



Non-Foreign Service Personnel and Their Family Members

Privacy Act Statements (PAS) only cover US citizens and legally permanent residents. Non-US citizens are not covered by the Privacy Act; therefore the PAS does not extend to them. This information is requested pursuant to the Foreign Service Act of 1980, as amended (22 USC 3084, 3901 and 3984). The primary purpose for soliciting this information is to screen employees who are not members of any Foreign Affairs agency and their family members for overseas duty.

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 enforcement and administration purposes. It may also be disclosed pursuant to court order. Failure to provide this information may result in denial of a medical clearance.

To Be Filled by Examinee (Complete all sections, type or in ink). Please Print Clearly

Name of Examinee (Last, First, Middle Initial)	Date (mm-dd-yyyy)	Agency
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Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth (mm-dd-yyyy)	Place of Birth
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Post of Assignment (Required)	Please Check if Going To <input type="checkbox"/> Baghdad <input type="checkbox"/> Iraq (Outside Baghdad) <input type="checkbox"/> Kabul <input type="checkbox"/> Afghanistan (Outside Kabul)
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Email Address	Mailing Address
Telephone Number	

Name of Employee (Last, First, Middle Initial)

Social Security Number _____

Status of Employee

Locally Engaged Staff
 3161
 Civil Service
 WAE
 Personal Services Contractor
 DoD Civilian/Contractor
 Other _____

Status of Examinee Employee Spouse Domestic Partner Dependent Child

To the Doctor: The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law we are asking that you NOT provide any genetic information when responding to this request for medical information. 'Genetic information' as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

Name of Examinee

Have you had within the past 10 years:

- | Yes | No | | Yes | No | |
|--------------------------|--------------------------|--|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | 1. Stroke, TIA, or Blackout? | <input type="checkbox"/> | <input type="checkbox"/> | 18. Diabetes or thyroid disease? |
| <input type="checkbox"/> | <input type="checkbox"/> | 2. Epilepsy or seizures? | <input type="checkbox"/> | <input type="checkbox"/> | 19. Arthritis, rheumatism, joint pain or altered mobility? |
| <input type="checkbox"/> | <input type="checkbox"/> | 3. Chronic eye trouble, vision problems or glaucoma? | <input type="checkbox"/> | <input type="checkbox"/> | 20. Debilitating back pain or back injury? |
| <input type="checkbox"/> | <input type="checkbox"/> | 4. Difficulty with your hearing? | <input type="checkbox"/> | <input type="checkbox"/> | 21. Skin cancer? |
| <input type="checkbox"/> | <input type="checkbox"/> | 5. Asthma? | <input type="checkbox"/> | <input type="checkbox"/> | 22. A thickening or lump in breast or elsewhere? |
| <input type="checkbox"/> | <input type="checkbox"/> | 6. Wheezing or shortness of breath? | <input type="checkbox"/> | <input type="checkbox"/> | 23. Have you ever been referred to or sought consultation or treatment from a mental health professional? Inpatient or Outpatient? |
| <input type="checkbox"/> | <input type="checkbox"/> | 7. Severe headaches or migraines? | <input type="checkbox"/> | <input type="checkbox"/> | 24. Have you consumed at any one time in the past year, more than 6 drinks for males or 5 drinks for females? |
| <input type="checkbox"/> | <input type="checkbox"/> | 8. Chronic cough or coughing up blood? | <input type="checkbox"/> | <input type="checkbox"/> | 25. Chronic Medical/Mental Health Conditions requiring medication or routine follow-up? |
| <input type="checkbox"/> | <input type="checkbox"/> | 9. Pain or pressure in your chest? | Females only: | | |
| <input type="checkbox"/> | <input type="checkbox"/> | 10. Heart problems, murmur, or palpitations? | <input type="checkbox"/> | <input type="checkbox"/> | Are you pregnant? |
| <input type="checkbox"/> | <input type="checkbox"/> | 11. High blood pressure? | <input type="checkbox"/> | <input type="checkbox"/> | Have you had an abnormal Pap smear within the last year? |
| <input type="checkbox"/> | <input type="checkbox"/> | 12. Stomach, liver or intestinal problems? | Children only: | | |
| <input type="checkbox"/> | <input type="checkbox"/> | 13. Jaundice or hepatitis (<i>Which type</i>)? | <input type="checkbox"/> | <input type="checkbox"/> | Special education requirement or learning disability? |
| <input type="checkbox"/> | <input type="checkbox"/> | 14. Untreated hernia? | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | 15. Rectal bleeding or black, tarry stools? | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | 16. Frequent urination or chronic urinary tract infection? | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | 17. Kidney trouble; stone, blood or protein in urine? | | | |

The intentional omission of any crucial medical information is a criminal offense (*Section 1001 of the USC Title 18*). Respondents who intentionally omit information may be subject to disciplinary action for intentional omission of information.

Please answer the following questions if you have been assigned to a high/threat unaccompanied post in the last three years:

- | Yes | No | |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | Have you been injured or experienced a blast or explosion? If yes, explain. |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you been exposed to any known toxic chemicals? If yes, explain. |

In your life, have you ever had any experience that was so frightening, horrible, or upsetting that, in the past month you...

- | | | |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | Have had nightmares about it or thought about it when you did not want to? |
| <input type="checkbox"/> | <input type="checkbox"/> | Tried hard not to think about it or went out of your way to avoid situations that reminded you of it? |
| <input type="checkbox"/> | <input type="checkbox"/> | Were constantly on guard, watchful, or easily startled? |
| <input type="checkbox"/> | <input type="checkbox"/> | Felt numb or detached from others, activities, or your surroundings? |

Signature of Examinee (*I certify I have read and understand the above statement.*)

Date

Examiner Please Comment on Significant History: Comment on all items checked Yes in the history on a separate piece of paper.

Name of Examinee:

Height	Weight	Pulse	Blood Pressure	BMI
Clinical Evaluation (<i>Check each item as indicated</i>)				
	Normal	Abnormal	Not examined	Describe abnormalities in detail
1. Skin (<i>Not abnormalities</i>)				
2. Head, neck, thyroid				
3. Ear, nose, throat				
4. Lymph nodes				
5. Lungs				
6. Breasts				
7. Heart (<i>Record murmurs or abnormalities</i>)				
8. Abdomen (<i>Comment on liver and spleen</i>)				
9. Genitalia (<i>Male testes descended? Masses</i>)				
10. Anus, rectum, and prostate				
11. Vascular system				
12. Extremities and spine <i>(Note physical limitations)</i>				
13. Neurological				
14. Psychiatric (<i>Specify any significant mood, cognitive, or behavioral observations</i>)				
15. Pelvic/Bimanual				
Comments				
Hospitalizations/Major Operations (<i>Include all medical and psychiatric illnesses</i>)				Date (mm-dd-yyyy)
List Current Medications and Dose			Drug or Other Allergies/Reaction	
1.				
2.				
3.				
4.				
5.				
6.				
7.				

Name of Examinee:

ALL TESTS ARE REQUIRED UNLESS OTHERWISE SPECIFIED. PLEASE ATTACH ALL LABORATORY REPORTS, EKG, AND CHEST X-RAY REPORTS.

Hematology (All ages)(Infants Hct only)	ECG (50 years and older, or earlier if indicated)	
Hct or Hgb	Date (mm-dd-yyyy)	
WBC	Results	
Platelets		
Screening Chemistry (12 yrs + older)		
Blood Sugar (Fasting)	PPD (Mantoux) Required for all ages unless previously positive	
HgbA1c when indicated		
Creatinine	Results	
ALT	Date (mm-dd-yyyy)	
Serology (12 yrs + older)	Chest x-ray is required if new PPD conversion or if clinically indicated	
HIV	Results	
	Date (mm-dd-yyyy)	
Assessment or Problem List	Recommendation for Treatment/Further Study/or Follow-up	
Typed Name of Examiner	Signature	Date
Address	Telephone Number	

Instructions for Examiner: Sign, Scan and Email this completed exam and supporting reports to MEDMR@state.gov.
 If you cannot scan your documents FAX to (703-875-4850).
 Keep the original for your files.