U.S. Department of State
Bureau of Medical Services, Room L101, SA-1, Washington, DC 20520-0102

MEDICAL CLEARANCE UPDATE

OMB APPROVAL NO. 1405-0131
EXPIRATION DATE XX/XX/20XX
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 from this form will assist in making a medical clearance decision for individuals eligible to participate in the Department of State Medical Program while assigned abroad. (16 FAM 100 - 200)
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: Complete all required fields, sign and date.

TO BE FILLED OUT BY PATIENT (*OR PARENT/GUARDIAN*)

Date *(mm-dd-yyyy)*

1a. Name of Patient *(Last, First, MI)*

1b. Chosen Name of Patient

2. If Family Member, Name of Employee

3. MED ID Number *(if available)*

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

5a. Gender Identity - Choose all that apply
☐ Man
☐ Woman
☐ Genderqueer/Non-binary
☐ ____________

5b. Sex Assigned at Birth
☐ Male
☐ Female
☐ Intersex
☐ ____________

5c. Are you/the patient transgender?
☐ Yes ☐ No

Gender Pronouns - Choose all that apply
☐ He/Him/His
☐ She/Her/Hers
☐ They/Them/Theirs
☐ ____________

5d. Sexual Orientation
☐ Lesbian, Gay, Homosexual
☐ Straight, Heterosexual
☐ Bisexual
☐ ____________

6. Place of Birth

City ____________ State ____________ Country ____________

7. Relationship to Employee
☐ Employee ☐ Spouse
☐ Dependent Child

8. Telephone Number of Examinee or Parent of Child under 18 Y/O (*Where You can be Reached for the Next 90 days*)

Primary ____________

Alternate ____________

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

Primary ____________

Alternate ____________

10. Name of Your Health Insurance Plan

11. Agency
☐ State ☐ USAID ☐ FAS/USDA ☐ FSC/Trade
☐ USAGM (Global Media) ☐ Other ____________

12. Type of Employment (*Applicable for employees only*)
☐ Foreign Service ☐ Civil Service ☐ LES
☐ REA-WAE ☐ Personal Service Contractor
☐ LNA ☐ Third Party Contractor
☐ DOD CS ☐ DOD Contractor

13. Post of Assignment

a. Proposed Post ____________ EDA ____________

b. Present Post ____________ EDD ____________

14. Type of Assignment
☐ Permanent Change of Station (*PCS*) ☐ Temporary Duty (*TDY*) Greater than 30 days ☐ Both PCS/TDY

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**.

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

I. CURRENT MEDICATIONS:

1. Does your medication require refrigeration?

☐ Yes ☐ No

2. Are you prescribed a narcotic or FDA controlled substance?

☐ Yes ☐ No

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

______________________ ______________________ ______________________

______________________ ______________________ ______________________

II. MEDICAL HISTORY UPDATE:

4. Since your last medical clearance was issued, have you been diagnosed with a new medical or mental health condition? If yes, explain and attach additional documentation as necessary.

☐ Yes ☐ No

5. Since your last medical clearance was issued, have you been hospitalized or medically evacuated? If yes, explain and attach additional documentation as necessary.

☐ Yes ☐ No

6. Since your last medical clearance, have there been any changes in your medical / mental health or drug/alcohol condition? If yes, explain and attach additional documentation as necessary.

☐ 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).*

IV. For Pregnant Women:

If you are pregnant and currently assigned/considering assignment over seas please contact MEDForeignPrograms@state.gov with questions on extreme altitude or any other travel warnings regarding pregnancy.

V. The Child Listed on this form:

7. Has the child been referred for any special educational services, accommodations or modifications? *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.*

☐ Yes ☐ No

8. Do you anticipate any special educational needs or requirements for the child now or in the future? *If YES, please explain below, and use additional pages as needed.*

☐ Yes ☐ No

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 *(mm-dd-yyyy)*

SUBMITTAL: Please scan and email the completed and signed form in a PDF format to Medical Records at **MEDMR@state.gov**. **You must include all supplemental pages, medical reports, and test results in English with your submission.** If it is not possible to send electronically, please fax the form to Medical Records at 202-647-0292.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.