UNHCR
United Nations High Commissioner for Refugees
Haut Commissariat des Nations Unies pour les réfugiés

MEDICAL EXAMINATION - CONFIDENTIAL

INTRODUCTION AND PURPOSE OF THE EXAMINATION:

The purpose of medical clearance is to ensure that personnel working for UNHCR are physically and mentally fit to perform their designated job functions without putting themselves and others at risk for illness or injury. This medical clearance evaluation considers an individual's health status, the job demands, the health risks and medical support available at the location in which they are to serve.

UNHCR assesses staff members' health at several stages of the employee's life cycle, through relevant medical examinations and provides time-limited medical clearance.

Medical clearance must be obtained in connection with: Entry medical examination for initial appointment/re-hire, periodic medical examinations for reassignment, Return after 12 months or more from SLWOP/secondment/loan.
Pursuant to relevant policies, Medical Section determines requirements for medical clearance.

PLEASE SPECIFY THE TYPE OF MEDICAL EXAMINATION YOU ARE GOING TO UNDERTAKE BY SELECTING THE CHECK BOX BELOW:

☐ PRE-EMPLOYMENT/ENTRY MEDICAL EXAMINATION

☐ PERIODIC MEDICAL EXAMINATION

☐ RETURN AFTER 12 MONTHS OR MORE FROM SLWOP/SECONDMENT/LOAN

IMPORTANT INFORMATION:

Staff/Candidates are reminded of their obligation to provide full and accurate medical information to the Medical Section. Failure to do so may lead to cancellation of any offer of employment or may be considered as misconduct under the Staff Rules and Regulations of the United Nations.

If assigned to a D or E duty station, please also ensure that you contact your designated psychosocial wellbeing officer for your psychological preparation as required prior to your next assignment.

DATA PROTECTION:

The personal medical information provided hereunder is used for the above-mentioned purpose, in accordance with relevant UNHCR internal policies concerning staff onboarding and assignments, and other human resources processes requiring an assessment of health status including as stated in the relevant parts of UNHCR/AI/2022/03/Rev.1AI on Medical Clearance and Fitness to Work
It is treated confidentially and disclosed only with the staff of the Medical Section. It may only be disclosed in exceptional cases with relevant medical personnel of other UNHCR services in the relevant administrative processes in strict compliance with the requirements of UNHCR data protection framework.

Your signature on this medical form indicates that you understand and agree with the above statement.

Date: **Signature:**

INTRODUCTION:

The purpose of medical clearance is to ensure that staff are physically and mentally fit to perform their designated job functions without putting themselves and others at risk for illness or injury. This medical clearance evaluation considers an individual's health status, the job demands, and the health risks and health support available at the location in which they are to serve. The Medical Section determines the need for workplace accommodation as well as requirements for medical clearance.

SECTION A - MUST BE COMPLETED BY THE STAFF MEMBER/CANDIDATE.

DEMOGRAPHICS:

Job Title :……

Duty Station, Country:……

(Mr/Mrs/Miss/Ms) Surname: ……...

First Name: ……

Date Of Birth:(dd/mm/year) …….....

Sex: M F

Nationality…….....

Place Of Birth…….....

Employee Number……

Email Address……..

Mobile Phone…….....

Address: ……..

JOB AND TASK ANALYSIS:

(Indicate where 'Not Applicable' as N/A)

(Please tick any of these boxes relevant to the normal duties of this post) ***(Indicate where 'Not Applicable' as N/A)***		
Regular lifting, bending, prolonged standing		
Working at heights/ladders		
Manual cleaning/sweeping/domestic duties		
Regularly outdoors in all weathers		
Working with people with challenging behaviours.		
Driving duties		
Significant use of computers		
High mental stress content (multiples interviews, long working hours > 8 hours /day)		
Exposure to noise above 80dB		
Working in isolation. (Lone working)		
Frontline humanitarian work,		
Use of respiratory sensitisers, i.e., wood dust		
Use of skin sensitisers i.e., latex gloves		
Shift work/irregular hours		
Risk of occupational exposure to mental or physical trauma		
Regular workdays include routine long-distance travel to the field.		
Risk of occupational exposure to specific infectious diseases:		

PERSONAL PHYSICIAN'S CONTACT DETAILS:

Doctor's Name/Address…… Email Address……...

……Post Code: ……Tel No: ……

PLEASE ANSWER ALL QUESTIONS and sign the form before submitting it to UNHCR Medical Section.

	QUESTIONS	YES	NO
1	Do you have, or have you had, any diagnosed physical or mental health condition(s) lasting 3 weeks or longer, for which you have sought medical assistance or treatment?		
2	Have you ever had a health problem that you think may recur in the future?		
3	Are you taking any prescribed medication at present? (do not answer 'yes' for Hormone Replacement Therapy (HRT) or birth control medication)		
	If yes: please give details:		
	If 'YES', is it required to be taken on a strict timetable?		
4	Do you require any medically necessary devices / aids or adaptations essential for routine daily activities?		
5	Are you restricted, for health reasons, from carrying out any specific types of work? If yes, please specify the restriction:		
6	In the last 5 years have you ever had any **serious** illness or injury which required a surgical operation, and / or hospitalisation?		
7	Are you currently pregnant or have recently given birth? Please write expected date of delivery or date of actual delivery: (dd/mm/yr)		
8	Do you require adjustments to your proposed work in relation to pregnancy? (for pregnancy please refer to the **AI on Parental Leave AI 2023/02**		
9	Have you had any absence from work, of three weeks or longer, due to illness or injury in the last 12 months?		
10	Do you have any known medical condition, which would require you taking sickness absence in the next 12 months?		
11	Do you have any health problems that could be affected or made worse by the activities identified in question number 10? If yes, please explain below: _____		
12.	Are you currently under medical supervision and treatment for a specific medical condition? If yes, write the diagnosis here:……		
13.	Has your treating doctor considered you fully recovered from your illness? Please attach a medical report to help us evaluate the condition in line with your fitness to work.		

Vaccination	Yes	No	
Are you fully vaccinated against COVID-19? (Fully vaccinated is defined as: 2 doses of WHO accepted COVID-19 vaccine).	☐	☐	If yes. Please attach the vaccination record.
Are you fully vaccinated against Yellow Fever?	☐	☐	If yes. Please attach the vaccination record.

Your past medical history: Have you been diagnosed with any of the following conditions?	Yes	No	**If yes, please write the diagnosis and explain how this condition affects your ability to work:**
Cancer	☐	☐	
Cardiovascular disease (e.g Hypertension, heart disease, DVT)	☐	☐	
Musculoskeletal diseases (e.g,Back pain, joint pains etc)	☐	☐	
Respiratory illness	☐	☐	
Digestive disorder	☐	☐	
Genito-urinary disorder / Kidney diseases	☐	☐	
Endocrinology illnesses (Eg. Diabetes Mellitus, Thyroid,etc)	☐	☐	
Neurological illness	☐	☐	
Allergy	☐	☐	
Mental Health Problems	☐	☐	
Congenital/Genetic Diseases	☐	☐	
Any Other Conditions? please specify:	☐	☐	
Do you take any long-term medication or other substances? If yes, please specify the medication.	☐	☐	

PRESENT MEDICAL HISTORY

1. Have you had any changes in your health status since the last Periodic Medical Examination?

Yes ☐ No ☐

If, yes please provide a summary of the condition in the space provided below and briefly describe how it affected your ability to perform your work.

2. Are you currently receiving care / treatment for the **above condition/s (question no. 1)?**

Yes ☐ No ☐

If, yes please describe briefly and include the effects this is having on your ability to perform your work?

3. Have you required to be on sick leave during this period stated above?

Yes ☐ No ☐

(What is this box for? The question calls for Yes or No response. Do you want to specify: For how long? Or if recurrent, what is the frequency of expected absence)

DECLARATION

I declare that these statements are correct to the best of my knowledge. I understand that their accuracy is a condition of any employment with UNHCR.

I further declare that I am, to the best of my knowledge, at present in good health unless stated otherwise above.

Applicant's signature: …… Date: (dd/mm/year): ……

Please Print Name: ……

SECTION B: TO BE COMPLETED BY THE EXAMINING PHYSICIAN

Your clinical examination record is vital for Medical Section to objectively assess a staff/prospective staff member's fitness to work. Please complete this section and write your medical history notes, clinical observations, and findings, as well was your assessment and recommendations. Please discuss the laboratory and radiological results with the examinee or client in a language they can understand.

Clinical Evaluation:

Anthropometry: Weight: kgs Height: cm BMI: Waist Circumference (cm)

Blood Pressure: Systolic (mmHg) Diastolic: (mmHg) Heart Rate: per min

For Armoured Vehicle Drivers: (or for personnel deployed / working in high-risk duty stations where security Personal Protective Equipment is required)

- Head circumference = cm
- Chest circumference = cm

		Normal	Abnormal	If abnormal, please explain how this affects the staff members ability to work.
a)	**Ophthalmology**			
	Last eye examination	☐	☐	**Date:** Click to select the date
	Visual Acuity	☐	☐	
b)	**Skin**			
	Examination	☐	☐	
c)	**Ear/ Nose &Throat**			
	Hearing	☐	☐	
	Eardrums	☐	☐	
	Upper respiratory tract, /mouth	☐	☐	
	Thyroid	☐	☐	Nodule? Yes ☐ No ☐.. Thyroid Size.....
d)	**Cardiovascular System**			
	Clinical Findings + Auscultation	☐	☐	Murmur? Yes ☐ No ☐ Specify:
e)	**Respiratory System**			
	Clinical Findings+Auscultation	☐	☐	
f)	**Digestive System**			
	Liver	☐	☐	
g)	**Musculo-skeletal System**			
	Upper limb	☐	☐	
	Lower limb	☐	☐	
	Spine	☐	☐	
h)	**Lymphatic System**			
	Examination	☐	☐	

i)Neuropsychological System	
Appearance	
Behaviour	
Mood	
Affect	
Speech	
Overall Conclusion	
j)Genito-Urinary System	
Female:	
a) When was the first day of the examinees' last Normal Menstrual period?	
b) Type of Birth control?	
c) Is the Examinee Pregnant? NO: ☐ If YES, indicate Expected Date of Delivery	
d) Year of last PAP smear	
Male:	
a) If > 40 years which year was your examinees last Prostate Specific Antigen Done?	

Laboratory Results (Please Attach Original Results to the report)			
Additional examinations	**Normal**	**Abnormal**	**Details**
Biochemistry + CBC: **+Urinalysis**	☐	☐	CRP… **Hemogram:** HGB… ……(Norm…….) RBC… ……(Norm…….) Platelets… ……(Norm…….) WBC…… ……(Norm……) • Neutrophills……. ...(Norm…….) • Lymphocytes …. ...(Norm…….) • Eosinophills……. ....(Norm……) Fasting Blood Sugar…. …….(Norm…..) Creatinine…… ……(Norm……) ASAT… ……...(Norm……) ALAT… ……(Norm…..) GGT… ……..…...(Norm…...) Uric Acid Cholesterol Total…… ……..(Norm……) HDL … ……..…...(Norm…….) LDL…… ……..…...(Norm…….) Triglycerides… ……..(Norm…….) Urine analysis … ……..
Chest X-ray is Mandatory for: • **Recruitment:** *Entry Medical Examination* regardless of age • *Periodic Medical Exam* if Examinee is observed to manifest symptoms or has abnormal chest exam findings or indicated having respiratory symptoms in the questionnaire.	☐	☐	**PLEASE ATTACH X-RAY REPORT. RETAIN THE FILMS WITH YOU.**
ECG is Mandatory for: • **Recruitment:** *Entry Medical Examination* regardless of age • *Drivers* • *Periodic Medical Exam* if examinee is age **over 45 years** or with a known cardiac condition.	☐	☐	**PLEASE ATTACH ECG TRACING RESULTS.**

TO BE COMPLETED BY EXAMINING PHYSICIAN:

Based on your clinical findings and imaging / laboratory investigations, what is your assessment / conclusion of the examinee's health status and capacity to work?

(Please explain verbally after the examination and share the results with the candidate/ staff member ***in a language they understand.)***

In the event you refer the candidate /staff member for further laboratory /specialist evaluation please write this referral message in an email and copy the candidate/staff member to help with subsequent follow up by the Medical Section.

Note*: Please read all the information /reports submitted or medical conditions declared by the patient. Write your comments If you find any other medical related elements relevant to this candidate/staff member, please explain it to the examinee and refer to relevant specialist to facilitate receiving care. guide them (candidate/staff member) to receive help accordingly.*

Date of Examination(dd/mm/year):

Name of Examining Physician:

Signature:

Physician's Email Address:

Physician's Mobile Phone Number**:**

This section is **OBLIGATORY** for **DRIVERS** to complete. **NO** clearance will be given without this Examination.

a) Vision Assessment:

1. To be completed by the ophthalmologist or examining physician[1] in English.

Complete Diagnosis:				
Ocular history:				
Inspection: slit lamp/ biomicroscopy examination (if available)				
Ocular motility – Cover test:				
Pupillary and corneal reflexes:				
Eye fundus - (papilledema, retinal hemorrhage, exudates, blood vessel abnormalities, cataract):	Left		Right	
Diplopia:				
Distance central Visual acuity	Left eye Right eye Binocular	Without Correction	With Correction	Dioptric correction
Twilight vision	Without correction		With correction	

Visual field (confrontation test may be	axis 0° - 180°	axis 90° - 270°	axis 45° - 225°	axis 135° - 315°

The above name staff member is declared for his / her ophthalmologic condition as (tick appropriate box):

- ☐ unfit for driving
- ☐ fit without conditions or restrictions.
- ☐ fit with the following conditions or restrictions:
  - ☐ with glasses
  - ☐ with eye lenses
  - ☐ with glasses or eye lenses

Recommendations for further evaluation, treatment, or refractive correction:

Ophthalmologist / examining physician.

Name, signature, and stamp:

_____

Date of examination(dd/mm/year):

[1] A general practitioner can carry out ocular examination of drivers if there are no ophthalmologists in the duty station.

TO BE COMPLETED BY UNHCR MEDICAL SECTION

Fit ☐ Fit with accommodation ☐ Unfit ☐ Valid until date. (dd/mm/yr) ……

Comment

Date (dd/mm/yr) :**……..** Signature: ……

NOTE: For reimbursement of the medical expenses linked to this medical examination, please contact your human resource contact person to provide you with the bills re imbursement forms.
Please remember to keep your receipts and attach them to the re - imbursement forms during submission to the Human Resources department for processing.