CONFIDENTIAL	UNITED NATIONS NATIONS UNIES	EMPLOYMENT MEDICAL REVIEW QUESTIONNAIRE

This questionnaire is used to evaluate the health status of new recruits and current employees who require medical clearance in accordance with ST/AI/2011/3. Based on the responses further medical evaluation may be required.

Please electronically complete and return this questionnaire as soon as possible to <medicaladmin@iaea.org>
Do NOT return this questionnaire to your recruiting or Human Resources department.

If there is insufficient space, or if you wish to provide additional documents, submit these as attachments with this questionnaire.

Family Name (In Block Capitals)	**Given Name**	**Previous Name**	**Gender** ☐ **M** ☐ **F**
Current Address (Street, Town, District Or Province, Country)		**Date of Birth**	**Birthplace**
		E-mail Address	**Telephone**

Index Number	**Proposed Job Title**	**Proposed Job Location**

1. Have you had a medical check-up in the last 2 years?

No ☐ Yes ☐ *Date of check-up:*

If "No" we strongly suggest you undertake a checkup with your usual doctor before you continue with this questionnaire.
Please document any findings your doctor considers significant or which you consider may be relevant to your proposed role.

2. Do you have any health condition (medical, surgical or psychological) requiring ongoing health care?

No ☐ Yes ☐ *If "yes" please provide details (please include the date of the initial diagnosis, the actual diagnosis and treatment).*

Diagnosis	Date	Treatment

3. Have you been admitted to a hospital for at least 2 consecutive days in the last 5 years, or have you been absent from work for more than 30 calendar days total in the last 12 months due to health reasons?

No ☐ Yes ☐

If "yes" please provide details of the reason for hospitalization or the reason(s) for your absences.

4. Are you regularly taking any prescribed medications?

No ☐ Yes ☐

If "yes" please provide details (please include name of EACH medication, dose and frequency).

Name	**Dose**	**Frequency**		**Name**	**Dose**	**Frequency**

5. Do you have any condition which will need medical, surgical or psychological intervention or treatment within the next 12 months? (Please also indicate "Yes" here if you are pregnant and provide your estimated date of delivery).

No ☐ Yes ☐

If "yes" please provide details.

6. Do you have any physical or mental health conditions which could make it difficult for you to live and work in, or travel to, a remote area with limited access to health care facilities?

No ☐ Yes ☐

If "yes" please provide details.

7. Have you been vaccinated against yellow fever?

No ☐ Yes ☐ *If "Yes", please provide date of vaccination*

8. Are there any vaccines you cannot receive? (Please list vaccine and reason, such as known allergy, religious beliefs, etc.)

No ☐ Yes ☐

If "yes" please provide details.

Note: There are a number of vaccinations which are protective of health and which are recommended for employment in different countries. If you have a vaccination record or International Health Record ("Yellow Book") attach either a scan or an electronic record of this with this questionnaire, labelled "Vaccine Record".

9. Have you ever suffered from a physical or psychological condition which has been recognized by your previous employer as caused by your work?

No ☐ Yes ☐

If "yes" please provide details.

10. Do you currently have, or will you need any workplace accommodations for medical conditions, and/or disability? (For example do you have travel limitations, or need a special desk, etc.)

No ☐ Yes ☐

If "yes" please provide details.

11. Are you aware of any other factors which could affect your health or your ability to perform your duties at the intended duty station? (Such as access to health care, family circumstances, etc)

No ☐ Yes ☐

If "yes" please provide details.

Declaration - Please read, sign and either check ACCEPT or DECLINE the declaration

I, , hereby declare that the answers to all questions are to the best of my knowledge a complete and accurate representation of my health. I also acknowledge that failure to disclose a known physical and psychological condition, including conditions under investigation, may result in withdrawal of medical clearance for employment, denial of benefits, termination or dismissal in accordance with the relevant administrative directives of my employing organization.

Date :

You must check one box : ACCEPT ☐ DECLINE ☐

Signature: