## Certificate of Good Health form

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| ***CERTIFICATE OF HEALTH FOR NATIONAL UN VOLUNTEERS*** | | | | | |  | | | | ***CERTIFICAT MEDICAL POUR LES VOLONTAIRES NATIONAUX DES NATIONS UNIES*** | | | | | | | | |
| Name of candidate – Nom du candidat | | | | | | | | | | | | | Sex(e) | Date of birth – Date de naissance | | | | |
| Length of appointment – Durée de l’engagement | | | | | Place of assignment – Lieu d’affectation | | | | | | | | | | | | | |
| Nature of appointment – Nature de l’engagement | | | | | | | | | | | | | | | | | | |
| **TO BE FILLED IN BY THE CANDIDATE: / A REMPLIR PAR LE CANDIDAT :** | | | | | | | | | | | | | | | | | | |
| Have you previously undergone any United Nations medical examination?  Avez-vous déjà subi un examen médical pour le compte d’une organisation des Nations Unies? | | | | | | | | | | | | | | | Yes  No | | | |
| If so, please state when  Dans l’affirmative: quand | | |  | | | | | where  où | | | |  | | | | | | |
| Have you ever had or have you now/Avez-vous eu ou avez vous actuellement : | | | | | | | | | | | | | | | | | | |
|  | | **yes/oui** | | **date** | | | **no/non** | |  | |  | | | | | **yes/oui** | **date** | **no/non** |
| 1 | Any heart disease Affection cardiaque |  | |  | | |  | | 7 | | Fainting spells Perte de connaissance | | | | |  |  |  |
| 2 | Tuberculosis Tuberculose |  | |  | | |  | | 8 | | Malaria Paludisme | | | | |  |  |  |
| 3 | High blood pressure Hypertension artérielle |  | |  | | |  | | 9 | | Any nervous or mental disorders Troubles nerveux ou mentaux | | | | |  |  |  |
| 4 | Amoebic dysentery Amibiase |  | |  | | |  | | 10 | | Depression or excessive anxiety Périodes de dépression ou d’anxiété | | | | |  |  |  |
| 5 | Epilepsy or fits Epilepsie |  | |  | | |  | |
| 6 | Blood in the stools Sang dans les selles |  | |  | | |  | | 11 | | Blood in the urine Sang dans les urines | | | | |  |  |  |

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 12 | | Indicate any illness in the last five years entailing your absence from work for one month or more:  Indiquez toute autre affection ayant entraîné un arrêt de travail d’un mois ou plus au cours des cinq dernières années: | | | | | | | | | | | | | | | | |
| 13 | | Do you take any medication regularly? If so, please provide details:  Prenez vous régulièrement un médicament? Si oui, indiquez les raisons: | | | | | | | | | | | | | | | | |
| 14 | | Have you ever been refused employment because of your health? If so, please provide details:  Vous a-t-on refusé un emploi pour raison de santé? Si oui, indiquez les raisons : | | | | | | | | | | | | | | | | |
| I certify that the above statements are true, complete and correct to the best of my knowledge and belief.  Je soussigné certifie que les informations ci-dessus sont à ma connaissance exactes et complètes. | | | | | | | | | | | | | | | | | | |
| Candidate’s signature  Signature du candidat | | | | ………………………………………….. | | | | | | | | | | | | | | |
| **FOR COMPLETION BY THE EXAMINING PHYSICIAN (see note below)\***  **A REMPLIR PAR LE MEDECIN-EXAMINATEUR (voir note)\*\*** | | | | | | | | | | | | | | | | | | |
| 1 | General appearance Aspect général | | | |  | | | 10 | Abdomen | | |  | | 18 | Alb. | | |  |
| 2 | Weight Poids | | | |  | | | 11 | Hernia Hernie | | |  | | Urine | Sugar Sucre | | |  |
| 3 | Height Taille | | | |  | | | 12 | Hemorrhoids Hémorroïdes | | |  | |  | Microscopic Sédiment | | |  |
| 4 | Lungs Poumons | | | |  | | | 13 | Genitalia Organes génitaux | | |  | | 19 | Blood Hb. Sang Hb. | | |  |
| 5 | Heart Coeur | | | |  | | | 14 | Mental condition Etat mental | | |  | | 20 | Results of a chest x-ray\* (dating from less than a year)  Compte-rendu d’examen radiographique pulmonaire\*\* (datant de moins d’un an) | | |  |
| 6 | Pulse Pouls | | | |  | | | 15 | Reflexes Réflexes | | |  | |  |  | | |  |
| 7 | Blood pressure Pression artérielle | | | |  | | |  |  | | |  | |  |  | | |  |
| 8 | ECG | | | |  | | | 16 | Eyes Vue | | |  | |  | **\*Indicate date, place, number of film**  **\*\*Indiquer date, lieu, numéro du film** | | |  |
| 9 | Tonsils Amygdales | | | |  | | | 17 | Hearing Ouïe | | |  | |  |  | | |  |
| Is the person examined at present in good health and enjoying a full working capacity? | | | | | | | | | | | yes  oui no  non | | Considérez-vous que la personne examineée est en bonne santé et qu’elle jouit d’une capacité totale de travail | | | | | |
| Is there any affection or definite predisposition to a disease which may result in premature disability or constitute an impediment to the accomplishment of his or her functions? | | | | | | | | | | | yes  oui no  non | | Présente-t-elle une affection ou une prédisposition nette à une maladie susceptible de la gêner dans l’accomplissement de ses fonctions? | | | | | |
| Other observations Autres observations | | | | | |  | | | | | | | | | | | | |
| Name (to be typewritten or printed) Nom ( à la machine ou en majuscules) | | | | | | |  | | | | | | | | | Date |  | |
| Exact address | | |  | | | | | | | Signature, examining Physician | | | ……………………………….. | | | | | |

*The examining doctor is requested before sending this report to verify that the questionnaire on page 1 of this form, has been fully completed by the candidate and that all the results of the investigations required are given on the report. Incomplete reports are a major source of delay in recruitment.*

This is to certify that Mr./Ms. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ has been examined today by the undersigned and found to be in good physical and mental health, and fit for the proposed post.

Place and date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physician’s name and signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_