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|  |  **IARC Research Training and Fellowship Programme**  **Medical Certificate of Fitness** **Period of validity:**  **One calendar year as of the date of signature by the attending physician below.** |

 **This certificate is mandatory:**

 **- for stays of any duration in the laboratories;**

 **- for stays of a duration ≥ 3 months outside the laboratories.**

**1. TO BE COMPLETED BY THE INDIVIDUAL**

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| --- | --- | --- | --- |
| Family name | Click here to enter text. | Maiden name | Click here to enter text. |
| Given name | Click here to enter text. | Gender | [ ]  F [ ]  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. |
| PLANNED STAY AT IARC: |
| Description of activities  | Click here to enter text. | Location | 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 follow the planned activities. Please ensure that vaccinations are up-to-date and in line with WHO recommendations. In particular and for those who are to stay in an IARC laboratory or handle human biological specimens, a copy of Hepatitis B vaccination record AND immuno-serology results should be provided (or evidence of the medical grounds for non-vaccination).

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| Mr / Mrs / Miss …………………………………… ……………………has been examined by me. He/she has been found fit to [travel and] carry out the planned activities at the International Agency for Research on Cancer (IARC) in Lyon, FRANCE. |
| Name of the attending physician who examined the individual: | ……………………………………………………………………... |
| Address: | ………………………………………………………………………………………………………………………………………………………………………………………… |
| **Date:** …………………… | **Signature:** ……………………………………… **Doctor’s Stamp:** …………………… |

**3. TO BE COMPLETED BY THE INDIVIDUAL**

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| 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 stay and/or the withdrawal of any offer of a stay IARC/WHO.**Medical Certificate of Fitness – IARC Feb 2018**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, it is my responsibility to inform my attending physician and to provide the responsible IARC Group and Medical Services with a new Certificate of Fitness.**Date:** …………………… **Signature:**  ……………………………………… |

 *Please electronically complete and return this questionnaire as soon as possible (preferably within 3 days) to the IARC Group.*