MEMORANDUM FOR ALL CONTRACTING OFFICERS, NEGOTIATORS AND EXECUTIVE OFFICERS

FROM: M/OP, Mark S. Ward, Director

SUBJECT: Revision of Medical Clearance Process – Personal Services Contracts (“PSCs”) with U.S. Citizens

CONTRACT INFORMATION BULLETIN No. 01 - 10

This CIB revises the medical clearance process for personal services contracts with U.S. citizens (USPSCs) to work outside the United States. Such contracts are commonly referred to as "offshore USPSCs" or "internationally recruited USPSCs". Appendix D requires medical clearances for all offshore (internationally recruited) USPSCs, and their dependents, who will be at post for more than 60 days. The procedural guidance in this CIB, also applies to US citizens overseas with contracts funded under the Technical Advisers in AIDS and Child Survival (TAACS) authority.

STATE Cable 14411, dated January 25, 2001, (Attachment 1), provides details of the change in the medical clearance process for USAID's Offshore USPSCs. **The announced effective date of the change was January 1, 2001, and applies both to new contracts as well as existing USPSCs.(See the following procedures for more detail).** Essentially, a "new contract" is defined as one signed on or after January 1, 2001. The cable also provides limitations and requirements concerning this policy and the authority of USAID's contracting officers. In agreement with Department of State, the effective date of implementation of this policy at USAID is March 31, 2001.

The following procedural guidance is provided to Contracting Officers, Negotiators, and Executive Officers. Again, this new policy and related procedures apply only to those USPSCs noted above. The appropriate Department of State medical office (M/MED) is committed to processing all USPSC medical clearances within 30 days of receipt, except when additional medical testing is required. This

additional requirement should be considered in procurement planning and the acquisition processes.

POLICY AND PROCEDURES FOR OBTAINING MEDICAL CLEARANCES FOR USPSCS

1. No personal services contract of any kind may be signed until all clearances have been received. For the type of USPSCs affected by these medical clearance changes, finalizing of contracts are contingent upon receipt of the M/MED medical clearance. The policies and procedures apply to new and existing USPSCs and their eligible dependents. Existing USPSCs must obtain a medical clearance from M/MED at the end of their existing contract, if they are moving to another offshore USAID PSC, or within three years, whichever occurs first.

A prospective USPSC shall be advised by the Contracting Officer that travel to the country of recruitment can only take place after the candidate has received a medical clearance from M/MED, unless the position is covered by an approved waiver(See Section 2, below). This policy/procedure change also applies to the prospective USPSC's eligible dependents. The cost of obtaining the examination for the prospective USPSC and eligible dependents continues to be reimbursed at the rate specified in Appendix D of the AIDAR.

Once an individual has been selected for a USPSC position, the Contracting Officer should immediately send the prospective USPSC a medical clearance packet, along with the other pre-contract materials. The medical clearance packet shall include the following:

- FORM AID 1420-62 (Attachment 2 - for the prospective USPSC and dependents 12 years of age and older – Adobe Acrobat copy attached)[1]
- FORM Department of State (DS) 1622 (Attachment 3 - for children under 12 years – Adobe Acrobat copy attached)
- Cover letter, (Attachment 4) instructions for candidate's examining health care provider, Memorandum of Transmittal (Word 97 version of a medical packet is attached as *"MedClear-sample"* and includes a cover letter to the

[1] AID 1420-62 mirrors DS 1843 and will be used for USPSCs and family member 12 years or more until further notice

examining physician, instructions to the examiner, and Memorandum of Transmittal)

M/MED shall provide medical clearances to prospective contractors by completing the DS 823 form (Attachment 5). However, prior to providing clearance, M/MED may require additional tests beyond those tests included on the forms above. These additional tests shall be detailed on the DS Form 616 (Attachment 6). Such additional tests shall be reimbursed to the prospective USPSC at 100% of the cost to the USPSC, minus any costs paid by the USPSC's insurance company or the USPSC's spouse's insurance company. The Contracting Officer ***and*** the requiring office shall be notified by the prospective USPSC **prior** to having any of these additional tests performed to ensure sufficient funds are included in the budget.

2. M/MED has agreed to waive clearances for BHR/OFDA PSCs who are travelling to overseas posts to work on emergency/disaster relief missions.

3. Except for contracts covered under #2 above, USPSC candidates hired after March 31, 2001, and their dependents, must be medically cleared through M/MED before any travel to post. Attachments 5 and 6 are provided for Informational Purposes Only and are not to be reproduced locally. They are for use by M/MED only.

4. We also wish to use this CIB as a reminder of the additional information required when submitting a USPSC advertising request to the OP Internet Coordinator. Please refer to the "Q's and A's" e-mail sent on February 1, 2001, and ensure that the additional information is included.

Questions regarding this CIB may be sent to M/OP/P. The contact point for that office is:

M/OP/P, Thomas Henson
RRB 7.08-106
Tel: (202) 712-5448
Fax: (202) 216-3136.

Attachments:
1. STATE CABLE 14411
2. FORM AID 1420-62
3. FORM DS-1622

4. Health Care Provider Cover Letter and Sample Transmittal Memo
5. DS 823-Medical Clearance (Informational Purposes Only)
6. DS 616-Authorization for Medical Tests/Consultations (Informational Purposes Only)
7. New General Provision 3, Appendix D, Physical Fitness And Health Room Privileges (APRIL 2001)

Clearance:
M/AS/OMS, Charles Knight _____ Dated _____.
M/OP/P, Barbara Brocker _____ Dated _____.
M/OP/OD, Kathleen J. O'Hara _____ Dated _____.
M/OP/OD, Mark S. Ward _____ Dated _____.

M/OP/P:THenson:sms:X25448:4/13/01 (statemedcib.doc)

ATTACHMENT 1

Subject: Health Unit Access for USAID USPSCS
Importance: High

14411 STATE Cable Subject: Policy Change for Providing Acess to Post Health Units for USAID Internationally-Recruited U.jS. Citizen Personal Service Contractors (USPSCS) was sent January 25, 2001

Printed By: Linda K Whitney 01/29/2001 09:18:52 AM

Cable Text:

UNCLASSIFIED

TELEGRAM January 25, 2001

To: HEALTH UNIT COLLECTIVE

Origin: AID

From: SECSTATE WASHDC (STATE 14411)

TAGS: AMED, AMGT

Captions: None

Subject: POLICY CHANGE FOR PROVIDING ACCESS TO POST HEALTH

UNITS FOR USAID INTERNATIONALLY-RECRUITED U.S. CITIZEN

PERSONAL SERVICE CONTRACTORS (USPSCS)

Ref: None

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1. The Office of Medical Services (M/DGHR/MED) in consultation with USAID announces a change in policy in providing access to post health units for USAID internationally-recruited USPSCs.

2. Effective immediately, any new-hire USAID internationally-recruited USPSC and their eligible family members will be allowed access to the health unit only with a valid clearance issued by M/DGHR/MED/Clearances. These individuals will receive the full range of medical services as provided to USDHs, including post support for medevac (although service will be provided by the medevac insurer) and post support for hospitalizations per the terms of the personal services contract.

3. A new-hire USPSC is defined as any contractor whose contract is signed after January 1, 2001. In addition, clearances shall be location specific, for the duration of the present contract or three years whichever is shorter.

Should during a medical intervention it be discovered that the contractor or eligible family member has a medical

condition that may not be treatable by local medical services, the information will be forwarded to MED/CLEARANCES for a further clearance determination.

4. In regard to present USAID USPSCs (internationally recruited) and eligible family members these patients will continue to be granted health unit access until the expiration of their present contract or three years, whichever is sooner. Their ability to access the health unit is specific to the location of their assignment. Should during a medical intervention it be determined that the contractor or eligible family member has a medical condition that may not be treatable by local medical services, the information will be forwarded to MED/CLEARANCES for a clearance/access determination.

5. It is USAID's intent to have their internationally-recruited USPSCs receive a MED clearance as a part of the hiring process. USAID will separately provide information to its contracting officers with procedures to follow to obtain the MED/CLEARANCE.

6. This telegram has been approved by USAID and supercedes any authority by USAID contracting officers to provide health unit access to their USPSCs within contract language except through the MED clearance process.

POWELL

Additional Addressees: None

cc: None

Distribution:

UTE2794

UNCLASSIFIED UTE2794

ORIGIN AID-00

INFO LOG-00 NP-00 AF-00 AIT-03 AMAD-00 WHA-00 SRPP-00
MEDE-01 EAP-00 EUR-00 OIGO-00 UTED-00 FOE-00 TEDE-00
L-00 NEA-00 SS-00 SA-00 SAS-00 /004R

014411
SOURCE: GUARD.003374

DRAFTED BY: M/DGHR/MED/EX:GRALEXANDER:LKW -- 01/25/2001
202-663-1611
APPROVED BY: M/DGHR/MED/DIR:CEDUMONT

AF/EX:JHUGGINS WHA/EX:PRHAYES
EAP/EX:MBFLAHERTY USAID:CKNIGHT
EUR/EX:LMDENT USAID:NLEWIS
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DESIRED DISTRIBUTION:

M/DGHR/MED

----------BB9C68 251932Z /38
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FM SECSTATE WASHDC
TO HEALTH UNIT COLLECTIVE PRIORITY
UNCLAS STATE 014411

PLEASE PASS TO USAID CONTRACTING OFFICERS AND POST HEALTH UNITS

E.O. 12958: N/A
TAGS: AID, AMED, AMGT

SUBJECT: POLICY CHANGE FOR PROVIDING ACCESS TO POST HEALTH UNITS FOR USAID INTERNATIONALLY-RECRUITED U.S. CITIZEN PERSONAL SERVICE CONTRACTORS (USPSCS)

End Cable Text

Printed By: Linda K Whitney 01/29/2001 09:18:52 AM
Linda K. Whitney
Office of Medical Services
Tel: 202 663-1611
Fax: 202 663-1613

OMB CONTROL NO. 0412-0520, EXPIRES 06/30/97

USAID CONTRACTOR EMPLOYEE PHYSICAL EXAMINATION FORM

PAPERWORK REDUCTION ACT INFORMATION: The information requested by this form is necessary to determine the physical ability of the individual to perform duties overseas. The Physician Statement at the end of the form may be used by USAID contractors and USAID contracting officers to make such a determination with regard to work overseas on an USAID contract. Medical information provided may be used by embassy health units to approve or disapprove the use of the health unit by USAID contractors and their dependents. Failure to provide the information requested by this form may result in an individual being denied overseas employment under an USAID contract and/or access to the U.S. embassy health room in a cooperating country.

TO BE COMPLETED BY EXAMINEE *(Please print all sections in INK or use TYPEWRITER)*

1. NAME OF EXAMINEE *(Last, First, Middle)*			2. CONTRACT NUMBER	3. DATE
4. DATE OF BIRTH	5. PLACE OF BIRTH	6. SEX	6a. CITIZENSHIP	6b. SSN *(Employee)*
7. MAILING ADDRESS IN THE U.S. Phone Number: ( )			8. NAME AND ADDRESS OF CONTRACTOR Contact person: Telephone: ( )	
9. NAME OF YOUR HEALTH PLAN			10. POST OF ASSIGNMENT Arrival Date: _____ Length of Tour _____	
11. IF DEPENDENT, FULL NAME OF SPONSOR:				

12. FAMILY HISTORY *(If relative has a chronic disease, Specify)*

Relation	Age	State of Health	If dead, cause of death	Age at Death
Father				
Mother				
Brother				
Sister				

Dependents Accompanying Employee	Age	State of Health
Spouse		
Child		
Child		
Child		
Child		

13. Has any blood relative *(parent, brother, sister, children)* had

YES	NO	*(Check each item)*	Relationship
		Allergies	
		Diabetes	
		Glaucoma	
		Heart Disease	
		High Blood Pressure	
		Cancer *(type)*	
		Emotional Disease	

14.
a. Examinee's statement *(or evaluation)* of present health:

b. Medication currently used *(Please list)*

ANSWER ALL QUESTIONS Do not use "PA" *(Previously Answered)*

15. DATE OF LAST EXAMINATION

Purpose of examination:

Result of examination:

16. Any special examination or treatment indicated at present time?

☐ Yes *(Specify)* ☐ No

17. Do you have any condition which would limit your assignment because of climate, altitude, isolation, or other factors?

☐ Yes *(Specify)* ☐ No

PRIVACY ACT STATEMENT: This information is requested for the purpose of assisting the physician to determine your medical status. Failure to provide full information concerning your health could result in the hampering of the medical review process. The information on this form is solely used for medical and administrative purposes. No one other than the reviewing physician and staff will have access to the medical form and information without the examinee's written authorization.

CHECK EACH ITEM "YES" OR "NO", EACH ITEM CHECKED "YES" MUST BE FULLY EXPLAINED IN BLANK SPACE ON RIGHT		
YES	NO	
		18. Have you had any significant illness or injury not noted elsewhere? *(specify condition and dates)*
		19. Have you ever been a patient in a mental hospital or sanitorium, or been treated by a psychiatrist or psychologist? *(Give date, name of doctor and/or hospital, and type of illness)*
		20. Have you been denied life insurance? *(Give details)*

21. DO YOU NOW HAVE OR HAVE YOU EVER HAD THE SYMPTOMS LISTED BELOW? *(Indicate "Yes" or "No" To Each item)*

YES	NO	*(Check each item)*	YES	NO	*(Check each item)*
		Frequent or severe headaches			Kidney trouble, stone or blood urine
		Epilepsy, fits or fainting spells			Sugar or albumin in urine
		Eye trouble or visual defect in either eye			Diabetes
		Skin disease			Rheumatic fever
		Ear, nose or throat trouble			Arthritis, rheumatism or joint pains
		Severe tooth or gum trouble			Painful or "trick" shoulder or knee
		Asthma			Bone, joint or other deformity
		Hayfever or other allergies			Recurrent back pain; wear a back support or brace
		Shortness of breath			Recent gain or loss of weight
		Chronic cough			Malaria, amoebic dysentery or other tropical disease
		Coughing up blood			Stutter or stammer habitually
		Tuberculosis, or close association with anyone who had or has tuberculosis			Frequent trouble sleeping
					Nervous trouble of any sort
		Pain or pressure in chest			Depression or excessive worry
		Palpitation or pounding of heart			Attempted suicide
		Swelling of feet or ankles			Any drug or narcotic habit *(specify)*
		High blood pressure			
		Frequent indigestion			Excessive bleeding after injury or tooth extraction
		Stomach, liver or intestinal trouble			Any reaction to serum immunization, drug or medicine
		Gall bladder trouble or gall stones			Tumor, growth, cyst, or cancer
		Jaundice or hepatitis			Do you use alcohol?
		Rupture or hernia			Are you a cigarette smoker?
		Piles or other rectal disease			Do you use any medication regularly? *(specify)*
		Blood in or on stool, or black (Tarry) Stool			
		Frequent or painful urination			

FEMALES ONLY

Specify any GYN surgery or disease:

Date of last Menses:

I CERTIFY THAT I HAVE READ THE ABOVE INSTRUCTIONS AND ANSWERED ALL QUESTIONS TRULY AND COMPLETELY TO THE BEST OF MY KNOWLEDGE.

22. TYPED OR PRINTED NAME OF EXAMINEE	DATE	SIGNATURE OF EXAMINEE

NOTE For the Examining Physician: Please review the Medical History and make appropriate comments on all positive historical data. You are required to inform the examinee of any abnormality which you have noted and/or which may require medical attention.

23. SIGNIFICANT AND/OR INTERVAL HISTORY: ***(Note: the examining physician MUST COMMENT on all items checked "Yes" in items 16-21).***

REPORT OF MEDICAL EXAMINATION

(To Be Completed And Signed By the Examining Physician)

GUIDELINES FOR EXAMINING PHYSICIAN: The individual you are examining will be serving at one of a variety of overseas posts. Many of these posts are remote, unhealthful, and have limited or no medical support such as doctors, nurses, laboratory facilities, and hospitals. Many illnesses and injuries that can be handled routinely in developed countries such as the U.S., become major or life threatening problems in many underdeveloped overseas locations.

The effect of adverse environmental conditions, such as altitude, air pollution, poor sanitation, and exposure to tropical diseases, on any existing medical problem should be considered.

Please evaluate thoroughly all items listed on the examination form. It is most import that you:

- Comment on all items checked "Yes" on the medical history, items 15-21.
- Record all physical findings after completing the examination as requested.
- Order and record (or attach copies of) all laboratory and x-ray data requested. We do want all of the tests completed as requested for the age of the examinee. Guidelines for age are noted on this form.
- Comment on all indicated follow-up examinations and conditions that may require frequent observation or prolonged treatment.
- Sign and date that portion of the examination form completed by you.

24. RACE *(Check one)*
☐ White ☐ Black ☐ Other _____

25.
HEIGHT _____ in. or _____ cm.
WEIGHT _____ lbs. or _____ kg.

26. HEARING

SPOKEN VOICE: right ☐ normal ☐ abnormal
left ☐ normal ☐ abnormal

AUDIOGRAM: *(performed if indicated by gross evaluation)*

Frequency in Hertz and levels in decibels.

	500	1000	2000	4000
right				
left				

27. DISTANT VISION
right 20/ corrected 20/
left 20/ corrected 20/

28. INTRAOCULAR TENSION (Over Age 40)
right _____ mmHg left _____ mmHg

29. PULSE (Sitting)

30. BLOOD PRESSURE (Sitting)

CLINICAL EVALUATION: *(Describe every abnormality in detail. Enter pertinent item number before each comment.)*

NORMAL	Check Each Item As Indicated. Enter "NE" If Not Evaluated.	ABNORMAL	DESCRIBE ABNORMAL FINDINGS
	31. Head, Face, Neck and Scalp		
	32. Nose and Sinuses		
	33. Mouth and Throat		
	34. Ears – including otoscopi		
	35. Eyes – including ocular mobility, pupillary reaction and ophthalmoscopic (visual acuity under item 27)		
	36. Lungs and Chest *(includes breast)*		
	37. Heart *(thrusts, size, rhythm, sounds)*		
	38. Vascular system *(varicosities, etc.)*		
	39. Abdomen and Viscera *(includes hernia)*		
	40. Anus and Rectum *(hemorrhoids, Fistulae, Prostate)*		
	41. Endocrine System		
	42. G-U System		
	43. Extremities *(strength, range of motion)*		
	44. Spine, Other Musculoskeletal		
	45. Identifying body marks, scars, tattoos		
	46. Skin, lymphatics		
	47. Neurologic		
	48. Psychiatric *(specify any personality deviation)*		
	49. Pelvic (over age 21) (Papanicolaou done ☐)		Papanicolaou Result Class _____
	50. Sigmoidoscopy *(over age 50 or if indicated)*		

"ALL TESTS ARE REQUIRED UNLESS OTHERWISE SPECIFIED"

NAME OF EXAMINEE: *(LAST),* *(FIRST)*

51. HEMATOLOGY *(all ages)*		52. STOOL EXAM FOR OCCULT BLOOD] *(40 yrs. and over or when indicated)*	53. ECG *(40 Yrs. and over or when indicated)*. Submit all tracings.
Hematocrit	%		Result:
Hemoglobin	gms		
WBC	/cmm	a. Pos Neg	
Differential:		b. Pos Neg	
Granulocytes	%	c. Pos Neg	54. CHEST X-Ray *(Required for all examinations for persons age 18 and over or when otherwise indicated.)*
Lymphocytes	%		Date: Results:
Eosinophils	%		
Other	%	X3 on successive days	

55. SCREENING CHEMISTRY PROFILE TO INCLUDE: *(FASTING)* 18 yrs. and over	56. URINALYSIS *(all ages)*	57. TUBERCULIN TEST:PPD *(all ages)*	58. G6PD *(if going to Malarial areas)*
Blood Glucose	Specific Gravity	Date _____	Normal _____
Cholesterol	Albumin	Results: _____ mm of induration	
Creatinine	Sugar	Previously positive Yes ____ No ____	
Uric Acid	WBC		Deficient _____
SGPT	RBC	Previous BCG Yes ____ No ____	
SGOT	Casts	59. MAMMOGRAPHY *(suggested if over age 40 and if clinically indicated)*	60. SICKLE HEMOGLOBIN *(when indicated)*
Alk Phos	Other	Results and Date:	Present _____
Billrubin			Not Present _____

61. SEROLOGY *(specify test and results) (12 yrs. and over)*

STS _____ HIV *(optional)* _____

62. ASSESSMENT OF SIGNIFICANT FINDINGS	RECOMMENDATION FOR TREATMENT/FURTHER STUDY

63. TYPED NAME OF EXAMINING PHYSICIAN	SIGNATURE	DATE
ADDRESS: *CITY*	DATE	DATE
TELEPHONE		

PHYSICIAN STATEMENT
(To Be Completed and Signed By The Examining Physician)

Guidelines for Examining Physician: Please complete the following medical opinion based on the results of the REPORT OF MEDICAL EXAMINATION.

Guidelines for Examinee: A copy of this medical opinion shall be submitted by USAID contractor employees and their dependents to the appropriate USAID contractor. Personal Services Contractors and their dependents shall submit a copy of this medical opinion to the appropriate USAID contracting officer.

IN MY OPINION, THE EMPLOYEE _____ IS PHYSICALLY QUALIFIED TO ENGAGE IN THE TYPE OF ACTIVITY FOR WHICH HE/SHE IS EMPLOYED, AND EMPLOYEE AND/OR DEPENDENT _____ IS PHYSICALLY ABLE TO RESIDE IN _____ *(THE COUNTRY OF ASSIGNMENT).*

EXAMINING PHYSICIAN *(Type or print name)*	SIGNATURE	
ADDRESS *CITY* *STATE* *ZIP*		TELEPHONE

U.S. DEPARTMENT OF STATE

Office of Medical Services, Room 2906, Washington, D.C. 20520

MEDICAL HISTORY AND EXAMINATION FOR FOREIGN SERVICE

For children 11 years and under

PRIVACY ACT NOTICE: This information is requested under the authority of section 904 of the Foreign Service Act of 1980, 22 U.S.C. 4084, to assist the Office of Medical Services in determining your medical clearance status. Failure to provide this information will delay the medical clearance process and may result in a determination not to grant a medical clearance. Medical records are normally used only by medical and administrative personnel of the Office of Medical Services, and are released to third parties only with the written permission of the individual. Such records may also be disclosed under the conditions specified in 5 U.S.C. 552a(b) or in accordance with the uses permitted for all Department of State records systems subject to 5 U.S.C. 552a. See 41 Fed. Reg. 41330, 41342 (Sept. 21, 1976).

I. TO BE FILLED OUT BY SPONSOR OR PARENT (Complete all sections, type or in ink). DATE

1. NAME OF EXAMINEE *(Last, First, M.I.)*

2. FULL NAME OF EMPLOYEE/APPLICANT/SPONSOR

3. DATE OF BIRTH

4. SEX ☐ MALE ☐ FEMALE

5. AGENCY OF EMPLOYEE/APPLICANT/SPONSOR

6. STATUS ☐ D/Son ☐ D/Daughter

7. SOCIAL SECURITY NUMBER *(Employee/ Applicant/ Sponsor)*

8. PLACE OF BIRTH

U.S. _____ OTHER _____

9. POST OF ASSIGNMENT AND DATES OF DEPARTURE/ARRIVAL

a. Present Post _____ EDD _____

b. Proposed Post _____ ETA _____

c. Last 3 Posts _____

10. MAILING ADDRESS *(Medical Clearance Abstract will be mailed to listed address)*

TELEPHONE NO.: ( )

11. PURPOSE OF EXAMINATION

☐ a. Preemployment ☐ c. In-Service

☐ b. Separation ☐ d. Other

12. NAME OF YOUR HEALTH INSURANCE PLAN

13. FAMILY HISTORY

FAMILY MEMBERS NAME	AGE	STATE OF HEALTH
Father		
Mother		
Sibling		
Sibling		
Sibling		
Sibling		

CHECK if relatives/family members have had any of the following illnesses or problems:

ILLNESS	RELATIONSHIP
☐ Alcoholism	
☐ Allergies/Asthma	
☐ Cancer	
☐ Diabetes	
☐ Emotional Disease	
☐ Heart Disease	
☐ High Blood Pressure	
☐ Other:	

DO NOT WRITE IN THE SPACE BELOW (FOR USE BY MEDICAL DIVISION ONLY)

CLEARANCE ACTION:

II. HAVE YOU EVER HAD: NAME OF EXAMINEE:

YES	NO		
☐	☐	1.	Frequent or severe headaches?
☐	☐	2	Dizzy spells, fainting, or blackouts?
☐	☐	3.	Epilepsy or seizures?
☐	☐	4.	Eye trouble or vision problems?
☐	☐	5.	Tooth or gum problems?
☐	☐	6.	Difficulty with your hearing?
☐	☐	7.	Other ear, nose, or throat problems?
☐	☐	8.	Hayfever or other allergies?
☐	☐	9.	Asthma?
☐	☐	10.	Wheezing or shortness of breath?
☐	☐	11.	Chronic cough?
☐	☐	12.	Coughing up blood?
☐	☐	13.	Heart problems or disease?
☐	☐	14.	Stomach, liver, or intestinal problems?
☐	☐	15.	Jaundice or hepatitis?
☐	☐	16.	Rupture or hernia?
☐	☐	17.	A change in bowel or bladder habits?
☐	☐	18.	Blood in or on stool; black, tarry stools?
☐	☐	19.	Frequent urination?
☐	☐	20.	Kidney trouble; stone or blood in urine?
☐	☐	21.	Sugar or albumin (protein) in urine?
☐	☐	22.	Diabetes?
☐	☐	23.	Arthritis, rheumatism, or joint pains?
☐	☐	24.	Joint or bone deformity or fracture?
☐	☐	25.	Malaria, dysentery, other tropical disease?
☐	☐	26.	A sore that does not heal?
☐	☐	27.	Recent gain or loss of weight?
☐	☐	28.	Obvious change (color, size) in a mole or wart?
☐	☐	29.	Frequent crying spells?
☐	☐	31.	Frequent trouble sleeping?
☐	☐	32.	Difficulty in relaxing or calming down?
☐	☐	33.	Swollen glands?
☐	☐	34.	Tuberculosis, or close association with anyone who had or has tuberculosis?
☐	☐	35.	A blood transfusion?
☐	☐	36.	Anemia?
☐	☐	37.	Rheumatic fever?
☐	☐	38.	Any neurological disorder?
☐	☐	39.	Learning disability or disorder?
☐	☐	40.	Behavioral or discipline problem at home or school?
☐	☐	41.	Have you ever been a patient in a mental health facility or been treated by a psychiatrist, psychologist, or other mental health practitioner?

III. CURRENT MEDICATIONS *(List all medications you take, prescription or over the counter)* | DRUG OR OTHER ALLERGIES

IV. HOSPITALIZATIONS / OPERATIONS / MEDICAL EVACUATIONS *(Include all medical and psychiatric illnesses)*

DATE	ILLNESS OR OPERATION	NAME OF HOSPITAL	CITY AND STATE

Anything else you would like to mention about your health or well being?

Please Recheck All Items for Completeness and Accuracy. DO NOT INDICATE: "Previously Answered."

The intentional omission of any crucial medical information is a criminal offense (Section 1001 of the U.S.C. Title 18). Preemployment applicants who intentionally omit information which would make them ineligible for appointment, will be subject to disciplinary action, including separation for cause if they are hired. Current employees may also be subject to disciplinary action for intentional omission of information.

SIGNATURE OF SPONSOR OR PARENT (I certify I have read and understand the above statements) | DATE

V. TO BE COMPLETED BY THE EXAMINING PHYSICIAN *(Read Section X Before Proceeding)*

SIGNIFICANT HISTORY: *(NOTE: The Examining Physician MUST comment on ALL items checked "YES" in Part II.)*

VI. TO BE COMPLETED BY THE EXAMINING PHYSICIAN

NAME OF EXAMINEE:

1. RACE *(Check One)*
☐ White ☐ Black
☐ Other *(Specify)* _____

2. HEIGHT
_____ in. or
_____ cm.

3. WEIGHT
_____ lb. or
_____ kg.

4. PULSE *(Sitting)*

5. BLOOD PRESSURE *(Sitting)* (Age 5 and Over)

6. DISTANT VISION *(Age 5 and Over)*
Right 20 / Corrected 20 /
Left 20 / Corrected 20 /

7. HEAD CIRCUMFERENCE *(18 Months and Under)*
_____ in. or
_____ cm.

8. AUDIOGRAM *(Age 5 and Over)*
Frequency in Hertz. Hearing level in decibels

	500	1000	2000	4000
Right				
Left				

VII. CLINICAL EVALUATION

Check each item as indicated. Enter "NE" if not evaluated.

	Normal	Abnormal
1. Skin *(Record Identifying Body Marks and Surgery Scars)*		
2. Head and Neck *(Thyroid)*		
3. Ear, Nose and Throat		
4. Lymph nodes		
5. Eyes *(Include Funduscopic Exam)*		
6. Lungs		
7. Breast		
8. Heart *(Record Split Sounds and Murmurs)*		
9. Abdomen		
10. Genitalia *(Male-Testes Descended?)*		
11. Anus		
12. Vascular System *(Record Peripheral Pulses)*		
13. Extremities and Spine		
14. Neurological *(Record Reflexes and Muscle Strength)*		
15. Psychiatric *(Specify Any Significant Mood, Cognitive, Behavioral Observations)*		

NOTES
(Describe Every Abnormality in Detail. Pertinent Item Number Before Each Comment)

VIII. ALL OF THE FOLLOWING TESTS ARE REQUIRED UNLESS OTHERWISE SPECIFIED

1. HEMATOLOGY
Hematocrit _____ %
Hemoglobin _____ gms%

2. STOOL EXAM FOR OVA AND PARASITES *(For children returning from developing countries, or when indicated.)*
a. _____
b. _____
c. _____

3. URINALYSIS
Specific Gravity _____
Albumin _____
Sugar _____
WBC _____
RBC _____
Casts _____
Other _____

4. BLOOD LEAD LEVEL *(Age 9 mo. - 7 years)*
_____

5. TUBERCULIN TEST: *(5TU PPD)*
Date _____ Not Done _____
Results: _____ mm of Induration
Previous Positive Yes ____ No ____
Previous BCG Yes ____ No ____
INH Recommended Yes ____ No ____
(Enter for New Converters Only)

6. CHEST X-RAY *(For New TB Skin Test Convertors, or When Indicated.)*
Date _____
Results: _____

7. PREEMPLOYMENT ONLY *(Or if Previously Not Done)*
a. Blood Group _____
b. Blood Type _____
c. G6PD
Normal _____
Deficient _____
d. Sickle Hemoglobin
Present _____
Not Present _____

NAME OF EXAMINEE:		
IX. ASSESSMENT OR PROBLEM LIST	RECOMMENDATION FOR TREATMENT/FURTHER STUDY	
TYPED NAME OF EXAMINING PHYSICIAN	SIGNATURE	DATE
EXAMINING FACILITY	ADDRESS	

☐ Check here if examination was done in the Office of Medical Services.

X. INSTRUCTIONS TO THE PHYSICIAN

IMPORTANCE OF EXAMINATION: IT IS IMPORTANT FOR THE EXAMINING PHYSICIAN TO IDENTIFY MEDICAL CONDITIONS WHICH WILL REQUIRE FOLLOW-UP MEDICAL CARE OR COULD BE ADVERSELY AFFECTED BY ENVIRONMENTAL CONDITIONS SUCH AS HIGH ALTITUDE. The consequences of not identifying preexisting health problems could be extremely serious for the examinee. As you perform the examination, keep in mind that the examinee may be living in a third world developing country where medical care (doctors, nurses, laboratory facilities and hospitals) are accessible only by air. The examinee may be exposed to tropical disease, all the problems related to poor sanitation, as well as environmental conditions such as high altitude and air pollution, which could aggravate preexisting health problems. Please keep these factors in mind as you perform the examination and complete the problem list.

SCOPE OF THE PHYSICAL EXAMINATION: The scope of the physical examination is contained within the physical examination form. There are certain tests requested that are not routinely done in the United States, but are indicated for our population who live overseas.

DISPOSITION OF REPORTS: All reports submitted from overseas locations must be in the English language. The completed medical report, any laboratory reports, X-rays or related medical documentation should be identified with the full name and date of birth of the examinee, and the name and social security number of the employee. Al reports should be placed in a sealed envelope and marked "Privileged Medical Information." The envelope should also show the name of the examinee and the employee. If overseas the report should be returned to the Embassy which requested the physical examination. If in the U.S., the report should be addressed to the **Medical Director, Department of State, Washington, D. C. 20520-2256.**

EXAMINATION FEES: Reimbursement of a reasonable and customary fee will be made for each examination, including laboratory tests, and X-ray procedures. In submitting the bill, please itemize tests and cost of each item.

NOTE: Copy of examination may be given to examinee.

Sample Letter to Examining Physician

Agency for International Development
USAID/XXXX
C/O Department of State
XXXX XXXX Place
Washington, DC 20521-XXXX

Dear Health Care Provider:

Thank you for performing this examination. Mr. (or Ms) name of candidate has been selected by the US Agency for International Development to fill a contractual position in location of post. Before the Agency can enter into a contract with Mr. (or Ms) name of candidate, he(she) and his(her) family members must undergo complete physical examinations that conform to the AID 1420-62 Contractor Employee Physical Examination Forms or DS 1622 for children under 12 years, enclosed herewith.

The scope of the exam and testing is outlined on the examination form and the attached instruction sheets. If you have any questions regarding what is required, please contact the Office of Medical Services, Medical Clearance Section at (202) 663-1668.

If you think further tests or consultations are indicated, please so note on page 4 of the exam form under the "recommendation for treatment/further study" section, but please do not do them.

If you are unable to perform any of the basic laboratory tests or procedures, please refer the patient to an appropriate place(s) and give the patient a copy of this letter to use by the facility or provider.

When the examination is completed, keep a copy of the signed and dated USAID Contractor Employee Physical Examination Form, give one copy to the examinee, and forward the original(s) under cover of the attached Transmittal Memorandum to the following address. A self-addressed envelope is enclosed.

Department of State
Office of Medical Services
Attn. Marian Wordsworth
2401 E. St., NW
Washington, DC 20522-0102

Billing Instructions

The patient and/or the patient's insurance carrier is the primary payee. Please bill the patient as appropriate.

Sincerely,

Your Name
USAID Contracting Officer

UNITED STATES DEPARTMENT OF STATE
Office of Medical Services

MEDICAL CLEARANCE

Name of Examinee:		Date of Clearance: February 27, 2001
Address: 14017 WESTVIEW FOREST DRIVE MD 20720		Date of Birth November 25, 1980 Rel Status: DD
Name of Employee:	SSN of Employee:	Agency:
Purpose of Examination: IN SERVICE	Place of Examination: OTHER	FileID:

An evaluation of the examince's current medical condition, in light of Foreign Service medical standards, indicates that the examinee has the following medical clearance:

01

POST:

DS 823

3. Copy to AGENCY - GATESBA

UNITED STATES DEPARTMENT OF STATE
Office of Medical Services

AUTHORIZATION FOR MEDICAL TESTS/CONSULTATIONS

Name of Examinee		Date of Birth
Address		FileID
		Rel Status
Name of Employee	SSN of Employee	Agency

TO THE EXAMINEE:
The following tests/consultations are REQUIRED to complete your physical examination and issuance of medical clearance.

Exam/Consultation Description	Comments/Remarks

Date of Authorization	Chief, Medical Clearances	Telephone Number

DS 616 (see ATTACHED for instructions) Copy to EXAMINEE -

INSTRUCTIONS FOR PATIENT AND PROVIDER

This form (DS-616) only authorizes payment for medical tests/consultations related to overseas service, assignment or separation. This form (or a copy) should be presented to each facility or physician for completion of the requested tests/consultations. The authorization is valid for 60 days.

TREATMENT OF MEDICAL CONDITIONS IS NOT AUTHORIZED. PAYMENT FOR STUDIES BEYOND THOSE LISTED AS REQUIRED OR RECOMMENDED IS NOT AUTHORIZED, UNLESS PRIOR APPROVAL HAS BEEN GIVEN BY THE CLEARANCE SECTION.

REPORTS

TO THE PATIENT:
The results of the REQUIRED medical tests/consultations are necessary in order to determine an appropriate medical clearance for you. As a valid medical clearance is mandatory for all employees and dependents proceeding overseas, you should insure that reports from the consultants/facilities are sent promptly to the Medical Clearances Section of the Office of Medical Services. Proceeding overseas without a valid clearance may result in forfeiture of medical benefits under the Department's overseas medical program (3 FAM 684.7-4).

TO THE PROVIDER:
Reports (both for REQUIRED and RECOMMENDED tests/consultations) should be sent to the Clearance Section, Office of Medical Services, Department of State, 2401 E. St. NW, Room L209 (SA-1), Washington, DC 20522 -0102. (N.B.: Please include the patient's FileID number, located next to the bar code, on all reports. Alternatively, reports may be FAXED to Medical Clearances, FAX number is 202-663-1851). Telephoned reports will be accepted, but must be followed by a written report. The telephone number for the Medical Clearances Section is (202) 663-1668. Exam Clinic: 202-663-1717.

BILLING

TO THE PATIENT AND/OR PROVIDER:
Bills for charges related to REQUIRED or RECOMMENDED tests/consultations must first be submitted for payment to the employee's health insurance company by either the provider or employee. Assignment may be made to the provider. The balance of charges, i.e. those not covered by the insurance company, will be paid by the Claims Section, Office of Medical Services, Department of State, 2401 E St. NW, (SA-1), Washington, DC 20522-0102 upon receipt of the insurance company's determination of payment. The Department's liability is limited to the balance of the primary payer's approved amount. Statements should be mailed to the Claims Section. The telephone number is: (202) 663-1931.

TO USAID U.S. CITIZEN PERSONAL SERVICES CONTRACTORS:
USAID U.S. Citizen Personal Services Contractors (USPSCs) must first obtain the prior approval of the requiring office and the Contracting Officer before obtaining additional medical tests as recommended by M/MED. USPSCS will be reimbursed in accordance with USAID regulations.

REQUIRED TESTS/CONSULTATIONS

These studies (noted as REQUIRED on the front of this form) must be completed before a medical clearance can be issued.

SCHEDULING AND COMPLETION OF THESE EXAMINATIONS IS THE PATIENT'S RESPONSIBILITY.

OVER 12 YEARS
(USAID PERSONAL SERVICES CONTRACTOR VERSION)

GENERAL REQUIREMENTS FOR EVERYONE WITH EACH CLEARANCE EXAM

- COMPLETE PHYSICAL EXAMINATION BY M.D., D.O., NP, PA
- URINALYSIS (INCLUDE MICROSCOPIC)
- HEMATOLOGY: HCT, HGB, WBC WITH DIFFERENTIAL
- SCREENING CHEMISTRY PROFILE: MUST INCLUDE BUT NOT LIMITED TO: BLOOD SUGAR, CHOLESTEROL, URIC ACID, CREATININE, ALT (SGPT), ALK, PHOS, GGT (RQUIRED FOR 18 YEARS AND OVER)
- SEROLOGY: RPR (SYPHILLIS TEST), HIV
- TUBERCULIN SKIN TEST (5TU PPD)

ADDITIONAL PRE-CONTRACT REQUIREMENTS

- CHEST X-RAY (REPORT REQUIRED)
- BLOOD GROUP AND TYPE
- G6PD
- SICKLE HEMOGLOBIN (WHEN APPLICABLE)

ADDITIONAL TESTS REQUIRED ACCORDING TO AGE

ALL WOMEN 21 YEARS AND OVER
- PAP SMEAR (RESULTS OF CYTOLOGY REQUIRED)

ALL WOMEN 50 YEARS AND OVER
- MAMMOGRAM (AGE 40-50 IT IS RECOMMENDED BUT NOT REQUIRED)

ALL MEN AND WOMEN 40 YEARS AND OVER
- EKG (TRACING REQUIRED)
- THREE CONSECUTIVE STOOL TESTS FOR OCCULT BLOOD

SPECIALTY TESTS

MEN AND WOMEN 50 YEARS AND OVER
- FLEXIBLE SIGMOIDOSCOPY IS RECOMMENDED BUT ONLY REQUIRED IF THERE IS A
  FAMILY HISTORY OR CLINICALLY INDICATED

MEN 50 YEARS AND OVER
- PSA IS RECOMMENDED BUT NOT REQUIRED UNLESS CLINICALLY INDICATED

ALL REPORTS SHOULD ACCOMPANY THE COMPLETED ORIGINAL PE FORM (AID 1420-62). PAGE 2 MUST BE SIGNED BY THE EXAMINEE. THE EXAMINER MUST SIGN PAGE 4.

CLEARANCE PE REQUIREMENTS BY AGE

INFANTS (Newborns to one year)

1. Pages 1 & 2 completed by parent and signed (Form DS-1622)
2. If any question in section I (page 2) is marked YES, the examiner need to comment on it in Section V on the same page.
3. Must have weight, length, and heart rate.
4. Examiner complete section VII on page 3. Any abnormal responses must be described in the not area of the same section.
5. No lab tests are required.
6. Examiner must sign the form on page 4. Examiner should list any problems and recommendations.
7. It is preferred that the newborn exam be done no sooner than 4 weeks.

CHILDREN AGE 1-11 YEARS OLD

1. Pages 1 & 2 completed by parent or guardian and signed (Form DS 1622)
2. If any questions in section II (page 2) are marked YES, the examiner needs to comment on it in section V, same page.
3. Must have height, weight, heart rate or pulse and EXAMINER marked normal/abnormal in boxes 1-15 in section VII on page 3. Any abnormal responses must be described in the note area of the same section.
4. Lab tests that are required: hemoglobin and/or hematocrit and urinalysis. (NB: urinalysis is required only after child is potty trained)
5. A blood lead level is optional for ages 1-6 years.
6. A PPD skin test for tuberculosis is required.
7. Examiner must sign the form on page 4. Examiner should list any problems and recommendations on page 4.
8. Children with learning disabilities or on medication for ADHD need to submit a completed School Report of Progress form with examination or CEP form.

*Examination must be done by a licensed health care provider (physician, nurse practitioner, physician assistant).

1/00 jll

Examining Health Care Provider: Please mail the patient's examination forms/reports to the Department of State, Office of Medical Services, under cover of this memorandum

United States of America
MEMORANDUM OF TRANSMITTAL

Date: _____

From: Name of Contracting Officer
Post/Address

Through _____ **Health Care Provider for USPSC candidate**

To: Marian Wordsworth
Department of State
Office of Medical Services
2401 E. St., NW
Washington, DC 20522-0102

Subject: Transmittal of PE (AID 1420-62) for Internationally Recruited USPSC And Request for Medical Clearance

Attached are forms 1420-62 (DS 1622 for children under 11 years) and other medical reports prepared by the personal health care provider of the USPSC-candidate and family members indicated below. I affirm that (insert the name of the USPSC) is a United States citizen and that the contract position for which he/she has been selected is an internationally recruited position.

Name of USPSC Candidate: Sam Sample
Birth Date 01/01/60

Social Security Number: XXX-222-3333

Position Selected for and location Project Officer, City and Country X

Eligible Family Members

Name/Status Jeanne/wife Birth Date 01/02/60
Name/Status _____ Birth Date_____
Name/Status _____ Birth Date_____
Name/Status _____ Birth Date_____
Name/Status _____ Birth Date_____

I understand that an abstract of the clearance will be faxed to me when available. My fax number is (011) 222-555-5555

Thank you.

3. PHYSICAL FITNESS AND HEALTH ROOM PRIVILEGES (Apr 1997)

(a) Physical Fitness.

(1) For all assignments outside of the United States the contractor and any authorized dependents shall be required to be examined by a licensed doctor of medicine and meet the requirements of this clause.

(2) For assignments of 60 days or more in the Cooperating Country, the Contracting Officer shall provide the contractor and all authorized dependents copies of the ``USAID Contractor Employee Physical Examination Form'' (AID 1420-62) and a letter to present to the examining physician. The contractor and all authorized dependents shall obtain a physical examination from a licensed physician, who will complete the form for each individual. The examining physician shall forward the original forms to the Department of State, Office of Medical Services (M/MED) as prescribed in the letter. The contractor and any dependents shall not travel until authorized by the Contracting Officer after receipt of clearance by the Office of Medical Services.

(3) For assignments of fewer than 60 days, the contractor shall obtain from the doctor a statement of medical opinion that, in the doctor’s opinion, the contractor is physically able to engage in the type of activity for which he/she is to be employed under the contract. A copy of the statement(s) shall be provided to the Contracting Officer prior to the contractor’s departure for the Cooperating Country, or for a U.S. resident hire, before he/she starts work under the contract. As an example, the doctor may choose to use the language of the doctor’s statement of medical opinion at the end of the form AID 1420-62 which

identifies the contractor by name may be used to meet this requirement. However, form AID 1420-62 is not required to be completed for contracts less than 60 days.

(b) Reimbursement.

(1) As a contribution to the cost of medical examinations required by paragraph (a)(3) of this clause, USAID shall reimburse the contractor not to exceed $100 for each physical examination, plus reimbursement of charges for immunizations.

(2) As a contribution to the cost of medical examinations required by paragraph (a)(2) of this clause the contractor shall be reimbursed in an amount not to exceed half of the cost of the examination up to a maximum USAID share of $300 per examination plus reimbursement of charges for immunizations for himself/herself and each authorized dependent 12 years of age or over. The USAID contribution for authorized dependents under 12 years of age shall not exceed half of the cost of the examination up to a maximum share of $120 per individual plus reimbursement of charges for immunizations. The contractor must obtain the prior written approval of the Contracting Officer to receive any USAID obligations higher than these limits.

If M/MED requires the proposed contractor and/or dependents to have additional tests done before providing medical clearance, the proposed contractor shall notify the Contracting Officer and the responsible individual in the requiring office. These additional tests shall be reimbursed to the proposed contractors at 100% of incurred costs, minus any payments by the proposed contractor's insurance company.

(c) Health Room Privileges Overseas. After the contractor and dependents receive M/MED clearance, routine health room services shall be available in their overseas location. Procedures at the Health Room

shall be in accordance with post policy at the post of duty. These services do not include hospitalization or predeparture examinations. The services normally include such medications as may be available, immunizations and preventive health measures, diagnostic examinations and advice, and home visits as medically indicated. Emergency medical treatment is provided to U.S. citizen contractor employees and dependents, whether or not they may have been granted access to routine health room services, on the same basis as it would be to any U.S. citizen in an emergency medical situation in the country.