



**Division of Occupational Licensure**  
**Office of Public Safety and Inspections 1000**  
**Washington Street, Suite 710**  
**Boston, MA 02118**

**ANSI/ASME B30.5 MEDICAL QUALIFICATIONS FORM**

This form is for the sole use to attain/renew a Massachusetts Hoisting license, in accordance with 520 CMR 6.02. The medical qualifications must be performed by the applicant's licensed primary care physician. The ANSI/ASME B30.5 Medical Qualifications Form will be valid for **three (3) years** from the date of completion, unless more frequent supervision is deemed necessary by the licensed primary care physician.

**Applicant/Licensee's Information (to be completed by patient)**

First Name	M. I.	Last Name	MA Hoisting License (if applicable) <b>HE -</b>
Home Street Address			Social Security Number - -
City		State	Zip Code
Phone Number ( ) -		Email Address	

**ANSI/ASME B30.5 Medical Qualification Requirements (to be completed by patient's licensed primary care physician)**

Does the patient meet the requirements listed below?	YES	NO
Vision of at least 20/30 Snellen in one eye and 20/50 in the other, with or without corrective lenses.	<input type="checkbox"/>	<input type="checkbox"/>
Ability to distinguish colors, regardless of position, if color differentiation is required.	<input type="checkbox"/>	<input type="checkbox"/>
Adequate hearing to meet operational demands with or without hearing aid.	<input type="checkbox"/>	<input type="checkbox"/>
Sufficient strength, endurance, agility, coordination, and speed of reaction to meet the operation demands.	<input type="checkbox"/>	<input type="checkbox"/>
Normal depth perception, field of vision, reaction time, manual dexterity, coordination, and no tendencies to dizziness or similar undesirable characteristics.	<input type="checkbox"/>	<input type="checkbox"/>
Negative result for a substance abuse test. (Testing shall be confirmed by a recognized laboratory service)	<input type="checkbox"/>	<input type="checkbox"/>
No evidence of having physical defects or emotional instability that could render a hazard to the operator or others, or that in the opinion of the examiner could interfere with the operator's performance.	<input type="checkbox"/>	<input type="checkbox"/>
No evidence of being subject to seizures or loss of physical control.	<input type="checkbox"/>	<input type="checkbox"/>

**If the patient does not meet one or more of the requirements listed above, please complete the section below.**

In accordance with ANSI/ASME B30.5-3.1.2 (a), "[t]he Operator... shall meet the following physical qualifications unless it can be shown that failure to meet the qualifications will not affect the operation of the [hoisting machinery]. In such cases, specialized clinical or medical judgments and tests may be required."	YES	NO
Will the failure to meet one or more of the requirements listed above affect the patient's ability to operate hoisting machinery?	<input type="checkbox"/>	<input type="checkbox"/>

If **NO**, please provide a written explanation on the failed requirement(s) not affecting the patient's ability to operate hoisting machinery, attaching extra pages as necessary.  
If **YES**, please acknowledge that the patient does not medically qualify to operate hoisting machinery below by checking the appropriate box below.

**Upon reviewing the ANSI/ASME B30.5 Medical Qualification Requirements, I determine that the patient listed on this form:**

☐ **Medically qualifies to operate hoisting machinery.** ☐ **Does not medically qualify to operate hoisting machinery.**

**CERTIFICATION: I hereby certify that this document and all attachments to the best of my knowledge are true and accurate.**

\_\_\_\_\_  
Applicant/Licensee's (Patient) Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Physician's Printed Name

\_\_\_\_\_  
Physician's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Physician's State License/Certificate/Registration Number

\_\_\_\_\_  
Phone Number