

PERSONALLY IDENTIFIABLE INFORMATION - WITHHOLD UNDER 10 CFR 2.390

Form 396 – CERTIFICATION OF MEDICAL EXAMINATION BY FACILITY LICENSEE.

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APPROVED BY OMB: NO. 3150-0024

EXPIRES: XX/XX/20XX

Estimated burden per response to comply with this voluntary 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 FOIA, Library, and Information Collections Branch (T-6 A10M), U.S. Nuclear Regulatory Commission, Washington, DC 20555-0001, 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.

APPLICANT INFORMATION

*Last Name <input type="text"/>	*First Name <input type="text"/>	Middle Initial <input type="text"/>	Suffix <input type="text"/>
*Date of Birth <input type="text" value="MM/YYYY"/>	*Date of Most Recent Biennial Examination <input type="text" value="MM/YYYY"/>		
*Applicant Address: Street Line 1 <input type="text"/>		Street Line 2 <input type="text"/>	

*Applicant Address: City <input type="text"/>	*Applicant Address: State <input type="text" value="Select"/>	*Applicant Address: ZIP <input type="text"/>
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Applicant/Operator Docket Number <input type="text"/>	*Applicant/Operator Email Address <input type="text"/>
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*Facility

Docket Numbers

[Add Dockets](#)

Name ↑	Docket Number	Region
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Docket selection is required

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

Other Guidance

Enter PHYSICIAN'S DEGREE, PHYSICIAN'S PRINTED NAME, PHYSICIAN'S CERTIFICATION DATE, LICENSE NUMBER, AND STATE OF LICENSURE.

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).

*Degree	*Name of Physician		
Select			
*Physician's Certification Date (See instructions)	*License Number	*State	
M/D/YYYY		Select	

BASED ON THE RECOMMENDATION OF THE PHYSICIAN, IT IS REQUESTED THAT THE APPLICANT/OPERATOR LICENSE BE CONDITIONED AS FOLLOWS (check all that apply).

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.

1. NO RESTRICTIONS.

Physical and mental condition and general health meet the minimum requirements, without exception.

2. CORRECTIVE LENSES SHALL BE WORN WHEN PERFORMING LICENSED DUTIES.

Corrective lenses must be worn to meet the minimum requirements for vision.

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

Hearing aid must be worn to meet the minimum requirements.

4. SHALL TAKE MEDICATION AS PRESCRIBED TO MAINTAIN MEDICAL QUALIFICATIONS.

Meets the minimum medical requirements only by taking prescribed medication(s).

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).

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.

7. SHALL SUBMIT MEDICAL STATUS REPORT EVERY:

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.

8. SHALL NOT PERFORM LICENSED DUTIES REQUIRING A RESPIRATOR.

Respiratory or integumentary (skin) condition.

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.

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.

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.

12. Supporting Documentation (Attach documentation in support of medical restrictions for new applicants/operators.)

B. APPLICANT/OPERATOR'S SIGNATURE

Signature - Applicant/Operator

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.

Date

 

C. FACILITY CERTIFICATION

*Name and Title of Senior Management Representative

Signature Senior Management Representative

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

Date

 

Attach additional files:

No file chosen

Progress: 0.00 %

Submissions will not be made publicly available and will only be used by NRC staff.

Attached files:

File	Size
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0/900000 KB used.