Peace Corps

Volunteer Medical Application

Health Status Review

Version 3.1

Please complete this Health Status Review and submit it at the same time you submit your Peace Corps Application. Use the enclosed envelope which is labeled "Medical Information Envelope". If the envelope is missing use a plain envelope, write "Medical History" on it, seal it, and send it with your application.

PC-1789S (7/02)

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Before you can be accepted to serve overseas, Peace Corps needs to assess your health. This Health Status Review Form is the first step in the medical review process. It will take about 15 minutes to complete the form. Your signature at the end of the form certifies that you have answered all questions accurately and completely.

A MEDICAL HISTORY FOR INTERNATIONAL PLACEMENT

A health condition you manage easily at home in the U.S. can become a significant medical issue in the countries Peace Corps serves. The Peace Corps Office of Medical Services assesses your health in the context of living conditions and medical care available in each country.

For these reasons the types of medical questions asked and their level of detail are unlike medical histories normally used for U.S. based health care.

The Applicant Medical Screening Process is thorough, and it is important for you to answer these questions accurately. You should know that we are able to medically clear more than 85% of all Applicants who complete the Medical Screening Process.

INSTRUCTIONS

Be sure to answer all questions.

Fill in all dates where it is appropriate to do so.

Fill in all bubbles completely.

If you are unfamiliar with a condition AND believe you may have had it, please check with your family physician or someone familiar with your medical history before answering the question.

Do not write explanatory notes on the form.

Do not send additional information about your health at this time.

Failure to answer all questions completely may mean you will have to complete a new form.

PRIVACY ACT AND PUBLIC BURDEN NOTICE - The Peace Corps is authorized by provisions of the Peace Corps Act to collect information regarding the suitability and qualifications of applicants for Peace Corps Service. The information you provide in this Health Status Review Form will be used to evaluate your suitability and qualifications to serve as a Volunteer. This form and the information you provide will be kept in a System of Records called the Volunteer Applicant and Service Record System. Because Volunteer Records have been kept according to Social Security Number (SSN) prior to 1975, we are authorized by the Privacy Act to request your SSN in order to keep your records straight. Completing this form is voluntary; if you do not give us your SSN or any other information requested, we may be unable to assess your suitability and qualifications for service. The Health Status Review Form is part of the Volunteer Application Kit consisting of this form and the Volunteer Application. The routine uses set forth in the Volunteer Application's Privacy Act Notice at Paragraph C, item 2 and Paragraph C, items 4–12 also apply to this form. In addition, information from the Health Status Review Form may be routinely disclosed in connection with claims under the Federal Employee's Compensation Act, to medical personnel treating or involved in the treatment or care of an applicant, Trainee, or Volunteer and to the U.S. Ambassador or his/her designee in Peace Corps countries, but only upon written certification that the information is needed to perform an official responsibility. OMB 0420-0510

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Version 3.1

1. Name: ____________________

(Fill in bubbles for the first three letters of your last name.)

A B C D E F G H I J K L M N O P Q R S T U V W X Y Z

2. Social Security Number:
(It is very important that these bubbles are filled in completely and correctly.)

0 1 2 3 4 5 6 7 8 9

MARKING INSTRUCTIONS

- Use a No. 2 pencil only. Do not use pen.
- Make solid marks that fill the response completely.
- Make no stray marks on this form.

Correct Mark: ● Incorrect Marks:

MARKING EXAMPLE:

Month	Day	Year
Jan	0 3	5 7
Feb		
Sept		
Oct		
Nov		

3. Are you:
Female Male

4. Are you a Returned Peace Corps Volunteer?
Yes No

5. Today's Date:

Month	Day	Year
Jan		
Feb		
Mar	0 0	0 0
Apr	1 1	1 1
May	2 2	2 2
June	3 3	3 3
July	4	4 4
Aug	5	5 5
Sept	6	6 6
Oct	7	7 7
Nov	8	8 8
Dec	9	9 9

6. Date of Birth:

Month	Day	Year
Jan		
Feb		
Mar	0 0	0 0
Apr	1 1	1 1
May	2 2	2 2
June	3 3	3 3
July	4	4 4
Aug	5	5 5
Sept	6	6 6
Oct	7	7 7
Nov	8	8 8
Dec	9	9 9

7. Height in Feet and Inches:

Feet: 3 4 5 6 7

Inches: 0 0 / 1 1 / 2 / 3 / 4 / 5 / 6 / 7 / 8 / 9

8. Weight in Pounds:

Pounds: 0 1 2 3 4 5 6 7 8 9

9. Are you applying with your spouse?
Yes No

If YES, enter your spouse's Social Security Number.

0 1 2 3 4 5 6 7 8 9

REMINDER: Do NOT write explanations on these pages.

BE SURE YOU HAVE ANSWERED ALL QUESTIONS AND ENTERED ALL DATES REQUIRED BEFORE GOING ON.

ALL APPLICANTS COMPLETE

10. Have you ever smoked or used tobacco products? Yes (Y) No (N)

If YES, do you currently smoke or use tobacco:

	Yes	No
every day	(Y)	(N)
some days	(Y)	(N)
former smoker only	(Y)	(N)

11. Do you currently wear dental braces? (This does NOT include removable orthodontic retainers, dentures, partial plates or bridges.) Yes (Y) No (N)

12. Do you have or have you ever had:

	Yes	No
Chronic inner ear infection (otitis media) after age 15	(Y)	(N)
Meniere's disease	(Y)	(N)
Cyst of the inner ear	(Y)	(N)

If any YES in Item 12, give date of most recent symptoms or treatment.

Month	Year	
Jan		
Feb		
Mar	0	0
Apr	1	1
May	2	2
June	3	3
July	4	4
Aug	5	5
Sept	6	6
Oct	7	7
Nov	8	8
Dec	9	9

13. Do you currently require the use of at least one hearing aid? Yes (Y) No (N)

14. Other than tonsillectomy, childhood tonsillitis or wisdom teeth extraction, do you have any condition or have you had any surgery on your ears, nose, face, sinuses, jaw or throat not listed in Items 11–13? Yes (Y) No (N)

15. Do you have or have you ever had:

	Yes	No
Glaucoma	(Y)	(N)
Herpes infection of the cornea (herpes keratitis)	(Y)	(N)
Two or more episodes of optic neuritis	(Y)	(N)
Chronic uveitis or iritis	(Y)	(N)
Cataract surgery	(Y)	(N)
Other vision correcting surgery, such as RK, PRK, LASIK	(Y)	(N)
Macular or lattice degeneration (degeneration of the retina)	(Y)	(N)
Retinal detachment	(Y)	(N)

16. Other than astigmatism or use of corrective lenses, do you have or have you had any other condition or surgery of the eye not listed in Item 15? Yes (Y) No (N)

17. Are you allergic to:

	Yes	No
Sulfa drugs (such as Bactrim, Septra)	(Y)	(N)
Other medication(s)	(Y)	(N)
Eggs	(Y)	(N)
Peanuts	(Y)	(N)
Shellfish	(Y)	(N)
Other food(s)	(Y)	(N)
Bee, wasp or other insect stings		
Hayfever or other environmental allergies (such as grass, pollen, dust, animal hair, etc.)	(Y)	(N)

18. During an allergic reaction, have you ever had:

	Yes	No
Difficulty breathing	(Y)	(N)
Loss of consciousness	(Y)	(N)
Severe swelling of your nose, lips, tongue or throat	(Y)	(N)
Emergency treatment in a medical facility for an allergic reaction	(Y)	(N)

19. Do you have or have you ever had:

	Yes	No
Chronic bronchitis	(Y)	(N)
Pneumonia more than once during the last 5 years	(Y)	(N)
Emphysema or COPD	(Y)	(N)
A collapsed lung (pneumothorax)	(Y)	(N)
Removal of a lung or a lobe of the lung	(Y)	(N)

BE SURE YOU HAVE ANSWERED ALL QUESTIONS AND ENTERED ALL DATES REQUIRED BEFORE GOING ON.

20. Since age 15, have you ever: Yes No
- Experienced wheezing Ⓨ Ⓝ
- Used an inhaler to prevent breathing problems or to help you breathe Ⓨ Ⓝ
- Been told you have asthma, bronchospasm or reactive (restrictive) airway disease Ⓨ Ⓝ

21. Do you have or have you had any respiratory condition, lung condition or surgery not listed in Items 19–20? Yes Ⓨ No Ⓝ

22. Do you take prescription medication to control your blood pressure? Yes Ⓨ No Ⓝ

23. Do you take prescription medication for high cholesterol? Yes Ⓨ No Ⓝ

24. Have you ever had: Yes No
- Angina Ⓨ Ⓝ
- A heart attack Ⓨ Ⓝ
- Coronary artery or heart by-pass surgery Ⓨ Ⓝ
- Coronary angioplasty ("balloon angioplasty") or insertion of stent(s) Ⓨ Ⓝ
- Other heart surgery Ⓨ Ⓝ
- Carotid artery surgery Ⓨ Ⓝ
- Other surgery of the arteries Ⓨ Ⓝ

25. Do you have or have you ever had: Yes No
- A pacemaker Ⓨ Ⓝ
- Coronary artery disease Ⓨ Ⓝ
- Congestive heart failure Ⓨ Ⓝ
- A disturbance of heart rhythm (arrhythmia) Ⓨ Ⓝ
- An aneurysm Ⓨ Ⓝ

26. Do you have or have you ever had: Yes No
- A heart murmur present after age 15 Ⓨ Ⓝ
- Heart valve disease Ⓨ Ⓝ
- Mitral valve prolapse Ⓨ Ⓝ
- A blood clot in the lung (pulmonary embolism) Ⓨ Ⓝ
- Thrombophlebitis Ⓨ Ⓝ
- Problems caused by poor circulation Ⓨ Ⓝ

27. Other than aspirin, do you currently take any blood-thinning (anti-coagulant) medication, such as Warfarin or Coumadin? Yes Ⓨ No Ⓝ

28. Do you have or have you had any other heart or circulatory condition or surgery not listed in Items 22–27? Yes Ⓨ No Ⓝ

29. Do you have or have you ever had: Yes No
- An esophageal stricture Ⓨ Ⓝ
- Esophageal varices Ⓨ Ⓝ
- Stomach or duodenal ulcers (peptic ulcer disease) Ⓨ Ⓝ
- Cirrhosis of the liver Ⓨ Ⓝ
- Yellow jaundice (other than at birth) Ⓨ Ⓝ
- Pancreatic disease Ⓨ Ⓝ
- Diverticulosis/diverticulitis Ⓝ
- Part or all of your small or large intestine removed Ⓨ Ⓝ

30. Do you now have: Yes No
- A hernia of the groin (inguinal) or abdomen
- A colostomy or an ileostomy Ⓨ Ⓝ

31. Have you had two or more episodes of a cyst near the rectum (pilonidal cyst)? Yes Ⓨ No Ⓝ

32. Do you have or have you had any other conditions or surgery of the esophagus, stomach, liver, gall bladder, pancreas or intestinal tract not listed in Items 29–31? Yes Ⓨ No Ⓝ

BE SURE YOU HAVE ANSWERED ALL QUESTIONS AND ENTERED ALL DATES REQUIRED BEFORE GOING ON.

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FEMALES: GO TO ITEM 35.

MALES ONLY

33. Have you ever had: (Yes / No)
    - Difficulty starting or stopping your urine stream — Ⓨ Ⓝ
    - An enlarged prostate — Ⓨ Ⓝ
    - Pain or swelling in your testicles — Ⓨ Ⓝ
    - hydrocele, spermatocele or varicocele — Ⓨ Ⓝ

34. Do you have or have you had any other genital condition or surgery not listed in Item 33? — Yes Ⓨ No Ⓝ

End of Male Only Items

MALES: GO TO ITEM 43.

BE SURE YOU HAVE ANSWERED ALL QUESTIONS AND ENTERED ALL DATES REQUIRED BEFORE GOING ON.

FEMALES ONLY

35. Are you currently using: (Yes / No)
    - Birth control pills — Ⓨ Ⓝ
    - Birth control implants (such as Norplant) — Ⓨ Ⓝ
    - Birth control injections (such as Depo-Provera) — Ⓨ Ⓝ
    - An intra-uterine device (IUD) — Ⓨ Ⓝ

If any YES in Item 35, give date treatment began.

Month	Year	
Jan		
Feb		
Mar	0	0
Apr	1	1
May	2	2
June	3	3
July	4	4
Aug	5	5
Sept	6	6
Oct	7	7
Nov	8	8
Dec	9	9

36. Have you ever had a Pap smear? — Yes Ⓨ No Ⓝ

37. Do you have or have you ever had: (Yes / No)
    - PID (pelvic inflammatory disease) or tubal infections — Ⓨ Ⓝ
    - Uterine fibroids — Ⓨ Ⓝ
    - Endometriosis — Ⓨ Ⓝ

38. Do you currently have: (Yes / No)
    - Menstrual cycles — Ⓨ Ⓝ
    - Irregular menstrual cycles (NOT monthly) — Ⓨ Ⓝ
    - Bleeding or spotting between menstrual cycles — Ⓨ Ⓝ

39. Are you: (Yes / No)
    - Post-menopausal (NOT due to removal of uterus, or hysterectomy) — Ⓨ Ⓝ
    - Post-menopausal with any vaginal bleeding or spotting — Ⓨ Ⓝ
    - Receiving hormone replacement therapy (HRT) — Ⓨ Ⓝ

40. Have you had your uterus removed (hysterectomy)? — Yes Ⓨ No Ⓝ

41. Do you have or have you ever had: (Yes / No)
    - A breast cyst or lump — Ⓨ Ⓝ
    - Fibrocystic breast changes — Ⓨ Ⓝ
    - Breast implants — Ⓨ Ⓝ

42. Do you have or have you ever had any other gynecological conditions or surgery not listed in Items 35–41? — Yes Ⓨ No Ⓝ

End of Female Only Items

FEMALES: CONTINUE WITH ITEM 43.

ALL APPLICANTS COMPLETE

43. Have you had four or more bladder infections (cystitis) in the past year? Yes Ⓨ No Ⓝ

44. Have you had two or more kidney infections (pyelonephritis) in the past two years? Yes Ⓨ No Ⓝ

45. Have you had:

	Yes	No
A single episode of kidney stones	Ⓨ	Ⓝ
Two or more episodes of kidney stones	Ⓨ	Ⓝ

If any YES in Item 45, give date of most recent occurrence.

Month	Year	
Jan		
Feb		
Mar	0	0
Apr	1	1
May	2	2
June	3	3
July	4	4
Aug	5	5
Sept	6	6
Oct	7	7
Nov	8	8
Dec	9	9

46. Do you have or have you had any urinary, bladder, or kidney condition or surgery not listed in Items 43–45? Yes Ⓨ No Ⓝ

47. Do you have or have you ever had:

	Yes	No
Eczema or psoriasis	Ⓨ	Ⓝ
Basal cell tumor(s) of the skin	Ⓨ	Ⓝ
A cancerous mole or other skin cancer (NOT basal cell)	Ⓨ	Ⓝ

48. Do you have any other skin condition not listed in Item 47 for which you are taking prescription medication or receiving medical treatment? Yes Ⓨ No Ⓝ

49. Have you ever broken any of the following bones?

	Yes	No
Back (spine) or neck	Ⓨ	
Hip	Ⓨ	Ⓝ
Skull	Ⓨ	Ⓝ
Pelvis	Ⓨ	Ⓝ

If any YES in Item 49, give date of injury.

Month	Year	
Jan		
Feb		
Mar	0	0
Apr	1	1
May	2	2
June	3	3
July	4	4
Aug	5	5
Sept	6	6
Oct	7	7
Nov	8	8
Dec	9	9

50. Do you have or have you ever been medically treated or had surgery for:

	Yes	No
Chronic or recurrent neck or back pain (excluding arthritis)	Ⓨ	
Pinched nerve(s)	Ⓨ	Ⓝ
A disc problem	Ⓨ	Ⓝ
Scoliosis or kyphosis	Ⓨ	Ⓝ

If any YES in Item 50, give date of most recent treatment or surgery.

Month	Year	
Jan		
Feb		
Mar	0	0
Apr	1	1
May	2	2
June	3	3
July	4	4
Aug	5	5
Sept	6	6
Oct	7	7
Nov	8	8
Dec	9	9

51. Other than for arthritis or bursitis, have you been medically treated more than twice for:

	Yes	No
Chronic shoulder pain, dislocation or rotator cuff injury	Ⓨ	Ⓝ
Chronic hip pain	Ⓨ	Ⓝ
Chronic knee pain	Ⓨ	Ⓝ
Chronic ankle pain (excluding uncomplicated ankle strains or sprains)	Ⓨ	Ⓝ

BE SURE YOU HAVE ANSWERED ALL QUESTIONS AND ENTERED ALL DATES REQUIRED BEFORE GOING ON.

52. Have you ever had: Yes No
- Shoulder arthroscopy, ligament repair, reconstruction or replacement Ⓨ Ⓝ
- Hip reconstruction or replacement Ⓨ Ⓝ
- Knee arthroscopy, ligament repair, reconstruction or replacement Ⓨ Ⓝ
- Orthopedic hardware (pins, plates, rods, screws, etc.) left in place Ⓨ Ⓝ

If any YES in Item 52, give date of most recent surgery.

Month	Year	
Jan		
Feb		
Mar	0	0
Apr	1	1
May	2	2
June	3	3
July	4	4
Aug	5	5
Sept	6	6
Oct	7	7
Nov	8	8
Dec	9	9

53. Do you have arthritis or bursitis that requires the use of prescription medication? Yes Ⓨ No Ⓝ

54. Do you have or have you ever had: Yes No
- Repetitive motion injury/syndrome Ⓨ Ⓝ
- Carpal tunnel syndrome Ⓨ Ⓝ

55. Do you currently have painful bunions? Yes Ⓨ No Ⓝ

56. Do you have or have you had any other joint, muscle or bone condition or surgery not listed in Items 49–55? Yes Ⓨ No Ⓝ

57. Do you have or have you ever had: Yes No
- Fibromyalgia Ⓨ Ⓝ
- Ankylosing spondylitis Ⓨ Ⓝ
- Rheumatoid arthritis Ⓨ Ⓝ
- Juvenile rheumatoid arthritis Ⓨ Ⓝ
- Reiter's Syndrome (either single or multiple episodes) Ⓨ Ⓝ

58. Do you currently have: No
- Iron deficiency anemia Ⓨ
- A folate deficiency Ⓨ Ⓝ
- A Vitamin B-12 deficiency (pernicious anemia) Ⓨ Ⓝ
- A low platelet count (thrombocytopenia) Ⓨ Ⓝ
- A missing spleen (due to surgery) Ⓨ Ⓝ
- Hemochromatosis Ⓨ Ⓝ
- Sickle cell disease, with symptoms Ⓨ Ⓝ
- Thalassemia disease, with symptoms Ⓨ Ⓝ
- A clotting disorder Ⓨ Ⓝ
- Polycythemia vera Ⓨ Ⓝ
- Systemic lupus erythematosis (SLE) Ⓨ Ⓝ

59. Do you have any other blood, immune system, connective tissue or collagen condition not listed in Items 57–58? Yes Ⓨ No Ⓝ

60. Do you have diabetes? Yes Ⓨ No Ⓝ

61. Do you have gout? Yes Ⓨ No Ⓝ

BE SURE YOU HAVE ANSWERED ALL QUESTIONS AND ENTERED ALL DATES REQUIRED BEFORE GOING ON.

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62. Do you have or have you ever had: — Yes / No
- A thyroid goiter — Y / N
- A thyroid nodule — Y / N
- An overactive thyroid (hyperthyroidism) — Y / N
- An underactive thyroid (hypothyroidism) — Y / N
- Other thyroid disease — Y / N

If any YES in Item 62, give date of most recent treatment.

Month	Year	
Jan		
Feb		
Mar	0	0
Apr	1	1
May	2	2
June	3	3
July	4	4
Aug	5	5
Sept	6	6
Oct	7	7
Nov	8	8
Dec	9	9

63. Do you have or have you ever had a disease of the pituitary gland? — Yes Y / No N

64. Do you have or have you had any other condition of the endocrine system not listed in Items 60–63? — Yes Y / No N

65. Did you ever have a blood transfusion before July 1992? — Yes Y / No N

66. Have you ever been exposed to Hepatitis C virus (HCV) by injury, accidental needlestick, injection of drugs (even once), or because your mother had Hepatitis C virus when you were born? — Yes Y / No N

67. Do you have or have you ever had (this does NOT refer to immunizations): — Yes / No
- Hepatitis A virus — Y / N
- Hepatitis B virus — Y / N
- Hepatitis C virus — Y / N

68. Do you have or have you ever had: — Yes / No
- Chronic fatigue syndrome — Y / N
- A positive skin test for tuberculosis — Y / N
- Active tuberculosis disease of the lungs or other organs — Y / N
- Lyme disease — Y / N

69. Other than a cold or the flu, do you currently have any other infectious or parasitic condition not listed in Items 65–68? — Yes Y / No N

70. Do you have severe or migraine headaches that require prescription medication? — Yes Y / No N

71. Have you ever had any seizures or convulsions? — Yes Y / No N

If YES, did they occur prior to age 5, and were they associated with high fever? — Y / N

72. Have you ever had a stroke or stroke-like symptoms? — Yes Y / No N

73. Do you have: — Yes / No
- Cerebral Palsy — Y / N
- Multiple Sclerosis — Y / N

74. Do you have or have you had any other neurological or nervous system condition or surgery not listed in Items 70–73? — Yes Y / No N

75. Do you have or have you ever had: — Yes / No
- Leukemia or lymphoma — Y / N
- Any other type of cancer or malignant tumor not previously noted on this form — Y / N

If any YES in Item 75, give date of most recent occurrence or treatment.

Month	Year	
Jan		
Feb		
Mar	0	0
Apr	1	1
May	2	2
June	3	3
July	4	4
Aug	5	5
Sept	6	6
Oct	7	7
Nov	8	8
Dec	9	9

76. Are you recovering from alcohol abuse or substance abuse? — Yes Y / No N

BE SURE YOU HAVE ANSWERED ALL QUESTIONS AND ENTERED ALL DATES REQUIRED BEFORE GOING ON.

77. Have you ever had: Yes No
- Family counseling (such as related to marital issues)
- Support group counseling (such as for grief or divorce) Ⓨ Ⓝ

78. Other than for academic guidance counseling only, have you ever had: Yes No
- Individual counseling or consultation with a psychiatrist, psychologist or mental health counselor Ⓨ Ⓝ
- Substance abuse or alcohol abuse counseling (other than awareness counseling or classes related to traffic citations) Ⓨ Ⓝ

If any YES in Item 78, give date of last counseling session. (NOTE: Failure to provide date, if counseled, will delay processing of your application.)

Month	Year	
Jan		
Feb		
Mar	0	0
Apr	1	1
May	2	2
June	3	3
July	4	4
Aug	5	5
Sept	6	6
Oct	7	7
Nov	8	8
Dec	9	9

79. Have you ever used medication(s) for a mental health issue? Yes Ⓨ No Ⓝ

If YES, give date of most recent use of medication.

Month	Year	
Jan		
Feb		
Mar	0	0
Apr	1	1
May	2	2
June	3	3
July	4	4
Aug	5	5
Sept	6	6
Oct	7	7
Nov	8	8
Dec	9	9

80. Have you ever received in-patient psychiatric care? Yes Ⓨ No Ⓝ

81. Have you ever tried to harm yourself or attempted suicide? Yes Ⓨ No Ⓝ

82. Have you ever been diagnosed with or treated for an eating disorder? Yes Ⓨ No Ⓝ

If YES, give date of your most recent treatment or support group participation.

Month	Year	
Jan		
Feb		
Mar	0	0
Apr	1	1
May	2	2
June	3	3
July	4	4
Aug	5	5
Sept	6	6
Oct	7	7
Nov	8	8
Dec	9	9

83. Do you have or have you had any other mental health condition not listed in Items 76–82? Yes Ⓨ No Ⓝ

84. Does walking 2 blocks on flat terrain cause you to experience shortness of breath, leg, joint, muscle or chest pain? Yes Ⓨ No Ⓝ

85. Does climbing 2 flights of stairs while carrying groceries or other items cause you to experience shortness of breath, leg, joint, muscle or chest pain? Yes Ⓨ No Ⓝ

BE SURE YOU HAVE ANSWERED ALL QUESTIONS AND ENTERED ALL DATES REQUIRED BEFORE GOING ON.

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86. Does kneeling, squatting or sitting cross-legged cause you leg, muscle or joint pain to the point that you cannot do these activities? Yes Ⓨ No Ⓝ

87. Do you use a prosthesis or other assistive device, e.g., wheelchair, walker, cane, leg braces, hearing aid(s)? Yes Ⓨ No Ⓝ

88. Do you have any deficit in your hearing, vision or speech that might affect your ability to learn a foreign language? Yes Ⓨ No Ⓝ

89. Do you require assistance with routine activities such as walking, dressing, bathing, shopping or cooking? Yes Ⓨ No Ⓝ

90. Does anything prohibit you from living and working in very hot, cold, humid or dry climates, or in polluted environments? (This refers to your ability to work and live in these environments, NOT your personal preferences.) Yes Ⓨ No Ⓝ

91. Does anything prohibit you from living and working at high altitudes, such as above 5000 feet? Yes Ⓨ No Ⓝ

92. Have you had treatment for periodontal disease which would require therapy (not just cleaning) more than once per year? Yes Ⓨ No Ⓝ

BE SURE YOU HAVE ANSWERED ALL QUESTIONS AND ENTERED ALL DATES REQUIRED BEFORE GOING ON.

I certify that all of the above information is true and complete. I understand that giving false or incomplete information will delay processing my application and may result in withdrawal of my Peace Corps nomination or invitation or in separation from Peace Corps Service.

Printed Name Date

Signature

DE Mark Reflex® forms by NCS Pearson EW-207740-6:6543 HR99 Printed in U.S.A.

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