UNITED NATIONS NATIONS UNIES

MEDICAL CLEARANCE FOR EMPLOYMENT

Instructions for the medical examination

1. Appointment with the United Nations is provisional on successful completion of a medical examination and medical clearance from the United Nations Medical Director or medical officer designated by the United Nations Medical Director. This is required to ensure, as far as possible, that candidates are physically and mentally fit to perform the functions for which they have been selected without risk to their own health and safety or the health and safety of others.

2. Candidates shall be examined by a medical officer of the United Nations system or a designated United Nations examining physician. The results of the medical examination, including mandatory diagnostic tests, shall be documented on a medical examination form and shall be forwarded to the United Nations Medical Director or medical officer designated by the United Nations Medical Director to obtain clearance.

3. Our records show that the location(s) for this purpose closest to your address is: _____ .

   If you have not already done so, please arrange to be examined by a physician named above. This must be done as soon as possible, as we cannot complete your appointment and arrange for your travel until you have been cleared by the United Nations Medical Director or medical officer designated by the United Nations Medical Director. If the physician/s named above is/are not available, you may arrange to see any physician in your location. Please keep in mind when selecting your physician that you will need, besides the physical examination, the following diagnostic tests:

   (i) Resting electrocardiogram (ECG),

   (ii) Urine testing for glucose, albumin, and microscopic examination,

   (iii) Blood or serum analyses for:

   - Hemoglobin, haematocrit, erythrocyte count, erythrocyte sedimentation rate, leukocyte count and different count, if indicated.
   - Fasting blood sugar and cholesterol, uric acid, and either urea or creatinine.

   (iv) Full size anterior-posterior chest X-ray.

4. Once your medical examination is complete (please review carefully the "Examination Checklist" below), send it to the United Nations Medical Service as indicated by the Human Resources Officer requesting the examination preferably via e-mail or fax.

Medical Examination Checklist

Before you go to the doctor, please ensure that:

- The version you have of the Entry Medical Examination form is **MS.2 (11-09)-E**. If it is not, ask the human resources officer requesting the medical examination to provide you with the proper form.
- You have filled pages 1 and 2 of the Entry Medical Examination form and that you have answered ALL the questions regarding Family and Personal Medical History.

At the physician's, please ensure that:

- The physician has completely filled out Pages 3 and 4.
- Visual acuity is entered in the form as numerical values.
- Pulse rate and blood pressure are entered in the form as numerical values.
- Laboratory results are entered in the form as numerical values.
- The physician has commented on all the positive answers you gave and summarized the abnormal findings.
- If you have a condition that requires treatment, ensure that the physician specified the treatment in the Comments section.

Before you send the result of the medical examination to the respective Medical Service, please ensure that:

- Page 1 is complete. The index number should be provided to you by the human resources officer requesting the medical examination. Do not submit the result of the medical examination without this number.
- You have attached the electrocardiogram tracing and the radiologist's report on your chest X-ray. The X-ray film itself is not required, and you should NOT send it with the Entry Medical Examination Form.
- You have filled the examining physician contact information

***Note* : if you have an untreated and uncontrolled condition, this may delay your medical clearance until your condition is under control. You should start treatment and proceed to send the examination form (The physician should state the situation in the comments section). Send the completed examination form to the respective United Nations Medical Service. Once you finish treatment and/or your condition is under control, please send an updated report from your physician to the respective United Nations Medical Service. Upon receipt of such report, medical clearance will be processed.**

FAO	IAEA	ILO	ITC	ITU	UN	UNDP	UNESCO	UNICEF	UNIDO	WHO	WIPO	WMO	WTO

CONFIDENTIAL

ENTRY MEDICAL EXAMINATION

UNITED NATIONS AND SPECIALIZED AGENCIES

I hereby authorize any of the doctors, hospitals or clinics mentioned in this form to provide the United Nations Medical Service with copies of all my medical records so that the Organization or specialized agencies take action upon my application for employment.

I certify that the statements made by me in answer to the questions below are, to the best of my knowledge, true, complete and correct. I realize that any incorrect statement or material omission in the medical information form or in any other document required by the Organization or specialized agencies renders a staff member liable to termination or dismissal.

Date:(dd/mm/yyyy) ..... Signature: .....

Pages 1 and 2 are to be completed by the candidate

FAMILY NAME (IN BLOCK CAPITALS)	GIVEN NAMES	MAIDEN NAME (FOR WOMEN ONLY)	SEX ☐ M ☐ F

ADDRESS (STREET, TOWN, DISTRICT OR PROVINCE, COUNTRY)	DATE OF BIRTH	NATIONALITY
	BIRTHPLACE	

E-MAIL ADDRESS	TELEPHONE	INDEX NUMBER (provided by Human Resources Officer)

POSITION APPLIED FOR (DESCRIBE NATURE OF WORK)	PRESENT MARITAL STATUS
	☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed
DUTY STATION	DATE OF LAST STATUS CHANGE (dd/mm/yyyy)

Have you ever undergone a medical examination for the United Nations or one of its agencies? .....

Have you ever been employed by the United Nations or one of its agencies? .....

If so, please state when, where and for which Organization: .....

FAMILY HISTORY

Relative	Age (if still alive)	State of Health (If still alive, present state; if deceased, cause of death)	Age At death	Have members of your family had the following illnesses or disorders?	Yes	No	Who?
Father				High Blood Pressure	☐	☐	
Mother				Heart Disease	☐	☐	
Brothers				Diabetes	☐	☐	
Sisters				Tuberculosis	☐	☐	
Spouse				Asthma	☐	☐	
Children				Cancer	☐	☐	
				Epilepsy	☐	☐	
				Mental Disorders	☐	☐	
				Paralysis	☐	☐	

HUMAN RESOURCES OFFICER REQUESTING THE EXAMINATION (To be completed by the candidate if not pre-filled)	TO BE COMPLETED BY THE DIRECTOR OF THE MEDICAL SERVICE
Name of Official:	Medical Classification: 1a 1b 2a 2b
Department or Unit:	Comments:
E-mail Address:	
Date:	Date: Signature:

***VERY IMPORTANT:* Please indicate the recruiting Agency or Organization:**

Each question requires a specific answer (yes, no, date, etc.); to leave a blank or draw a line is not sufficient. If the questionnaire is not fully completed and enquiries are therefore needed, time may be lost.

1. Have you suffered from any of the following diseases or disorders? Check yes or no. If yes, state the year:

	YES Year	NO		YES Year	NO		YES Year	NO		YES Year	NO
Frequent sore throats		☐	Heart and blood vessel disease		☐	Urinary disorder		☐	Fainting spells		☐
Hay fever		☐	Pains in the heart region		☐	Kidney trouble		☐	Epilepsy		☐
Asthma		☐	Varicose veins		☐	Kidney stones		☐	Diabetes		☐
Tuberculosis		☐	Frequent indigestion		☐	Back pain		☐	Gonorrhoea		☐
Pneumonia		☐	Ulcer of stomach or duodenum		☐	Joint problems		☐	Any other sexually transmitted disease		☐
Pleurisy		☐	Jaundice		☐	Skin disease		☐	Tropical diseases		☐
Repeated bronchitis		☐	Gall stones		☐	Sleeplessness		☐	Amoebic dysentery		☐
Rheumatic fever		☐	Hernia		☐	Any nervous or mental disorder		☐	Malaria		☐
High blood pressure		☐	Haemorrhoids		☐	Frequent headaches		☐			☐

2. Are you being treated for any condition now? _____ Describe: _____
3. Have you ever coughed up blood? _____
4. Have you ever noticed blood in your stools? _____ In your urine? _____ Give details: _____
5. Have you ever been hospitalized (hospital, clinic, etc.)? _____
   Why, where and when? _____
6. Have you ever been absent from work for longer than one month through illness? _____ If so, when? _____
   And for what illness? _____
7. Have you had any accidents or illnesses as a result of which you are partially disabled? _____ If so, what and when? _____
   _____ Do you have any other disability? _____
8. Have you ever consulted a neurologist, a psychiatrist or a psychoanalyst? _____
   If so, please give his/her name and address: _____
   For what reason? _____ Date of consultation: (dd/mm/yyyy)
9. Are you taking any medicine regularly? _____ If so, which? _____
10. Have you gained or lost weight during the last three years? _____ If so, how much? _____
11. Have you ever been refused life insurance? _____ If so, state reason: _____
12. Have you ever been refused employment on health grounds? _____ If so, state reason: _____
13. Have you ever received or applied for a pension or compensation for any permanent disability? _____ Degree? _____
    Please give details: _____
14. Have you ever stayed in a tropical country? _____ If so, for how long? _____
15. Have you in the past suffered from any condition which prevented travel by air? _____
16. Do you consider yourself to be in good health? _____ Do you have full work capacity? _____
17. Do you smoke regularly? ☐ Yes ☐ No If so, what do you smoke? ☐ Cigarettes ☐ Pipe ☐ Cigars
    For how many years have you smoked? _____ How much per day? _____
18. Daily consumption of alcoholic beverages: _____
19. Has any doctor or dentist advised you to undergo medical or surgical treatment in the foreseeable future? _____
    Give details: _____
20. Give any other significant information concerning your health: _____

21. What is your occupation? _____ Indicate at least three posts you have occupied: _____
22. List any occupational or other hazards to which you have been exposed: _____
23. Have you been rejected for military service for medical reasons? _____
24. **FOR WOMEN** Are your periods regular? ☐ Yes ☐ No | Do you take contraceptive pills? ☐ Yes ☐ No .
    Are they painful? ☐ Yes ☐ No | If so, for how many years have you been _____ .
    Do you have to stay in bed when they come? ☐ Yes ☐ No | Have you ever been treated for a gynaecological complaint? ☐ Yes ☐ No
    If so, for how long? _____ Date of your last period: _____ If so, which? _____

TO BE COMPLETED BY THE EXAMINING PHYSICIAN

GENERAL APPEARANCE — Height: cm. _____ Weight: kg. _____

Skin: _____ Scalp: _____

SIGHT, MEASURED VISUAL ACUITY (Please enter numerical values when applicable)

Gross vision	: Right		Left		Pupils: Equal?		Regular?
Vision with spectacles	: Right		Left		Fundi (if necessary):		
Near vision	: Right		Left		Colour vision:		
With correction	: Right		Left				

HEARING (test by whispering)	Right : Normal :		Sufficient:		Insufficient:	
	Left : Normal :		Sufficient:		Insufficient:	
	Ear drum : Right :		Left:			

NOSE-MOUTH-NECK	Nose :		Pharynx :		Teeth :	
	Tongue :		Tonsils :		Thyroid :	

CARDIOVASCULAR SYSTEM (Please enter numerical values for pulse and blood pressure)

Pulse rate :		Auscultation :		Peripheral arteries -carotid :	
Rhythm :		Blood pressure :		-posterior tibial :	
Apex beat :		Varicose veins :		-dorsalis pedes :	

Electrocardiogram: _____ Please attach tracing

RESPIRATORY SYSTEM

Thorax: _____ Breasts : _____

DIGESTIVE SYSTEM — Spleen: _____

Abdomen : _____ Hernia: _____

Liver : _____ Rectal examination: _____

NERVOUS SYSTEM

Papillary reflexes: { - To light: _____ - On accommodation: _____

Patellar reflexes : _____

Achilles reflexes: _____

Plantar reflexes : _____

Motor functions : _____

Sensory functions : _____

Muscular tonus : _____

Romberg's sign : _____

MENTAL STATE

Appearance: _____ Behaviour: _____

GENITO-URINARY SYSTEM

Kidneys: _____ Genitals: _____

SKELETAL SYSTEM

Skull : _____ Upper extremities: _____

Spine: _____ Lower extremities: _____

LYMPHATIC SYSTEM

CHEST X-RAY (Please send only the radiologist's report based on a "full-size" X-ray film).

LABORATORY (Please enter numerical results)

The results of all the following investigations must be included except where marked "if indicated".

Except by prior agreement, only the investigations mentioned are done at the Organization's expense.

Urine : Albumin : _____ Sugar _____ Microscopic : _____

Blood: Haemoglobin : _____ % _____ Grams/1 Leucocytes : _____

Haematocrit : _____ % _____ Differential count (if indicated): _____

Erythrocytes : _____ Blood sedimentation rate: _____

Blood chemistry:

Sugar : _____ Urea or creatinine: _____

Cholesterol : _____ Uric acid : _____

Serological test for syphilis: Please attach laboratory report

Stool examination (if indicated):

COMMENTS (Please comment on all the positive answers given by the candidate and summarize the abnormal findings)

CONCLUSIONS (Please state your opinion on the physical and mental health of the candidate and fitness for the proposed post)

The examining doctor is requested before sending this report to verify that the questionnaire, pages 1 and 2 of this form, has been fully completed by the candidate and that all the results of the investigations required are given on the report. Incomplete reports are a major source of delay in recruitment.

EXAMINING PHYSICIAN INFORMATION

PHYSICIAN NAME (IN BLOCK CAPITALS)	TELEPHONE No.	FAX No.

E-MAIL ADDRESS:	Signature: _____
ADDRESS (STREET, TOWN, DISTRICT OR PROVINCE, COUNTRY)	Date (dd/mm/yyyy):