

PERSONALLY IDENTIFIABLE INFORMATION - WITHHOLD UNDER 10 CFR 2.390

NRC FORM 396
(09-11-2024)
10 CFR 55.21, 55.23,
55.25, 55.27, 55.31
55.33, 55.53, 55.57.



U.S. NUCLEAR REGULATORY COMMISSION

**CERTIFICATION
OF MEDICAL EXAMINATION BY
FACILITY LICENSEE**

APPROVED BY OMB: NO. 3150-0024

EXPIRES: 12/31/2025

Estimated burden per response to comply with this mandatory collection request: 1 hour. NRC requires this information to determine that the physical condition and health of operator licensees is such that the applicant would not be expected to cause operational errors endangering the public health and safety. Send comments regarding burden estimate to the Information Services Branch (T-6 A10M), U.S. Nuclear Regulatory Commission, Washington, DC 20555-0001, or by email to Infocollects.Resource@nrc.gov, and the OMB reviewer at: OMB Office of Information and Regulatory Affairs, (3150-0024), Attn: Desk Officer for the Nuclear Regulatory Commission, 725 17th Street NW, Washington, DC 20503. The NRC may not conduct or sponsor, and a person is not required to respond to, a collection of information unless the document requesting or requiring the collection displays a currently valid OMB control number.

Last Name	First Name	Middle Initial	Suffix	Applicant/Operator Docket Number	Facility
Full Address of Applicant/Operator			Date of Birth	Facility Docket Number (Separate multiple docket numbers by ";")	
				<input type="checkbox"/> 050- <input type="checkbox"/> 052-	
			Date of Most Recent Biennial Examination (MM/DD/YYYY) (See instructions)	Applicant/Operator Email Address	

A. MEDICAL EXAM INFORMATION

BASED ON THE RESULTS OF THE PHYSICAL EXAMINATION, INCLUDING INFORMATION FURNISHED BY THE APPLICANT/OPERATOR, I CERTIFY THAT THE ABOVE NAMED APPLICANT/OPERATOR HAS BEEN FOUND TO MEET THE MEDICAL REQUIREMENTS FOR LICENSED OPERATORS AT THIS FACILITY. I ALSO CERTIFY THAT IN REACHING THIS DETERMINATION, THE GUIDANCE CONTAINED IN THE ANSI STANDARD OR AN APPROVED NRC ALTERNATIVE METHOD WAS FOLLOWED AND THAT DOCUMENTATION IS AVAILABLE FOR REVIEW BY THE NRC.

GUIDANCE USED:

- | | | | |
|-----------------------------------------------|------------------------------------------------|------------------------------------------------|-----------------------------------------------------|
| <input type="checkbox"/> ANSI/ANS 3.4 -- 1983 | <input type="checkbox"/> ANSI/ANS 3.4 -- 2013 | <input type="checkbox"/> ANSI/ANS 15.4 -- 2007 | <input type="checkbox"/> Other (Must specify below) |
| <input type="checkbox"/> ANSI/ANS 3.4 -- 1996 | <input type="checkbox"/> ANSI/ANS 15.4 -- 1988 | <input type="checkbox"/> ANSI/ANS 15.4 -- 2016 | |

Typed or Printed Name of Physician	Physician's Certification Date (MM/DD/YYYY) (See Instructions)	State	License Number
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BASED ON THE RECOMMENDATION OF THE PHYSICIAN, IT IS REQUESTED THAT THE APPLICANT/OPERATOR LICENSE BE CONDITIONED AS FOLLOWS: Check all that apply. (See instructions)

- 1. NO RESTRICTIONS.
- 2. CORRECTIVE LENSES SHALL BE WORN WHEN PERFORMING LICENSED DUTIES.
- 3. HEARING AID SHALL BE WORN WHEN PERFORMING LICENSED DUTIES. THIS DOES NOT APPLY TO CONDITIONS THAT REQUIRE PROTECTION IN HIGH NOISE AREAS.
- 4. SHALL TAKE MEDICATION AS PRESCRIBED TO MAINTAIN MEDICAL QUALIFICATIONS.
- 5. SHALL USE THERAPEUTIC DEVICE(S) AS PRESCRIBED TO MAINTAIN MEDICAL QUALIFICATIONS.
- 6. SOLO OPERATION IS NOT AUTHORIZED (Check one box). RO SRO LSRO
- 7. SHALL SUBMIT MEDICAL STATUS REPORT EVERY: (Check one box. When Other is checked, a specific time frame must be entered).
 3 6 12 months, or Other

Enter the date that the medical status report requirement was added and/or removed (as applicable). (MM/DD/YYYY)	
Date Restriction Added:	Date Restriction Removed:
- 8. SHALL NOT PERFORM LICENSED DUTIES REQUIRING A RESPIRATOR.
- 9. OTHER RESTRICTIONS OR EXCEPTION
- 10. RESTRICTION CHANGE FROM PREVIOUS SUBMITTAL
- 11. INFORMATION ONLY
- 12. SUPPORTING DOCUMENTATION (Attach documentation in support of medical restrictions for new applicants/operators).

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(09-11-2024)

U.S. NUCLEAR REGULATORY COMMISSION

**CERTIFICATION OF MEDICAL EXAMINATION
BY FACILITY LICENSEE (continued)**

Last Name	First Name	Middle Initial	Suffix	Applicant/Operator Docket Number	Facility
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Proposed Wording of Restriction

Relationship of Restriction to Disqualifying Condition (Briefly indicate how restriction will address the disqualifying medical condition).

Explanation(s)

B. APPLICANT/OPERATOR'S SIGNATURE

I acknowledge the information in this certification and attachments as they apply to my licensure by the NRC. I authorize my facility to provide this certification and attachments to the NRC to use in the exercise of its authority over my licensure.

Signature - Applicant / Operator	Date
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C. FACILITY CERTIFICATION

I CERTIFY UNDER PENALTY OF PERJURY THAT THE INFORMATION IN THIS DOCUMENT AND ATTACHMENTS IS TRUE AND CORRECT.

Printed Name and Title of Senior Management Representative

Signature - Senior Management Representative	Date
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CERTIFICATION OF MEDICAL EXAMINATION BY FACILITY LICENSEE (Instructions)

Enter **NAME OF APPLICANT** as it appears on NRC Form 398 or **NAME OF OPERATOR** as it appears on the NRC issued License, **DOCKET NUMBER** and **DATE OF MOST RECENT BIENNIAL MEDICAL EXAMINATION**. If the time since the applicant's initial medical examination exceeds 24 months before an initial licensing action is completed, the applicant must be reexamined by a physician and a new NRC Form 396 must be submitted. If, during the term of the license, an operator develops a permanent physical or mental condition that causes the operator to fail to meet 10 CFR 55.21 that can be mitigated by requesting a license restriction, the facility licensee shall notify the NRC within 30 days of learning of the diagnosis by submitting an NRC Form 396. 10 CFR 55.25 requires a submission for only permanent conditions. Do not submit temporary conditions for which an operator is being administratively held by your facility. Per 10 CFR 55.55, NRC Operator license renewals (NRC Form 396 and NRC Form 398) shall be submitted at least 30 days prior to the license expiration date.

Enter **ADDRESS OF APPLICANT/OPERATOR**

Enter **Date of Birth OF APPLICANT/OPERATOR (MM/DD/YYYY)**

Enter **NAME OF FACILITY(IES)** and **FACILITY DOCKET NUMBER(S)** - Use Check Box to indicate 050-XXX or 052-XXX.

Enter **Email Address of the Applicant/Operator** - If you provide an email address, you are electing to receive operator licensing correspondence from the NRC, electronically. If you do not provide an email address, the NRC will correspond using mail to the address you provided.

Use **Check Box** to indicate which **Guidance Document** (ANSI 3.4, 15.4 or Other) was used to determine the applicant's physical condition. If **Other** is checked, include the title of the document.

SECTION A - MEDICAL EXAM INFORMATION - Enter **PHYSICIAN'S PRINTED NAME, PHYSICIAN'S CERTIFICATION DATE, LICENSE NUMBER, AND STATE OF LICENSURE**. (Indicate MD or DO following printed name). Physicians Certification Date = Date of physician's final certification of applicant/operator's medical suitability (including recommended license conditions) and/or the date of the physician's certification of a required medical status update (Check Box 7).

License Conditions - **Check all the applicable boxes** to request license condition(s). For each checked box in Nos. 4 through 11, provide supporting medical evidence that the requested license condition addresses the disqualifying medical condition. The supporting medical evidence shall consist of a brief narrative from the examining physician (provided either in the "Explanation" box or in an attached letter) addressing the pertinent medical history, objective findings (for example, blood pressure, HgA1C, and TSH), the diagnosis, and the recommended treatment (including name, dosing, and any adverse reactions), to demonstrate the efficacy of the proposed license condition.

Box 1 - NO RESTRICTIONS - Physical and mental condition and general health meet the minimum requirements, without exception.

Box 2 - CORRECTIVE LENSES SHALL BE WORN WHEN PERFORMING LICENSED DUTIES - Corrective lenses must be worn to meet the minimum requirements for vision.

Box 3 - HEARING AID SHALL BE WORN WHEN PERFORMING LICENSED DUITES - Hearing aid must be worn to meet the minimum requirements.

Box 4 - SHALL TAKE MEDICATION AS PRESCRIBED TO MAINTAIN MEDICAL QUALIFICATIONS - Meets the minimum medical requirements only by taking prescribed medication(s).

Box 5 - SHALL USE THERAPEUTIC DEVICE(S) AS PRESCRIBED TO MAINTAIN MEDICAL QUALIFICATIONS - Meets the minimum medical requirements only by using a therapeutic device (e.g., CPAP and Spinal Cord Stimulator).

Box 6 - SOLO OPERATION IS NOT AUTHORIZED - Another individual, capable of summoning help must be present when the operator is performing licensed duties. Check the applicant/operator's license type.

Box 7 - SHALL SUBMIT MEDICAL STATUS REPORT EVERY 3, 6, 12 or Other Months - Medical condition that requires more frequent monitoring than the two (2) years required by 10 CFR 55.21. If Other is checked, include the requested time frame.

Box 8 - SHALL NOT PERFORM LICENSED DUTIES REQUIRING A RESPIRATOR - Respiratory or integumentary (skin) condition.

Box 9 - OTHER RESTRICTIONS OR EXCEPTION - Other license condition(s) necessary to mitigate identified medical or psychological issue(s) that do not meet minimum medical requirements. Use "**Proposed Wording of Restriction**" and "**Relationship of Restriction to Disqualifying Condition**" boxes. If an applicant or operator fails to meet a medical requirement but can demonstrate complete capacity to perform assigned duties, as proven by a test administered by the physician, the physician may recommend and justify a waiver of that portion of the applicable ANSI standard. For an applicant the waiver request must be made on the NRC Form 398, "Personal Qualification Statement - Licensee," by checking Box 12.c.3 and justifying the waiver/exception request in Box 25.

Box 10 - RESTRICTION CHANGE FROM PREVIOUS SUBMITTAL - Additional license condition request, modification of an existing condition or deletion of an existing condition. Must include an explanation in the **Explanation Box** and provide **Medical Evidence**.

Box 11 - INFORMATION ONLY - Check box if providing required established medical status updates that do not request new restrictions, removal of restrictions or change in status report frequency. Use for reporting any other medical situation you determine that needs to be reported to the NRC. Do not report temporary medical conditions for operators on administrative hold.

Box 12 - SUPPORTING DOCUMENTATION (Attach documentation in support of medical restrictions for new applicants).

SECTION B - SIGNATURE - Applicant/Operator

SECTION C - CERTIFICATION - Senior Management Representative

Detach these instructions prior to submittal.

In accordance with 10 CFR 55.5, this form shall be submitted to the appropriate NRC office electronically (for example, via the EIE system or by Box) or by mail to:

REGIONAL ADMINISTRATOR, REGION I
U.S. NUCLEAR REGULATORY COMMISSION
475 ALLENDALE ROAD, SUITE 102
KING OF PRUSSIA, PA 19406-1415

REGIONAL ADMINISTRATOR, REGION III
U.S. NUCLEAR REGULATORY COMMISSION
2056 WESTINGS AVENUE, SUITE 400
NAPERVILLE, IL 60563-2657

U.S. NUCLEAR REGULATORY COMMISSION
NON-POWER PRODUCTION AND UTILIZATION
FACILITIES OVERSIGHT BRANCH
OFFICE OF NUCLEAR REACTOR REGULATION
WASHINGTON, DC 20555-0001

REGIONAL ADMINISTRATOR, REGION II
U.S. NUCLEAR REGULATORY COMMISSION
245 PEACHTREE CENTER AVENUE, NE., SUITE 1200
ATLANTA, GA 30303-1257

REGIONAL ADMINISTRATOR, REGION IV
U.S. NUCLEAR REGULATORY COMMISSION
1600 E. LAMAR BOULEVARD
ARLINGTON, TX 76011-4511