## 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 whenDans l’affirmative: quand |       | whereoù |       |
| 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 diseaseAffection cardiaque | [ ]  |       | [ ]  | 7 | Fainting spellsPerte de connaissance | [ ]  |       | [ ]  |
| 2 | TuberculosisTuberculose | [ ]  |       | [ ]  | 8 | MalariaPaludisme | [ ]  |       | [ ]  |
| 3 | High blood pressureHypertension artérielle | [ ]  |       | [ ]  | 9 | Any nervous or mental disordersTroubles nerveux ou mentaux | [ ]  |       | [ ]  |
| 4 | Amoebic dysenteryAmibiase | [ ]  |       | [ ]  | 10 | Depression or excessive anxietyPériodes de dépression ou d’anxiété | [ ]  |       | [ ]  |
| 5 | Epilepsy or fitsEpilepsie | [ ]  |       | [ ]  |
| 6 | Blood in the stoolsSang dans les selles | [ ]  |       | [ ]  | 11 | Blood in the urineSang 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 signatureSignature du candidat | ………………………………………….. |
| **FOR COMPLETION BY THE EXAMINING PHYSICIAN (see note below)\*****A REMPLIR PAR LE MEDECIN-EXAMINATEUR (voir note)\*\*** |
| 1 | General appearanceAspect général |       | 10 | Abdomen |       | 18 | Alb. |       |
| 2 | WeightPoids |       | 11 | HerniaHernie |       | Urine | SugarSucre |       |
| 3 | HeightTaille |       | 12 | HemorrhoidsHémorroïdes |       |  | MicroscopicSédiment |       |
| 4 | LungsPoumons |       | 13 | GenitaliaOrganes génitaux |       | 19 | Blood Hb.Sang Hb. |       |
| 5 | HeartCoeur |       | 14 | Mental conditionEtat 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 | PulsePouls |       | 15 | ReflexesRéflexes |       |  |  |  |
| 7 | Blood pressurePression artérielle |       |  |  |  |  |  |  |
| 8 | ECG |       | 16 | EyesVue |       |  | **\*Indicate date, place, number of film****\*\*Indiquer date, lieu, numéro du film** |       |
| 9 | TonsilsAmygdales |       | 17 | HearingOuïe |       |  |  |  |
| Is the person examined at present in good health and enjoying a full working capacity? | yes [ ]  ouino [ ]  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 [ ]  ouino [ ]  non | Présente-t-elle une affection ou une prédisposition nette à une maladie susceptible de la gêner dans l’accomplissement de ses fonctions? |
| Other observationsAutres 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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_