

PHYSICAL EXAMINATION FORM (CONT'D)

HERNIA: Yes No If so, where? _____ Is truss worn? _____

GASTROINTESTINAL: Ulceration or other disease? Yes? _____ No? _____

GENITO-URINARY: Scars: _____ Urinal Discharge: _____

REFLEXES: Rhomberg _____
Pupillary: _____ Light R _____ L _____
Accommodation: _____ R _____ L _____

KNEE JERKS: Right Normal _____ Increased _____ Absent _____
Left Normal _____ Increased _____ Absent _____

REMARKS: _____

EXTREMITIES: Upper _____ Lower _____ Spine _____

LABORATORY & OTHER SPECIAL FINDINGS: Urine Spec. Gr. _____ Alb. _____ Sugar _____
Other Laboratory Data (Serology, etc.) _____
Radiological Data _____ Electrocardiograph _____

GENERAL COMMENTS: _____

NAME OF EXAMINING DOCTOR (PLEASE PRINT) _____ SIGNATURE _____

ADDRESS OF EXAMINING DOCTOR _____

CITY _____ STATE _____ ZIP _____

MEDICAL EXAMINER'S CERTIFICATE TO BE COMPLETED ONLY IF OPERATOR IS FOUND QUALIFIED

MEDICAL EXAMINER'S CERTIFICATE
I certify that I have examined

CRANE OPERATOR'S NAME (PRINT)

**with the knowledge of his / her duties,
I find him / her qualified under the regulations.**

Qualified only when wearing corrective lenses.
 Qualified only when wearing a hearing aid.
 Qualified — see Accommodation Statement attached.

A complete examination form for this person is on file in my office:

ADDRESS _____

DATE OF EXAMINATION _____ NAME OF EXAMINING DOCTOR _____

SIGNATURE OF EXAMINING DOCTOR _____

SIGNATURE OF OPERATOR _____

ADDRESS OF OPERATOR _____

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