Sifre, Wayne

From: Center, Health
Sent: Tuesday, May 09, 2017 1:38 PM
Subject: IT'S TIME FOR YOUR PHYSICAL
Attachments: BIANNUALPENOTIFICATIONFOREMPLOYEESdoc (8).doc; NRC 800A (Regional Package) 4-2016pdf.pdf

Importance: High

Dear Employee,

See the attachments regarding your physical.

Thank you

Mary Ferguson, RN, BSN
Lead Nurse
NRC Health Center

Hearing Identifier: WCS_CISF_Saf_Public
Email Number: 5

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Subject: IT'S TIME FOR YOUR PHYSICAL
Sent Date: 5/9/2017 1:37:38 PM
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Files	**Size**	**Date & Time**	
MESSAGE	153	5/9/2017 1:37:41 PM	
BIANNUALPENOTIFICATIONFOREMPLOYEESdoc (8).doc			38726
NRC 800A (Regional Package) 4-2016pdf.pdf		1848680	

Options
Priority: High
Return Notification: No
Reply Requested: No
Sensitivity: Normal
Expiration Date:
Recipients Received:

TO: ELIGIBLE NRC EMPLOYEE

FROM: Office of Human Resources

SUBJECT: BIENNIAL PHYSICAL EXAMINATION AND/OR RESPIRATOR CERTIFICATION EXAMINATION

You are eligible for your NRC sponsored complete physical examination. Your participation in this program is entirely voluntary and the results of the examination are strictly confidential. This visit will include the following procedures ONLY. ***Any additional testing other than those listed below is your responsibility and should be discussed with and ordered by your personal health care provider.***

- Physical examination (**PHYSICALS ARE SCHEDULED EVERY TWO YEARS)** by a physician which includes; family history (past & current), fasting blood work, chemistry panel, lipid profile, CRP, CBC and urinalysis.
- Audiogram (hearing test)
- Electrocardiogram (EKG)
- Visual acuity exam
- Prostate Specific Antigen (PSA) for males age 50 and older; or age 45 and older if African-American; or age 45 and older if immediate family history of prostate cancer.

Additional optional testing:

- Breast examination/PAP smear for interested females
- Tetanus-Diphtheria (TD) or Tetanus-Diphtheria-Pertussis (Tdap)

If you are an **inspector or in a position that would require the use of a respirator**, you are eligible for:

- Pulmonary function testing with completion of **NRC forms 805 (questionnaire) and 806 (physician clearance). (NOT TO BE DONE IF YOU HAVE HAD A RESPIRATORY CERTIFICATION EXAM IN THE PAST 10 MONTHS.)**

Call the provider directly to schedule an appointment, and coordinate the time with your supervisor. **If you must cancel or reschedule your appointment, please do so at least 24 hours in advance of your scheduled time to avoid unnecessary charges to the NRC.**

In order for the tests to be completed accurately, **you will need to fast for eight hours the night before your physical examination; you may take prescribed medication, if necessary.** It is also recommended that you drink two glasses of water prior to your arrival.
If fasting presents a problem please notify the health care provider with whom you scheduled your appointment.

If you have any questions, please contact your Regional Personnel Office or the Headquarters Health Center. Call your medical provider in your Region as listed below to schedule your appointment.

NRC Headquarters	NRC Health Center	301-415-8400
Region I- Riqueza Marziale	Penn Med @ Valley Forge	610-576-7630
Region II- Gloria Reeves	Concentra II	404-881-1155
Region III- Gail Christopher-Baruch	Advocate Occupational Health	630-275-2900
Region IV- Lisa Quayle	Concentra Arlington North	972-988-0441
TTC-Sally Dee	Parkridge Medical	423-493-1700

7.13.15 jc

APPOINTMENT INSTRUCTIONS FOR PHYSICALS FOR REGIONAL EMPLOYEES

Dear: Employee

Please schedule an appointment for a physical examination with your health care provider. This will require two (2) visits. The first appointment includes lab work (blood & urine), hearing & vision testing, and an electrocardiogram.

Fast for 8 hours prior to your appointment.
Drink at least 2 glasses of water!
Insulin dependent diabetics may choose not to fast and take their insulin.
Not fasting may affect blood sugar and triglyceride levels.
You may take prescribed medications if necessary.

PLEASE REMEMBER TO:

- ***Electronically Complete and Print*** NRC Forms 801, 802, 825 and SF88 (attached to this email) and bring the printed forms with you.
  (It is not necessary to print the privacy act statements found on pages 6-7).

Wear or bring prescription glasses or contact lenses.

Your second appointment will include a physical examination by the physician and a discussion of your test results.

NRC HEALTH CENTER
EMPLOYEE HEALTH RECORD

Last Name, First Name, and Middle Name	Date of Birth	Employee ID (Located in HRMS & iLearn)	DATE ☐ Male ☐ Female
Job Title		Building/Room	Work Telephone Number
Supervisor			Supervisor's Telephone Number
Employee Home Address (Include Street Name & Number, City, State and Zip Code)			Home Telephone Number
Name of Private Physician			Physician's Telephone Number
Address of Private Physician (Include Street Name & Number, City, State and Zip Code)			
Name of Emergency Contact	Relationship to Employee		Emer. Cont. Telephone Number

Do you have? / Have you had? (Check Yes or No)

☐ Yes	☐ No	Heart Disease (heart attack, heart surgery)
☐ Yes	☐ No	High Blood Pressure
☐ Yes	☐ No	Diabetes ☐ oral medications ☐ insulin
☐ Yes	☐ No	Epilepsy
☐ Yes	☐ No	Stroke
☐ Yes	☐ No	Elevated Cholesterol
☐ Yes	☐ No	Lung Disease ☐ asthma ☐ emphysema ☐ TB
☐ Yes	☐ No	Hearing Loss ☐ hearing aid
☐ Yes	☐ No	Other medical condition
☐ Yes	☐ No	Family member with heart disease.
Do you smoke? ☐ Yes	☐ No	If yes, How much?

List any allergies:

Allergies to medications:

Medications unable to take:

Current Medications:

Date medication(s) started:

Operations and Serious Medical Problems:

NRC HEALTH CENTER
PHYSICAL EXAMINATION HEARING HISTORY

Last Name, First Name, and Middle Name	Date of Birth	Employee ID (Located in HRMS & iLearn)	Date

1. Pertinent Medical History:
Please check if you have ever experienced any of the following:

- ☐ Loud noise exposure
  Describe: _____
- ☐ Tinnitus (ringing)
- ☐ Allergy
- ☐ Ear surgery Please explain: _____
- ☐ Ear drum rupture
- ☐ Earaches / Drainage
- ☐ Dizziness

2. Medications -- Have you ever had any of the following:

- ☐ Quinine
- ☐ Streptomycin
- ☐ Neomycin
- ☐ Kanamycin
- ☐ Gentamycin

3. Self-Evaluation of Hearing

☐ Good ☐ Fair ☐ Poor

Any deterioration in the past 2 years?	☐ Yes	☐ No
Any problems hearing in a group?	☐ Yes	☐ No
Have you ever been fitted for a hearing aid?	☐ Yes	☐ No

4. Comments and additional information:

NRC FORM 825
(10-2015)

U.S. NUCLEAR REGULATORY COMMISSION

NRC HEALTH CENTER
CONSENT FOR RELEASE OF MEDICAL RECORDS

Last Name, First Name, and Middle Name	**Date of Birth**	**Employee ID** (Located in HRMS & iLearn)

I hereby authorize the NRC Health Services contractor, its employees, and/or its subcontractors to release my medical records covering the period

from _____ to _____ .

To (Type or print full name)	**Relationship to Employee**

Address (Number, Street, City, State and Zip Code)

This consent is subject to revocation at any time, at my election, except to the extent that action has been taken in reliance on the above authorization.

This consent expires on _____ . If I do not enter an expiration date, my consent will expire 120 days after the date of my signature below.

Signature - Employee	**Date**

Signature - Witness	**Date**

MEDICAL RECORD — REPORT OF MEDICAL EXAMINATION

Date of Examination

1. Last Name, First Name, and Middle Name	2. Employee ID (Located in HRMS & iLearn)	3. Grade and Component or Position

4. Home Address (Number, street or RFD, city or town, state and zip code)	5. Emergency Contact (Name and address of contact)
(NOT REQUIRED AT NRC)	

6. Date of Birth	7. Age	8. Sex	9. Relationship of Contact
		☐ Female ☐ Male	

10. Place of Birth	11. Race					
	☐ White	☐ Black	☐ American Indian/Alaska Native	☐ Hispanic White	☐ Hispanic Black	☐ Asian/Pacific Islander

12a. Agency	12b. Organization Unit	13. TOTAL YEARS GOVERNMENT SERVICE	
		a. MILITARY	b. CIVILIAN

14. NAME OF EXAMINING FACILITY OR EXAMINER, AND ADDRESS	15. RATING OR SPECIALITY OF EXAMINER	16. PURPOSE OF EXAMINER
U. S. NUCLEAR REGULATORY COMMISSION HEALTH CENTER O-2 E13 11555 ROCKVILLE PIKE ROCKVILLE, MD 20852		

17. CLINICAL EVALUATION (TO BE COMPLETED BY NRC HEALTH CENTER)

NORMAL	(Check each item in appropriate column, enter "NE" If not evaluated	ABNORMAL	NORMAL	(Check each item in appropriate column, enter "NE" If not evaluated	ABNORMAL
	A. HEAD, FACE, NECK AND SCALP			P. TESTICULAR	
	B. EARS - GENERAL (INTERNAL CANALS) (Auditory acuity under items 39 and 40)			Q. ANUS AND RECTUM (Hemorrhoids, Fistulae) (Hemocult Results)	
	C. DRUMS (Perforation)			R. ENDOCRINE SYSTEM	
	D. NOSE			S. G-U SYSTEM	
	E. SINUSES			T. UPPER EXTREMITIES (Strength, range of motion)	
	F. MOUTH AND THROAT			U. FEET	
	G. EYES - GENERAL (Visual acuity and refraction under items 28, 29, and 36)			V. LOWER EXTREMITIES (Except feet)(Strength, range of motion)	
	H. OPTHALMOSCOPIC			W. SPINE, OTHER MUSCULOSKELETAL	
	I. PUPILS (Equality and reaction)			X. IDENTIFYING BODY MARKS, SCARS, TATTOOS	
	J. OCULAR MOTILITY (Associated parallel movements nystagmus)			Y. SKIN, LYMPHATICS	
	K. LUNGS AND CHEST			Z. NEUROLOGIC (Equilibrium tests under item 41)	
	L. HEART (Thrust, size, rhythm, sounds)			AA. PSYCHIATRIC (Specify any personality deviation)	
	M. VASCULAR SYSTEM (Varicosities, etc.)			BB. BREASTS	
	N. ABDOMEN AND VISCERA (include hernia)			CC. PELVIC (Females only)	
	O. PROSTATE (Over 40 or clinically indicated)				

NOTES: (Describe every abnormality in detail. Enter pertinent item number before each comment. Continue in item 42 and use additional sheets if necessary.)

18. DENTAL (Place appropriate symbols, shown in examples, above or below number of upper and lower teeth.)

0 / 1 2 3 / 32 31 30 / 0	Restorable Teeth	/ / 1 2 3 / 32 31 30 / /	Non-Restorable Teeth	X / 1 2 3 / 32 31 30 / X	Missing Teeth	X X X / 1 2 3 / 32 31 30 / X X X	Replaced by Dentures	(X) / 1 2 3 / 32 31 30 / (X)	Fixed Partial Dentures

RIGHT	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	LEFT
	32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	

REDEFECTS AND DISEASESMARKS AND ADDITIONAL DENTAL

19. TEST RESULTS (Copies of results are preferred as attachments)

A URINALYSIS: (1) SPECIFIC GRAVITY		B. CHEST X-RAY OR PPD (Place, date, film number and result)
(2) URINE ALBUMIN	(4) MICROSCOPIC	
(3) URINE SUGAR		F. OTHER TESTS
C. SYPHILIS SEROLOGY (Specify test used and results)	D. EKG	

1. Last Name, First Name, and Middle Name	2. Employee ID (Located in HRMS & iLearn)	Number of Sheets Attached

MEASUREMENTS AND OTHER FINDINGS

20. HEIGHT	21. WEIGHT	22. COLOR OF HAIR	23. COLOR OF EYES	24. BUILD	25. TEMPERATURE
				☐ Slender ☐ Medium ☐ Heavy ☐ Obese	

26. BLOOD PRESSURE (Arm at heart level)

A. SITTING	SYS.	B. RECUMBENT	SYS.	C. STANDING (5 mins.)	SYS.
	DIAS.		DIAS.		DIAS.

27. PULSE (Arm at heart level)

A. SITTING	B. RECUMBENT	C. STANDING (3 mins)	D. AFTER EXERCISE	E. 2 MINS. AFTER

28. DISTANT VISION		29. REFRACTION			30. NEAR VISION	
RIGHT 20/	CORR. TO 20/	BY	S.	CX	CORR. TO	BY
LEFT 20/	CORR. TO 20/	BY	S.	CX	CORR. TO	BY

31. HETEROPHORIA (Specify distance)

ESO	EXO	R.H.	L.H.	PRISM DIV.	PRISM CONV. CT	PC	PD

32. ACCOMMODATION		33. COLOR VISION (Test used and score)	34. DEPTH PERCEPTION (Test used and score)	UNCORRECTED	
RIGHT	LEFT			CORRECTED	
35. FIELD OF VISION		**36. NIGHT VISION (Test used and score)**	**37. RED LENS TEST**	**38. INTRAOCULAR TENSION**	
RIGHT	LEFT			RIGHT	LEFT

39. HEARING			40. AUDIOMETER								
RIGHT W/V	/155V	/15		250 256	500 512	1000 1024	2000 2048	3000 2896	4000 4096	6000 6144	8000 8192
LEFT W/V	/155V	/15	RIGHT								
			LEFT								

41. PSYCHOLOGICAL AND PSYCHOMOTOR (Tests used and score)

42. NOTES (Continues) AND SIGNIFICANT OR INTERVAL HISTORY (Use additional sheets if necessary)

43. SUMMARY OF DEFECTS AND DIAGNOSES (List diagnoses with item numbers)

44. RECOMMENDATIONS - FURTHER SPECIALIST EXAMINATIONS INDICATED (Specify)

45A. PHYSICAL PROFILE

P	U	L	H	E	S

46. EXAMINEE (Check)

A. ☐ IS QUALIFIED FOR

B. ☐ IS NOT QUALIFIED FOR

45B. PHYSICAL CATEGORY

47. IF NOT QUALIFIED, LIST DISQUALIFYING DEFECTS BY ITEM NUMBER

A	B	C	E

48. TYPED OF PRINTED NAME OF PHYSICIAN — SIGNATURE

49. TYPED OR PRINTED NAME OF PHYSICIAN — SIGNATURE

50. TYPED OR PRINTED NAME OF DENTIST OR PHYSICIAN (Indicate which) — SIGNATURE

51. TYPED OR PRINTED NAME OF REVIEWING OFFICER OR APPROVING AUTHORITY — SIGNATURE