National Aeronautics and
Space Administration

Lyndon B. Johnson Space Center
2101 NASA Parkway
Houston, Texas 77058-3696

Reply to Attn of: AHX

August 1, 2012

Joern A. Jernsletten, Ph.D.
[redacted]

Dear Dr. Jernsletten:

The initial evaluation of your application for the Astronaut Candidate Program has been completed. The next stage in the selection process is to identify the interviewees. Before you can be considered for an interview, you must obtain a prescreening medical examination. This does not guarantee you will be interviewed.

An FAA certified Aviation Medical Examiner (AME) must perform the NASA Astronaut Selection Pre-Screening Medical History and Examination. It is similar to a Class II or III FAA medical examination, however it uses the enclosed form. Please arrange to have a medical examination by a certified AME and forward the results on the enclosed form to our office by October 1, 2012. You will be reimbursed up to $75.00 for the medical examination. Please enclose a copy of the physician's fee receipt with the results of the examination. A postage-paid envelope is enclosed for your convenience. You can obtain a list of AME's in your area at the following website: http://www.faa.gov/pilots/amelocator/.

If you have any questions regarding the medical standards, please call the Flight Medicine Clinic at 281-483-7999. For questions regarding the astronaut candidate selection process, please call the Astronaut Selection Office at 281-483-5907.

Sincerely,

Teresa Gomez

Teresa Gomez
Assistant Manager
Astronaut Selection Office

Enclosures

Instructions for the NASA Medical Screening Examination

NOTE

The physical examination is to be performed by a certified **FAA Aviation Medical Examiner** (AME). You can find FAA AMEs by visiting http://www.faa.gov/pilots/amelocator/ or, if unable to access the internet, you may find an AME by calling your local chamber of commerce or local medical society.

1. Please print or type.

2. Answer all the questions to the best of your knowledge. When data is not available, enter "N/A" (do not leave blank answer spaces).

3. The applicant will complete page 1 of the form and sign it.

4. The examining physician will complete the second page of the form.

    a. Height should be in inches.
    b. Weight should be in pounds.
    c. Blood pressure should be taken in the seated position after at least 2 minutes rest in the chair.
    d. Distant visual acuity - if the applicant does not see 20/200 and your equipment does not measure past 20/200, please indicate so on the form by a visual acuity > **20/200**.

Please return all the medical information in the enclosed postage-paid envelope.

May 24, 2012

NASA ASTRONAUT SELECTION PRE-SCREENING
MEDICAL HISTORY AND EXAMINATION

Name:	Social Security number:	Date of birth:
Address:	Telephone number:	Sex:

1. List any medications (include prescription, non-prescription, vitamins, herbal supplements) which you use on a regular basis and note the purpose you use it for. Use additional sheets if necessary.

2. List any hospitalizations or surgeries, the date, and the reason. Use additional sheets if necessary.

3. List any physician seen in the last 3 years and the reason including physicals. Use additional sheets if necessary.

4. MEDICAL HISTORY: Have you ever had or have you now any of the following? Explain any yes answers in the space below. Use additional sheets if necessary.

Condition	Yes	No	Condition	Yes	No
Frequent or severe headaches including migraines			Jaundice or hepatitis		
Dizziness or fainting spells			Rupture or hernia		
Eye or vision trouble except glasses			Kidney stone or blood in urine		
Orthokeratology			Head injury or skull fracture		
Surgical alteration of the cornea such as radial keratotomy, PRK, LASIK			Neurological disorders: seizures, stroke, paralysis		
Ear, nose, or throat trouble			Unconsciousness for any reason		
Hay fever or allergy			Mental disorders: depression, anxiety		
Tuberculosis or positive TB skin test			Suicide attempt		
Asthma or wheezing			Substance dependence or abuse		
Shortness of breath			Recurrent back pain		
Pain or pressure in chest			Bone, joint or other deformity		
Palpitations or pounding heart			Arthritis, rheumatism		
Heart or vascular trouble			Fractures		
High or low blood pressure			Diabetes		
Stomach, liver, or intestinal trouble			Tumor, growth, cancer		
Gallbladder trouble or gallstones			Thyroid disorder		

5. EXPLANATIONS: Explain any 'yes' answer in number 4 above. Use additional sheets if necessary.

Signature of Applicant	Date

Physician's Signature: _____

May 24, 2012

CLINICAL EVALUATION

HEIGHT (inches)	WEIGHT (pounds)	BLOOD PRESSURE (sitting)	PULSE

DISTANT VISION		NEAR VISION	
Right 20/	corr. to 20/	Right 20/	corr. to 20/
Left 20/	corr. to 20/	Left 20/	corr. to 20/
COLOR VISION	Normal Abnormal	FIELD OF VISION	Normal Abnormal

Note color vision test Method:	Esophoria	Exophoria	Right Hyperphoria	Left Hyperphoria

CHECK EACH ITEM IN THE APPROPRIATE COLUMN	Normal	Abnormal	CHECK EACH ITEM IN THE APPROPRIATE COLUMN	Normal	Abnormal
Head, face, neck, and scalp			Vascular system		
Nose			Abdomen and viscera		
Sinuses			Anus and rectum		
Mouth and throat			Skin		
Ears - general			G-U system (pelvic not reqd)		
Ear drums			Upper and lower extremities		
Eyes - general			Spine, other musculoskeletal		
Ophthalmoscopic			Identifying body marks, scars		
Pupils (equality and reaction)			Lymphatics		
Ocular motility			Neurologic		
Lungs and chest			Psychiatric		
Heart			General systemic		

NOTES: Describe every abnormality in detail. Use additional sheets if necessary.

SUMMARY OF DEFECTS AND DIAGNOSES

Typed or printed name of physician	Signature
Date of examination	AME serial number

May 24, 2012