FIT TO WORK CERTIFICATE

Name & Surname:	
Date of Birth:	*ID/Passport No:*

Please provide details/numbers for:	Blood type: Blood pressure: Pulse: BMI:
Electrocardiogram (ECG) *For applicants over 45 years*	Please provide information here:
Other comments	Please state comments here:

On the basis of the signed Medical Declaration [ANNEX I] and the medical examination which I carried out on ____/____/_____, hereby I certify that the above-mentioned person has been found to be in good health, without any medical limitations and therefore medically fit to travel and work abroad for an international mission, possibly in a post-conflict environment, that may present the following characteristics:

- Tropical weather conditions (high temperatures/humidity) or cold dry weather conditions
- High altitude
- Work under stressful situations which may involve long working hours
- Mosquito borne diseases
- Water-borne diseases
- Limited dietary choices
- Basic amenities available

Doctor' Name & Surname:	
Signature & Stamp: *Date & Place:*	
Email:	*Tel:*

MEDICAL DECLARATION

[to be filled by the involved person]

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.

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(?)	Yes:	No:

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? Have you at any time for a period of more than six months used intoxicating substances?		
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?	
Other remarks	Please state comments here:	

I, the undersigned, hereby declare that:

- **All information provided in this Medical Declaration Form is correct to the best of my knowledge, and that no information concerning my past or present health has been withheld;**
- **This medical declaration has been provided to my physician prior to obtaining the Fit to Work Certificate;**
- **In the event of apparent change of my medical condition, I understand that I am obliged to update my fit-to-work certificate.**

Name & Surname:	
Date of Birth:	*ID/Passport No:*
Signature: *Date and Place:*	