OMB Control Number: 0648-0822
Expiration Date: 05/31/2027

NOAA Form 57-03-54
(02-25)

U.S. DEPARTMENT OF COMMERCE
NATIONAL OCEANIC AND ATMOSPHERIC ADMINISTRATION

REPORT OF MEDICAL HISTORY – ANNUAL UPDATE

LAST NAME	FIRST NAME	MIDDLE NAME	DATE OF BIRTH	DATE

WORK ADDRESS	WORK PHONE NUMBER
	WORK E-MAIL ADDRESS
	CELL PHONE NUMBER

STATEMENT OF PRESENT HEALTH	AGE	SEX
	HEIGHT	WEIGHT

CURRENT PRESCRIPTION AND NON-PRESCRIPTION MEDICATIONS (Indicate dosage, frequency and condition being treated)	ALLERGIES (List all insect bites / stings, foods and medicines)

MEDICAL HISTORY OF THE PAST YEAR: Have you had any of the following in the past 12 months? Check each item. Explain any item that has changed since you last submitted a Report of Medical History form to the NOAA Diving Program. Physician signature is not required.

	YES	NO		YES	NO
Tuberculosis or positive TB test			Aneurysm, frequent or severe headaches		
Exposed to someone who had tuberculosis			Other neurologic disorder or injury		
Asthma or any breathing difficulty			Prolonged bleeding, blood clot or embolism		
Lung squeeze or collapsed lung (pneumothorax)			Heart murmur or other disorder		
Thyroid trouble or goiter			High or low blood pressure		
Ear infection or ruptured ear drum			Abnormal heart anatomy or patent foramen ovale		
Inability to equalize middle ear pressure			Depression, anxiety or claustrophobia		
Bone, joint or other deformity			Been evaluated or treated for a mental condition		
High or low blood sugar			Difficulty performing moderate to heavy exercise		
Unexplained weight loss or gain			Diabetes, high cholesterol, stroke or heart disease		
Head injury, memory loss or amnesia			Parent or sibling with diabetes, stroke or heart disease		
Concussion or period of unconsciousness			Treated in a decompression chamber		
Seizures, convulsions, epilepsy or fits			Decompression illness (symptoms of both AGE/DCS)		
Dizziness or fainting spells			Currently pregnant/ may be pregnant (women only)		

Indicate the type and frequency of use for the following.

Alcohol	Tobacco	Illegal drugs

Indicate date, location and reason for each hospitalization and surgery, had or advised to have. Indicate the reasons for any declined surgery.

Provide a detailed explanation for each item checked "YES" in either Medical History section. Add additional pages if necessary.

APPLICANT CERTIFICATION:

_____ I have reviewed the attached medical information and consider the application package to be complete.

_____ I acknowledge that it is my responsibility to notify the NOAA Diving Medical Office of any illness or injury requiring medical treatment and/or surgery.

_____ I acknowledge it is my responsibility to notify my UDS and the onsite diving supervisor of any conditions or restrictions that will affect my diving on any given day. Failure to do so could compromise the mission and endanger myself or my fellow divers.

I certify that I have reviewed the medical information provided by me. It is true and complete to the best of my knowledge.

APPLICANT NAME	APPLICANT SIGNATURE	DATE

NOAA DIVING MEDICAL OFFICER APPROVAL:

I have reviewed the attached medical information and have found the applicant named above to be:

☐ Medically cleared for NOAA diving duty ☐ Not medically cleared for NOAA diving duty

DIVING MEDICAL OFFICER NAME	DIVING MEDICAL OFFICER SIGNATURE	DATE

PRA Public Burden Statement

A Federal agency may not conduct or sponsor, and a person is not required to respond to, nor shall a person be subject to a penalty for failure to comply with an information collection subject to the requirements of the Paperwork Reduction Act of 1995 unless the information collection has a currently valid OMB Control Number. The approved OMB Control Number for this information collection is 0648-0822. Without this approval, we could not conduct this information collection. Public reporting for this information collection is estimated to be approximately 10 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the information collection. All responses to this information collection are required to obtain benefits. Send comments regarding this burden estimate or any other aspect of this information collection, including suggestions for reducing this burden to the NOAA Diving Center Executive Officer, NOAA Diving Program, 7600 Sand Point Way NE, Building 8, Seattle, WA 98115, 206-526-6460.

Privacy Act Statement

Authority: The collection of this information is authorized under 29 CFR 1910, Subpart T, Commercial Diving Operations. Additional authorities include 29 U.S.C. 653, 655, 657; 40 U.S.C. 333; 33 U.S.C. 941; Secretary of Labor's Order No. 8-76 (41 FR 25059), 9-83 (48 FR 35736), 1-90 (55 FR 9033), 6-96 (62 FR 111), 3-2000 (65 FR 50017), 5-2002 (67 FR 65008), 5-2007 (72 FR 31160), or 4-2010 (75 FR 55355) as applicable, and 29 CFR 1911.

Purpose: NOAA is collecting this information to assess an individual's medical fitness to dive, proficiency, and further training. Information will also be used to ensure diving equipment is safe and well maintained and that all policies are being adhered to for safety reasons. Aggregate data is used for annual reports and other leadership documents.

Routine Uses: NOAA will use this information in the determination of an individual's medical fitness to dive. Disclosure of this information is permitted under the Privacy Act of 1974 (5 U.S.C. Section 552a) to be shared among Department staff for work-related purposes. Disclosure of this information is also subject to all of the published routine uses as identified in the Privacy Act System of Records Notice NOAA-10, NOAA Diving Program.

Disclosure: Furnishing this information is voluntary. However, the failure to provide complete and accurate information will exclude the individual from NOAA's Diving Program.