National Defence Défense nationale

# WARNING

In accordance with National Defence Security Orders and Directives (NDSOD), form **DND 4342-E - Statement of Health for Dependant Postings Outside Canada or Isolated Locations Within Canada** is designated "**Protected B**" information once completed.

Completed "**Protected B**" forms **MUST NOT BE SAVED UNENCRYPTED** on any network and workstation drive or storage media. "**Protected B**" forms, when completed, **MUST BE ENCRYPTED USING THE DND ISSUED PKI SMARTCARD**. Failure to respect this requirement will result in a breach of security and administrative measures shall be applied in accordance with the policy.

# Statement of Health for Dependant
# Postings Outside Canada or Isolated Locations Within Canada

**Complete a DND 4342 for EACH dependant identified on the MPRR even if he/she won't accompany the member during the posting.**

**Parts 1 and 2 are to be completed by the dependant or parent/legal guardian of the dependant**

Part 1

| **Dependant** | | |
|---|---|---|
| Last name | First name | DOB *(yyyy-mm-dd)* |
| Relationship to member | | |

| **Member** | | | |
|---|---|---|---|
| SN | Last name | First name | DOB *(yyyy-mm-dd)* |
| Rank | Location of posting (Country / city / area / unit) | | |

Part 2

1. To the best of my knowledge, the dependant named above, is being or has been investigated or treated at any time in the past.

| Condition | Yes | No | Condition | Yes | No |
|---|---|---|---|---|---|
| a. in a mental hospital or mental health clinic | ☐ | ☐ | n. for a condition of muscles, bones or joints | ☐ | ☐ |
| b. in a child guidance centre | ☐ | ☐ | o. for back pain | ☐ | ☐ |
| c. by a counsellor, psychiatrist, social worker, psychologist | ☐ | ☐ | p. for a skin condition | ☐ | ☐ |
| d. by a physician for epilepsy | ☐ | ☐ | q. for paralysis or weakness or loss of coordination | ☐ | ☐ |
| e. for weight loss / gain / eating disorder | ☐ | ☐ | r. for an eye or ear condition | ☐ | ☐ |
| f. for cancer | ☐ | ☐ | s. for diabetes or metabolic syndrome | ☐ | ☐ |
| g. for heart disease or chest pain | ☐ | ☐ | t. for gout | ☐ | ☐ |
| h. for a lung condition or shortness of breath | ☐ | ☐ | u. for heat or cold intolerance | ☐ | ☐ |
| i. for a condition of the liver, stomach or bowel | ☐ | ☐ | v. for allergies / allergic reaction | ☐ | ☐ |
| j. for nausea or vomiting | ☐ | ☐ | w. for problems with alcohol or drugs | ☐ | ☐ |
| k. for a condition of the kidneys or bladder | ☐ | ☐ | x. for behaviour problems | ☐ | ☐ |
| l. for a gynaecological condition | ☐ | ☐ | y. for depression, anxiety, adjustment disorder, or mood disorder | ☐ | ☐ |
| m. for infertility | ☐ | ☐ | z. phobias, including but not limited to fear of flying | ☐ | ☐ |

***Formulaire disponible en français - DND 4342-F***

## Dependant

| Last name | First name | DOB *(yyyy-mm-dd)* |
|---|---|---|
| | | |

Part 2 *(cont'd)*

2. For all "yes" responses in question 1, or for any medical conditions not mentioned above but for which you have been investigated, please describe the condition / diagnosis as well as treatment provided and follow up required.

3. Are you pregnant? ☐ Yes ☐ No ☐ N/A

4. List all current medications

| Medication | Dose | Date started *(yyyy-mm-dd)* | Medication | Dose | Date started *(yyyy-mm-dd)* |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

5. List all medications that have been discontinued in the past 3 years.

| Date discontinued *(yyyy-mm-dd)* | Medication | Date discontinued *(yyyy-mm-dd)* | Medication |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

## Dependant

| Last name | First name | DOB *(yyyy-mm-dd)* |
|---|---|---|
| | | |

## Part 2 *(cont'd)*

| 6. List all admissions to hospital and visits to emergency in the past 3 years. | |
|---|---|
| Date *(yyyy-mm-dd)* | Admissions |
| | |
| | |
| | |
| | |
| | |
| | |

| 7. List all treatment(s) provided by specialists in the past 3 years. | |
|---|---|
| Date *(yyyy-mm-dd)* | Specialist treatments |
| | |
| | |
| | |
| | |
| | |
| | |

| 8. Date of last complete medical: | |
|---|---|
| 9. For female dependant over 18 years old. | |
| Date of last Pap test *(yyyy-mm-dd)* | Result |
| Date of last Mammogram *(yyyy-mm-dd)* | Result |

## Dental

| | | |
|---|---|---|
| 10. Requires orthodontic treatment during the next posting period: | ☐ Yes | ☐ No |
| 11. Requires immediate or extensive dental treatment: | ☐ Yes | ☐ No |

## Privacy Notice statement

*Personal information is collected under the authority of the* National Defence Act *and* QR&O Chap 34 *and is protected pursuant to the provisions of the* Privacy Act. *Your information is required for the purpose of conducting a comprehensive medical / social work assessment as required for all OUTCAN postings, Isolated Postings and Isolated units within Canada. The completion of this form is mandatory for all dependants of members posted Outside Canada and Isolated Postings and Isolated units within Canada. If you refuse to provide the information your medical suitability cannot be confirmed. The information collected is administered and disclosed in accordance with the* Privacy Act, *and is described in the DND Personal Information Bank PPE 810 and retained in accordance with the Defence Subject Classification and Disposition System (DSCDS) Primary 6610. Instructions for obtaining this information are outlined in the government publication, "Info Source", which also is available at the following URL: <http://infosource.gc.ca>.*

I declare that the information I have provided is accurate and complete as per the *Privacy Act*. I declare that I have read the Privacy Notice Statement above.

| Name *(please print)* | Signature | Date *(yyyy-mm-dd)* | Relationship if minor *(16 years or under)* |
|---|---|---|---|
| | | | |

## Dependant

| Last name | First name | DOB *(yyyy-mm-dd)* |
|---|---|---|
| | | |

## Part 3 - To be completed by dependant's Family Physician / MO / NP / PA

☐ Dependant has no known medical conditions

1. Please provide a detailed history, diagnosis, current treatment, current status, and prognosis for all conditions mentioned in question 1.
   - If dependant is part of the CAF, please review Annex A to CF Health Svcs Instr 5020-66 *(for OUTCAN postings only)*.
   - If dependant is civilian, please review Annex B to CF Health Svcs Instr 5020-66 *(for OUTCAN postings only)*.
   - For questions or clarification regarding OUTCAN postings, please contact: OUTCANdmedpol.Affectationhorsdpolmed@forces.gc.ca

### Please attach to this form

- A copy of the dependant's immunization booklet;
- A copy of relevant specialist consultations and investigations.

| Number of months treating Dependent | Name of Family Physician / MO / NP / PA *(printed / stamp)* |
|---|---|
| | |

| Signature of Family Physician / MO / NP / PA | Date *(yyyy-mm-dd)* |
|---|---|
| | |