CONFIDENTIAL

ANNUAL MEDICAL EXAMINATION FORM (AME)

This form should be used for Annual Medical Examinations for specific type of work (drivers and security guards) and for staff who may occasionally drive IOM vehicles.

Important Instructions and Information

All IOM staff members who drive IOM vehicles as part of their official duties must undergo an annual medical examination. The results are reviewed by the Medical Officer in the Occupational Health Unit (OHU) of:

- **PANAMA: for All staff members based in Africa or in the Americas**
- **GENEVA: for All staff members in Headquarters**
- **MANILA: for All staff members in all other locations**

The medical examination procedure consists of four steps:

1. A form to be completed by the staff member giving personal and medical information - pages 1 & 2 (in blue);
2. A medical assessment (in green) including a physical exam, standard laboratory investigations and other exams – pages 3 & 4
3. Examining physician's conclusions and recommendations – page 5
4. The information is sent to the IOM Medical Officer of the OHU who determines if the person is fit to continue driving IOM vehicles.

The AME costs (examining physician and specialist fees, various exams, vaccinations costs) are refunded at 100% and should be addressed to the HR Focal person in the Mission. Any further investigations are refunded under General Health, at 90%.

All the information is treated **confidentially** by the IOM Medical Officer of the OHU and kept in OHU only.

Final Medical Fitness Certification – INTERNAL (to be completed by IOM OHU services ONLY)	
Fitness to work: 1a ☐ 1b ☐ 2 ☐ **Medical profile:** 1. Illnesses(s): 2. Accident(s): 3. Allergy(ies): 4. Risk factors: **Current treatment:**	**Comments:** Date : OHU Doctor's Signature :

Information received from the staff member

I hereby authorize any of the doctors, hospitals or clinics mentioned in this form to provide the IOM Medical Officer of the OHU in Panama, Geneva and Manila with copies of all relevant medical information.

I certify that the statements made by me in answer to the questions below are, to the best of my knowledge, true, complete and correct.

Date: **Staff member's signature**:

Family name: (in block capitals)	**First name:**	**PERN** N/A
Position title:	Driver ☐ Occasional driver ☒ Security guard ☐	

Lifestyle and medication			
Do you currently:	**NO**	**YES**	**If yes, please indicate daily quantity**
Smoke tobacco?	☐	☐	
Smoke or use drugs? (such as marijuana, khat or cannabis)?	☐	☐	
Take any medications (prescription, over the counter and/or herbal remedies)?	☐	☐	
Drink alcohol? (Please refer to the picture below)	☐	☐	

Staff member's health history			
Over the past year, did you have:	**NO**	**YES**	**If yes, please provide details and date**
Sick leave of more than 20 working days?	☐	☐	
Surgery?	☐	☐	
Head/brain injury or illness, convulsions, seizures, epilepsy, dizziness, headaches, numbness, tingling, or memory loss?	☐	☐	
Vision problems?	☐	☐	
Ear or hearing problems?	☐	☐	
Heart diseases? (e.g; high blood pressure)?	☐	☐	
Respiratory tract and lung disease (e.g. chronic coughs)?	☐	☐	
Kidney problem (e.g. kidney stones, or pain problems with urination)?	☐	☐	
Liver/Digestive problems?	☐	☐	
Diabetes or blood sugar problems?	☐	☐	
Anxiety, panic attacks, phobias, depression, nervousness, psychosis, memory problems)?	☐	☐	
If so, would you like to benefit from the OHU's counsellor support?	☐	☐	
Fainting attacks or passing out?	☐	☐	
Limited use of arm, hand, finger, leg, foot, toes?	☐	☐	
A broken bone?	☐	☐	
Neck or back problems?	☐	☐	

Blood clots or bleeding problems?	☐	☐	
Cancer?	☐	☐	
Chronic (long-term) disease?	☐	☐	
Infectious diseases (e.g. tuberculosis)?	☐	☐	
Sleep disorders (e.g. pauses in breathing while asleep, daytime sleepiness, loud snoring, difficulty falling asleep, etc.)?	☐	☐	
Do you have any other illnesses, diseases or disabilities not listed above that can make it difficult for you to drive motor vehicles?	☐	☐	If yes, please provide details:

MEDICAL EXAMINATION (To be filled in by the examining physician)

Body measurement

Weight:		Kg	Height:		cm
		Ibs		/	Feet/inches
BMI:		Kg/m2	Neck Circumference:		cm
					inches

Cardiovascular

Resting state blood pressure	**Systolic**		**Diastolic**		**Pulse Rate**	
First reading:		mmHg		mmHg		bpm
Second reading:		mmHg		mmHg		bpm

Is the rhythm of pulse regular? If not, please indicate	☐ No ☐ Yes
Murmurs, extra sounds, enlarged heart, abnormal peripheric pulse, carotic or arterial bruits, lower limb oedema	Normal ☐ Abnormal ☐ If so, please specify:

Vision - Use the Snellen's chart with or without correction

Acuity	Near		Far		Horizontal **field** of vision (degrees)
	Uncorrected	Corrected	Uncorrected	Corrected	
Right eye					
Left eye					
Both eyes					

Eyes: Pupillary equality, reaction to light, accommodation, ocular motility, ocular muscle imbalance, extra ocular movement, nystagmus, exophthalmos.	Normal ☐ Abnormal ☐ If so, please specify

Staff member	No	Yes
• can recognize and distinguish among traffic control signal and devices showing – red, amber and green colours? • has got monocular vision? • is referred to the ophthalmologist or optometrist?	☐ ☐ ☐	☐ ☐ ☐

Hearing

	Right ear	Left ear
Whispering test results without hearing aid	Meters or feet	Meters or feet
Hearing aid used for test	■ No ☐ Yes	☐ No ☐ Yes

Scaring of tympanic membrane, occlusion of external canal, perforated eardrums. Refer to a specialist if appropriate.	Normal ☐ Abnormal ☐ If so, please specify:

Audiometry (when possible, to assess locally)

Every two years	Frequency in Hertz					
	Right Ear			Left Ear		
	500Hz	1000Hz	2000Hz	500Hz	1000Hz	2000Hz
Average Intensity/Threshold (dB)						

Others			**Normal**	**Abnormal**
1	General appearance	• Marked overweight, tremors, signs of alcoholism, problem drinking or drug abuse, behaviour during examination	☐	☐
2	Respiratory System	• Irremediable deformities likely to interfere with breathing or swallowing: Abnormal chest wall expansion, abnormal respiratory rate, abnormal breath sounds including wheezes or alveolar rales, impaired respiratory function	☐	☐
3	Locomotor System	• Loss or impairment of leg, foot, toe, arm, hand, finger. Perceptible limp, deformities, atrophy, weakness, paralysis, clubbing, oedema, hypotonia. Insufficient grasp and prehension in upper limb to maintain steering wheel grip. • Insufficient mobility and strength in lower limb to operate pedals properly. • Spine: Previous surgery, deformities, limitation of motion neck/back/limbs	☐	☐
4	Neuro-psychiatric system	• Impaired equilibrium, coordination or speech pattern, asymmetric deep tendon reflexes, sensory or positional abnormalities, abnormal patellar and Babinski's reflexes, ataxia • Orientation, memory, behavior, mental disturbance, mental retardation, dementia.	☐	☐

LABORATORY TESTS (Please attach a copy of the detailed laboratory results)

Urinalysis

Stick Analysis	Specific Gravity	Protein	Blood	Sugar

Blood cell count	**Blood chemistry: empty stomach**
Haemoglobin .....g/l	Glycemia ..... (HBA1C only if diabetic: ..... %)
Haematocrit .....%	ALT (SGPT)–alanine amino transferase .....
MCV .....µ m3/cell	AST (SGOT)–aspartate amino transferase .....
Red blood count ...../ mm3	GGT –gamma glutamyl transferase .....
White blood count ...../ mm3	Serum creatinine or urea .....
Platelets count	Cholesterol TOTAL .....
	Cholesterol (HDL/LDL) .....
	Triglycerides .....

OTHER EXAMS (every 3 years of if clinically justified) – Please attach a copy of the report

Chest X-Ray	No ☐	Yes ☐	Findings
ElectroCardiogram if over 50 years old	No ☐	Yes ☐	Findings

EXAMINING PHYSICIAN'S CONCLUSIONS

(This is only a recommendation. The final determination of fitness-to-work will be made at the IOM Occupational Health Unit's level)

I have performed this evaluation for certification. I have personally reviewed all provided personal and medical information as well as the information recorded from this medical fitness evaluation, and to the best of my knowledge, attest to their validity.

In my professional opinion informed by the outcome of this fitness to work medical evaluation, I recommend that the staff member be declared:

☐ FIT ☐ UNFIT Temporarily ☐ UNFIT Permanently

Comment or recommendation:

Full name of the examining physician:	Signature & Stamp:
Address:	
Email Address:	Date of examination:
Tel No:	/ / (dd/mm/yyyy)

Please **send** this form **with copies of laboratory, radiology and, if requested, cardiology reports** under sealed cover marked **"CONFIDENTIAL"** by fax or scan to:

For GS and P staff in Africa and the Americas	**For P staff and GS staff in Other locations**	**For all staff members in Geneva/Headquarters**
Medical Officer in PANAMA	**Medical Officer in MANILA**	**Medical Officer in GENEVA**
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