HEALTH DECLARATION

European Commission – FPI

Please fill in each question.

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

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

	Is the treatment ongoing, completed or recurrent?		
Psychiatric and behavioral disorders	Yes:	No:	
Nervousness, anxiety, psychosis, depression,	If yes; what and when:		
mania, insomnia, or disorders related to			
addiction to alcohol or drugs, or other addictions. Dementia. Developmental and	What was the outcome of the treatment ?		
behavioral disorders, compulsive behaviors	Is the treatment ongoing, completed or recurrent?		
(ADHD, OCD, etc.). Other psychiatric disorders	is the treatment ongoing, completed of recurrent:		
and symptoms?			
Alcohol and intoxicating	Yes:	No:	
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?			
Allergies Drugs:	Yes: No:		
Foods:	If yes, what kind?		
Other:			
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