U.S. Department of State

OMB APPROVAL NO. 1405-0194
EXPIRATION DATE 09/30/2017
ESTIMATED BURDEN: 2 HOURS*

NON-FOREIGN SERVICE PERSONNEL AND THEIR FAMILY MEMBERS

The information collected in this form is requested pursuant to the Foreign Service Act of 1980, as amended *(22 USC 3084 and 3901)*. The primary purpose for soliciting this information is to make appropriate medical clearance decisions for employees who are not members of any Foreign Affairs agency and their family members. 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. More information on the routine uses for this collection can be found in the System of Records Notice, State-24, Medical Records. Disclosure of this information, including the Social Security Number, is voluntary. However, failure to provide this information may result in denial of a medical clearance.

***Public reporting burden for this collection of information is estimated to average 2 hours per response, including time required for searching existing data sources, gathering the necessary documentation, providing information, and/or documents required, and review the final collection. You do not have to supply this information unless this collection displays a currently valid OMB control number. If you have comments on the accuracy of this burden estimate and/or recommendations for reducing it, please send them to: M/MED/EX, Room L217 SA-1, U.S. Department of State, Washington, DC 20522.**

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

Sex ☐ Male ☐ Female	Date of Birth*(mm-dd-yyyy)*	Place of Birth

Post of Assignment *(Required)*	Please Check if Going To: ☐ Baghdad ☐ Iraq *(Outside Baghdad)* ☐ Kabul ☐ Afghanistan *(Outside Kabul)*

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	
☐	☐	1. Stroke, TIA, or Blackout?	☐	☐	18. Diabetes or thyroid disease?
☐	☐	2. Epilepsy or seizures?	☐	☐	19. Arthritis, rheumatism, joint pain or altered mobility?
☐	☐	3. Chronic eye trouble, vision problems or glaucoma?	☐	☐	20. Debilitating back pain or back injury?
☐	☐	4. Difficulty with your hearing?	☐	☐	21. Skin cancer?
☐	☐	5. Asthma?	☐	☐	22. A thickening or lump in breast or elsewhere?
☐	☐	6. Wheezing or shortness of breath?	☐	☐	23. Have you ever been referred to or sought consultation or treatment from a mental health professional? Inpatient or Outpatient?
☐	☐	7. Severe headaches or migraines?	☐	☐	24. Have you consumed at any one time in the past year, more than 6 drinks for males or 5 drinks for females?
☐	☐	8. Chronic cough or coughing up blood?	☐	☐	25. Chronic Medical/Mental Health Conditions requiring medication or routine follow-up?
☐	☐	9. Pain or pressure in your chest?			
☐	☐	10. Heart problems, murmur, or palpitations?			
☐	☐	11. High blood pressure?			
☐	☐	12. Stomach, liver or intestinal problems?			
☐	☐	13. Jaundice or hepatitis *(Which type)*?			
☐	☐	14. Untreated hernia?			
☐	☐	15. Rectal bleeding or black, tarry stools?			
☐	☐	16. Frequent urination or chronic urinary tract infection?			
☐	☐	17. Kidney trouble; stone, blood or protein in urine?			

Females only:

☐	☐	Are you pregnant?
☐	☐	Have you had an abnormal Pap smear within the last year?

Children only:

☐	☐	Special education requirement or learning disability?

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	
☐	☐	Have you been injured or experienced a blast or explosion? If yes, explain.
☐	☐	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...

☐	☐	Have had nightmares about it or thought about it when you did not want to?
☐	☐	Tried hard not to think about it or went out of your way to avoid situations that reminded you of it?
☐	☐	Were constantly on guard, watchful, or easily startled?
☐	☐	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 *(Check each item as indicated)*				
	Normal	Abnormal	Not examined	Describe abnormalities in detail
1. Skin *(Not abnormalities)*				
2. Head, neck, thyroid				
3. Ear, nose, throat				
4. Lymph nodes				
5. Lungs				
6. Breasts				
7. Heart *(Record murmurs or abnormalities)*				
8. Abdomen *(Comment on liver and spleen)*				
9. Genitalia *(Male testes descended? Masses)*				
10. Anus, rectum, and prostate				
11. Vascular system				
12. Extremities and spine *(Note physical limitations)*				
13. Neurological				
14. Psychiatric *(Specify any significant mood, cognitive, or behavioral observations)*				
15. Pelvic/Bimanual				

Comments

Hospitalizations/Major Operations *(Include all medical and psychiatric illnesses)*	**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.