U.S. Department of State
Bureau of Medical Services, Room L101, SA-1, Washington, DC 20522-0102

OMB APPROVAL NO. 1405-0068
EXPIRATION DATE: 01-31-2027
ESTIMATED BURDEN: 30 Minutes

MEDICAL CLEARANCE UPDATE

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.

TO BE FILLED OUT BY EXAMINEE OR PARENT/GUARDIAN	**DATE** *(mm-dd-yyyy)*

1a. Legal Name of Examinee (Last, First, MI)	1b. Maiden/Other Name of Examinee (*if applicable*)
2. Date of Birth of Examinee (*mm-dd-yyyy*)	3. If Eligible Family Member, Name of Employee/Applicant
4. Place of Birth of Examinee	5. MED ID Number (*if available*)

6a. Gender Identity - Choose all that apply	6b. Sex Assigned at Birth	6c. Gender Pronouns - Choose all that apply	7. Examinee Status
☐ Male	☐ Male	☐ He/Him/His	☐ Applicant
☐ Female	☐ Female	☐ She/Her/Hers	☐ Employee
☐ Transgender		☐ They/Them/Theirs	☐ Dependent Child
☐ Non-binary		☐ ____________	☐ Spouse
☐ Another Gender ____________			

8. Agency of Employee/Applicant/Sponsor

☐ STATE ☐ USAID ☐ FCS ☐ FAS ☐ U.S. Agency for Global Media ☐ DoD Civilian ☐ DoD Contractor

☐ Other Government Agency ____________ ☐ Contracting Company ____________

9. Purpose of Review

☐ Pre-Employment
☐ In-Service

10. Employment Type

☐ 3rd Party Contractor ☐ Fellow ☐ LNA ☐ REA-WAE
☐ CA-EFM ☐ FS Generalist ☐ LES ☐ Other: ____________
☐ Civil Service ☐ FS Specialist ☐ PSC Contractor

11. Post of Assignment and Estimated Dates of Arrival / Departure

a. Proposed Post ____________ EDA ____________ *(mm-dd-yyyy)*

b. Present Post ____________ EDD ____________ *(mm-dd-yyyy)*

12. Special Assignment/ESCAPE Post(s) (*if applicable*)

☐ Iraq ☐ Yemen
☐ Afghanistan ☐ Syria
☐ Libya ☐ Peshawar
☐ Somalia ☐ Other: ____________

13. Assignment Type

☐ Temporary Duty (TDY) greater than 30 days ☐ Permanent Change of Station (PCS)

14. Contact Information of examinee or parent of child < 18 y/o (*where you can be reached for the next 90 days*)

Primary Email Address: ____________ Primary Telephone: ____________

Alternate Email Address: ____________ Alternate Telephone: ____________

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.

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.

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.

Name of Examinee	DOB

I. MEDICAL HISTORY

PLEASE SCAN THE COMPLETED AND SIGNED FORM AND EMAIL IN PDF FORMAT TO MEDMR@state.gov.
Answer each of the following questions in the space provided, attach additional pages if necessary. If you have questions, please discuss with the Health Unit staff or contact Medical Clearances at MEDClearances@state.gov.
PLEASE NOTE: Additional information may be requested via the primary email address provided on page 1.

II. LIST OF CURRENT MEDICATIONS *(Include prescription, over the counter, vitamins, and herbs)*

________________ ________________ ________________

III. MEDICAL HISTORY UPDATE

1. Since your last medical clearance was issued, have you been diagnosed with a new medical or mental health condition or started on new medication? If yes, explain and attach additional sheets as needed.

   ☐ Yes ☐ No

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

   ☐ Yes ☐ No

3. Have you been advised to see a specialist more than once a year for a medical/mental health condition? (Check all that apply)

   ☐ Cardiologist ☐ Hematologist/Oncologist ☐ Ophthalmologist ☐ Rheumatologist
   ☐ Endocrinologist ☐ Nephrologist ☐ Psychiatrist/Mental Health Provider ☐ Other: ________
   ☐ Gastroenterologist ☐ Neurologist ☐ Pulmonologist

IV. IF EXAMINEE IS A CHILD

4. Has your 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

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

   ☐ Yes ☐ No

V. If 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 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 Medical Clearances) to be completed by your treating provider(s).

VI. IF EXAMINEE IS PREGNANT, please contact MEDForeignPrograms@state.gov.

VII. SIGNATURE OF EXAMINEE/PARENT/GUARDIAN (I certify I have read and understand the expressed statements in this document.)

	Date (mm-dd-yyyy)

THIS SPACE RESERVED FOR OFFICIAL USE BY U.S. DEPARTMENT OF STATE MEDICAL STAFF ONLY

Department of State / US Embassy Medical Professional Comments (attach additional sheets if needed)

MED USE ONLY

Signature of FS Regional Medical Officer / FS Medical Provider	Printed Name	Date

SUBMITTAL: PLEASE SCAN THE COMPLETED AND SIGNED FORM AND EMAIL IN PDF FORMAT TO MEDMR@state.gov.

For more information on completion of forms and best practice advice on managing a medical/mental health condition while traveling or living overseas, please visit our website at: https://www.state.gov/bureaus-offices/under-secretary-for-management/bureau-of-medical-services/medical-clearances/.