NAME		DATE
ORGANIZATION **Reactor Operations & Engineering (610.01), NCNR, NIST**	FACILITY DOCKET# **50-184**	PURPOSE OF EXAMINATION **NRC-Issued SRO/RO License**
EXAMINING FACILITY OR EXAMINER, AND ADDRESS **NIST HEALTH UNIT, BUILDING-101, ROOM. C-33. 100 BUREAU DRIVE GAITHERSBURG Md. 20899**		

I. MEDICAL HISTORY

A. Check YES box or the NO box for items one through forty.

	YES	NO		YES	NO
1. Frequent or severe headaches	○	⊙	23. Painful or "trick" shoulder, elbow, hip, or knee	○	⊙
2. Dizziness or fainting spells	○	⊙			
3. Diabetes	○	⊙	**24. Foot pain**	○	⊙
4. Thyroid disorder	○	⊙	25. Carpal Tunnel Syndrome	○	⊙
5. Cancer or blood disorder	○	⊙	**26. Tremors or hands shaking**	○	⊙
6. Skin problems	○	⊙	27. Numbness or tingling	○	⊙
7. Cataracts	○	⊙	**28. Unsteadiness**	○	⊙
8. Other eye trouble	○	⊙	29. Paralysis	○	⊙
9. Hearing loss or ringing in the ears	○	⊙	**30. Epilepsy or seizures**	○	⊙
10. Asthma, wheezing, or chronic cough	○	⊙	31. Other neurologic disorder	○	⊙
11. Shortness of breath	○	⊙	**32. Depression or excessive worry**	○	⊙
12. Tuberculosis	○	⊙	33. Excessive fatigue	○	⊙
13. Chest pain or tightness	○	⊙	**34. Loss of memory or amnesia**	○	⊙
14. Palpitations or irregular heart beat	○	⊙	35. Nervous condition which could impair judgment or reliability	○	⊙
15. High blood pressure	○	⊙			
16. Low blood pressure	○	⊙	**36. Claustrophobia**	○	⊙
17. Heart trouble	○	⊙	37. Illegal drug use or drug addiction or excessive alcohol consumption	○	⊙
18. Peptic ulcer	○	⊙			
19. Abdominal pain	○	⊙	**38. Consideration of suicide**	○	⊙
20. Inguinal hernia	○	⊙	39. Use corrective lenses to see	○	⊙
21. Back pain	○	⊙	**40. Hearing impairment requiring use of a hearing aid**	○	⊙
22. Bone, joint, or other deformity	○	⊙			

B. Check the YES box or the NO box for questions 1 through 9.

	YES	NO		YES	NO
1. Are you taking routine medication?	○	⊙	6. Have you ever been arrested or detained for alcohol or drug related charges?	○	⊙
2. Has your work ever been limited or restricted for medical reasons?	○	⊙			
3. Have you ever been seen or evaluated by a psychologist, psychiatrist, or counselor?	○	⊙	**7. Have you ever been hospitalized/admitted with mental health or substance abuse problems?**	○	⊙
4. Have you been diagnosed with any mental condition?	○	⊙	8. Have you been rejected for, or discharge from employment for medical reasons? Have you been rejected for, ordischarged from the military for medicalreasons?	○	⊙
5. Have you ever had drug or alcohol problems?	○	⊙	**9. Have you received, are receiving, or anticipate receiving compensation for a disability?**	○	⊙

C. For any box checked YES in I.A or I.B, provide further details here. "Described *mm/dd/yyyy."*

D. Give a brief description of your present health.

E. I CERTIFY THAT THE FOREGOING INFORMATION SUPPLIED BY ME IS TRUE TO THE BEST OF MY KNOWLEDGE, AND AUTHORIZE THE RESPONSIBLE AUTHORITY TO USE THE INFORMATION ON THIS FORM IN THE EXERCISE OF ITS AUTHORITY OVER THE LICENSING OF OPERATORS .	
SIGNATURE	DATE

II. MEDICAL EXAMINATION

A. GENERAL

Project Task Number	6101110-000	Organizational Code	30-61-0610-01-00-00-00

HEIGHT	WEIGHT	PULSE	

BLOOD PRESSURE

LYING_____SITTING_____STANDING _____

B. CLINICAL

NORMAL	YES	NO	NOTES
1. Vital signs			
2. Head, face, neck			
3. Eyes, general			
4. Ears, general			
5. Ear drums			
6. Nose and sinuses			
7. Mouth and throat			
8. Lungs and chest			
9. Heart			
10. Vascular system			
11. Abdomen and viscera			
12. Endocrine system			
13. G-U system			
14. Upper extremities, strength and range of motion			
15. Feet			
16. Lower extremities, strength, and range of motion			
17. Spine, other musculoskeletal			
18. Skin, lymphatics			
19. Neurologic			
20. Psychiatric, specify any personality deviation			
21. EKG/ECG			
22. Bloodwork			
23. Urinalysis			
24. Pulmonary Function Test / Spirometry			

ADDITIONAL CLINICAL NOTES

Referrals for further evaluation or testing

C. VISION AND HEARING			
1. Vision			
DESCRIPTION	LEFT	RIGHT	METHOD USED
Distant Visual Acuity Uncorrected	20/	20/	
Distant Visual Acuity Corrected	**20/**	**20/**	
Near Visual Acuity Uncorrected	20/	20/	
Near Visual Acuity Corrected	**20/**	**20/**	
Peripheral Vision Degrees			
Stereovision	**PASS**	**FAIL**	
Color Vision	PASS	FAIL	
Notes			
2. Hearing			
FREQUENCY	LEFT	RIGHT	METHOD USED
500 Hz			
1000 Hz			
2000 Hz			
3000 Hz			
Notes			

D. SPECIFIC RESULTS AND PHYSICIANS RECOMMENDATIONS

	YES	NO
1. Was there any condition, habit or practice which might result in sudden or unexpected incapacitation?		

	YES	NO
2. Was there any mental or physical disability which might cause impaired judgement or motor coordination?		

3. Based on the results of the examination and medical history, using the criteria contained in ANSI/ANS 15.4 – 2016 and ANSI/ANS 3.4 – 2013 Section 5.7, I havedetermined that the applicants physical condition and general health are such that **(circle all that apply)**

A. THERE ARE NO RESTRICTIONS OR DISQUALIFYING CONDITIONS

B. THE FOLLOWING RESTRICTIONS OR WAIVERS APPLY

1. CORRECTIVE LENSES SHALL BE WORN WHEN PERFORMING LICENSE DUTIES

2. HEARING AID SHALL BE WORN WHEN PERFORMING LICENSE DUTIES. THIS DOES NOT APPLY TO CONDITIONS THAT REQUIRE PROTECTION IN HIGH NOISE AREAS

3. SHALL TAKE THE FOLLOWING MEDICATIONS AS PRESCRIBED TO MAINTAIN MEDICAL QUALIFICATION

a. _____ d. _____
b. _____ e. _____
c. _____ f. _____

4. OTHER _____

C. A DISQUALIFYING CONDITION EXISTS AS NOTED BELOW

NAME OF PHYSICIAN	STATE IN WHICH LICENSED	LICENSE NUMBER

SIGNATURE	DATE

AUTHORIZATION TO RELEASE HEALTH INFORMATION

I AUTHORIZE THE NIST HEALTH UNIT TO RELEASE MY PRIVATE / PERSONAL HEALTH INFORMATION TO: (NAME, ADDRESS, PHONE / FAX NUMBER)

Chief of Reactor Operations
NIST Center for Neutron Research
100 Bureau Drive Bldg. 235/A137 Mail Stop 6101
Gaithersburg Md 20899-6101
(301) 975-6262 (Phone)

Type of Information to be released:

- [ ] History and physical exams
- [ ] Consultations and Evaluations
- [ ] Progress Notes
- [ ] Radiology, laboratory, pathology, EKG and other diagnostic reports
- [ ] Operative reports
- [ ] Psychological reports
- [ ] Medical opinions regarding accommodations, fitness for duty, light duty assignments
- [ ] Emergency medicine reports
- [ ] NRC Physical Examination Form
- [ ] Other: _____

Date or time period for information selected above [ ]

The purpose of this release:

- [ ] At the request of the patient
- [ ] To make an assessment regarding work related accommodations
- [ ] To determine employee's fitness for duty
- [ ] To determine an appropriate light duty assignment, if available

My Rights and Responsibilities

> This authorization is voluntary

> Patients may revoke this authorization at any time by submitting written notice to the Medical Officer, PA-C The revocation will take effect when Imani Patterson, PA-C receives it, unless the request has already been released. Revocations cannot reverse any releases that have already occurred.

> Patients are entitled to receive a copy of this authorization if requested

> The NIST Health Unit has no control over, responsibility for, or liability related to any private health information once released to another entity at patient request

Expiration of authorization:

Unless otherwise revoked , this Authorization expires [ ] (insert applicable date)

If no date indicated, Authorization expires 12 months after date of signing.

SIGNATURE _____ DATE _____

PRINT NAME _____ TIME _____ AM / PM

RECEIVED BY: _____ DATE / TIME _____

DATE PROCESSED: _____ TIME PROCESSED: _____

PROCESSED BY: _____