HEALTH DECLARATION – LTO

European Commission – DG FPI

Please fill in each question.

Name:	
Date of birth:	ID/Passport No.:

1. MEDICAL HISTORY Do you suffer from or have you ever suffered from, had symptoms of, been examined for or been treated for any of the following ailments, or anything related to them? Consider the examples as help - they do not cover all conditions. Any other symptoms or ailments must also be stated, and a clarification and further details should be written on the last page. *If your state of health changes after you have submitted your health information, you are required to notify EC/SP of this immediately for an assessment of new information.*		
Please state numbers for the following	Blood type: Blood pressure: Pulse: BMI: Waist:	
Diabetes, metabolic diseases, respiratory diseases, gastrointestinal diseases, and diseases of the musculoskeletal system	If yes; what and when: What was the outcome of the treatment ? Is the treatment ongoing, completed or recurrent?	
Cardiac and circulatory diseases Blood clots, pain/tightness in the chest, high blood pressure, varicose veins, phlebitis, swollen ankles, heart rhythm disorders, pacemaker, elevated cholesterol. Other cardiovascular disorders	Yes:	No:
	If yes; what and when: What was the outcome of the treatment ? Is the treatment ongoing, completed or recurrent?	
Cancer, other tumors/growths, immune system-related disorders Any type of cancer or cancer precursor/suspected cancer. Polyps in the bowel, benign tumors/growths	Yes:	No:
	If yes; what and when: What was the outcome of the treatment ? Is the treatment ongoing, completed or recurrent?	
Neurological disorders Epilepsy, migraine and headache disorders, multiple sclerosis, stroke, alcohol-related disorders, dementia, brain injury, infections and genetic diseases, Parkinson's disease, chronic pain and other neurological	Yes:	No:
	If yes; what and when: What was the outcome of the treatment ?	

	Is the treatment ongoing, completed or recurrent?	
Psychiatric and behavioral disorders Nervousness, anxiety, psychosis, depression, mania, insomnia, or disorders related to addiction to alcohol or drugs, or other addictions. Dementia. Developmental and behavioral disorders, compulsive behaviors (ADHD, OCD, etc.). Other psychiatric disorders and symptoms?	Yes:	No:
	If yes; what and when: What was the outcome of the treatment ? Is the treatment ongoing, completed or recurrent?	
Alcohol and intoxicating substances/narcotics(?) Do you currently or have you at any time for a period of more than six months, consumed more than 14 units of alcohol (men)/ 7 units of alcohol (women) per week? Do you currently or have you at any time for a period of more than six months used intoxicating substances?	Yes:	No:
Allergies Drugs: Foods: Other:	Yes:	No:
	If yes, what kind?	
Do you presently take any kind of medicine	Yes:	No:
	If yes, what kind of medicine and for what reason:	
Previous hospital admissions	Yes:	No:
	If yes; for what and when? If yes, is the treatment ongoing or are you cured?	
ECG (only for applicants over 45 years)	Please state numbers here:	
Other comments	Please state comments here:	

I certify, that (name): _____ has been examined on the date indicated above and has been found to be in good health, without any medical limitations and therefore medically fit to travel and work abroad in an international mission in post conflict areas and often under stressful conditions with long working hours.

Place:

Date:

_____

Doctor's name, signature, phone number, e-mail and stamp