U.S. Department of State
Office of Medical Services, M/MED, Washington, DC 20520-0102

MEDICAL CLEARANCE UPDATE

OMB APPROVAL NO. 1405-0131
EXPIRATION DATE xx/xx/xxxx
ESTIMATED BURDEN: 30 MINUTES*
Serial Number xxxxxxxxx

PRIVACY ACT NOTICE

This information is requested pursuant to the Foreign Service Act of 1980, as amended (Title 5 U.S.C. 552A.). The primary purpose for soliciting this information is to determine medical eligibility to enter the Foreign Service and to make appropriate assignments abroad. Unless otherwise protected by medical privacy regulations, the information solicited on this form may be made available to appropriate agencies, whether Federal, state, local, or foreign, for law enforcement and administration purpose. It may also be disclosed pursuant to court order. Failure to provide this information may result in denial of a medical clearance and affect your Foreign Service eligibility.

TO BE FILLED OUT BY EXAMINEE *(Complete all sections on both sides, type or in ink.)*

Date *(mm-dd-yyyy)*

1. Name of Examinee (Last, First, MI.)

2. If Family Member, Name of Employee *(Applicant)*

3. Social Security Number (Employee or Applicant)

4. Date of Birth *(mm-dd-yyyy)*

5. Sex ☐ Male ☐ Female

6. Place of Birth
City _____ State _____ Country _____

7. Status ☐ Employee/ Applicant ☐ Spouse ☐ Daughter ☐ Son ☐ Other _____

8. Name of Your Health Insurance Plan

9a. Agency ☐ State ☐ USAID ☐ Other _____

10. Mailing Address *(Medical Clearance Abstract and all clearance correspondence will be mailed to listed address.)*

9b. Type of Employment ☐ Foreign Service ☐ Contractor ☐ Civil Service Excursion Tour

11. Post of Assignment/Date of Departure/Arrival *(mm-dd-yyyy)*
a. Proposed Post _____ EDA _____
b. Present Post _____ EDD _____
c. Last 3 Posts _____

Telephone Numbers *(Where You Can be Reached for the Next 90 Days)*

E-mail Address *(Where You can be Reached for the Next 90 days)*

Health Unit Comments (Attach Additional Sheets if Needed)

Signature

Date *(mm-dd-yyyy)*

FOREIGN SERVICE MEDICAL PERSONNEL ONLY

☐ Issue Class 1 Clearance - Unlimited
☐ Issue Class 2 Clearance -Specific
☐ Recommend Full Physical Examination For Clearance Decision

Clearance Action

Additional Comments

Print Name

Signature of RMO/FSHP

Date *(mm-dd-yyyy)*

Class 1: Worldwide Available
Class 2: Post Approval Required

*Public reporting burden for this collection of information is estimated to average 30 minutes per response, including time required for searching existing data sources, gathering the necessary data, providing the information required, and reviewing the final collection. In accordance with 5 CFR 1320 5(b), persons are not required to respond to the collection of this information unless this form displays a currently valid OMB control number. Send comments on the accuracy of this estimate of the burden and recommendations for reducing it to: U.S. Department of State (A/ISS/DIR), Washington, DC 20520.

Instructions: Please answer each of the following questions with particular emphasis on the period of time since your last medical clearance was issued. Provide explanations for any positive response in the space provided at the bottom of the page. Be sure to attach copies of any medical reports that will be helpful in clarifying the medical situation. Failure to provide us with pertinent information will delay processing of the clearance decision and post approval for an onward assignment. Discuss this form with your Health Unit medical personnel or Foreign Service Medical Officer. You or your Health Unit should mail or FAX 703-875-4850 their form to Medical Records, SA-1, Room L101, U.S. Department of State, 2401 E St, NW, Washington, DC 20522-0102.

SINCE YOUR LAST CLEARANCE WAS ISSUED:

Yes	No	
☐	☐	1. Have you seen a health care provider for routine health maintenance? ***Example: Blood Pressure, PPD, Cholesterol Screen. For women: pap smear, mammogram, For men: PSA, rectal prostate exam.***
☐	☐	2. Are you being evaluated on a regular basis for any ongoing or recurrent medical conditions(s)?
☐	☐	3. Have you been hospitalized?
☐	☐	4. Have you had any surgical procedures?
☐	☐	5. Have you been treated by (or been recommended to receive treatment from) a health care provider for any medical or mental health condition?
☐	☐	6. Have you required any medical evacuation travel or per diem (either to the United States or to a geographical regional site)?
☐	☐	7. Do you have any physical or emotional concerns that you feel should be evaluated?
☐	☐	8. Do you take medication? List all medication(s) and the reason for taking it.
For Children:		
☐	☐	9. Does the child have any special educational needs or requirements such as tutoring or other special assistance? If yes, please have a School Report of Progress completed by the child's teacher and /or tutor and attach it to this form.
☐	☐	10. Do you anticipate any special educational needs or requirements at anytime in the future?

Please list any chronic medical condition(s) you currently have and explain any positive responses: Attach any additional documentation ***(Medical Reports, Health Maintenance Flow Sheet, Etc.).***

The intentional omission of any crucial medical information is a criminal offense (Section 1001 of the U.S.C. Title 18). For this offense employees may also be subject to disciplinary action.

Signature of Examinee/Parent/Guardian

Date *(mm-dd-yyyy)*

FOR OFFICE OF MEDICAL SERVICES USE ONLY