



RÉPUBLIQUE DU BÉNIN

MINISTÈRE DE LA DÉFENSE NATIONALE

ETAT-MAJOR GENERAL



51 BP 772 Cotonou

Tel : +(229) 2130 0258

etmajorgeneral_fabi@yahoo.fr

N°19- 0057 /EMG/POE/DOMP/SA

Cotonou, le 10 avril 2019

Le Chef d'Etat-Major Général,

A

- Monsieur le Colonel,
Chef d'Etat-Major de l'Armée de Terre
Cotonou

- Monsieur le Capitaine de Vaisseau,
Chef d'Etat-Major des Forces Navales
Cotonou

- Monsieur le Lieutenant-Colonel,
Chef d'Etat-Major des Forces Aériennes.
Cotonou

Objet : Entrée en vigueur du nouveau formulaire d'habilitation médicale pour les Opérations de Maintien de la Paix (MS-3).

Référence : Transmis N°19-0057/EMG/POE/DOMP/SA du 04 janvier 2019.

Pièce-Jointe : Formulaire utilisé pour évaluer la santé des candidats (MS-3) (Version électronique disponible au secrétariat POE/EMG).

Par la correspondance de référence, vous avez été informé de la modification du processus d'habilitation médicale pour les OME.

Par la présente, j'ai l'honneur de vous demander de vouloir bien instruire vos personnels éligibles à divers postes dans les OME sur l'engagement individuel que confère le nouveau formulaire d'habilitation médicale (MS-3) entré en vigueur le 1^{er} avril 2019.

Ce formulaire utilisé pour évaluer la santé des candidats MILOBs et MSD aux OME ne dispose d'aucun endroit où le médecin pourrait apposer sa signature. De ce fait, il devient un acte de foi du candidat qui n'est plus obligé de subir une visite médicale. Toutefois, le candidat pourrait demander, pour s'assurer

de son bon état de santé, à se faire examiner par le DSSA qui rend compte sous pli confidentiel des résultats de la visite médicale au CEMG. Le Certificat subséquent est remis au candidat par le POE.

Ceci signifie que d'aurénavant, les Nations Unies déclinent toute responsabilité médicale d'un quelconque mal, volontairement caché par le candidat aux OME, qui se révélerait sur théâtre d'opération.

Je vous demande donc de procéder à une large diffusion des contraintes implicites du MS-3 désormais utilisé, au sein de l'ONU afin que chaque candidat MILOBs et MSD sache que sa responsabilité individuelle est engagée.

Les dispositions de MS-3 ne s'appliquent pas aux personnels du contingent qui continueront par faire l'objet de visite d'aptitude médicale comme par le passé.



Contre-Amiral Patrick Jean-Baptiste AHD

Copie :
- CDT CFOMP-C

CONFIDENTIAL

UNITED
NATIONS



NATIONS
UNIES

EMPLOYMENT MEDICAL
REVIEW QUESTIONNAIRE

This questionnaire is used to evaluate the health status of new recruits and current employees who require medical clearance in accordance with ST/AI/2011/3. Based on the responses further medical evaluation may be required.

If there is insufficient space, or if you wish to provide additional documents, submit these as attachments with this questionnaire.

Family Name (In Block Capitals)		Given Name		Previous Name		Gender <input type="checkbox"/> M <input type="checkbox"/> F	
Current Address (Street, Town, District Or Province, Country)				Date of Birth		Birthplace	
				E-mail Address		Telephone	
Index Number		Proposed Job Title		Proposed Job Location/Mission			

1. Have you had a medical check-up in the last 2 years?

No Yes Date of check-up:

If "No" we strongly suggest you undertake a checkup with your usual doctor before you continue with this questionnaire. Please document any findings your doctor considers significant or which you consider may be relevant to your proposed role.

2. Do you have any health condition (medical, surgical or psychological) requiring ongoing health care?

No Yes *If "yes" please provide details (please include the date of the initial diagnosis, the actual diagnosis and treatment).*

Diagnosis	Date	Treatment

3. Have you been admitted to a hospital for at least 2 consecutive days in the last 5 years, or have you been absent from work for more than 30 calendar days total in the last 12 months due to health reasons?

No Yes

If "yes" please provide details of the reason for hospitalization or the reason(s) for your absences.

4. Are you regularly taking any prescribed medications?

No Yes

If "yes" please provide details (please include name of EACH medication, dose and frequency).

Name	Dose	Frequency	Name	Dose	Frequency

5. Do you have any condition which will need medical, surgical or psychological intervention or treatment within the next 12 months? (Please also indicate "Yes" here if you are pregnant and provide your estimated date of delivery).

No Yes

If "yes" please provide details.

6. Do you have any physical or mental health conditions which could make it difficult for you to live and work in, or travel to, a remote area with limited access to health care facilities?

No Yes

If "yes" please provide details.

7. Have you been vaccinated against yellow fever?

No Yes If "Yes", please provide date of vaccination

8. Are there any vaccines you cannot receive? (Please list vaccine and reason, such as known allergy, religious beliefs, etc.)

No Yes

If "yes" please provide details.

Note: There are a number of vaccinations which are protective of health and which are recommended for employment in different countries. If you have a vaccination record or International Health Record ("Yellow Book") attach either a scan or an electronic record of this with this questionnaire, labelled "Vaccine Record".

9. Have you ever suffered from a physical or psychological condition which has been recognized by your previous employer as caused by your work?

No Yes

If "yes" please provide details.

10. Do you currently have, or will you need any workplace accommodations for medical conditions, and/or disability? (For example do you have travel limitations, or need a special desk, etc.)

No Yes

If "yes" please provide details.

11. Are you aware of any other factors which could affect your health or your ability to perform your duties at the intended duty station? (Such as access to health care, family circumstances, etc)

No Yes

If "yes" please provide details.

Declaration - Please read, sign and either check ACCEPT or DECLINE the declaration

I, _____, hereby declare that the answers to all questions are to the best of my knowledge a complete and accurate representation of my health. I also acknowledge that failure to disclose a known physical and psychological condition, including conditions under investigation, may result in withdrawal of medical clearance for employment, denial of benefits, termination or dismissal in accordance with the relevant administrative directives of my employing organization.

Date :

You must check one box : ACCEPT DECLINE

Signature: