

PHYSICAL FITNESS INQUIRY FOR MOTOR VEHICLE OPERATORS

FPM Chapter 930 (EF-V1)(PerForm Pro)

1. Name (Last, First, Middle)	2. Date of Birth (MM/DD/YY)	3. Title of Position (Rank)
4. Home Address (Number, Street or RFD, City, State and Zip Code)		5. Employing Agency
6. Have you ever had or have you now: (Please check at left of each item.)		

YES	NO
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>

Poor vision in one or both eyes
Eye disease
Poor hearing in one or both ears
Diabetes
Palpitation, chest pain, or shortness of breathe
Dizziness or fainting spells
Frequent or severe headaches
High or low blood pressure
Drug or narcotic habit

YES	NO
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>

Arthritis, rheumatism, swollen or painful joints
Loss of hand, arm, foot, or leg
Deformity of hand, arm, foot, or leg
Nervous or mental trouble of any kind
Blackouts or epilepsy
Sugar or albumin in urine
Excessive drinking habit (Alcohol)
Other serious defects or diseases

7. If your answer is "Yes" to one or more of the above question, explain fully in this space, indicating date of original condition and current status:

8. (A) Do you wear glasses (or contact lenses) while driving? ☐ YES ☐ NO
(B) Do you wear a hearing aid? ☐ YES ☐ NO

PRIVACY ACT STATEMENT

Solicitation of this information is authorized by 40 U.S.C. 491 and 5 CFR Part 930 Subpart A, which require OPM to regulate Federal employee's use of Government-owned or -leased motor vehicles. It is used to ascertain the physical fitness of Federal employees, whose jobs require authorization to drive Government-owned or leased vehicles. It is also used in the renewal of authorizations for all such employees.

Based on the information provided, employees may be referred for a medical examination before being granted an initial authorization or a renewal. The disclosure of this information is mandatory when an employee's job requires driving a Federal motor vehicle and is voluntary otherwise. However, failure to complete when requested may result in you not being permitted to operate a Government vehicle.

Certification: I certify that my answers to the above are full and true, and I understand that a willfully false statement or a dishonest answer may be grounds for cancellation of my eligibility or my dismissal from the service and is punishable by law.	9. Signature	10. Date Signed (MM/DD/YY)
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REVIEW AND CERTIFICATION BY DESIGNATED OFFICIAL

I certify that I have reviewed this physical fitness injury form and other available information regarding the physical condition of the applicant, and that I have made the following determination.

- ☐ 1. There is no information on this form or otherwise available to indicate that the applicant should be referred for physical examination.
- ☐ 2. On the basis of items checked on this form or other information, this applicant must be referred for physical examination before authorized to operate a Government -owned or -leased motor vehicle or current authorization is renewed.
- ☐ 3. Items checked on this form or otherwise available do not warrant referral for medical examination because of the following facts:

Signature of Designated Official	Date Signed (MM/DD/YY)
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