

MEDICAL EXAMINER'S CERTIFICATE - NAVY EMPLOYMENT
I Certify that I have examined

Employee's Name _____
SS# _____ Empt. Sign _____
Address of Employee _____
 Qualified only when wearing corrective lenses
 Qualified only when wearing a hearing aid
A complete examination form of this person is on file in my office
Date _____ Doctor _____
Signature of Doctor _____
Address of Clinic _____

Name of Command _____
Issued _____ Command/Sign _____

NMCP 2130/IA (New 3/99)

VALID ONLY FOR NAVY EMPLOYMENT

- Qualified for DOT Vehicle OP _____ Expiration Date
 (Not _____ in accordance with the Motor Carrier Safety
Applicable) Regulations (49 CFR 391.41 through 391.49)
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- Qualified for Explosives Handlers/Explosive Vehicle Operator
 (Not _____ Expiration Date
Applicable) in accordance with the Manual of the Medical
Department and 49 CFR 391.41 through 391.49
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- Qualified for Wt Handling Equip _____ Expiration Date
 (Not _____ in accordance with 49 CFR and NAVFAC P 307
Applicable) Waiver Issued Yes / No
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- Qualified for Forklift/MHE Operator _____ Expiration Date
 (Not _____ in accordance DOD 4145.19-R-1
Applicable) Regulations (49 CFR 391.41 through 391.49)
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