

**MEDICAL SELF-CERTIFICATION
U.S. CUSTOMS AND BORDER PROTECTION (CBP)**

Name: _____ SSN: _____

CBP Position Applied for: _____ (e.g., BPA, CBPO, etc.)

***PLEASE READ THE ENTIRE DOCUMENT CAREFULLY BEFORE
COMPLETING AND SIGNING THIS UPDATE, AND INITIAL AT THE
BOTTOM OF EACH PAGE WHERE INDICATED.***

The purpose of this questionnaire is to determine if you have had medical changes that affect your eligibility, and if you can safely participate in training. We may need to verify your answers.

Failure to respond completely and honestly to the questions that follow may result in the rescission of the tentative offer of employment. Neither your truthful answers nor any information or evidence derived as a result of your responses can be used against you in a court of law. However, you should be aware that making willfully false statements in order to obtain a Federal benefit is a criminal offense (18 USC 1001).

PRIVACY STATEMENT

The information you give on this questionnaire is subject to the Privacy Act, 5 USC 552a. CBP will appropriately safeguard it from improper disclosure and will make it available only to officials having a need for it, for purposes related to the hiring process.

Please provide your answers in the space below each question. If additional space is needed, continue your response on an attached page and number the response to the corresponding question. You must initial and date pages 1, 2, and 3, and sign and date page 4.

Initials: _____ Date: _____

DATE OF LAST CBP MEDICAL CLEARANCE _____

Current occupation: _____

Current employer: _____

How long in current position (years/months): _____

- 1. Since the date of your last CBP medical clearance, have you had a change in your medical history or incurred a physical injury? If YES, please fully explain the circumstances surrounding the change or injury, and include nature and date of the change or injury, treating physician's name, address, telephone number, and current status:**

- 2. Since the date of your last CBP medical clearance, have you taken or are you currently taking any new prescription medication? If YES, please provide complete details regarding usage, including name of the medication, dosage, reason for the medication; and if you stopped taking the medication, the date you stopped:**

Name: _____ **SSN:** _____

Initials: _____ **Date:** _____

3. Since the date of your last CBP medical clearance, have you been hospitalized for any reason? If YES, please provide a detailed explanation of the circumstances, the dates of hospitalization, the name and address of the hospital, treating physician, telephone number, and current status:

4. Since the date of your last CBP medical clearance, have you consulted with or been treated by any clinics, physicians, healers, or other kind of practitioner? If YES, please provide full details, including the reason for the treatment, the date(s), and name of the health care professional and/or clinic, address, telephone number, and current status:

Name: _____ **SSN:** _____

Initials: _____ **Date:** _____

5. Since the date of your last CBP medical clearance, have you consulted with or been treated by a psychological or psychiatric professional? If YES, please provide complete details, including the reason, date(s) of treatment, and the name, address and telephone number of the therapist or doctor:

6. Since the date of your last CBP medical clearance, have you had any incidents occur that resulted from the use of alcohol or any intoxicant? If Yes, please provide a full explanation, and include the date(s) and location(s) of incident:

Print Name: _____ SSN: _____

Signature: _____ Date: _____

Current mailing address: _____
Street address City, State, zip code

E-mail address: _____

Phone numbers with area code: Daytime: _____

Home: _____ Work: _____