CRIMINAL JUSTICE EDUCATION AND TRAINING STANDARDS COMMISSION

CRIMINAL JUSTICE STANDARDS DIVISION
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MEDICAL EXAMINATION REPORT

THIS INFORMATION IS FOR OFFICIAL USE ONLY AND WILL NOT BE RELEASED TO UNAUTHORIZED PERSONS.

Form F-2 (Adult Corrections) (Revised 10/15)

INSTRUCTIONS:
To be completed by a licensed physician/physician assistant/ nurse practitioner or surgeon following actual physical examination. The original or a copy of this report must be retained in personnel file by the appointing agency.

1. Name (Last, First, Middle)			2. Birth Date (Mo., Day., Yr.)
3. Height (without shoes)	4. Weight (without shoes and coat)	5. Chest Girth (Expiration)	6. Abdomen Girth

7. Visual Acuity (If applicant wears glasses, test and record acuity both with and without glasses)

a. Without glasses R20/_____ L20/ _____ B20/_____ b. With glasses R20/_____ L20/_____ B20/_____

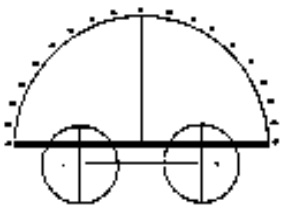
c. Depth perception_____ d. Color perception _____

c. Pupils: Equal _____ Reaction_____

f. Eye Grounds: _____

g. Form Fields of Vision (Temporal): Right eye _____Left eye _____ Each eye on Zero Line _____

(Record degrees of temporal fields obtained by instrumentation or confrontation in spaces above and on diagram below)



h. Evidence of Suppression_____
Note any abnormality

8. HEARING
(Whispered conversation at 15 ft. considered normal)

	HEARING AID USED	DRUM PERFORATION OR DRAINAGE
Right 15/_____ Left 15/_____	☐ No ☐ Yes	☐ No ☐ Yes

Note any abnormality

9. Head (note any defect, disease, or injury involving eyes, ears, nose, mouth, throat)		10. Dentistry Recommended ☐ No ☐ Yes
11. Lungs	12. Date Chest X-ray Taken	13. Chest X-ray normal ☐ No ☐ Yes

14. **CARDIO VASCULAR SYSTEM**

A. Blood Pressure _____ B. Resting pulse rate_____

C. Heart Sounds
1. S1_____ S2_____ Click _____ Ejection sound _____
2. Gallop sounds? S3 _____ S4 _____
3. Murmur describe_____
4. Circulation to extremities _____

15. **NERVOUS SYSTEM** (describe any pathology of abnormal reflexes)

CONTINUED ON BACK

16. ABDOMEN	17. RECTAL
Masses	**Fissure**
Tenderness	**Fistula**
Hernia	**Hemorrhoids**

18. GENITO URINARY SYSTEM (note any abnormalities)

19. MUSCULO-SKELETAL

(Test by bending, stooping, squatting: also by head, arm, leg, and finger motions)

A. Spine	**Mobility**	**Symmetry**	**Posture**	**X-Ray Recommended** ☐ **No** ☐ **Yes**
B. Upper Extremities	**Limited Function**	**Missing Parts**		
C. Lower Extremities	**Limited Function**	**Missing Parts**		

20. Skin: scars, varicosities, disease, abnormalities – nature and severity)

21. LABORATORY (Report May Be Attached)

A. Urinalysis	**SP Gravity**	**Alb.**	**Sugar**	**Microscope**

B. Serology (optional) ☐ **Positive** ☐ **Negative** ☐ **Non Reactive** ☐ **Blood Type**

22. Is this applicant able to perform the essential job and training functions of this certified position? ☐ **Yes** ☐ **No**

(If **NO,** explain in #23 below which essential job or training function(s) he/she cannot perform.)

NOTE: If necessary to help the examiner answer this question, the examiner should review the applicant's medical record and/or contact the current health care provider.

23. Summary/Comments

I have examined this individual. I have read, reviewed and indicated whether this individual can perform the essential job and training functions for the position applied. **Signature of Physician/Physician Assistant/Nurse Practitioner**	**Name and Address of Physician/Physician Assistant/Nurse Practitioner (Print or Type)**
Date	