Authorization for Peace Corps Use of Medical Information

This authorization permits the Peace Corps to use my protected health information to determine my eligibility for the Peace Corps and as necessary for administration of the Peace Corps program. **This document *must* be signed, dated, and returned with your medical information. We will be unable to review your information without this signed document!**

I, _____, hereby authorize that:

A. All health information I provide to the Peace Corps or that is provided by anyone who has provided health care services or treatment to me, consulted on such services, or otherwise has health care information responsive to the information requests of the Peace Corps, including my response to the Health Status Review, and any follow-up health information requested by and provided to the Peace Corps Office of Medical Services relating to me prior to my being sworn in as a Peace Corps Volunteer (including but not limited to information about my prior physical and mental health history, my current health status, and possible future care and treatment), may be disclosed to the following people:

Peace Corps staff, including in the Office of Medical Services, Office of Special Services, Office of Volunteer Recruitment Selection, Office of Safety and Security, Office of General Counsel, appropriate Regional Operations offices, Peace Corps Medical Officers, Country Directors at overseas posts, and any other Peace Corps staff or contractors who have a need to know the information to perform their duties, for the purposes of making a determination of my medical or other eligibility for Peace Corps service and of placement/assignment.

B. If I am accepted for Peace Corps service, the information listed above will become part of my Peace Corps health record. All information in my Peace Corps health record, and any other personal health information relevant to me that is provided to the Peace Corps by me or any health care provider or other person, may be disclosed to Peace Corps staff or contractors, as described in paragraph A above, who have a specific need to know the information for the purposes of performing their duties in connection with administration of the Peace Corps program only. This may include (but is not limited to) information relevant to my continued service as a Peace Corps trainee or Peace Corps Volunteer.

This authorization is effective until five years following either my close of Peace Corps service or final determination by the Peace Corps that I am not eligible for Peace Corps service. I understand that I may revoke this authorization at any time by sending a written revocation to the Office of Medical Services, Peace Corps, 1111 20th Street, NW, Washington DC, 20526, but that my revocation before acceptance will stop consideration of my application, and that my service as a Volunteer is conditioned on the existence of this authorization, which is necessary to administer the Peace Corps program.

I also understand, however, that during the entire period of my authorization to use my health care information, Peace Corps will protect the confidentiality of my health care information, consistent with the Privacy Act, the Health Insurance Portability and Accountability Act (as applicable), and Peace Corps policies on confidentiality of medical information, as described in the Peace Corps Notice of Privacy Practices.

I have read and understand this authorization.

Signature **Date** **DOB**

HIPAA FOR APPLICANTS - FAQs

(please keep this for your records)

What is HIPAA?

HIPAA – the Health Insurance Portability and Accountability Act – is a set of federal laws and regulations designed in part to protect information about your health care from unreasonable disclosure. It limits the extent to which your "protected health information" -- individually identifiable information about your health condition or treatment -- can be used for purposes other than treatment and payment, and the business operations to support them. HIPAA also requires individuals to be given a notice describing how medical professionals and health plans use their medical information; most of you have probably received these kinds of notices from your doctors over the last year or so. Peace Corps' notice is available on its website. **www.peacecorps.gov/policies/pdf/hipaa.pdf**

What impact does HIPAA have on the Peace Corps?

As you probably know, the Peace Corps provides medical care to its Volunteers while they are overseas. It also pays for certain tests and exams before, during, and after Peace Corps service.

Even without HIPAA, the Peace Corps takes its responsibilities to protect the confidentiality of your medical information very seriously. Peace Corps policy strictly limits disclosure of such information only to those who have a need to know it to do their jobs; and they all are required to protect its confidentiality. This policy, which applies to Peace Corps wherever Peace Corps operates, is consistent with our obligations under the Privacy Act, a federal law applying to all federal agencies. The Privacy Act permits only those agency staff with the need to use the information to do their jobs to use personal information in agency files, such as medical records.

The Peace Corps does much more than provide medical services. It provides diverse support to more than 7500 Volunteers in more than 70 countries. This includes recruiting, giving medical clearance, placing thousands of Volunteers each year, training them, protecting their safety and security, providing program support to them overseas, and ensuring that the whole Peace Corps system operates as effectively and efficiently as possible. Administration of the program does sometimes (although relatively rarely) require the use of health information about an applicant or Volunteer for reasons other than for medical care; e.g., in ensuring the safety and security of Volunteers.

Because HIPAA puts strict limits on the use of personal health information in the U.S., the Peace Corps is required to observe the formality of getting a signed authorization from you to use your medical information for most purposes other than for treatment. The Peace Corps is not changing the confidential way it uses medical information. What has changed is the law about the permissible routine use of such information.

So, what does this mean for me as an applicant?

Since Peace Corps Volunteers (PCVs) spend their time in places with relatively less sophisticated sanitation and health care networks, and in countries with higher level of endemic illness, all applicants must get a medical clearance before they are invited to join the Peace Corps. Your medical status is a key factor in your eligibility to be a Volunteer. To do this medical screening, the Peace Corps needs access to information about your medical status. Under the formalities of HIPAA, we are required to ask you to authorize us to receive such information and to use it for screening and for placement purposes; without that authorization, we will not be able to provide the necessary medical clearance for you to be a Volunteer.

So, one piece of the application kit is an "Authorization For Peace Corps Use of Medical Information." This document must be signed and returned to the Peace Corps as part of the application. Without it, we cannot consider your application.

This authorization also will permit us to use medical information as described below if and when you become a Volunteer.

What will this mean for me as a Volunteer?

If you are accepted for Peace Corps service, the medical information that was part of your application and the medical screening is put into your health record, which goes with you overseas. The Peace Corps Medical Officer(s) in your country will use and add to the information as they care for you.

For the most part, your medical information is used for treatment and payment purposes only. This information may be disclosed to Peace Corps staff in-country and in the U.S. on a need-to-know basis. But, there are occasional situations where Peace Corps staff in the U.S. need access to information about your medical situation for non-treatment purposes in order to provide support to and manage the Peace Corps Volunteer program itself. For example, there may be times when it is relevant to protecting your safety and security, and that of your fellow Volunteers. It may be relevant to whether it is appropriate for you to continue to serve as a Volunteer.

The authorization HIPAA requires us to get from you permitting us to use medical information for program administration purposes included in the "Authorization For Peace Corps Use of Medical Information." The protections of the Privacy Act apply, and the information will be used only by those Peace Corps staff who have a specific need to know the information to do their job, and only for those limited purposes. We appreciate your cooperation.

OMB # 0420-0510
Expiration Date: 07/31/2011

Peace Corps Volunteer Medical **Application**

HEALTH STATUS REVIEW

1. Name _____
First Middle (not initial) Last

2. Social Security Number ____–____–____

The Peace Corps asks for your Social Security number, or SSN, because the Peace Corps Act (22 U.S.C. 2519) requires a background check on all Volunteers. Your SSN is needed for this background check, so providing it is mandatory. The Peace Corps will also use it to ensure that our records are accurate, and for tax and other financial accounting purposes.

3. Gender ❑ Female ❑ Male

4. Are you a returned Peace Corps Volunteer?
❑ Yes ❑ No

5. Today's Date: ____/____/____
Month Day Year

6. Date of Birth: ____/____/____
Month Day Year

7. Height: ____/____
Feet Inches

8. Weight: ____
Lbs

9. Are you applying with your spouse? ❑ Yes ❑ No

10. Have you ever smoked cigarettes or used tobacco products? ❑ Yes ❑ Never

A. If yes, do you currently smoke or use tobacco? ❑ Yes ❑ No

B. If you are a former smoker, have you smoked or used tobacco products in the last 5 years? ❑ Yes ❑ No

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

12. Do you have or have you ever had?

A. Meniere's Disease? ❑ Yes ❑ Never

B. Multiple inner ear infections after age 15?
❑ Yes ❑ Never

C. Tinnitus? (Ringing in the ear) ❑ Yes ❑ Never

D. Vertigo? (Dizziness due to an inner ear problem)
❑ Yes ❑ Never

13. Do you currently require the use of one hearing aid? ❑ Yes ❑ No

14. Other than tonsillectomy, childhood tonsillitis or wisdom teeth extraction, have you had any condition or have you had any surgery on your ears, nose, face, sinuses, jaw or throat not listed in 11-12? ❑ Yes ❑ No

If yes, please specify:

OPHTHALMOLOGY

15. Do you have or have you ever had?

A. Glaucoma? (Mark resolved if you no longer see a physician regarding this condition and/or no longer have symptoms)
❑ Yes ❑ Resolved ❑ Never

B. Herpes infection of the cornea? (herpes keratitis)
❑ Yes ❑ Never

C. Optic neuritis? ❑ Yes ❑ Never

D. Chronic uveitis or iritis? ❑ Yes ❑ Never

E. Cataracts/Cataract surgery? ❑ Yes ❑ Never

F. Other vision correcting surgery, such as RK, PRK, LASIK?❑ Yes ❑ Never

G. Macular or lattice degeneration (degeneration of the retina)? ❑ Yes ❑ Never

H. Retinal detachment?❑ Yes ❑ Never

I. Eye Trauma? ❑ Yes ❑ Never

16. Other than astigmatism or use of corrective lenses, have you had any other condition or surgery of the eye not listed in item 15?
❑ Yes ❑ No

If yes, please specify:

ALLERGIES/SENSITIVITIES

17. Are you allergic to:

A. Penicillin? ❑ Yes ❑ No

B. Sulfa drugs? (such as Bactrim, Septra)
❑ Yes ❑ No

C. Other medication(s)? ❑ Yes ❑ No

D. Eggs? ❑ Yes ❑ No

E. Peanuts? ❑ Yes ❑ No

F. Shellfish? ❑ Yes ❑ No

G. Other food(s)? ❑ Yes ❑ No

H. Bee, wasp or other insect stings?❑ Yes ❑ No

I. Environmental allergies (such as grass, pollen, dust animal hair, etc)? ❑ Yes ❑ No

J. Sun Screen? ❑ Yes ❑ No

18. Do you require allergy shots? ❑ Yes ❑ No

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

A. Difficulty breathing? ❑ Yes ❑ Never

B. Loss of consciousness?
❑ Yes ❑ Never

C. Severe swelling of your nose, lips, tongue or throat? ❑ Yes ❑ Never

D. Emergency treatment in a medical facility for an allergic reaction? ❑ Yes ❑ Never

20. Are you sensitive to:

A. Gluten? ❑ Yes ❑ No

B Lactose? (milk or dairy intolerance)
❑ Yes ❑ No

C. Sunlight? ❑ Yes ❑ No

D. Sun Screen?❑ Yes ❑ No

PULMONARY/RESPIRATORY

21. Do you have or have you ever had:

A. Chronic bronchitis? ❑ Yes ❑ Never

B. Emphysema or COPD?
❑ Yes ❑ Never

C. Pulmonary Disease? ❑ Yes ❑ Never

D. Removal of a lung or a lobe of the lung?
❑ Yes ❑ Never

E. Pneumonia more than once during the last 5 years? ❑ Yes ❑ Never

F. Collapsed lung (Pneumothorax)?
❑ Yes ❑ Never

G. Cystic Fibrosis? ❑ Yes ❑ Never

22. Since age 15, have you ever:

A. Experienced wheezing? ❑ Yes ❑ Never

B. Used an inhaler to prevent breathing problems or to help you breathe?
❑ Yes ❑ Never

C. Been told you have asthma, bronchospasm or reactive (restrictive) airway disease?
❑ Yes ❑ Never

23. Within the last 5 years, have you had any respiratory condition, lung condition or surgery not listed in items 21-22? ❑ Yes ❑ Never

If yes, please specify:

_____

_____

CARDIOVASCULAR

24. Do you take prescription medication to control your blood pressure? ❑ Yes ❑ No

25. Do you take prescription medication for high cholesterol or high triglycerides? ❑ Yes ❑ No

26. Do you have or have you ever had:

A. Angina? ❑ Yes ❑ Never

B. A heart attack?
❑ Yes ❑ Never

C. Coronary artery or heart by-pass surgery?
❑ Yes ❑ Never

D. Coronary angioplasty (“balloon angioplasty”) or insertion of stent(s)?
❑ Yes ❑ Never

E. Other heart surgery? ❑ Yes ❑ Never

F. Carotid artery surgery?❑ Yes ❑ Never

G. Other surgery of the arteries? ❑ Yes ❑ Never

27. Do you have or have you ever had:

A. Pacemaker? ❑ Yes ❑ Never

B. Coronary artery disease?
❑ Yes ❑ Never

C. Congestive heart failure?
❑ Yes ❑ Never

D. A disturbance of heart rhythm (arrhythmia)?
❑ Yes ❑ Never

E. An aneurysm? ❑ Yes ❑ Never

F. An implantable defibrillator?❑ Yes ❑ Never

CARDIOVASCULAR CONTINUED

28. Do you have or have you ever had:

A. A heart murmur present after age 15?
❑ Yes ❑ Never

B. Heart valve disease?
❑ Yes ❑ Never

C. Mitral valve prolapse?
❑ Yes ❑ Never

D. Raynaud's disease (Vasospasm in parts of the hands)?
❑ Yes ❑ Never

E. A blood clot in the lung (Pulmonary embolism)?
❑ Yes ❑ Never

F. A blood clot in the legs (Thrombophlebitis)?
❑ Yes ❑ Never

G. Problems caused by poor circulation?
❑ Yes ❑ Never

28. Continued:

H. Varicose veins? (Mark resolved if you no longer see a physician regarding this condition and/or no longer have symptoms)
❑ Yes ❑ Resolved ❑ Never

I. Chronic leg or ankle swelling? (Mark resolved if you no longer see a physician regarding this condition and/or no longer have symptoms)
❑ Yes ❑ Resolved ❑ Never

29. Other than aspirin, do you currently or have you ever taken any blood-thinning (anti-coagulant) medication such as Warfarin or Coumadin? (Mark resolved if you no longer see a physician regarding this condition and/or no longer have symptoms)
❑ Yes ❑ Resolved ❑ Never

30. Do you have or have you ever had any other heart or circulatory condition or surgery not listed in items 24-29? ❑ Yes ❑ Never

If yes, please specify:

GASTROINTESTINAL

31. Do you have or have you ever had:

A. An esophageal stricture?
❑ Yes ❑ Never

B. Heartburn requiring daily medication? (Mark resolved if you no longer take heartburn medication and no longer have symptoms)
❑ Yes ❑ Resolved ❑ Never

C. Esophageal varices?
❑ Yes ❑ Never

D. Stomach or duodenal ulcers/Peptic ulcer disease? (Mark resolved if you no longer see a physician regarding this condition and/or no longer have symptoms)
❑ Yes ❑ Resolved ❑ Never

E. Gall Bladder disease? (Mark resolved if you no longer see a physician regarding this condition and/or no longer have symptoms)
❑ Yes ❑ Resolved ❑ Never

F. Cirrhosis of the liver? ❑ Yes ❑ Never

G. Pancreatic disease? ❑ Yes ❑ Never

H. Irritable Bowel Syndrome?
❑ Yes ❑ Resolved ❑ Never

I. Inflammatory Bowel Disease/Crohn's/Ulcerative Colitis? (Mark resolved if you no longer see a physician regarding this condition and/or no longer have symptoms)
❑ Yes ❑ Resolved ❑ Never

31. Continued:

J. Diverticulosis/diverticulitis? (Mark resolved if you no longer see a physician regarding this condition and/or no longer have symptoms)
❑ Yes ❑ Resolved ❑ Never

K. Gastric Bypass Surgery (Bariatric Surgery) or other weight loss surgery?
❑ Yes ❑ Never

32. Do you have or have you ever had:

A. A hernia of the groin (inguinal) or abdomen? (Mark resolved if you no longer see a physician regarding this condition and/or no longer have symptoms)
❑ Yes ❑ Resolved ❑ Never

B. A colostomy or an ileostomy? ❑ Yes ❑ Never

33. Do you have or have you ever had:

A. A cyst near the rectum (pilonidal cyst)?
❑ Yes ❑ Never

B. Internal hemorrhoids?
❑ Yes ❑ Never

34. Do you have or have you ever had any other conditions or surgery of the esophagus, stomach, liver, gall bladder, pancreas or intestinal tract not listed in items 31-33?
❑ Yes ❑ Never

If yes, please specify:

GENDER

35. Have you undergone sexual reassignment to change your gender? ❑ Yes ❑ No

B. If yes, were you born male or female? ❑ Male ❑ Female

Male Gender-Specific/Genitourinary (Males Only)

36. Do you have or have you ever had:

A. Difficulty starting or stopping your urine stream?
❑ Yes ❑ Never

B. An enlarged prostate?
❑ Yes ❑ Never

C. Prostate Cancer?
❑ Yes ❑ Never

D. Pain or swelling in your testicles?
❑ Yes ❑ Never

E. Hydrocele, spermatocele or varicocele?
❑ Yes ❑ Never

F. Testicular Cancer?
❑ Yes ❑ Never

G. Erectile Dysfunction requiring medication?
❑ Yes ❑ Never

37. Do you have or have you ever had any other genital condition or surgery not listed in item 36?
❑ Yes ❑ Never

If yes, please specify:

Female Gender-Specific/Gynecology (Females Only)

38. Are you currently using:

A. Birth control pills?
❑ Yes ❑ No

B. Birth control implants (Norplant®)?
❑ Yes ❑ No

C. Birth control injections (such as Depo-Provera)?
❑ Yes ❑ No

D. An Intrauterine device (IUD)?
❑ Yes ❑ No

E. Intra-vaginal contraception such as NuvaRing®?
❑ Yes ❑ Never

39. Have you ever had:

A. A pap smear?
❑ Yes ❑ Never

B. If yes, have you ever had an abnormal Pap smear?
❑ Yes ❑ Never

40. Do you have or have you ever had:

A. Pelvic Inflammatory disease (PID) or tubal infections? (Mark resolved if you no longer see a physician regarding this condition and/or no longer have symptoms)
❑ Yes ❑ Resolved ❑ Never

B. Uterine fibroids? (Mark resolved if you no longer see a physician regarding this condition and/or no longer have symptoms)
❑ Yes ❑ Resolved ❑ Never

C. Endometriosis? (Mark resolved if you no longer see a physician regarding this condition and/or no longer have symptoms)
❑ Yes ❑ Resolved ❑ Never

40. Continued:

D. Polycystic Ovarian Syndrome?
❑ Yes ❑ No

E. Ovarian Cysts? (Mark resolved if you no longer see a physician regarding this condition and/or no longer have symptoms)
❑ Yes ❑ Resolved ❑ Never

41. Do you currently have:

A. Menstrual cycles?
❑ Yes ❑ No

B. Irregular menstrual cycles (NOT monthly)?
❑ Yes ❑ No

C. Bleeding or spotting between menstrual cycles?
❑ Yes ❑ No

42. Are you:

A. Post-menopausal NOT due to removal of uterus (hysterectomy)?
❑ Yes ❑ No

B. Post-menopausal with any vaginal bleeding or spotting?
❑ Yes ❑ No

C. Receiving hormone replacement therapy (HRT)?
❑ Yes ❑ No

43. Have you had your uterus removed (hysterectomy)? ❑ Yes ❑ No

Female Gender-Specific/Gynecology Continued (Females Only)

44. Do you have or have you ever had:

A. A breast cyst or lump?
❑ Yes ❑ Never

B. Fibrocystic breast changes?
❑ Yes ❑ Never

C. Breast implants?
❑ Yes ❑ Never

D. Breast cancer?
❑ Yes ❑ Never

45. Within the last six months, have you had a colposcopy procedure due to an abnormal PAP?
❑ Yes ❑ No

46. Within the last five years, have you had any other gynecological conditions or surgery not listed in items 38-45? ❑ Yes ❑ Never

If yes, please specify:

NEPHROLOGY

47. Have you had four or more bladder infections (cystitis) in the past year? ❑ Yes ❑ No

48. Have you had two or more kidney infections (pyelonephritis) in the past two years?
❑ Yes ❑ No

49. Have you ever had kidney stones? ❑ Yes ❑ No

50. Do you have or have you ever had any urinary, bladder, or kidney condition or surgery not listed in items 47-49? ❑ Yes ❑ Never

If yes, please specify:

DERMATOLOGY

51. Do you have or have you ever had:

A. Eczema?
❑ Yes ❑ Never

B. Psoriasis?
❑ Yes ❑ Never

C. Basal cell tumor(s) of the skin?
(Mark resolved if you no longer see a physician regarding this condition and/or no longer have symptoms)
❑ Yes ❑ Resolved ❑ Never

D. A Cancerous mole or other skin cancer (not basal cell)? ❑ Yes ❑ Never

E. Acne currently requiring prescription medications?
❑ Yes ❑ Never

52. Within the last five years, have you had any other skin condition not listed in item 51 for which you are taking prescription medication or receiving medical treatment? ❑ Yes ❑ No

If yes, please specify:

ORTHOPEDIC

53. Have you ever had an accident or event resulting in a head or traumatic injury? ❑ Yes ❑ No

54. Within the last five years, have you ever broken any of the following bones?

A. Back (spine) or neck?
❑ Yes ❑ No

B. Hip?
❑ Yes ❑ No

C. Skull?
❑ Yes ❑ No

D. Pelvis?
❑ Yes ❑ No

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

A. Chronic or recurrent neck or back pain (excluding arthritis)?
❑ Yes ❑ Never

B. Pinched Nerves?
(Mark resolved if you no longer see a physician regarding this condition and/or no longer have symptoms)
❑ Yes ❑ Resolved ❑ Never

C. A Disc problem? ❑ Yes ❑ Never

D. Scoliosis or kyphosis?
(Mark resolved if you no longer see a physician regarding this condition and/or no longer have symptoms)
❑ Yes ❑ Resolved ❑ Never

E. Osteoporosis or Osteopenia? ❑ Yes ❑ Never

ORTHOPEDIC CONTINUED

56. Other than for arthritis or bursitis, have you been medically or surgically treated for:

A. Chronic shoulder pain, dislocation or rotator cuff injury? ❑ Yes ❑ Never

B. Chronic hip pain? ❑ Yes ❑ Never

C. Chronic ankle pain (excluding uncomplicated ankle strains or sprains)? ❑ Yes ❑ Never

D. Chronic knee pain? ❑ Yes ❑ Never

57. Have you ever had

A. Shoulder arthroscopy, ligament repair, reconstruction or replacement? ❑ Yes ❑ Never

B. Hip reconstruction or replacement? ❑ Yes ❑ Never

C. Knee arthroscopy, ligament repair, reconstruction or replacement? ❑ Yes ❑ Never

D. Orthopedic hardware (pins, plates, rods, screws, etc)? ❑ Yes ❑ Never

58. Do you have arthritis or bursitis that requires the use of prescription medication?

❑ Yes ❑ Never

59. Do you have or have you ever had:

A. Repetitive motion injury/syndrome? ❑ Yes ❑ Never

B. Carpal tunnel syndrome? ❑ Yes ❑ Never

60. Do you have or have you ever had:

A. Painful bunions? ❑ Yes ❑ Never

B. Foot pain? ❑ Yes ❑ Never

C. Fascitis? ❑ Yes ❑ Never

D. The need to use orthotics as treatment for a foot or other condition? ❑ Yes ❑ Never

61. Within the last five years, have you had or been treated for any acute or chronic joint, muscle or bone condition or surgery not listed in items 53-60? ❑ Yes ❑ Never

If yes, please specify:

RHEUMATOLOGY

62. Do you have or have you ever had:

A. Fibromyalgia? ❑ Yes ❑ Never

B. Ankylosing spondylitis? ❑ Yes ❑ Never

C. Rheumatoid arthritis? ❑ Yes ❑ Never

D. Juvenile rheumatoid arthritis? ❑ Yes ❑ Never

62. Continued

E. Reactive arthritis (Reiter's Syndrome)? ❑ Yes ❑ Never

F. Systemic Lupus Erythematosis (SLE)? ❑ Yes ❑ Never

G. Connective Tissue disorder? ❑ Yes ❑ Never

H. Myasthenia Gravis (Variable neuro-muscular weakness)? ❑ Yes ❑ Never

HEMATOLOGY

63. Do you have or have you ever had:

A. Iron deficiency anemia? ❑ Yes ❑ Never

B. Anemia due to folate or B-12 deficiency/Pernicious anemia? ❑ Yes ❑ Never

C. A low platelet count (thrombocytopenia)? ❑ Yes ❑ Never

D. A missing or diseased spleen? ❑ Yes ❑ Never

E Hemochromatosis? ❑ Yes ❑ Never

F. Sickle cell disease? ❑ Yes ❑ Never

G. Thalessemia? ❑ Yes ❑ Never

H. A clotting disorder? ❑ Yes ❑ Never

I. Polycythemia vera? ❑ Yes ❑ Never

64. Do you have or have you had any other blood, immune system, connective tissue or collagen condition not listed in items 62-63? ❑ Yes ❑ Never

If yes, please specify:

ENDOCRINOLOGY

65. Do you have diabetes? ❑ Yes ❑ No

A. If yes, do you use oral medication?
❑ Yes ❑ No

B. Insulin injections? ❑ Yes ❑ No

C. An insulin pump? ❑ Yes ❑ No

66. Do you have or have you ever been treated for gout? ❑ Yes ❑ Never

67. Do you have or have you ever had:

A. A thyroid goiter? (Mark resolved if you no longer see a physician regarding this condition and/or no longer have symptoms)
❑ Yes ❑ Resolved ❑ Never

B. A thyroid nodule? (Mark resolved if you no longer see a physician regarding this condition and/or no longer have symptoms)
❑ Yes ❑ Resolved ❑ Never

C. An overactive thyroid (Hyperthyroidism)?
❑ Yes ❑ Never

67. Continued:

D. An underactive thyroid (Hypothyroidism)?
❑ Yes ❑ Never

E. Other thyroid disease?
❑ Yes ❑ Never

68. Do you have or have you ever had a disease of the pituitary gland? ❑ Yes ❑ Never

69. Do you have Addison's Disease (Underactive adrenal gland)? ❑ Yes ❑ Never

70. Do you have or have you ever had any condition of the endocrine system not listed in items 65-69? ❑ Yes ❑ Never

If yes, please specify:

INFECTIOUS DISEASE

71. Did you have a blood transfusion before July 1992? ❑ Yes ❑ No

72. Do you have or have you ever had (this does NOT refer to immunizations):

A. Hepatitis A virus? (Mark resolved if you no longer see a physician regarding this condition and/or no longer have symptoms)
❑ Yes ❑ Resolved ❑ Never

B. Hepatitis B virus? ❑ Yes ❑ Never

C. Hepatitis C virus? ❑ Yes ❑ Never

D. HIV/AIDS? ❑ Yes ❑ Never

73. Do you have or have you ever had:

A. Chronic fatigue syndrome? ❑ Yes ❑ Never

B. A positive skin test for tuberculosis?
❑ Yes ❑ Never

C. Tuberculosis disease of the lungs or other organ?
❑ Yes ❑ Never

D. Lyme Disease? ❑ Yes ❑ Never

74. Other than a cold or the flu, do you currently have any other infectious or parasitic condition not listed in items 72-73? ❑ Yes ❑ Never

If yes, please specify:

NEUROLOGY

75. Do you have severe or migraine headaches that require prescription medication? ❑ Yes ❑ Never

76. Have you ever had any seizures or convulsions?
❑ Yes ❑ Never

If yes, were they prior to the age of five and associated with a high fever? ❑ Yes ❑ Never

77. Have you ever had a stroke or stroke-like symptoms (TIA, Mini-stroke)? ❑ Yes ❑ Never

78. Do you have:

A. Cerebral Palsy?
❑ Yes ❑ Never

B. Multiple Sclerosis? ❑ Yes ❑ Never

78. Continued:

C. Muscular Dystrophy ❑ Yes ❑ Never

D. Amyotrophic Lateral Sclerosis(Lou Gehrig's disease)? ❑ Yes ❑ Never

E. Narcolepsy? ❑ Yes ❑ Never

79. Do you have or have you ever had any other neurological or nervous system condition or surgery not listed in items 75-77? ❑ Yes ❑ Never

If yes, please specify:

ONCOLOGY

80. Do you have or have you ever had:

A. Leukemia or lymphoma? ❑ Yes ❑ No

B. Any other type of cancer or malignant tumor not previously noted on this form? ❑ Yes ❑ No

PSYCHOLOGY/MENTAL HEALTH

81. Are you:

A. Recovered or recovering from alcohol abuse/ dependence? ❑ Yes ❑ No

B. If yes, give start date of sobriety.
_____/_____/_____
Month Day Year

C. If yes, do you rely on AA to maintain sobriety?
❑ Yes ❑ No

D. Recovered or recovering from substance abuse/ dependence?
❑ Yes ❑ Never

E If yes, give start date of abstinence
_____/_____/_____
Month Day Year

F. If yes, do you rely on NA to maintain abstinence
❑ Yes ❑ No

82. Have you ever been told that you have or have had a medical condition caused by excessive alcohol or drug use? ❑ Yes ❑ Never

If yes, please specify:

_____

_____

83. Have you ever had:

A. Family counseling (such as related to marital issues)? ❑ Yes ❑ Never

B. Support group counseling (such as for grief or divorce)? ❑ Yes ❑ Never

84. Other than counseling for academic guidance, an eating disorder, or ADD/ADHD, have you ever had:

A. Individual counseling or consultation with a psychiatrist, psychologist or mental health counselor? ❑ Yes ❑ Never

B. If yes, give date of last counseling session?
_____/_____/_____
Month Day Year

C. Substance abuse or alcohol abuse counseling?
❑ Yes ❑ Never

D. If yes, give date of last counseling session?
_____/_____/_____
Month Day Year

85. Have you been told you have Depression?

❑ Yes ❑ Never

86. Have you been told you have Anxiety?

❑ Yes ❑ Never

87. Have you been told you have Panic Attacks?

❑ Yes ❑ Never

88. Do you use medication(s) for a mental health issue?: (Mark resolved if you no longer take medications)
❑ Yes ❑ Resolved ❑ Never

B If resolved, give date of most recent use of medication. _____/_____/_____
Month Day Year

89. Have you ever received in-patient psychiatric care? ❑ Yes ❑ Never

B If yes, give date of last in-patient psychiatric care.
_____/_____/_____
Month Day Year

90. Have you ever tried to harm yourself or attempted suicide? ❑ Yes ❑ Never

B If yes, give date of incident
_____/_____/_____
Month Day Year

91. Have you ever been diagnosed with, had symptoms of, or been treated for an eating disorder? ❑ Yes ❑ Never

B If yes, give date of last symptoms, treatment, or support group participation.
_____/_____/_____
Month Day Year

92. Have you ever been diagnosed with, or had symptoms of ADD/ADHD?: (Mark resolved if you no longer see a physician regarding this condition and/or no longer have symptoms)
❑ Yes ❑ Resolved ❑ Never

B If resolved, give date of resolution.
_____/_____/_____
Month Day Year

93. Are you currently using or have you ever used medication for ADD/ADHD? ❑ Yes ❑ Never

B If yes, give date of last treatment?
_____/_____/_____
Month Day Year

PSYCHOLOGY/MENTAL HEALTH CONTINUED

94. Do you have or have you ever had any other mental health condition not listed in items 81-93 ?
❑ Yes ❑ No

If yes, please specify:

ACTIVITIES OF DAILY LIVING

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

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

97. Does kneeling, squatting or sitting cross-legged cause you shortness of breath, leg, joint, muscle or chest pain?
❑ Yes ❑ No

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

99. Do you have or have you been told that you have any hearing or speech condition that might affect your ability to communicate?
❑ Yes ❑ No

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

101. Does anything prohibit you from living and working in 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

102. Does anything prohibit you from living and working in high altitudes, such as above 5,000 feet? ❑ Yes ❑ No

103. Do you have or have you ever had any other medical condition(s) that could impact your ability to provide 27 months of service?
❑ Yes ❑ No

If yes, please specify:

I **CERTIFY** that all of the above information is true, correct and complete. I understand that providing misleading, inaccurate, or incomplete information will delay processing my application and may be cause for disqualification (result in withdrawal of my Peace Corps nomination or invitation) or in termination from Peace Corps service. In addition, any intentionally false statement (or intentional omission of information) may be subject to fines and/or imprisonment pursuant to 18 U.S.C. § 1001.

I understand that it is my responsibility throughout the application process to inform the Peace Corps Office of Medical Services of any changes to the information provided here, and to keep them updated on any other changes to my medical status.

Signature **Date**