DCA15MR010
Philadelphia, PA
May 12, 2015

Medical Factual Group Chairman's Report
Attachment 3: Amtrak Medical Examination Forms

AMTRAK

Medical Examination – Instructions – Print All Answers

INSTRUCTIONS - EMPLOYEE or APPLICANT: *Enter your name and requested information at the top of pages 1 through 6 of this document. Provide the information requested below; PRINT all answers.*

Sign the Release at the bottom of this page; your signature is required or the exam cannot be performed.

Complete the MEDICAL HISTORY on pages 2 and 3, and the HEARING HISTORY on page 4.

Name ***(Last, First, Middle Initial)***	**Position - Job Title** ☐ ***Check if Applicant***

Amtrak requires medical examinations during the new-hire process and periodically for employees in specific job categories as required by applicable agreements and standards. This form is used to document all Amtrak medical examinations, except for commercial motor vehicle driver (CMV) examinations. Amtrak's Medical Department reviews all medical examinations to ensure that employees and applicants meet applicable standards.

Complete each answer block clearly and accurately. Incomplete or illegible information will delay the review process, and could require repeating the examination. Providing false information or withholding information is not compatible with Amtrak's Standards of Excellence. Amtrak employees and applicants are expected to cooperate fully with the examination process.

Employees: Enter your Date of Birth, SAP ID and Manager or Supervsior's Name below. **Applicants and individuals without a SAP ID** must enter their Date of Birth and the last 4 digits of their Social Security number to ensure proper identification.

Date of Birth	***EMPLOYEE'S ONLY:***	**SAP ID**	**Manager or Supervisor's Name**
	APPLICANT'S ONLY:	**Last 4 Digits of Social Security Number xxx-xx -**	

Enter the address and phone numbers where you may be contacted during the review process if necessary. This information will not be used to update your Amtrak address of record.

Street Address	**City**	
	State	**Zip Code**
Phone Number	**2nd Phone Number**	
Email (optional)		

RELEASE OF INFORMATION TO AMTRAK'S MEDICAL DEPARTMENT

Your signature below authorizes the examining facility to release the Medical Examination Form and all information obtained during your examination to Amtrak's Medical Department. This information is considered CONFIDENTIAL, is retained separate from your personnel file, and is stored and maintained by Amtrak's Medical Department.

_____ _____

SIGNATURE of EMPLOYEE or APPLICANT ***DATE***

Version – July, 2014

Medical History *(Page 1 of 2)*

Name *(Last, First)*	Position – Job Title	Date

Applicants – A complete medical history is required at your initial medical examination. Review the medical conditions listed below, and continued on page 3. ***Circle*** each medical condition that you have **EVER** had, and enter the dates when you experienced the condition; use "***present***" for the end date if condition is still present. Check (✓) ***No*** only if you have ***NEVER*** experienced any of the listed conditions

Employees – ***An interval medical history is required covering the past 3 years***. Review the medical conditions listed below, and continued on page 3. ***Circle*** each medical condition that you have had ***during the past 3 years*** and the dates you had the condition. All medical conditions experienced ***in the past 3 years*** must be reported, even if reported previously; use "**present**" for the end date if condition is still present. Check (✓) ***No*** only if you have experienced none of the listed conditions ***in the past 3 years***.

Example: If you were diagnosed with asthma in 2012, you would circle asthma in Item 5 and put "2012 - present" in **Yes - Dates** column.

Explain any **Yes** answers in the space at the bottom of page 3.

Item	Medical Condition	No	Yes
1	Wear glasses or contact lenses for distant vision.		
	Wear glasses or contact lenses for reading (near vision).		
2	Use hearing aid(s).		
3	Hearing – ***Complete information and Hearing History on page 4.***		
		No	**Yes - Dates**
4	Color blindness or problem with color vision.		
	Eye or vision problem, loss of peripheral vision, cataract(s), glaucoma, retinal disease or retinal detachment, macular degeneration, eye surgery.		
5	Asthma, shortness of breath, persistent or chronic cough.		
6	Emphysema, chronic bronchitis, chronic obstructive pulmonary disease (COPD), lung disease.		
7	Pneumonia, lung infection, tuberculosis (TB) or history of positive TB test.		
8	High blood pressure, hypertension.		
9	Heart palpitations, irregular heartbeat, arrhythmia, atrial fibrillation or atrial flutter, history of cardioversion or cardiac defibrillation.		
10	Heart disease, heart failure, swelling of ankles or legs, edema.		
11	Chest pain, angina, coronary artery disease, heart catheterization, coronary angioplasty, coronary stents. Implanted pacemaker or defibrillator.		
12	Coronary artery bypass surgery (CABG), heart surgery.		
13	Heart murmur, heart valve disease, aortic stenosis, mitral valve prolapse.		
14	Stomach, bowel, liver, gallbladder or pancreatic disease; hepatitis B or C, hernia other than hiatal hernia.		
15	Chronic urinary problem, kidney disease, bladder problem, kidney failure, dialysis.		
16	Head injury, skull fracture, concussion, loss of consciousness.		
17	Migraine headaches; headaches that are frequent, severe or incapacitating.		
18	Dizziness, vertigo, fainting, passing out, syncope, black-out spells.		

Version – July, 2014

Medical History – *(Page2 of 2)*

Name *(Last, First)*	Date

	Medical Condition (Continued)	No	Yes - Dates
19	Seizures, epilepsy, convulsions, fits.		
20	Stroke, paralysis, transient ischemic attack - TIA, bleed into brain or skull.		
21	Neurological condition such as multiple sclerosis (MS), Parkinson's disease, tremor.		
22	Neuropathy, carpal tunnel syndrome, numbness, tingling, pins and needles.		
23	Memory problems, attention deficit disorder, delerium, dementia.		
24	Muscle problems, muscular dystrophy, muscle weakness or wasting.		
25	Gait disorder, problem walking, foot or ankle problems, plantar fasciitis.		
26	Arthritis, rheumatism, gout, joint problem.		
27	Shoulder, elbow, wrist, hip, or knee problem; joint injections, joint or orthopedic surgery. Problems with fingers or hands. Problems with grip, reaching, lifting, carrying.		
28	Neck or low back pain that is severe, chronic or recurrent; sciatica, neck surgery, back surgery; neck or back or epidural injection(s).		
29	Diabetes, complications from diabetes.		
30	Chronic fatigue, severe anemia, blood disorder(s), bleeding disorder(s), cancer, malignancy, leukemia, or lymphphoma.		
31	Phlebitis, blood clot(s), pulmonary embolism.		
32	Depression, anxiety, mental health problem, post-traumatic stress disorder.		
33	Problem with drugs or alcohol; substance abuse, dependency or addiction.		
34	Current use of narcotic, controlled or addicting medications.		
35	Problems sleeping, frequent insomnia, sleep apnea, narcolepsy, restless leg syndrome; CPAP recommended or used.		
36	Chronic skin disorder or rash.		
37	Within the past 60 days have you received medical treatment for any condition? Explain in the space below.		
37	List in the space below any medical condition(s) not covered above for which you have seen a health care provider more than once.		

Employee/Applicant: Comment below on items identified in Medical History

☐ *Check if comments continue on reverse side of this page.*

Examiner: Ensure Medical History and Hearing History on pages 2, 3 and 4 have been completed fully. Review Medical and Hearing History and Comment below as appropriate.

☐ *Check if comments continue on reverse side of this page.*

_____

MEDICAL EXAMINERS SIGNATURE

Version – July, 2014

Medical Examination – Hearing History and Audiogram

Employees - Enter information requested below and complete Hearing History.
Applicants and individuals without a SAP ID must enter the last 4 digits of their Social Security number.
Check the box indicating your sex. Ensure ALL information is complete, accurate and legible.

Last Name	*First Name*	*Middle Initial*

Date of Birth	*SAP ID*	*Last 4 Digits of Social Security Number xxx-xx -*	*SEX* ☐ Male ☐Female

Job Title	*Work Location*	*Manager or Supervisor's Name*

Hearing History: Circle "Y"if question applies to you; "N" if it doesn't; "U" If you don't know the answer.

Y N U 1. Do you have a hearing loss?	Y N U 7. Do you have excessive ear wax?	Y N U 14. Do you use hearing protection? ☐ muff ☐ premolded ☐ foam ☐ custom ☐ none ☐ other
Y N U 2. Have you had your hearing tested?	Y N U 8. Do you have earaches/ear drainage?	
3. No question here	Y N U 9. Have you ever had exposure to fire arms?	Y N U 15. In the last 14 hours have you been exposed, without hearing protection, to noise that you needed to shout to be heard above it?
Y N U 4. Have you ever worked in noise?	Y N U 10. Have you ever had a severe head injury?	
Y N U 5. Do you have dizziness or balance problems?	Y N U 11. Do you take prescription drugs?	Y N U 16. Have you had a cold or sinus problem in the last 24 hours?
Y N U 6. Do you have ringing or roaring in the ears?	Y N U 12. Do you have noisy hobbies?	Y N U 17. Have you seen a physician for Your ears or hearing in the last year?
	Y N U 13. Have you ever been in the military?	

Audiometer

Audiometer Make:	*Audiometer Model:*	*Serial Number (S/N)*	*Last Acoustic Calibration Date*

Test Date			**Unmasked RIGHT Ear Test Results**							**Unmasked LEFT ear Test Results**						
Mon	Day	Year	500	1000	2000	3000	4000	6000	8000	500	1000	2000	3000	4000	6000	8000

Tester: _____ _____
Print *Signature*

☐ Audiologist ☐ CAOHC Cetrified Technician - CAOHC # _____
☐ Physician ☐ Other: _____

Notes: You are asked to conduct an air conduction hearing threshold test for OSHA or FRA purposes.
Pass/Fail screening are not acceptable. ALL results must be numeric threshold values.
Both ears must be tested completely, even if the subject reports being "deaf."
No test is to be performed with subject wearing hearing aids.
No comparison to baseline is necessary.

Medical Examination – *(Page 1 of 2)*

Name *(Last, First)*	Position – Job Title	Date

INSTRUCTIONS for EXAMINER – Required components of each examination are specified on the MED-1 Form; complete each authorized exam component and document appropriately below. Ensure Medical History and Hearing History, pages 2, 3 and 4, have been completed fully. Review Medical History, and Sign Medical History at the bottom of Page 3 to document your review.

Height (inches)	**Weight** (pounds)	**Pulse Rate** ☐ Irregular	**Blood Pressure** Obtain seated after several minutes. If greater than 140/90, record the average of 3 readings taken minutes apart. ☐ Check if average blood pressure is recorded

VISION

- DO NOT perform distant vision examination if individual uses correction, glasses or contacts, and did not bring corrective lenses to examination.
- If distant vision is poorer than 20/40 in either eye when tested using a multifunction tester, retest using a Snellen chart. Record the Snellen chart vision as the vision of record.
- Note that vision must be recorded for each eye individually and with both eyes (binocular).

Distant (Far) Vision	**Near Vision**	**Peripheral Vision** *Measured in degrees in the horizontal meridian*
☐ Without Corrective Lenses ☐ With Glasses ☐ With Contact Lenses	☐ Without Corrective Lenses ☐ With Glasses ☐ With Contact Lenses	
Right: 20/	Right : 20/	Right: ˚ (degrees)
Left: 20/	Left: 20/	Left: ˚ (degrees)
Both: 20/	Both: 20/	

COLOR VISION

- Color vision must be tested using one of the tests listed on Appendix A.
- Ishihara 14 plate test is Amtrak's preferred test.
- A test score form may be attached to this form if it provides all the information requested below.
  ☐ Check if test score form attached.

Name of Test Used:		Pass ☐ Fail ☐
Number of plates correct	Number of errors	List plates that were incorrect

HEARING and AUDIOGRAM

- Ensure Page 4 is completed properly by subject and examiner.

ELECTROCARDIOGRAM Normal ☐ Abnormal ☐

- Attach ECG tracing to physical
- Written Interpretation:

URINALYSIS	Specific gravity	Protein	Blood	Sugar

Version – July, 2014

Medical Examination - Hearing History and Audiogram – *(Page 2 of 2)*

Employee Name *(Last, First)*	**Position – Job Title**	**Date**

INSTRUCTIONS for EXAMINER – Perform and document Physical Examination below.
Perform Medication Review. Document your recommendations below.
Print your name, degree, and NPI #. Sign and date below.

PHYSICAL EXAMINATION – Check (✓) Normal or Abnormal. Describe any abnormality			
	Normal	**Abnormal**	**Abnormality - specify**
General Appearance			
Head			
Eyes			
Ears, Nose and Throat			
Mouth, Tongue			
Teeth, Dental Health			
Neck, Thyroid			
Thorax, Lungs			
Heart			
Pulses and circulation			
Abdomen, Hernia			
*Musculoskeletal Exam			
**Neck, Spine and Back			
Neurologic			
Gait			
Skin			

- ** Musculoskeletal exam should include shoulders, upper and lower extremities.*
- ***Neck, Spine and Back exam should include neck, thoracic and lumbar spine.*
  - *These exams should assess range of motion, strength and function.*
  - *Document all impairments and abnormalities.*

MEDICATION REVIEW - Review ***ALL*** medications taken by employee/applicant to identify medications that could cause impairment, sedation or side effects that could impact on individual's ability to work safely in a railroad environment. Medication review needs to include prescription and over-the-counter medications, vitamins, supplements and herbal products, whether taken regularly or on an as needed basis (prn). Amtrak Medical Department will follow-up with individual when an impairing medication or safety concern is noted.

☐ No impairing medication ☐ Possible Impairing Medication or Safety Concern

Medical Examiner's Recommendations based on Review of Medical History and Examination

_____

Medical Examiner's Name, Degree (print) ***NPI#*** ***Signature*** ***Date***

Note: MED-1 Form must also be completed and signed by Medical Examiner

Version – July, 2014

Appendix A

FRA Accepted Color Vision Tests

The Medical Facility is responsible for ensuring that color vision is tested using a method approved by the Federal Railroad Administration as specified in 49 CFR Part 240 or Part 242; these tests are the only color vision tests approved for use on Amtrak employees. The information below is provided as information and was current as of January, 2014.

49 CFR Part 242

Qualification and Certification of Conductors - Appendix D — Medical Standards Guidelines

(1) The purpose of this appendix is to provide greater guidance on the procedures that should be employed in administering the vision and hearing requirements of § 242.117.

(2) In determining whether a person has the visual acuity that meets or exceeds the requirements of this part, the following testing protocols are deemed acceptable testing methods for determining whether a person has the ability to recognize and distinguish among the colors used as signals in the railroad industry. The acceptable test methods are shown in the left hand column and the criteria that should be employed to determine whether a person has failed the particular testing protocol are shown in the right hand column.

Accepted tests	Failure criteria
Pseudoisochromatic Plate Tests	
American Optical Company 1965	5 or more errors on plates 1-15
AOC—Hardy-Rand-Ritter plates—second edition	Any error on plates 1-6 (plates 1-4 are for demonstration — test plate 1 is actually plate 5 in book)
Dvorine—Second edition	3 or more errors on plates 1-15
Ishihara (14 plate)	2 or more errors on plates 1-11
Ishihara (16 plate)	2 or more errors on plates 1-8
Ishihara (24 plate)	3 or more errors on plates 1-15
Ishihara (38 plate)	4 or more errors on plates 1-21
Richmond Plates 1983	5 or more errors on plates 1-15
Multifunction Vision Tester	
Keystone Orthoscope	Any error
OPTEC 2000	Any error
Titmus Vision Tester	Any error
Titmus II Vision Tester	Any error

49 CFR Part 240

Qualification and Certification of Locomotive Engineers Certification - Appendix F – Medical Standards Guidelines

Accepted tests are identical to those above.

Note: Ishihara 14 plate test is preferred test for Amtrak.