Peace Corps Report of Medical Examination

PEACE CORPS USE ONLY

Action	Date	Initials
Cleared	_____	____
MNQ	_____	____
Deferred	_____	____
Restrictions	_____	____
Type:		

Name (Last, First, Middle Initial) Sex M ☐ F ☐

Social Security Number Date of Birth (MO / DAY / YR)

Current Address **Until** / /

Telephone No. ( )

Home/Permanent Address

Telephone No. ( )

E-mail

All sections must be completed

THIS SECTION TO BE COMPLETED BY APPLICANT

IV. Health Evaluation

A. Symptoms experienced within the past 12 months

Applicant: Answer each question by checking either Yes or No.

Physician: Please review this list. If any are marked "yes," please consider this a current problem requiring further comment or work-up. Use space provided in Section X on page 4 (Summary and Comments) or additional pages if necessary, identified with the applicant's name and social security number.

Symptoms or problems	No	Yes (Resolved)	Yes (Current)	Physician comments
Frequent or severe headaches	☐	☐	☐	
Fainting spells, blackouts or seizures	☐	☐	☐	
Vision problems (e.g., eye injuries, disorders, inflammation)	☐	☐	☐	
Hearing problems/loss	☐	☐	☐	
Persistent cough	☐	☐	☐	
Chest pain or chest pressure	☐	☐	☐	
Shortness of breath or wheezing	☐	☐	☐	
Repeated episodes of indigestion, heartburn, or stomach pain	☐	☐	☐	
Frequent diarrhea (colitis, Crohns)	☐	☐	☐	
Frequent constipation (irritable bowel syndrome)	☐	☐	☐	
Frequent or painful urination	☐	☐	☐	
Blood in urine	☐	☐	☐	
Repeated episodes of back or neck pain	☐	☐	☐	
Muscle, bone, or joint injuries	☐	☐	☐	
Painful or swollen joints	☐	☐	☐	
Breast lump or mass or nipple discharge	☐	☐	☐	
Skin problems (e.g., eczema, dermatitis, psoriasis)	☐	☐	☐	
Change in color or size of a mole or other growth	☐	☐	☐	
A sore that does not heal	☐	☐	☐	
Frequent sadness or feelings of depression	☐	☐	☐	
Frequent or severe nervousness or anxiousness	☐	☐	☐	
Frequent sleeplessness or insomnia	☐	☐	☐	
Use of cigarettes or other tobacco products	☐	☐	☐	
(Females) Gynecologic symptoms or disorders	☐	☐	☐	

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B. Health issues/problems (not described in Section A)

❑ None

C. Family history

List family members (mother, father, siblings) who have had any of the following illnesses or problems:

❑ Alcoholism ❑ Cardiovascular disease

❑ Diabetes ❑ Mental illness

❑ Cancer ❑ Other (specify)

❑ High blood pressure

D. List all current medications, including over-the-counter medications/supplements and herbals

Name	Dose	Frequency

❑ None

E. Allergies and hypersensitivities

Allergies	Description of reaction	Treatment	Date of last reaction
Medications			
Food			
Other			

❑ None

Important *I certify that the above information is accurate and complete. I understand that the Peace Corps may verify the information provided by me and my doctors. I understand that giving false or incomplete information will delay processing my application and may result in disqualification from or termination of Peace Corps service.*

HIPAA and Privacy Act Notice

This information is collected under the authority of the Peace Corps Act, 22 U.S.C. 2501 et seq., for the purposes of determining medical and other eligibility for Peace Corps service. Disclosure of this information is voluntary, but without it the Peace Corps will be unable to provide a medical clearance for service. This information may be used for the routine uses described in the Privacy Act, 5 USC 552a, and in the Federal Register at 65 Fed. Reg. 53,722 (September 5, 2000) and 50 Fed. Reg. 1950, 1962 (January 14, 1985) regarding the Peace Corps system of records PC-17 (Volunteer Records). It may also be used in compliance with the Health Insurance Portability and Accountability Act (HIPAA) and any currently effective authorizations.

Signature

Date

SSN

V. Measurements and Other Findings

Height	Weight	Blood Pressure	Pulse	Hearing	Gross Vision	
					Uncorrected Right 20/__ Left 20/__	Corrected Right 20/__ Left 20/__
feet/inches	lbs.	mm (resting)	bpm (resting)	whisper test or other gross test	attach eyeglass form if appicable	

VI. Clinical Examination

THIS SECTION TO BE COMPLETED BY EXAMINING PHYSICIAN

Notes: Describe each abnormality in detail. Enter item number before each comment. Use additional sheets if necessary.

Normal	Abnormal	Check each item in appropriate column. All systems must be examined.
❑	❑	1. Head and neck
❑	❑	2. Nose, sinuses
❑	❑	3. Mouth and throat
❑	❑	4. Thyroid
❑	❑	5. Ears
❑	❑	6. Eyes (include fundoscopic exam)
❑	❑	7. Lungs and chest
❑	❑	8. Breasts
❑	❑	9. Cardiac (rate, rhythm, heart sounds)
❑	❑	10. Peripheral pulses
❑	❑	11. Abdomen
❑	❑	12. Prostate exam (men over 50 only)
❑	❑	13. Anus and rectum
❑	❑	14. Genitalia (include hernia)
❑	❑	15. Pelvic exam (females only)
❑	❑	16. Spine
❑	❑	17. Musculoskeletal
❑	❑	18. Neurologic
❑	❑	19. Skin, lymphatics
❑	❑	20. Identifying marks, scars, tattoos
❑	❑	21. Psychiatric (specify any significant cognitive or behavioral observations)

VII. Laboratory Evaluation

Urinalysis

Date _____

Albumin ____ Blood ____

Sugar ____ Other ____

PAP Smear cytology results

Date _____

(Lab report MUST be attached)

Tuberculin Test (5 IU PPD required)

Date read _____

Do Not Report "Negative"

Size of induration must be recorded in box below.

mm of induration

Other Required Lab Tests

(Lab reports MUST be attached)

- ❑ HIV Serology
- ❑ CBC
- ❑ Hepatitis B surface Antigen
- ❑ Hepatitis B core Antibody
- ❑ Hepatitis C Antibody
- ❑ G6PD titer

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VIII. Required Tests for Female Applicants 40 Years and Older.

Mam[redacted]s (females only)
(Attach radiology report)

Tests for Applicants 50 Years and Older.

[redacted]	[redacted]od (x3) [redacted]	
(EKG tracing must be attached)	1. Pos ____	Neg ____
	2. Pos ____	Neg ____
	3. Pos ____	Neg ____

IX. Required Immunizations:

Physician - Initial & Date Administration

Type of Immunization	Date of Immunization	Physician Initials
1. Td Booster (with in 5 years of the Report of Medical Examination)		
2. Polio Booster (after age 18)		
3. MMR Booster (one booster needed per lifetime)		

Immunizations History:

Do NOT Give These Immunizations.

	[redacted]	Physician Initials
4. Yellow Fever		
5. Hep $B_{(1)}$		
6. Hep $B_{(2)}$		
7. Hep $B_{(3)}$		
8. Hep $A_{(1)}$		
9. Hep $A_{(2)}$		

X. Summary of the Medical Examination and Additional Comments

Provide your summary and assessment of the medical examination. Comment on all abnormal findings including recommendations for evaluation and/or treatment required for the next three years of service in a developing country. If additional pages are required, include applicant's name and social security number on each page.

List Condition	Recommendations & Comments

1. Do you have any medical concerns about the applicant that might limit his/her assignment to a specific geographic area (e.g. mountainous terrain, high altitude, sun exposure, harsh environmental or climatic conditions, etc?) YES ❑ NO ❑ If yes, specify

2. In your opinion, does the applicant have any physical condition(s) that would limit or restrict full participation in a Peace Corps program? YES ❑ NO ❑ If yes, specify

3. Does the applicant have any psychological condition(s) or psychosocial needs that would limit or restrict full participation in a Peace Corps program? YES ❑ NO ❑ If yes, specify

***Important* Medical examination is complete only when:**

- Applicant has signed and dated statement on page 2.
- Physician has signed and dated page 4.
- Physician has initialed all documented immunizations on page 4.
- Required lab reports are attached.
- PAP, EKG tracing and mammography report are attached (when indicated).

(must be signed or co-signed by a licensed M.D. or D.O. if exam performed by other than M.D. or D.O.)

Physician Signature/Title

Date

Physician License Number/State

Physician Address and Phone Number

INCOMPLETE FORMS WILL BE RETURNED TO THE APPLICANT AND WILL DELAY PROCESSING!