FD-866 (Rev. 7-24-00)

Federal Bureau of Investigation Fitness For Duty (FFD) Examination

Check One: ☒ Applicant ☐ Employee Date of FFD Exam 5/27/09

1. Were you greeted courteously? ☒ Yes ☐ No

2. Was there a suitable changing facility for examination preparation? ☒ Yes ☐ No

3. Were your screening tests in preparation for physician examination conducted in a complete and professional manner (blood draw, blood pressure, pulse, height, weight, eye pressures, vision and hearing testing, electrocardiogram)? ☒ Yes ☐ No

Comment? _____

4. Did the physician conducting the examination perform an appropriate review of your medical history, including questions regarding alcohol use, medications, operations, allergies, accidents, and hospitalization? ☒ Yes ☐ No

Comment? _____

5. Was the physician examination performed in a courteous and professional manner and were the results discussed with you, answering questions to your satisfaction? ☒ Yes ☐ No

Comment? _____

6. Was the physical examination thorough, covering all important body areas? ☒ Yes ☐ No

Comment? _____

7. What was your waiting time for examination? ☐ 10 min ☐ 10-20 min ☒ 20 min or more

8. Overall Quality of Service	Excellent	Very Good	Good	Fair	Poor
Examining Physician	☒	☐	☐	☐	☐
Nursing/Support Staff	☒	☐	☐	☐	☐
Facility Hygiene/Cleanliness	☐	☒	☐	☐	☐
Hearing Test Environment	☐	☐	☒	☐	☐

May we contact you for clarification or additional information? ☒ Yes ☐ No

Name: [redacted] Telephone Number: [redacted]

Comment? (Please comment if rating is fair or poor) Excessive waits between greeting and test battery; really long wait for physician.

NAME [redacted] | IDENTIFICATION NUMBER | NO. OF SHEETS ATTACHED

MEASUREMENTS AND OTHER FINDINGS

20. HEIGHT	21. WEIGHT	22. COLOR HAIR	23. COLOR EYES	24. BUILD	25. TEMPERATURE
[redacted]	[redacted]	[redacted]	[redacted]	☐ SLENDER ☑ MEDIUM ☐ HEAVY ☐ OBESE	✓

26. BLOOD PRESSURE *(Arm at heart level)*

	A. SITTING	B. RECUMBENT	C. STANDING (5 mins.)
SYS.	125		
DIAS.	83		

27. PULSE *(Arm at heart level)*

A. SITTING	B. RECUMBENT	C. STANDING (3 mins.)	D. AFTER EXERCISE	E. 2 MINS. AFTER
96	—	—	—	✓
108				

28. DISTANT VISION		29. REFRACTION			30. NEAR VISION		
RIGHT 20/ 15	CORR. TO 20/	BY	S.	CX	20/12	CORR. TO	BY
LEFT 20/ 15	CORR. TO 20/	BY	S.	CX	20/12	CORR. TO	BY

31. HETEROPHORIA *(Specify distance)*

ESO	EXO	R.H.	L.H.	PRISM DIV.	PRISM CONV. CT	PC	PD
				9	9		

32. ACCOMMODATION		33. COLOR VISION *(Test used and result)*	34. DEPTH PERCEPTION *(Test used and score)*	UNCORRECTED
RIGHT 14	LEFT 14	Ishihara's test 14/14	Stereo test 80	CORRECTED

35. FIELD OF VISION		36. NIGHT VISION *(Test used and score)*	37. RED LENS TEST	38. INTRAOCULAR TENSION	
RIGHT 90	LEFT 90			RIGHT 15	LEFT 13

39. HEARING			40. AUDIOMETER								41. PSYCHOLOGICAL AND PSYCHOMOTOR *(Tests used and score)*
				250 256	500 512	1000 1024	2000 2048	3000 2896	4000 4096	6000 6144	8000 8192
RIGHT W/V	/15 S/V	/15	RIGHT								
LEFT W/V	/15 S/V	/15	LEFT								

42. NOTES *(Continued)* **AND SIGNIFICANT OR INTERVAL HISTORY**

usual resting pulse ~72-76

FBS - 100
Hgb 16.0
HCT 49.5
ECG, spiro, audio, CXR - wnl
Stool heme ⊖

(Use additional sheets if necessary)

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

WNL

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

A	B	C	E

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

48. TYPED OR PRINTED NAME OF PHYSICIAN [redacted] MD	SI [redacted]
49. TYPED OR PRINTED NAME OF PHYSICIAN	SI
50. TYPED OR PRINTED NAME OF DENTIST OR PHYSICIAN *(Indicate which)*	SIGNATURE
51. TYPED OR PRINTED NAME OF REVIEWING OFFICER OR APPROVING AUTHORITY	SIGNATURE

MEDICAL RECORD — REPORT OF MEDICAL EXAMINATION

DATE OF EXAM: 5/27/09

1. LAST NAME–FIRST NAME–MIDDLE NAME: [redacted]
2. IDENTIFICATION NUMBER: [redacted]
3. GRADE AND COMPONENT OR POSITION:
4. HOME ADDRESS (Number, street or RFD, city or town, state and ZIP code): [redacted]
5. EMERGENCY CONTACT (Name and address of contact): [redacted]
6. DATE OF BIRTH: [redacted]
7. AGE: 28
8. SEX: ☐ FEMALE ☒ MALE
9. RELATIONSHIP OF CONTACT: FATHER
10. PLACE OF BIRTH: [redacted]
11. RACE: ☒ WHITE ☐ BLACK ☐ AMERICAN INDIAN/ALASKA NATIVE ☐ HISPANIC WHITE ☐ HISPANIC BLACK ☐ ASIAN/PACIFIC ISLANDER
12a. AGENCY: Federal Bureau of Investigation
12b. ORGANIZATION UNIT:
13. TOTAL YEARS GOVERNMENT SERVICE: a. MILITARY: b. CIVILIAN:
14. NAME OF EXAMINING FACILITY OR EXAMINER AND ADDRESS: [redacted]
15. RATING OR SPECIALTY OF EXAMINER:
16. PURPOSE OF EXAMINATION: Fitness for Duty Exam

17. CLINICAL EVALUATION

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		NE	O. PROSTATE (Over 40 or clinically indicated)	
✓	B. EARS-GENERAL (INTERNAL CANALS) (Auditory acuity under items 39 and 40)		✓	P. TESTICULAR	
✓	C. DRUMS (Perforation)		NE	Q. ANUS AND RECTUM (Hemorrhoids, Fistulae) (Hemocult Results)	
✓	D. NOSE		✓	R. ENDOCRINE SYSTEM	
✓	E. SINUSES		✓	S. G-U SYSTEM	
✓	F. MOUTH AND THROAT		✓	T. UPPER EXTREMITIES (Strength, range of motion)	
✓	G. EYES-GENERAL (Visual acuity and refraction under items 28, 29, and 36)		✓	U. FEET	
✓	H. OPHTHALMOSCOPIC		✓	V. LOWER EXTREMITIES (Except feet) (Strength, range of motion)	
✓	I. PUPILS (Equality and reaction)		✓	W. SPINE, OTHER MUSCULOSKELETAL	
✓	J. OCULAR MOTILITY (Associated parallel movements nystagmus)		✓	X. IDENTIFYING BODY MARKS, SCARS, TATTOOS [redacted]	
✓	K. LUNGS AND CHEST		✓	Y. SKIN, LYMPHATICS	
✓	L. HEART (Thrust, size, rhythm, sounds)		✓	Z. NEUROLOGIC (Equilibrium tests under item 41)	
✓	M. VASCULAR SYSTEM (Varicosities, etc.)		✓	AA. PSYCHIATRIC (Specify any personality deviation)	
✓	N. ABDOMEN AND VISCERA (Include hernia)			BB. BREASTS	
				CC. PELVIC (Females only)	

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.)

Restorable Teeth: 1 2 3 — 32 31 30 — O
Non-restorable teeth: 1 2 3 — 32 31 30 — /
Missing Teeth: 1 2 3 — 32 31 30 — X
Replaced by Dentures: 1 2 3 — 32 31 30 — X X X
Fixed Partial Dentures: 1 2 3 — 32 31 30 — X

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

REMARKS AND ADDITIONAL DENTAL DEFECTS AND DISEASES: Ø

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

A. URINALYSIS: (1) SPECIFIC GRAVITY
(2) URINE ALBUMIN
(3) URINE SUGAR
(4) MICROSCOPIC

B. CHEST X-RAY OR PPD (Place, date, film number and result): Sent to xrays / PPD placed

C. SYPHILIS SEROLOGY (Specify test used and results):

D. EKG

E. BLOOD TYPE AND RH FACTOR

F. OTHER TESTS: Hemoccults x 3 neg

NO. OF ATTACHED SHEETS:

MEDICAL RECORD — REPORT OF MEDICAL HISTORY

DATE OF EXAM: 5/27/09

NOTE: This information is for official and medically-confidential use only and will not be released to unauthorized persons

1. NAME OF PATIENT (Last, first, middle)

2. IDENTIFICATION NUMBER

3. GRADE

4a. HOME STREET ADDRESS (Street or RFD; City or Town; State; and ZIP Code)

5. EXAMINING FACILITY

4b. CITY

4c. STATE

4d. ZIP CODE

6. PURPOSE OF EXAMINATION

7. STATEMENT OF PATIENT'S PRESENT HEALTH AND MEDICATIONS CURRENTLY USED (Use additional pages if necessary)

a. PRESENT HEALTH: Excellent.

b. CURRENT MEDICATION

REGULAR OR INTERM.

c. ALLERGIES (Include insect bites/stings and common foods): Poison Oak

d. HEIGHT

e. WEIGHT

8. PATIENT'S OCCUPATION: LAWYER

9. ARE YOU (Check one): [X] RIGHT HANDED [ ] LEFT HANDED

10. PAST/CURRENT MEDICAL HISTORY

CHECK EACH ITEM	YES	NO	DON'T KNOW
Household contact with anyone with tuberculosis		X	
Tuberculosis or positive TB test		X	
Blood in sputum or when coughing		X	
Excessive bleeding after injury or dental work		X	
Suicide attempt or plans		X	
Sleepwalking		X	
Wear corrective lenses		X	
Eye surgery to correct vision		X	
Lack vision in either eye		X	
Wear a hearing aid		X	
Stutter or stammer		X	
Wear a brace or back support		X	
Scarlet fever		X	
Rheumatic fever		X	
Swollen or painful joints		X	
Frequent or severe headaches		X	
Dizziness or fainting spells		X	
Eye trouble		X	
Hearing loss		X	
Recurrent ear infections B	X		
Chronic or frequent colds		X	
Severe tooth or gum trouble		X	
Sinusitis B	X		
Hay fever or allergic rhinitis A	X		
Head injury		X	
Asthma		X	

CHECK EACH ITEM	YES	NO	DON'T KNOW
Shortness of breath		X	
Pain or pressure in chest		X	
Chronic cough		X	
Palpitation or pounding heart B	X		
Heart trouble		X	
High or low blood pressure		X	
Cramps in your legs		X	
Frequent indigestion		X	
Stomach, liver or intestinal trouble		X	
Gall bladder trouble or gallstones		X	
Jaundice or hepatitis		X	
Broken bones B	X		
Adverse reaction to medication		X	
Skin diseases		X	
Tumor, growth, cyst, cancer		X	
Hernia		X	
Hemorrhoids or rectal disease		X	
Frequent or painful urination		X	
Bed wetting since age 12		X	
Kidney stone or blood in urine		X	
Sugar or albumin in urine		X	
Sexually transmitted diseases		X	
Recent gain or loss of weight A	X		
Eating disorder (anorexia bulimia; etc.)		X	
Arthritis, Rheumatism, or Bursitis		X	
Thyroid trouble or goiter		X	

CHECK EACH ITEM	YES	NO	DON'T KNOW
Bone, joint or other deformity		X	
Loss of finger or toe		X	
Painful or "trick" shoulder or elbow		X	
Recurrent back pain or any back injury		X	
"Trick" or locked knee		X	
Foot trouble		X	
Nerve injury		X	
Paralysis (including infantile)		X	
Epilepsy or seizure		X	
Car, train, sea or air sickness		X	
Frequent trouble sleeping A	X		
Depression or excessive worry B	X		
Loss of memory or amnesia		X	
Nervous trouble of any sort		X	
Periods of unconsciousness		X	
Parent/sibling with diabetes, cancer, stroke or heart disease		X	
X-ray or other radiation therapy		X	
Chemotherapy		X	
Asbestos or toxic chemical exposure		X	
Plate, pin or rod in any bone		X	
Easy fatigability		X	
Been told to cut down or criticized for alcohol use B	X		
Used illegal substances B	X		
Used tobacco		X	

NSN 7540-00-181-8368
Previous edition not usable

A = Current B = Past

STANDARD FORM 93 (REV. 6-96)
Prescribed by ICMR/GSA
FIRMR (41 CFR) 201-9.202-1

11. FEMALES ONLY

CHECK EACH ITEM	YES	NO	DON'T KNOW	DATE OF LAST MENSTRUAL PERIOD	DATE OF LAST PAP SMEAR	DATE OF LAST MAMMOGRAM
Treated for a female disorder		N/A		N/A	N/A	N/A
Change in menstrual pattern		N/A				

CHECK EACH ITEM. IF "YES" EXPLAIN IN BLANK SPACE TO RIGHT. LIST EXPLANATION BY ITEM NUMBER.

ITEM	YES	NO
12. Have you been refused employment or been unable to hold a job or stay in school because of:		
a. Sensitivity to chemicals, dust, sunlight, etc.		X
b. Inability to perform certain motions.		X
c. Inability to assume certain positions.		X
d. Other medical reasons *(If yes, give reasons.)*		X
13. Have you ever been treated for a mental condition? *(If yes, specify when, where, and give details.)*	X	
14. Have you ever been denied life insurance? *(If yes, state reason and give details.)*		X
15. Have you had, or have you been advised to have, any operation. *(If yes, describe and give age at which occurred.)*		X
16. Have you ever been a patient in any type of hospital? *(If yes, specify when, where, why, and name of doctor and complete address of hospital.)*		X
17. Have you consulted or been treated by clinics, physicians, healers, or other practitioners within the past 5 years for other than minor illnesses? *(If yes, give complete address of doctor, hospital, clinic, and details.)*	X	
18. Have you ever been rejected for military service because of physical, mental, or other reasons? *(If yes, give date and reason for rejection.)*		X
19. Have you ever been discharged from military service because of physical, mental, or other reasons? *(If yes, give date, reason, and type of discharge; whether honorable, other than honorable, for unfitness or unsuitability.)*		X
20. Have you ever received, is there pending, or have you ever applied for pension or compensation for existing disability? *(If yes, specify what kind, granted by whom, and what amount, when, why.)*		X
21. Have you ever been arrested or convicted of a crime, other than minor traffic violations. *(If yes, provide details.)*		X
22. Have you ever been diagnosed with a learning disability? *(If yes, give type, where, and how diagnosed.)*		X

13. 2005-Present I see a counselor/therapist [redacted] for various personal/family/job-related issues. I have never been medicated for any mental health issues. [redacted]

17. I sustained a chip fracture in my right wrist during a [redacted] I was treated by the Emergency Dept at [redacted]

23. LIST ALL IMMUNIZATIONS RECEIVED

See Attachment 23

I certify that I have reviewed the foregoing information supplied by me and that it is true and complete to the best of my knowledge. I authorize any of the doctors, hospitals, or clinics mentioned above to furnish the Government a complete transcript of my medical record for purposes of processing my application for this employment or service. I understand that falsification of information on Government forms is punishable by fine and/or imprisonment.

24a. TYPED OR PRINTED NAME OF EXAMINEE	24b. SIGNATURE	24c. DATE
[redacted]	[redacted]	5/24/09

NOTE: HAND TO THE DOCTOR OR NURSE, OR IF MAILED MARK ENVELOPE "TO BE OPENED BY MEDICAL OFFICER ONLY".

26. PHYSICIAN'S SUMMARY AND ELABORATION OF ALL PERTINENT DATA *(Physician shall comment on all positive answers in Items 7 through 11. Physician may develop by interview any additional medical history deemed important, and record any significant findings here.)*

No residual wrist pain
Psychosocial probs — Has not initiated therapy. Min current stress
sleep probs
Smoke - 0
ETOH 0
Exercise: FBI Physical test daily. Hard run/pullups/situps

26a. TYPED OR PRINTED NAME OF PHYSICIAN OR EXAMINER	26b. SIGNATURE	26c. DATE
[redacted]	[redacted]	5/27/09

QUEST DIAGNOSTICS NICHOLS INSTITUTE
P.O. Box 10841 * 14225 Newbrook Drive, Chantilly, Virginia 20153-0841
Telephone: (703) 802-6900

Age and sex dependent reference ranges are printed when available if age and sex are designated. Otherwise, adult values are given.

[redacted] 49093210/0

Page 1 From Chantilly FOR [redacted] X
COLLECTED: 05/27/2009 00:00 25389
RECEIVED: 05/28/2009
REPORTED: 06/01/2009
2009/ 0/ 25389/ 0/31670709
HISTORY NO: 56263

TESTS	RESULTS	FLAG	REF. RANGE	UNITS
7496/Chantilly				
Health Profile #466				
CBC with Differential				
RBC VALUES				
ERYTHROCYTE COUNT	5.03		4.20-5.10	Mill/uL
HEMOGLOBIN	16.0	H	13.2-15.5	g/dL
HEMATOCRIT	49.5	H	38.5-45.0	%
MCV	98.4		80.0-100.0	FL
MCH	31.8		27.0-33.0	pg
MCHC	32.3		32.0-36.0	g/dL
RDW	14.7		11.0-15.0	%
WBC TOTAL AND DIFF				
WBC TOTAL	9.90		3.8-10.8	Thous/uL
WBC PERCENT COUNTS				
NEUTROPHILS	84.1	H	45.0-75.0	%
LYMPHOCYTES	12.5	L	15.0-45.0	%
MONOCYTES	3.4		3.0-12.0	%
EOSINOPHILS	0.0	L	1.0-8.0	%
BASOPHILS	0.0		0.0-1.0	%
WBC DIFF ABSOLUTES				
NEUTROPHILS	8326	H	1500-7800	Cells/mcL
LYMPHOCYTES	1238		850-3900	Cells/mcL
MONOCYTES	337		200-950	Cells/mcL
EOSINOPHILS	0	L	15-550	Cells/mcL
BASOPHILS	0		0-200	Cells/mcL
ADDITIONAL FINDINGS				
PLATELET COUNT	243		140-400	Thous/uL
RBC MORPHOLOGY	NORMAL			
Blood Group and Rh Type				
Blood Group (ABO)	O			
Rh Type	D POSITIVE			

PROFILE CONTINUED ON NEXT PAGE...

[redacted]

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TESTS	RESULTS	FLAG	REF. RANGE	UNITS
7496/Chantilly				
Health Profile #466 (CONTINUATION)				
Urinalysis, Chemical with Microscopic Examination				
Routine Urinalysis				
Color	YELLOW		YELLOW	
Appearance	CLEAR			
Specific Gravity	1.003		1.001-1.035	
pH	7.5		5.0-8.0	
Leukocyte Esterase	NEG		NEG	
Protein	NEG		NEG	
Glucose	NEG		NEG	
Ketones	NEG		NEG	
Bilirubin	NEG		NEG	
Occult Blood	NEG		NEG	
Nitrite	NEG		NEG	
Microscopic Urinalysis				
WBC	0		0-4	/HPF
RBC	0		0-3	RBC/HPF
Squamous Epith. Cells	NONE			
Bacteria	NONE			

PROFILE CONTINUED ON NEXT PAGE...

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[redacted]

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TESTS	RESULTS	FLAG	REF. RANGE	UNITS
7496/Chantilly				
Health Profile #466 (CONTINUATION)				
Chemistry-24				
Calcium	9.7		8.6-10.2	mg/dL
Ionized Ca, Calculated	4.1		3.6-4.6	mg/dL
Phosphate (as Phosphorus)	3.4		2.5-4.5	mg/dL
Glucose	100	H✓	65-99	mg/dL
Uric Acid	5.1		2.5-8.0	mg/dL
Urea Nitrogen (BUN)	9		7-25	mg/dL

PROFILE CONTINUED ON NEXT PAGE...

[redacted]

GK

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2009/ 0/ 25389/ 0/31670709
HISTORY NO: 56263

TESTS	RESULTS	FLAG	REF. RANGE	UNITS
7496/Chantilly				
Health Profile #466 (CONTINUATION)				
Creatinine w/eGFR				
Creatinine	0.95	***		mg/dL

*** Unable to flag abnormal result(s), please refer
to reference range(s) below:

Serum Creatinine Reference Ranges (mg/dL):

Age	Male	Female
0 - 2 days	0.79 - 1.58	
3 - 5 days	0.46 - 1.23	
6 - 7 days	0.37 - 1.05	
8 - 30 days	0.35 - 0.92	
1 - 11 months	0.27 - 0.72	
1 - 3 years	0.30 - 0.70	
4 - 6 years	0.29 - 0.68	
7 - 9 years	0.38 - 0.73	
10 - 12 years	0.42 - 0.78	
13 - 15 years	0.54 - 0.95	
16 - 17 years	0.70 - 1.16	0.51 - 1.00
18 - 19 years	0.67 - 1.26	0.48 - 1.01
20 - 29 years	0.80 - 1.30	0.57 - 1.03
30 - 39 years	0.79 - 1.33	0.58 - 1.06
40 - 49 years	0.78 - 1.34	0.59 - 1.07
50 - 59 years	0.76 - 1.46	0.60 - 1.10
60 - 69 years	0.76 - 1.46	0.60 - 1.18
>69 years	0.67 - 1.54	0.63 - 1.22

eGFR Non-African American
Age and/or gender not provided. Unable to calculate.
eGFR African American
Age and/or gender not provided. Unable to calculate.

REFERENCE RANGE:>=60 mL/min/1.73m^2

Creatinine/BUN Ratio	0.11	0.03-0.12

PROFILE CONTINUED ON NEXT PAGE...

[redacted]

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TESTS	RESULTS	FLAG	REF. RANGE	UNITS
7496/Chantilly				
Health Profile #466 (CONTINUATION)				
Total Protein	7.7		6.2-8.3	g/dL
Albumin	4.9		3.6-5.1	g/dL
Globulin	2.8		2.1-3.9	g/dL
A/G Ratio	1.7		1.0-2.1	
Bilirubin, Total	0.8		0.2-1.2	mg/dL
ALT	16		6-60	U/L
Alkaline Phosphatase	84		33-115	U/L
LD	175		100-250	U/L
AST	16		10-40	U/L
GGT	17		3-70	U/L
Sodium	138		135-146	mmol/L
Potassium	4.2		3.5-5.3	mmol/L
Chloride	101		98-110	mmol/L
Carbon Dioxide	25		21-33	mmol/L
Triglycerides	73		<150	mg/dL
Cholesterol, Total	163		125-200	mg/dL
Coronary Risk Profile				
Triglycerides	73		<150	mg/dL
Cholesterol, Total	163		125-200	mg/dL
HDL-Cholesterol	54		>=40	mg/dL

PROFILE CONTINUED ON NEXT PAGE...

[redacted]

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HISTORY NO: 56263

TESTS	RESULTS	FLAG	REF. RANGE	UNITS
7496/Chantilly				
Health Profile #466 (CONTINUATION)				
Cholesterol/HDL Ratio	3.0		<=5.0	
VLDL-Chol. Calculated	15		8-32	mg/dL
LDL-CHOL. Calculated	94		<130	mg/dL

RISK OF CORONARY HEART DISEASE

	TOTAL CHOL./HDL-CHOL. RATIO	
	MEN	WOMEN
1/2 average risk	3.4	3.4
average risk	5.0	4.4
2 times average risk	9.6	7.1
3 times average risk	23.4	11.0

Reference ranges for HDL-cholesterol are valid only for persons age 16 and above.

T-4 (Thyroxine), Total	8.5		4.5-12.5	mcg/dL
500X/Chantilly				
G-6-PD, RBC				
G-6-PD, RBC	8.3		4.6-13.5	U/g Hb

*** FINAL REPORT ***

[P 62521]-[S 2929] Printed 14:45:33 01 JUN 2009
Kenneth Sisco, M.D.
Director of Laboratories

[redacted]

[redacted]

Occupational Health Services

[redacted]

May 27, 2009

PATIENT NAME: [redacted]
DOE: 05/27/2009

[redacted]

Resting Electrocardiogram: The resting record is sinus rhythm at a rate of 80, PR interval 0.15, QRS duration 0.08, axis +90 degrees. Normal QRS complexes and T waves.

Conclusion: Within normal limits.

[redacted]

[redacted]

DD: 05/29/2009
DT: 05/30/2009
Job: 306901

[redacted]

[redacted]

[redacted]

ID:

27-May-2009 10:50:53

28years
Male Caucasian
[redacted]

Vent. rate	89	bpm
PR interval	148	ms
QRS duration	94	ms
QT/QTc	350/425	ms
P-R-T axes	66 86 55	

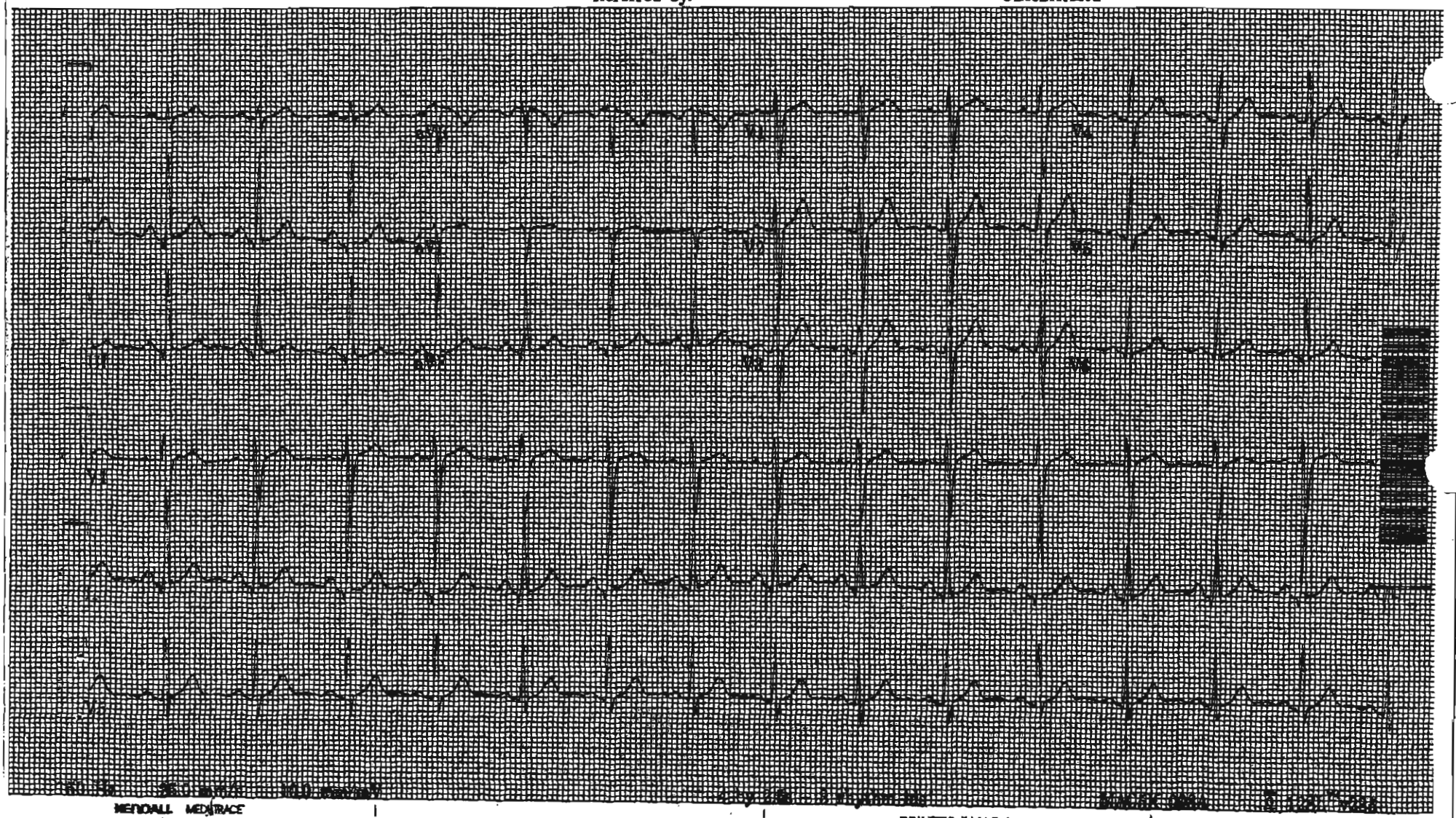
Normal sinus rhythm
Normal ECG

[redacted]

Technician: [redacted]
Test ind:

Referred by:

Unconfirmed



[redacted]

Occupational Health Services

AUDIOMETRY EXAMINATION

PRINT NAME: [redacted] LAST FIRST M.I.

EMPLOYER: [redacted] DATE: 5/27/09

(FBI applicant)

Have you ever had any of the following?:

	YES	NO
Difficulty hearing when background noise is present		✓
Hearing loss		✓
Worn a hearing Aid		✓
Persistent ringing or buzzing in ears		✓
Recurrent ear infections or mastoiditis	✓	
Ear injury or perforated ear drum		✓
Ear or mastoid surgery		✓
Head injury, skull fracture, or unconsciousness		✓
Multiple sclerosis, meningitis, or syphilis		✓
Mumps, measles, or scarlet fever		✓
Frequent dizziness or Meniere's disease		✓
Hay fever or sinusitis	✓	
Family history of hearing loss before age 50		✓
Hearing problem resulting from taking a medication		✓
Currently have a cold, sinusitis, or ear infection		✓
Excessive exposure to noise in last 24 hours		✓

Have you had noise exposure in the form of?:

	YES	NO
Military gunfire or explosions	✓	
Target shooting or hunting	✓	
Loud engines (aircraft/ truck/ marine)		✓
Motorcycles, all-terrain vehicles		✓
Chain saws, lawnmowers, other power tools	✓	
Loud music or walkman radios	✓	
Machine shop or other industrial		✓
Other exposure to loud noise		✓

Explain any yes responses above:
Allergies occasionally result in fluid in ears, which occasionally get infected
miscellaneous power tools used w/ protection.

Are you exposed to loud noise in your present job? YES NO

Do you wear hearing protection when working around loud noise?
☑Always ☐Usually ☐Occasionally ☐Rarely ☐never

If yes, what type of hearing protection do you wear?
☑ disposable plugs ☐molded plugs ☐muffs ☐other: _____

All jobs together, how many years have you worked in loud noise? 0

Employee's Signature [redacted]

Clinician"s review and comments
Both drums and canals: ☐ normal ☐other

Clinician's name: (Print) [redacted] Signature [redacted]

Interpretation:
☑ no hearing loss (up to 25 decibels in all frequencies)
☐ mild hearing loss (25 to 40 decibels in any frequencies)
☐ moderate hearing loss (40 to 60 decibels in any frequencies)
☐ severe hearing loss (over 60 decibels in any frequencies)

[redacted]

DATE: 05/27/09
TIME: 10:17:51

PATIENT:56263

CURRENT AUDIOGRAM

FREQ.	L/DB	R/DB
1000 HZ	10	05
500 HZ	20	20
V1000 HZ	10	05
2000 HZ	05	00
3000 HZ	05	10
4000 HZ	00	05
6000 HZ	10	15
8000 HZ	05	05
AVG 2.3.4	003.3	005.0

TEST ID:157101725090401B

ELAPSED TIME = 04:56

TEST TYPE = BASELINE
TEST MODE = PULSED
M = MANUALLY TESTED FREQ

TREMETRICS RA500+
SERIAL NUMBER...05024018
SOFTWARE REV. 2.09H-0102
CALIBRATION: 07/24/08
CAL. ANSI S3.6 1989

[redacted]

X [redacted]

EXAMINER:XB

X [redacted]

XX

[redacted]

Patient Information

Name	[redacted]
ID	
Age	28
Height	[redacted]
Weight	[redacted]
Gender	MALE
Ethnic	CAUCASIAN
Smoker	NO
Asthma	NO

Test Information

Test Date/Time	05/27/09 11:55am
Post Time	--:--
Test Mode	DIAGNOSTIC
Interpretation	NLHEP
Predicted Ref	Knudson83
Value Select	BEST VALUE
Tech ID	
Automated QC	ON
BTPS (IN/EX)	-.--/ 1.02

Test Results

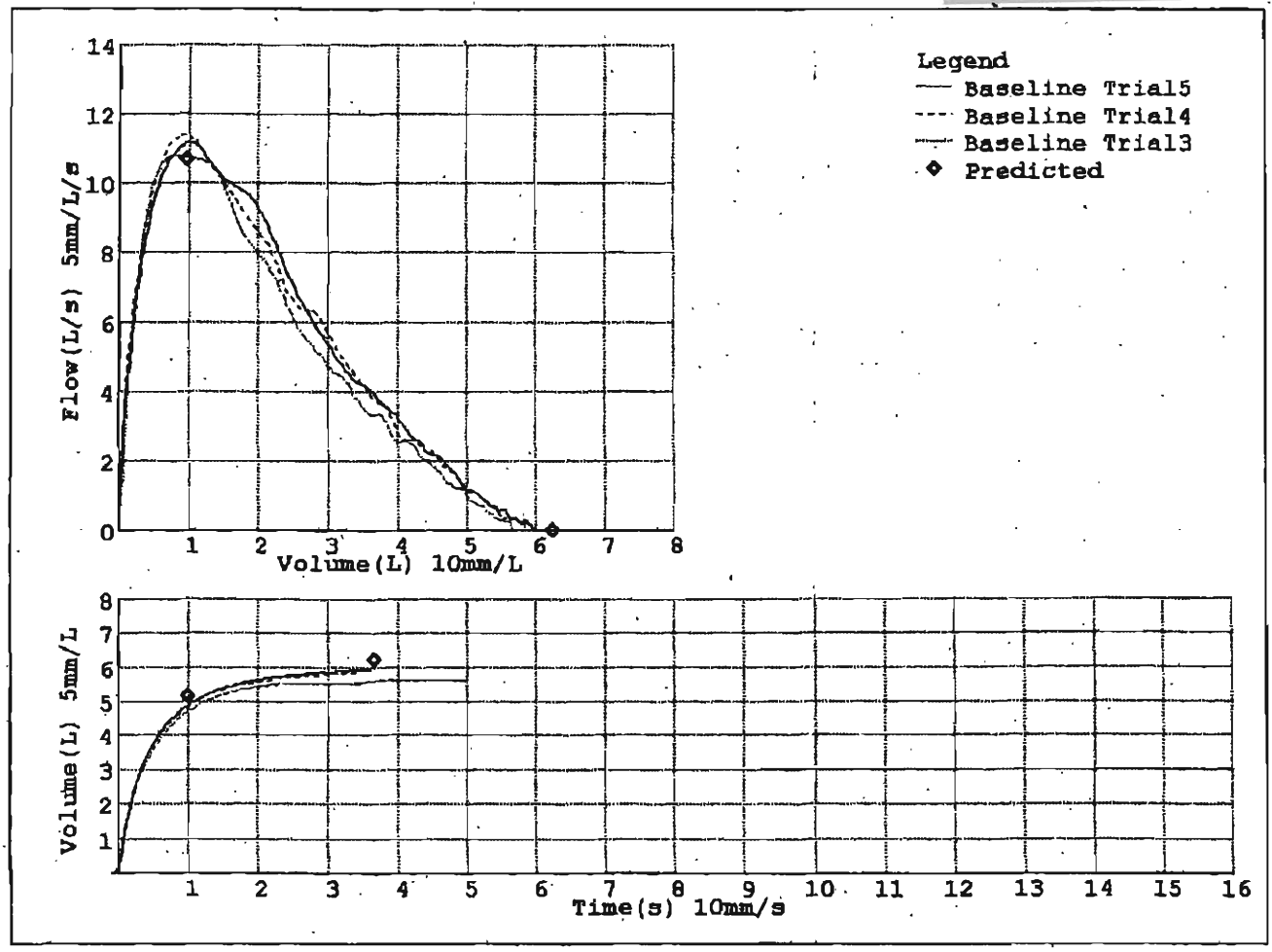
Your FEV1 is 95% Predicted

Parameter	Baseline Best	Trial5	Trial4	Trial3	Pred	%Pred
FVC(L)	5.95	5.95	5.88	5.66	6.25	95
FEV1(L)	4.90	4.90	4.87	4.71	5.17	95
FEV1/FVC	0.82	0.82	0.83	0.83	0.84	98
PEF(L/min)	667	667	679	647	642	104
FEF25-75(L/s)	4.80	4.80	4.82	4.57	5.35	90
FET(s)	3.65	3.65	3.46	5.04	-.--	--

Baseline Interpretation: FEV1 Var=0.03L 0.6%; FVC Var=0.07L 1.3%; Session Quality A

Normal Spirometry

[redacted]



[redacted]

RADIOLOGY CONSULTATION REPORT

Name: [redacted] DOB: [redacted] MR#: 06574895
Indication: PHYSICAL EXAM Term Loc: [redacted]
Report Status: Final Exam Date: 05/27/2009
Location: [redacted] Exam Code: D00165 Order#: CPR0948349
ACCT#: 08137209 Exam: Chest PA/LAT Standard

Chest radiograph, PA and lateral views

CLINICAL HISTORY: PHYSICAL EXAM

COMPARISON: None.

FINDINGS:
The lungs are clear. There is a normal cardiomediastinal silhouette. The costophrenic sulci are sharp.

IMPRESSION:
Negative exam.

Dictated By: [redacted], MD, [redacted]
Dictate Date/Time: 05/27/2009 12:05:33
Electronically Signed: 7621 [redacted], MD
Signed Date/Time: 05/27/2009 12:06:13

T: 05/27/2009 TC
Physician(s): [redacted] Ord. MD: [redacted]
Non Staff Physician

[redacted]

Occupational Health Services

[redacted]

PPD TESTING AND RESULT

Print Name [redacted] (Patient) _____ (M.I.)

05/27/2009
SSN: DOB: [redacted]
Case#: 56263 MRN:
F.B.I.

Company: _____

Date Administered: 5/27/09 ☐ ~~FLFA~~ ☐ RFA

Administered by: [redacted]
(Signature) (Title)

Date Test Must Be Read: 5/29 **(48-72 hours)**

Lot# C306 2mm Exp. 7/3/11

Your TB test must be read by one of the following healthcare workers trained in the reading of TB: Occupational Health personnel, physicians, or nurses. Self-reading of the test is not permitted.

PPD Result: ☐ **Negative** ☐ **Positive** _____ **mm**
(Please record the result in mm of induration; zero if none)

Designated Reader: _____

Signature: _____

Title: _____

Date Read: _____

Fax Form/Result to: [redacted]

Pt: [redacted] DOB [redacted] Dr: Date: 5/27/09 Initials: YS

Hemoccult: + 3 (neg) (mag) (+)ctl: + 3 (+) (-)ctl: neg (-) Lot#: 5204092 Exp: 11/07

Developer Lot#: + 5026 Exp: 5/10

STOOL OCCULT BLOOD

[redacted]

FD-967
Revised
06-12-2003

FEDERAL BUREAU OF INVESTIGATION

NEW AGENT PHYSICAL ACTIVITIES

EMPLOYEE INFORMATION

Name:	Date:
[redacted]	3/11/2008

AGENT PHYSICAL ACTIVITIES

Please indicate if applicant/trainee can perform the following:

1. Control Techniques: ✓ Yes ○ No

   Subject takedown requires grappling in both standing and sitting positions. This drill often includes the fugitive crawl with two trainees restraining a third.

2. Personal Weapon Attacks utilizing confrontation drills:

   a.) Full contact boxing ✓ Yes ○ No

   b.) Kicks ✓ Yes ○ No

   c.) Fist to elbow strikes ✓ Yes ○ No

3. Officer Survival Techniques: ✓ Yes ○ No

   This activity stresses live or die drills, weapons disarming and retention.

4. Carotid Restraint: ✓ Yes ○ No

   This technique is used against violently resisting subjects and requires a takedown from the standing position.

5. Handcuffing: ✓ Yes ○ No

   Actors or students who pose as arrest subjects sometimes resist strenuously.

6. Break Falls and Shoulder Rolls: ✓ Yes ○ No

7. "O" Course to include:

   a.) Climbing and Vaulting ✓ Yes ○ No

   b.) Jumping from High Obstacles ✓ Yes ○ No

   c.) Net rope climbing ✓ Yes ○ No

8. Yellow Brick Road: ✓ Yes ○ No

   A 7.2 run - includes rope climbs and obstacles both natural and man-made.

9. Firearms: ✓ Yes ○ No

   This activity includes long periods of firing from a prone position. Students must also qualify on an obstacle course, which requires shooting from standing, kneeling and prone positions.

PHYSICIAN INFORMATION

Physician's Signature: [redacted]	Date: 5/21/09
Print or Type Name: [redacted]	Telephone Number:
Specialty Board Certified: ✓ Yes ○ No	List Specialty: OCC med

Attachment 23

OTHER IMMUNIZATIONS/PROPHYLAXIS RECEIVED
Autres vaccinations/prophylaxies reçues

This space is provided to record immunizations/prophylaxis that are not required for entrance into any country but have been obtained by the traveler for additional health protection (immune globulin, malaria, measles, etc.)

Date	Vaccine/prophylactic drug Vaccin/médicament prophylactique	Dose	Physician's signature Signature du médecin
[redacted]	DPT/OPV #1		[redacted]
1/13/81	DPT/OPV #2		
4/1/81	DPT/OPV #3		
7/12/84	DPT/OPV #4		
7/23/85	DPT/OPV #5		
12/15/81	MMR 1		[redacted]
10/19/91	MMR2		[redacted]
6/92	D-T BOOSTER (ADULT)		[redacted]
2/8/85	HEPATITIS B #1		[redacted]
3/8/85	HEPATITIS B #2		[redacted]
7/23/85	HEPATITIS B #3		[redacted]
2/21/89	TB-TINE	NEGATIVE	[redacted]
10/19/91	TB-TINE	NEGATIVE	[redacted]
12/20/94	TB-TINE	NEGATIVE	[redacted]
5/10/02	ADULT D-T BOOSTER		[redacted] EMERGENCY RECM
5/26/09	MCV4		[redacted]

I certify that the above is correct. [redacted]

MEDICAL CONTRAINDICATION TO VACCINATION
Contre-indication médicale à la vaccination

This is to certify that immunization against
Je soussigné(e) certifie que la vaccination contre

_____ for / pour
(Name of disease – Nom de la maladie)

_____ is medically / est médicalement
(Name of traveler – Nom du voyageur)

contraindicated because of the following conditions:
contre-indiquée pour les raisons suivantes:

_____

_____

_____

_____

_____
(Signature and address of physician)
(Signature et adresse du médecin)

PERSONAL HEALTH HISTORY

Le certificat doit être signé de sa propre main par la personne à vacciner ou une autre personne habilitée par l'administration sanitaire nationale, un cachet officiel ne pouvant être considéré comme tenant lieu de signature.
Toute correction ou rature sur le certificat ou l'omission d'une quelconque des mentions qui composent peut affecter sa validité.

How to Complete Your International Certificate of Vaccination

1. Enter your name and address on the cover of the booklet before presenting it to your physician.

2. At the beginning of the Yellow Fever Certificate, print your name on the first line; sign your name on the second line; indicate your sex; and indicate your date of birth in the following sequence: day, month, year. Example: 5 June 1958.

3. It is your responsibility to have the Yellow Fever Certificate validated with an "approved stamp." THE YELLOW FEVER CERTIFICATE IS NOT VALID WITHOUT AN "APPROVED STAMP."

INSTRUCTIONS TO PHYSICIANS

INFORMATION REQUESTED IN EACH SECTION MUST BE COMPLETED FOR THE SECTION TO BE VALID.

1. The dates are to be written with the day in arabic numerals, followed by the month in letters and the year in arabic numerals.
Example: 2 Jan. 1982.

2. Vaccinations may be given by a licensed physician or under the direct supervision of a qualified medical practitioner. The WRITTEN signature of the physician or other person authorized by the physician must appear on the Certificate. A signature stamp is not acceptable.

3. If yellow fever immunization is required for your patient but is contraindicated on medical grounds, you should complete the "Medical Contraindication to Vaccination" statement indicating the nature of the contraindication.

4. It is strongly recommended that persons traveling abroad and those entering the United States be immune from measles by prior disease or vaccination.

5. There is a risk of acquiring MALARIA when traveling to parts of the Caribbean, Central and South America, Africa, the Middle East, the Indian subcontinent, the Far East, and Oceania. For information on malaria prophylaxis, areas where malaria transmission occurs, recommended prophylactic drug regimens, and on preparing patients for international travel, contact your local or State Health Department or call the CDC's toll-free information service at 1-888-232-3228.

For sale by the U.S. Government Printing Office
Superintendent of Documents, Mail Stop: SSOP, Washington, DC 20402-9328

*U.S. Government Printing Office: 1998 — 443-098

FOLD HERE TO PLACE WITH PASSPORT

INTERNATIONAL CERTIFICATE OF VACCINATION

AS APPROVED BY
THE WORLD HEALTH ORGANIZATION

CERTIFICAT INTERNATIONAL DE VACCINATION

APPROUVÉ PAR
L'ORGANISATION MONDIALE DE LA SANTÉ

TRAVELER'S NAME–NOM DU VOYAGEUR

ADDRESS–ADRESSE (Number–Numéro) (Street–Rue)

(City–Ville)

(County–Département) (State–État)

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

PUBLIC HEALTH SERVICE

PHS–731 (REV.11-91)

[redacted]

[FBI Applicant file]

[redacted]

[redacted] (name of patient) was given a

Tuberculin skin test on 05/27/09 (date). It was

Read on 05/29/09 (date) and was non reactive.

Signature, Title

[redacted]

6/2/09

From: [redacted] [FBI Applicant]

[redacted]

To: [redacted] Health Services

RE: TB test results
MMR Serology results

Note: If this form is not acceptable, please fax me your preferred TB test form for my primary care physician to sign. [redacted]

D-864 (Rev. 2-23-98)

FEDERAL BUREAU OF INVESTIGATION

Immunization Questionnaire

Name: [redacted] Date: 5/24/04

Division: _____ SSN: [redacted]

Known Medical Problems: _____ Blood Type: unknown

Allergies: Poison Oak; hay fever

Please respond **Yes, No** or **Unknown** to the following questions. If Yes, please place the date, the dosage, facility where given, and person (if known), who gave it to you. If you have traveled overseas you should have all injections listed on your Travel Immunization Record. Some of these are a series of immunizations and some are childhood immunizations. A good resource is the college where you graduated.

Have you ever been immunized or had any of the following?

Immunization	Yes	No	Unk	Date	Dosage	Facility Where Injection Given	Person Giving Injection
Diphtheria/Tetanus (Td)							
Dose one	✓			[redacted]		[redacted]	[redacted]
Dose two	✓			4/13/81		[redacted]	↓
Dose three	✓			4/1/81			
Hepatitis A (Havrix or VAQTA)							
Dose one							
Dose two							
Hepatitis B	✓						
Dose one	✓			2/8/85		[redacted]	[redacted]
Dose two	✓			3/8/85		[redacted]	↓
Dose three	✓			7/23/85		↓	
Influenza							
Measles (3 days) (Rubella)	✓						
Measles (9 days) (Rubeola)	✓						
Meningococcal Meningitis (MM)							
MMR (Measles, Mumps, Rubella)	✓			12/15/81 10/14/91		[redacted]	[redacted]

Immunization	Yes	No	Unk	Date	Dosage	Facility Where Injection Given	Person Giving Injection
Pertussis (Whooping Cough)							
Dose one							
Dose two							
Dose three							
Polio							
Dose one	✓			10/28/80		[redacted]	[redacted]
Dose two	✓			1/13/81			
Dose three	✓			4/1/81			
Adult Booster (OPV)	✓						
Rabies							
Pre Exposure							
Dose one							
Dose two							
Dose three							
Post exposure							
Dose one							
Dose two							
Dose three							
Dose four							
Booster							
Typhoid (oral)							
Yellow Fever							
Japanese Encephalitis							
Other Adult D-T	✓			5/10/02		[redacted]	unknown
Booster MCV4	✓			5/26/09		[redacted]	[redacted]

FD-300 (Rev. 3-20-79)

Attachment to Standard Form 88, Report of Medical Examination
For Information and Guidance of Medical Examiner

Name of Examinee _____ [redacted] _____
(Type or print) Last First

The following portions of the attached examination report form need not be completed:

3	9	17	67	76
4	11	62	68	
8	14	65	72	

45, 46, 47 and 49; required for all Special Agent and FBI National Academy applicants but not for any other applicant unless the examining physician deems one, two, three or all four of the examinations necessary. 45, 46 and 47 are required in examination of any current employee.

48. Required for (1) all Special Agent applicants; (2) all FBI National Academy applicants; (3) all examinees over 35 years of age; (4) any other where examination indicates such as desirable.

69. Required for all examinees over 40 years of age.

71. Audiometer examinations must be afforded for all Special Agent applicants and Special Agents and decibel readings must be recorded at 500, 1000, 2000, 3000 and 4000 Hertz. Applicants for the Special Agent position will not be accepted if the hearing loss exceeds a 25 decibel average (ANSI) in either ear in the frequency range 1000, 2000, and 3000 Hertz. No single reading in that range may exceed 35 decibels and no applicant will be accepted if found to have a hearing loss exceeding 35 decibels at 500 or 45 decibels at 4000 Hertz.

For All Examinees, Whether Clerical or Special Agent Applicants, National Academy Applicants, or Employees:

The medical examiner should answer the following question:

Examinee ☒ is ☐ is not qualified for strenuous physical exertion.

To be Answered in the Case of All Special Agents, Special Agent Applicants, and National Academy Applicants:

1. Does examinee have any defects restricting or prohibiting his/her participation in defensive tactics and dangerous assignments which might entail the practical use of firearms?

☒ No ☐ Yes If "yes" please specify defects. _____

_____

To be Answered in the Case of All Special Agents, Special Agent Applicants, and other Employees who drive Bureau vehicles:

1. Does examinee have any defects prohibiting safe operation of motor vehicles?

☒ No ☐ Yes If "yes" please specify defects. _____

_____

2. For safe driving of motor vehicles, Office of Personnel Management requires distant vision must test at least 20/40 in one eye and 20/100 in the other, corrected or uncorrected. Should examinee wear corrective glasses while operating a motor vehicle? ☐ Yes ☒ No
If recommendation is based on a factor other than above standard, indicate basis _____

_____

_____

DESIRABLE WEIGHT RANGES

MALES				FEMALES			
Height	Small Frame	Medium Frame	Large Frame	Height	Small Frame	Medium Frame	Large Frame
5'4"	117 - 138	123 - 149	131 - 163	5'0"	96 - 114	101 - 124	109 - 138
5'5"	120 - 142	126 - 153	134 - 167	5'1"	99 - 118	104 - 128	112 - 141
5'6"	124 - 146	130 - 157	138 - 173	5'2"	102 - 121	107 - 131	115 - 144
5'7"	128 - 151	134 - 163	143 - 178	5'3"	105 - 124	110 - 135	118 - 149
5'8"	132 - 155	138 - 167	147 - 183	5'4"	108 - 128	113 - 139	121 - 152
5'9"	136 - 161	142 - 172	151 - 187	5'5"	111 - 132	117 - 144	125 - 156
5'10"	140 - 165	146 - 177	155 - 193	5'6"	114 - 135	120 - 149	129 - 161
5'11"	144 - 169	150 - 183	160 - 198	5'7"	118 - 140	124 - 153	133 - 165
6'	148 - 174	154 - 188	164 - 204	5'8"	122 - 144	128 - 157	137 - 169
				5'9"	126 - 149	132 - 162	141 - 174
				5'10"	130 - 154	136 - 166	145 - 179
				5'11"	134 - 158	140 - 171	149 - 185
				6'0"	138 - 163	144 - 175	153 - 190
6'5"	174 - 204	182 - 222	192 - 238				

4. Examinee's frame is ☐ small ☑ medium ☐ large

5. Considering the above weight table, the examinee's frame, and other individual physical characteristics, I consider his/her present weight ☑ Satisfactory ☐ Excessive ☐ Deficient

6. Under proper medical supervision, employee should ☐ lose _____ pounds
☐ gain _____ pounds

Remarks: _____

_____

_____

_____
Signature of Medical Examiner

5/27/09
Date

Attn: [redacted]

[redacted]

May 22, 2009

[redacted]

Dear Mr. [redacted]

Here are the results of your serologies showing immunity to Mumps, Measles, and Reubella.

Component	5/21/2009
Rubella virus IgG	IMMUNE
Mumps virus IgG, EIA	POSITIVE
Measles virus IgG, EIA	POSITIVE

Sincerely,

[redacted]