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 can 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 renders a staff member liable to termination or dismissal.

Date:(dd/mm/yy) _____ 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

POSITION APPLIED FOR (DESCRIBE NATURE OF WORK)

TELEPHONE

BIRTHPLACE

DUTY STATION

PRESENT MARITAL STATUS

Single ☐

Married ☐ DATE: (d/m/y) _____ **Divorced** ☐ DATE: (d/m/y) _____

Separated ☐ DATE: (d/m/y) _____ **Widowed** ☐ DATE: (d/m/y) _____

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	☐	☐	

TO BE COMPLETED BY THE OFFICIAL REQUESTING THE MEDICAL EXAMINATION	TO BE COMPLETED BY THE DIRECTOR OF THE MEDICAL SERVICE
Name of Official:	Medical Classification: 1a 1b 2a 2b
Department or Unit:	Comments:
Date:	DATE: (d/m/y) 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 Date	NO		YES Date	NO		YES Date	NO		YES Date	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		☐	headaches		☐			☐

Are you being treated for any condition now? _____ Describe: _____

3. _____

Have you ev _____ In your urine? _____ Give details: _____

5. _____

Why, where and when? _____

6. _____ If so, when? _____

_____

Have you had any accidents as a result of which you are partially disa _____ If so, what and when? _____

_____

Have you ever consulted a neurologist, a psychiatrist or a psychoanalyst? _____

name and address: _____

For what reason? _____ Date of consultation:(d/m/y)

Are you taking any medicine regularly? _____ If so, which? _____

10. lost weight during the last three years? _____ _____

Have you ever been refused life insurance? _____ If so, state reason: _____

12. n health grounds? _____ _____

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? _____ _____

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. ☐ ☐ If so, what do you smoke? ☐ Cigarett ☐ Pipe ☐ Cigars

_____ How much per day? _____

18. Daily consumption of alcoholic beverages: _____

19. dvised 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? _____ _____

_____

22. _____

_____

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 If so, for

Are they painful? ☐ Yes ☐ No | how many years have you been doing so? _____ Have you ever

Do you have to stay in bed when they come? ☐ Yes ☐ No | 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

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

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

Electrocardiogram _____ Please attach tracing

RESPIRATORY SYSTEM

Thorax: _____

Breasts

DIGESTIVE SYSTEM

Abdomen : _____

Liver : _____

Spleen: _____

Hernia: _____

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 (Full size film - Please send the radiologist's report).

LABORATORY

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.

Name of the examining physician (in block capitals):

_____

Address:

_____

Signature: _____

DATE: (d/m/y) _____