

Medical Certificate of Fitness for Work

Period of validity: One calendar year as of the date of signature by the attending physician below

1. TO BE COMPLETED BY THE INDIVIDUAL (OR THE TECHNICAL UNIT)

Family name	Click here to enter text.	Maiden name	
Given name	Click here to enter text.	Gender	<input type="checkbox"/> F <input type="checkbox"/> M
Date of Birth (dd/mm/yyyy)	Click here to enter text.	Nationality	Click here to enter text.
ADDRESS & CONTACT DETAILS:			
Street	Click here to enter text.	City	Click here to enter text.
Zip Code	Click here to enter text.	District / State	Click here to enter text.
Country	Click here to enter text.	Email address	Click here to enter text.
WORK ASSIGNMENT:			
Description of work assignment	Click here to enter text.	Location of work assignment	Click here to enter text.
Expected dates, from:	Click here to enter text.	To	Click here to enter text.

2. TO BE COMPLETED BY THE ATTENDING PHYSICIAN

Instructions: This medical examination is to assess the individual's general state of health in accordance to his/her medical history, and his/her ability to travel, if required, and to perform the work assignment. N.B.: For drivers, this medical examination will also include visual tests. Please ensure that vaccinations are up-to-date, and that malaria prophylaxis is prescribed if needed and in line with WHO recommendations (<http://www.who.int/ith/en/>).

Mr / Mrs / Misshas been examined by me. He/she has been found fit to [travel and] perform the work assignment, and the required inoculations and prophylactic medicines for the country to which he/she is required to travel have been done and / or prescribed as applicable.

Name of the attending physician who examined the individual:

Address:

Date: **Signature:** **Doctor's Stamp:**

3. TO BE COMPLETED BY THE INDIVIDUAL

I, Mr / Mrs / Miss hereby declare that all information provided by me in the context of the above medical examination is true and complete to the best of my knowledge. I understand that a false statement or a material omission, in particular a failure to disclose a known physical and/or psychological condition, including conditions under investigation, may result in the cancellation of the contract and/or the withdrawal of any offer of a contract with WHO.

I further understand that, if any new medical condition or a substantial change in an existing medical condition, appears during the period of validity of this Medical Certificate of Fitness for Work, or if the location of the work assignment changes, it is my responsibility to inform my attending physician and to provide the responsible WHO Technical Unit with a new Certificate of Fitness for Work.

Date : **Signature :**

Please electronically complete and return this questionnaire as soon as possible (preferably within 3 days) to Technical Unit