

MEDICAL CLEARANCE UPDATE

ESTIMATED BURDEN: 30 MINUTES*

PRIVACY ACT NOTICE

AUTHORITIES: The information is sought pursuant to the Foreign Service Act of 1980, as amended (Title 22 U.S.C.4084).
PURPOSE: The information solicited on this form will be used to make appropriate medical clearance decisions.
ROUTINE USES: Unless otherwise protected by law, the information solicited on this form may be made available to appropriate agencies, whether Federal, state, local, or foreign, for law enforcement and other authorized purposes. The information may also be disclosed pursuant to court order. More information on routine uses can be found in the System of Records Notice State-24, Medical Records.
DISCLOSURE: Providing this information is voluntary; however, not providing requested information may result in the failure of the individual to obtain the requisite medical clearance pursuant to 16 FAM 211.

PAPERWORK REDUCTION ACT STATEMENT: 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 documentation, providing the information and/or documents required, and reviewing 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 recommendation for reducing it, please send them to: M/MED/EX, Room L101 SA-1, U.S. Department of state, Washington, DC 20522

INSTRUCTIONS: **Assigned overseas: please seek assistance from the US Embassy Health Unit medical staff.**
Assigned domestically: complete page 1 demographic information fields 1 – 13, complete questions on page 2 and sign.

TO BE FILLED OUT BY PATIENT (OR PARENT / GUARDIAN)	Date: (mm-dd-yyyy)
1. Name of Patient: (Last, First, MI)	2. If Eligible Family Member, Name of Employee
3. MED ID Number: (if available)	4. Date of Birth (mm-dd-yyyy) 5. Sex <input type="checkbox"/> Male <input type="checkbox"/> Female
6. Place of Birth: City _____ State _____ Country _____	7. Status: <input type="checkbox"/> Employee <input type="checkbox"/> Spouse <input type="checkbox"/> Domestic Partner <input type="checkbox"/> Dependent Child
8. Name of Your Health Insurance Plan:	9a. Agency <input type="checkbox"/> State Bureau/Office of assignment _____ <input type="checkbox"/> USAID <input type="checkbox"/> Other Agency _____
10. Mailing Address: _____ _____ _____	9b. Type of Employment <input type="checkbox"/> Foreign Service <input type="checkbox"/> Civil Service <input type="checkbox"/> WAE <input type="checkbox"/> PSC or other Contractor <input type="checkbox"/> LNA <input type="checkbox"/> Other _____
11. Telephone number: (where you can be reached for the next 90 days) (for patient or dependent ≥ 18 years of age): _____	12. Post of Assignment a. Proposed Post _____ EDA _____ b. Present Post _____ EDD _____ c. Last 3 Posts _____ _____ _____
13. Email Address (where you can be reached for the next 90 days): (for patient or dependent ≥ 18 years of age): _____	

THIS SPACE RESERVED FOR OFFICIAL USE BY U.S. Department of STATE MEDICAL STAFF ONLY

Department of State / US Embassy Medical Professional Comments (attach additional sheets if needed)

MED USE ONLY

- Recommend World Wide Available – Class 1 Medical Clearance
- Recommend Post Specific – Class 2 Medical Clearance
- Recommend Full Physical Examination for Medical Clearance Determination

Signature of FS Regional Medical Officer / FS Medical Provider Printed Name Date

To the individual and/or health care provider completing the medical history review /exam: 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 members' 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.

Page 2 INSTRUCTIONS: Please answer each of the following questions in the space provided, attach additional pages if necessary. If you have questions, please discuss the form with the Health Unit medical staff or Foreign Service Medical Specialist, or contact the Medical Clearances Division at MEDClearances@State.gov. Please scan the completed and signed form and email in PDF format to MEDMR@State.gov. Please include all supplemental pages/ medical reports / test results in English with your submission. If it is not possible to scan, please fax the form to Medical Records FAX: 703-875-4850.

Please note: MED Clearances may request additional information in order to make a Clearance determination.

I. CURRENT MEDICATIONS:

1. Please list your current prescription and over the counter medications and dosage. Attach additional pages as needed.

II. MEDICAL HISTORY UPDATE:

For YES answers, please provide a brief explanation, and use additional pages as needed.

2. Since your last medical clearance was issued, have you been diagnosed with a new medical or mental health condition? Yes No

3. Since your last medical clearance was issued, have you been hospitalized or medically evacuated? Yes No

III. If your current medical clearance is Post Specific – Class 2, or Domestic Assignment Only – Class 5:

- For MEDICAL Class 2 or Class 5 Clearance status: Please submit a written update from your medical provider(s) to include current medical treatment plan and follow up recommendations.
 - For MENTAL HEALTH or Drug/Alcohol Class 2 or Class 5 Clearance status: Please submit a Treatment Provider Information form (TPI) (obtain from your Health Unit or the Medical Clearances Division) to be completed by your treating provider(s).
4. Since your last medical clearance, have there been any changes in your medical / mental health or drug/alcohol condition? Yes No
If YES, please explain below, and use additional pages as needed.

IV. For Pregnant Women: If you are pregnant and currently assigned / considering assignment to La Paz, please be advised that the current recommendation is for pregnant women to leave La Paz as soon as possible after confirmed pregnancy. Extreme altitude (over 10,000 ft.) in La Paz can have a negative effect on the fetus. Please contact MEDForeignPrograms@state.gov with questions on this, or any other travel warnings regarding pregnancy (e.g. Zika virus).

V. For Children:

5. Has your child been referred for any special educational services, accommodations or modifications? Yes No
If YES, please explain below and have your child's teacher or service provider complete a School Report of Progress and submit with this form.

6. Do you anticipate any special educational needs or requirements for your child now or in the future? Yes No
If YES, please explain below, and use additional pages as needed.

To all Employees and family members: The Bureau of Medical Services strongly encourages you to see your medical provider to review age-appropriate preventive health screening guidelines/testing.

Signature of Patient/Parent/Guardian

Date:

Any knowing and willful omission, falsification, or fraudulent statement regarding material medical information may constitute a criminal offense under 18 U.S.C. § 1001, and individuals committing such an offense may be subject to criminal prosecution. Employees of the United States Government also may be subject to disciplinary action, up to and including separation, for any knowing and willing omission or falsification or fraudulent statement of material information.