



## Physician's Medical Verification Form

### Operator Information

Date of Examination: \_\_\_/\_\_\_/\_\_\_

OPERATOR'S NAME (Last, First, Middle)	BIRTHDATE m/d/y	SEX m/f	AGE
SOCIAL SECURITY NUMBER OR CIC NUMBER	PHONE/EMAIL ADDRESS		
HOME ADDRESS	CITY	STATE	ZIP

### Health History

Yes	No		Yes	No	
()	()	<b>Asthma, Lung disease</b>	()	()	<b>Digestive problems</b>
()	()	<b>Kidney disease</b>	()	()	<b>Stroke or paralysis</b>
()	()	<b>Tuberculosis</b>	()	()	<b>Rx drug use</b>
()	()	<b>Diabetes</b>	()	()	<b>Head or spinal injuries</b>
()	()	<b>Liver disease</b>	()	()	<b>Seizures, dizziness</b>
()	()	<b>Rheumatic Fever</b>			<b>or fainting</b>
()	()	<b>Narcotic or habit forming drug use</b>	()	()	<b>Chronic low back pain</b>
()	()	<b>Muscular Disease</b>	()	()	<b>Psychiatric Disorder, e.g.</b>
()	()	<b>Any other nervous disorder</b>			<b>severe depression</b>
()	()	<b>Cardiovascular Disease</b>	()	()	<b>Suffering from any other</b>
()	()	<b>Regular, frequent alcohol use</b>			<b>disorder</b>

If answered yes to any above please explain

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**Carefully read the ASME B30.5-3.1.2 physical requirements listed below. (Physician please initial in yes/no)**

1. Patient has a vision of at least 20/30 Snellen in one eye and 20/50 in the other, with or without corrective lenses. \_\_\_\_ YES \_\_\_\_ NO
  
2. Patient has the ability to distinguish colors, regardless of position, if color differentiation is required. \_\_\_\_ YES \_\_\_\_ NO
  
3. Patient has adequate hearing to meet operational demands, with or without a hearing aid. \_\_\_\_ YES \_\_\_\_ NO

4. Patient has sufficient strength, endurance, agility, coordination, and speed of reaction to meet crane operation or rigger and signalperson demands. \_\_\_\_ YES \_\_\_\_ NO

5. Patient has normal depth perception, field of vision, reaction time, manual dexterity, coordination, and no tendencies to dizziness or similar undesirable characteristics. \_\_\_\_ YES \_\_\_\_ NO

6. Patient has negative results for a substance abuse test. The level of testing is determined by the standard practice for the industry where the crane is employed and confirmed by a recognized laboratory service. \_\_\_\_ YES \_\_\_\_ NO

7. Patient has no physical defects or emotional instability that could render a hazard to themselves or others, or which, in the opinion of the physician, could interfere with the candidate's performance. \_\_\_\_ YES \_\_\_\_ NO

8. Patient is not subject to seizures or loss of physical control. \_\_\_\_ YES \_\_\_\_ NO

*Disclaimer: Understanding that medical conditions can change rapidly, the above responses indicate that at the time the person listed as "operator" met the physical conditions as indicated.*

If there are any NO answers to one or more of the eight (8) requirements listed above, but you as the Physician believe that failure to meet the qualification will not affect the ability of the person listed as operator to operate cranes, please explain why:

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Operator  
Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Physician  
Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Physician's Name Printed: \_\_\_\_\_

Physician Phone Number: \_\_\_\_\_