

Candidate DOB: _____



Candidate name: _____

Dear Healthcare Provider:				
Comprehensive Health Services provides occupational health services for the Department of Interior (DOI), and we are responsible for providing the final medical clearance recommendation for participation in arduous duty positions. Your assistance is requested to help CHS determine if this individual can safely perform their essential job tasks without undue risk to themselves or others.				
Your professional medical opinion and any supporting documentation such as copies of diagnostic studies, office notes, or dictations on the following items will assist CHS in providing the appropriate medical recommendations to the DOI. Neither CHS nor DOI are responsible for any additional costs associated with obtaining the items listed below. Please sign, date and return this form with relevant supporting documentation to CHS at your earliest convenience.				
Thank you for participating in the medical management of this individual's seizures.				
Sincerely,				
Comprehensive Health Services, Inc. Exam Management				
As this individual's personal neurologist, I confirm that the following are true and accurate regarding this individual's seizures :				
YES NO N/A or (please initial) Not Done				
At least 5 years seizure free on a stable medication regimen with at least annual medical evaluations. Date of last seizure:				
Normal neurological evaluation to include awake and sleep EEG with photic stimulation, hyperventilation and sleep deprivation after achieving the above 5-year seizure free period. If abnormal, explain:				
Normal brain imaging study, such as MRI of the brain. If abnormal, explain:				





<u>YES</u>	<u>NO</u>	N/A or	=	
			No medication side effects. List all medications, dosages and side effects (if ar	ny):
			Compliant with all prescribed medications.	
			As this individual's neurologist, in my professional can safely perform duties of an arduous duty wildle review).	-
List k	Unkno	wn	cted triggers or factors that may lead to seizure a	
	_		imated risk or likelihood of future seizure activi	ty and overall medical
G	ood / A	verage F	Risk of recurrence (less than 1%) Risk of recurrence (less than 5%) Risk of recurrence (greater than 5%)	
Other	comm	ents:		
(Name	e/Degre	ee)	(Signature)	(Date)
(Medi	cal Spe	cialty)		