agent Medical (Preplacement/Incumbent)****Part I - Demographic Data** *(To be completed by special agent/applicant)*

1. Name <i>(Please print or type)</i>	2. Date of Birth	3. Date of Testing	4. Social Security Number	5. Sex <input type="checkbox"/> Male <input type="checkbox"/> Female
6. Home Address		7. Home Telephone Number	8. Work Telephone Number	
9. Field Office	10. Field Office Mailing Address		11. Personal Telephone Number	
12. Current Employer	13. Current Occupation		14. How Long in Current Position? <i>(Years/months)</i>	

**Part II - Medical History** *(To be completed by special agent/applicant. Please check each item yes or no. If yes, please explain)*

15. Have you been refused employment or been unable to hold a job or stay in school due to any medical condition?  Yes  No

16. Have you ever been treated for any mental condition?  Yes  No

17. Have you ever been denied life or health insurance? *(If yes, state reason and provide details.)*  Yes  No

18. Have you had, or been advised to have, any operation?  Yes  No

19. Have you ever been a patient in any type of hospital? *(If yes, specify when, where and give details.)*  Yes  No

20. Have you ever had any illness or injury other than those already noted? *(including learning disabilities and Attention Deficit Disorder (ADD), etc. If yes, specify when, where and give details.)*  Yes  No

21. Have you consulted or been treated by clinics, physicians, healers, or other practitioners within the past 5 years for other than minor illness? *(If yes, give complete address of doctor, hospital, clinic, and give details.)*  Yes  No

22. **Females Only:** Are you currently pregnant? *(If yes, provide trimester. This question relates only to issue of the safe participation in training.)*  
 Yes  No

23. Have you ever been rejected or discharged from military service because of physical, mental condition, or for other reasons? *(If yes, give date, reason and type of discharge: whether honorable, other than honorable, for unfitness or unsuitability.)*  Yes  No

24. Have you ever received, is there pending, or have you applied for pension or compensation for existing disability? *(If yes, specify what kind, granted by whom, what amount, when, and why.)*  Yes  No

25. Have you had or are you currently experiencing any of the following? *(If yes, please explain)*

Blurred vision?  Yes  No

Color blindness?  Yes  No

Glaucoma?  Yes  No

26. Do You? *(If yes, please explain)*

Wear glasses or contact lenses?  Yes  No

Have cataracts?  Yes  No

Have you ever been diagnosed with any eye disease? *(If yes, please explain)*  Yes  No

Have you had any type of eye surgery (i.e., RK, PRK, cataracts, etc.)? (If yes, please explain what specific surgery was performed and the date of surgery.)

Yes  No

27. Have You Experienced Any of the Following? (If yes, please explain below)

Difficulty hearing	<input type="checkbox"/> Yes <input type="checkbox"/> No	Loud, constant noise or music within the last 14 hours	<input type="checkbox"/> Yes <input type="checkbox"/> No
Dizziness	<input type="checkbox"/> Yes <input type="checkbox"/> No	Do you wear a hearing aid?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Loud, impact noise in past 14 hours	<input type="checkbox"/> Yes <input type="checkbox"/> No	Do you use hearing protective equipment?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Are you in a hearing conservation program?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Ankles or feet swelling	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chest pains	<input type="checkbox"/> Yes <input type="checkbox"/> No	Palpitations (rapid or skipped heart beat)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Leg pains	<input type="checkbox"/> Yes <input type="checkbox"/> No	Past history or diagnosis of heart disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Heart murmur	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart attack or stroke	<input type="checkbox"/> Yes <input type="checkbox"/> No
Coronary bypass surgery/other heart surgery	<input type="checkbox"/> Yes <input type="checkbox"/> No	Abnormal treadmill	<input type="checkbox"/> Yes <input type="checkbox"/> No
Abnormal EKG (Resting)	<input type="checkbox"/> Yes <input type="checkbox"/> No	Cold hands or feet when others are comfortable in same room	<input type="checkbox"/> Yes <input type="checkbox"/> No
Numbness in feet/hands	<input type="checkbox"/> Yes <input type="checkbox"/> No	High blood pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No
Phlebitis or blood clots	<input type="checkbox"/> Yes <input type="checkbox"/> No	Problems with breathing, wheezing, persistent cough, /shortness of breath	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bronchitis, tuberculosis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Past history or diagnosis of lung disease or surgery	<input type="checkbox"/> Yes <input type="checkbox"/> No
Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No
Heat/sun stroke	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pituitary gland problem	<input type="checkbox"/> Yes <input type="checkbox"/> No
Thyroid disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Anemia	<input type="checkbox"/> Yes <input type="checkbox"/> No
Blood disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No	Back surgery	<input type="checkbox"/> Yes <input type="checkbox"/> No
Back pain	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tingling in head/hands/legs	<input type="checkbox"/> Yes <input type="checkbox"/> No
Joint pain or swelling	<input type="checkbox"/> Yes <input type="checkbox"/> No	Epilepsy (seizure)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Lack of coordination	<input type="checkbox"/> Yes <input type="checkbox"/> No	Loss of sensation	<input type="checkbox"/> Yes <input type="checkbox"/> No
Tremors/shakiness	<input type="checkbox"/> Yes <input type="checkbox"/> No	Stomach ulcers	<input type="checkbox"/> Yes <input type="checkbox"/> No
Persistent stomach/abdominal pain	<input type="checkbox"/> Yes <input type="checkbox"/> No	Trouble using hip/knee/shoulder	<input type="checkbox"/> Yes <input type="checkbox"/> No
Vomiting blood	<input type="checkbox"/> Yes <input type="checkbox"/> No	Loss of joint/limb movement	<input type="checkbox"/> Yes <input type="checkbox"/> No
Trouble walking	<input type="checkbox"/> Yes <input type="checkbox"/> No	Any limb or finger amputations	<input type="checkbox"/> Yes <input type="checkbox"/> No
Loss of strength/muscle weakness	<input type="checkbox"/> Yes <input type="checkbox"/> No	Gout	<input type="checkbox"/> Yes <input type="checkbox"/> No
Arthritis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Urinary pain/infection/bleeding	<input type="checkbox"/> Yes <input type="checkbox"/> No
Skin problems, urticaria	<input type="checkbox"/> Yes <input type="checkbox"/> No	Localized weakness/numbness	<input type="checkbox"/> Yes <input type="checkbox"/> No
Kidney disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Are you right handed?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Are you left handed?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Blood in stool	<input type="checkbox"/> Yes <input type="checkbox"/> No
Persistent diarrhea/constipation	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hepatitis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Liver disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hernia	<input type="checkbox"/> Yes <input type="checkbox"/> No
Gall bladder problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Feelings of depression	<input type="checkbox"/> Yes <input type="checkbox"/> No
Psychiatric/psychologic consult	<input type="checkbox"/> Yes <input type="checkbox"/> No	Fainting	<input type="checkbox"/> Yes <input type="checkbox"/> No
Periods of nervousness	<input type="checkbox"/> Yes <input type="checkbox"/> No	Syncope	<input type="checkbox"/> Yes <input type="checkbox"/> No
Ringling or buzzing in ears	<input type="checkbox"/> Yes <input type="checkbox"/> No		

Explanation:

28. Your Current Physical Activity or Exercise Program Intensity <input type="checkbox"/> Low <input type="checkbox"/> Moderate <input type="checkbox"/> High	29. Frequency of _____ Days Per Week	30. Duration of _____ Minutes Per Session	31. Activities
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32. Medications (List all medications (prescription and non-prescription) you are currently taking with dosage, frequency and reason.)

33. Allergies (Please check where applicable)

<input type="checkbox"/> None	<input type="checkbox"/> Dust or molds (Specify) _____
<input type="checkbox"/> Drugs (Specify) _____	<input type="checkbox"/> Animals (Specify) _____
<input type="checkbox"/> Pollens (Specify) _____	<input type="checkbox"/> Food (Specify) _____
<input type="checkbox"/> Other (Specify) _____	

**Part III - Social History (To be completed by special agent/applicant)**

34. Have You Ever Smoked? <input type="checkbox"/> Yes <input type="checkbox"/> No	35. If Yes, When? <input type="checkbox"/> Currently <input type="checkbox"/> Past (Number of years since you quit) _____	36. Type <input type="checkbox"/> Cigarette <input type="checkbox"/> Pipe <input type="checkbox"/> Cigar
37. How Many Do or Did You Smoke Per Day?		38. For How Many Years?



6. Uncorrected Vision ( <i>Snellen Units</i> ) Near: Both 20/____ Right 20/____ Left 20/____ Far: Both 20/____ Right 20/____ Left 20/____	7. Corrected Vision ( <i>Snellen Units</i> ) Near: Both 20/____ Right 20/____ Left 20/____ Far: Both 20/____ Right 20/____ Left 20/____
8. Comment on Heent Abnormalities:	

**Part VII - Audiology** (*To be completed by Health Care Provider*)

9. Frequency	500 Hz	1000 Hz	2000 Hz	3000 Hz	4000 Hz	6000 Hz	8000 Hz
Right Ear							
Left Ear							

10. Audiogram:  Baseline  Annual  Termination (*Attach current and baseline audiogram*)

Calibration Method:  Oscar  Biological Date \_\_\_\_\_

Review/Compare With Baseline:  Change  No Change  Normal  Abnormal

<u>Right Ear</u> Canal/External Ear: <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal Tympanic Membrane: <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	<u>Left Ear</u> Canal/External Ear: <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal Tympanic Membrane: <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal
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Comments: \_\_\_\_\_

11. Vital Signs:

Height	Weight	Blood Pressure _____ mm/hg ( <i>sitting</i> )	Pulse _____ ( <i>sitting</i> )	Temperature ( <i>If indicated</i> )
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Comments: \_\_\_\_\_

12. Tuberculosis

Date Administered	Date Read	Degrees of Induration	Date of Last Chest X-ray
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Comments (*Chest X-rays, TB treatment/dates*): \_\_\_\_\_

13. Cardio/Pulmonary:

EKG ( <i>Attach with interpretation</i> ): <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	Lungs/Chest ( <i>includes breast</i> ): <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	Heart ( <i>murmur, palpitations, ectopic beats</i> ): <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	Vascular ( <i>varicosities</i> ): <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal
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Comments: \_\_\_\_\_

14. Pulmonary Function Testing (*Attach copy*):

% Predicted FVC	% Predicted FEV1	% Predicted FEV1/FVC	% Predicted FEF 25 - 75
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Comments: \_\_\_\_\_

**Part VIII - Diagnosis and Physical Findings** *(To be completed by Health Care Provider)*

15. Musculoskeletal

Upper Extremities <i>(strength)</i> : <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	Upper Extremities <i>(range of motion)</i> : <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	Lower Extremities <i>(strength)</i> : <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal
Lower Extremities <i>(range of motion)</i> : <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	Feet <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	Spine <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal
Flexibility <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	Deep Tendon Reflexes <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	Other Neurological <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal

16. Can Applicant Participate in the Following:

Vigorous Aerobic Exercise Program 3 Hr/Wk *(minimum)*    Yes    No     
 Push Ups    Yes    No  
 Pull Ups    Yes    No     
 Sit Ups    Yes    No     
 One and One Half Mile (1.5) Time Run    Yes    No

Comments: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

17. Is Applicant Capable of the Following:

Yes    No   Squat and rise without holding on to any object. Maintain squatting and kneeling for up to 45 seconds repeatedly.  
 Yes    No   Kneel on one knee with arms extended in front of body at eye level for seven (7) seconds.  
 Yes    No   Assume a one and two-knee kneeling position within two (2) seconds and be able to rise without assistance. Be able to repeat twice.  
 Yes    No   Maintain a kneeling position for 2 - 3 minutes repeatedly.

Please Comment on "Cannot Participate" Responses: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal	Mental/Emotional Affect <i>(describe if abnormal)</i>
<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal	G -U System
<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal	Abdomen, Viscera
<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal	Skin <i>(scar/unique markings)</i>
<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal	Lymphatic
<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal	Other _____

Comments: \_\_\_\_\_

**Part IX - Education and Referral** *(To be completed by the Health Care Provider)*

18. Check the Topics Discussed During the Diagnosis Work-up or Physical Exam:

<input type="checkbox"/> Lipids	<input type="checkbox"/> Hypertension	<input type="checkbox"/> Exercise
<input type="checkbox"/> Obesity	<input type="checkbox"/> Smoking Cessation	<input type="checkbox"/> Alcohol Use
<input type="checkbox"/> Hearing Protection	<input type="checkbox"/> Vision Referral	<input type="checkbox"/> Other Personal Protective Equipment
<input type="checkbox"/> Job Stressors	<input type="checkbox"/> Referral(s)	<input type="checkbox"/> Immunizations

**Part X - Examining Physician's Summary of Significant Findings With Recommendations**

**Note:** Please do not provide any official statement *(oral or written)* concerning the applicant's fitness or capability to perform the duties of any occupation. The Agency's Medical Review Officer will provide this statement.

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Examining Physician's Name <i>(Print or type)</i>	Examining Physician's Signature	Date
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When Exam is Complete, UPS Within Two Days To:

**Program Support Center  
U.S. Department of Health and Human Services  
299 Main Street, Suite 446  
Salt Lake City, UT 84111**

**ATF Use Only**

**Action Taken:**

- Hired or Retained  
 Non-selected For Appointment, or Eligibility Objected to  
 Action Taken to Separate

Human Resources Officer's Name <i>(Print or type)</i>	Human Resources Officer's Signature	Date
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**Privacy Act Information**

Executive Order, 9830 and 5 CFR 339.301 authorizes collection of this information. The primary use of this information is to determine medical suitability to qualify for a position that has specific medical standards, physical requirements, or is covered by a medical evaluation program established under these regulations. Furnishing this information is mandatory because such information is part of the basic qualifications for the position. If this information were not provided, the applicant would fail to meet the qualifications for the position.

Additional disclosures of this information may be: To the Department of Labor when processing a claim for compensation regarding a job connected injury or illness; to Federal Life Insurance or Health Benefits carriers regarding a claim; to another Federal agency; to a court, or a party in litigation before a court or in an administrative proceeding when the government is a party or when the agency deems it to be relevant and necessary to the litigation; to a Federal, State, or local law enforcement agency when such agency becomes aware of a violation or possible violation of civil or criminal law; to a Federal agency when conducting an investigation for employment or security reasons; to the General Services Administration in connection with responsibilities for records management.

**Paperwork Reduction Act Notice**

This information collection request is in accordance with The Paperwork Reduction Act of 1995. The purpose of this information is to determine whether or not an applicant is actually qualified for the position. The information will be initially used to make a recommendation on either hiring or not hiring an applicant or retaining an individual in a special agent position.

The estimated average burden associated with this collection of information is 45 minutes per respondent or recordkeeper, depending on individual circumstances. Comments concerning the accuracy of this burden estimate and suggestions for reducing this burden should be addressed to Reports Management Officer, Document Services Branch, Bureau of Alcohol, Tobacco, Firearms and Explosives, Washington, DC 20226.

An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number.