Peace Corps Report of Physical Examination

PC-OMS-1790 S
OMB No.: 0420-xxxx
Expiration Date:

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

Date of Birth (MO / DAY / YR)
/ /

Current Address Until / /

Home/Permanent Address

Telephone No. ( )

Email

Telephone No. ( )

Guide to Completing the Report of Physical Examination

The Physical Examination is one of the final pre-service requirements for individuals applying for Peace Corps service. Most Peace Corps countries have limited access to Western-trained health professionals, and medical resources are seldom as advanced, or as available, as they are in the United States. In many assignments a Volunteer may be geographically isolated and without easy access to medical care. It would not be in a Volunteer's best interest to be placed in an area where adequate support is not available for existing health problems or new health needs. In order for the Peace Corps to be able to make appropriate medical decisions regarding qualification and placement, it must have the most accurate and complete description of the applicant's current health status and the medical support that will be needed over the next three years.

Privacy Act Notice

This information is collected under the authority of the Peace Corps Act, 22 U.S.C. 2501 et seq. It will be used primarily for the purpose of determining your eligibility for Peace Corps service and, if you are invited to serve as a Peace Corps Volunteer, for the purpose of providing you with medical care during your Peace Corps service. Your disclosure of this information is voluntary; however, your failure to provide this information will result in the rejection of your application to become a Peace Corps Volunteer.

This information may be used for the purposes described in the Privacy Act, 5 USC 552, including the routine uses listed in the Peace Corps' System of Records. Among other uses, this information may be used by those Peace Corps staff who have a need for such information in the performance of their duties. It may also be disclosed to the Office of Workers' Compensation Programs in the Department of Labor in connection with claims under the Federal Employees' Compensation Act and, when necessary, to a physician, psychiatrist, clinical psychologist or other medical personnel treating you or involved in your treatment or care. A full list of routine uses for this information can be found on the Peace Corps website at http://multimedia.peacecorps.gov/multimedia/pdf/policies/systemofrecords.pdf.

Burden Statement:

Public reporting burden for this collection of information is estimated to average 90 minutes per applicant response and 45 minutes per physician response. This estimate includes the time for reviewing instructions and completing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to: FOIA Officer, Peace Corps, 1111 20th Street, NW, Washington, DC 20526 ATTN: PRA (0420-####). Do not return the completed form to this address.

Application Case ID

Health History

A copy of the applicant's health history is included in this packet. Please check one of the boxes below:

❒ The medical history is complete and accurate

❒ The medical history is not complete and/or not accurate (List changes, including unreported past history and/or new medical events since the applicant completed this Health History): _____

_____

_____

_____

_____
Physician's Signature

Measurements and Other Findings

Height	Weight	Blood Pressure	Pulse	Gross Vision
				Right 20/____ ❒ Corrected Left 20/____ ❒ Uncorrected
feet/inches	lbs.	(resting)	bpm (resting)	complete prescription for eyeglass form if uncorrected vision of 20/40 or greater

Clinical Examination

All Sections MUST be completed by examining physician

Check each item in appropriate column. All systems must be examined.
Please check either normal or abnormal for all applicable questions. The only questions that may not be applicable are the gender and age-specific questions (Nos. 12 and 15).
Describe each abnormality in detail. Enter item number before each comment. Use additional sheets if necessary.

Normal	Abnormal	
❒	❒	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)

Prior to this visit have you provided medical care to this Candidate? ❒ yes ❒ no
If yes, how many times in the past 12 months have you seen this Candidate? _____

Application Case ID

Medications

Please check one box below. *Note that medications include prescribed, over the counter, and any herbal remedies.*

❒ The medications list is complete and accurate, including the dose and frequency.

❒ The medications listed are not complete and/or not accurate: (Provide a complete list of medications, including dose, frequency, and route for all medications the applicant is currently taking).

_____

_____

_____

_____

Functional Abilities

Please check one box below.

❒ I have reviewed the positive health history answers that reported decreased functional ability. I believe this is an accurate representation of the functional abilities of the applicant to meet his or her Activities of Daily Living.

❒ There are no reported functional limitations reported on the health history. I believe this is an accurate representation of no functional limitations of the applicant to meet his or her Activities of Daily Living.

❒ I am reporting functional limitations that were not reported on the Health History: _____

_____

_____

_____

_____

_____

_____

Laboratory Evaluation

Documentation of results must be included for this Physical Exam to be complete. (Please use cover sheet provided). ***Abnormal lab results require an explanation, a treatment plan or, if chronic abnormality exists, historical results with a plan for follow up.***

Tuberculin Test

TB test performed no more than six months prior to physical exam

❒ 5 TU PPD

Date read _____

Size of induration must be recorded in box below.

Do not report "Negative"

mm of induration

OR

A blood test was done in lieu of the PPD

❒ T SPOT. TB (negative or postive)

❒ QuantiFERON® - TB gold *(lab report must be attached)*

❒ negative ❒ positive

Other Required Lab Tests

Lab report peformed no more than six months prior to the physical exam MUST be attached

❒ HIV (bloodwork or rapid oral test)

❒ CBC

❒ Hepatitis B surface Antigen

❒ Hepatitis C Antibody

❒ G6PD titer

❒ Basic Metabolic Panel

❒ Urinalysis

Application Case ID

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 Candidate's name and social security number on each page.

List all **active** and/or applicant's **chronic** Conditions	Recommendations for evaluation and/or treatment required for the next thee years of service
1	
2	
3	
4	
5	
6	

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:**

Understanding that health care resources may be very limited and potentially hours away from his/her living or working site, do you have any concerns about this applicant serving safely in the Peace Corps? YES ❑ NO ❑ **If yes, specify:**_____

* Important

Medical examination is complete only when:
(Please check all boxes)

- ❑ Candidate has signed and dated HIPPA statement on Page 1.
- ❑ Examining Provider has signed and dated Page 4.
- ❑ All required laboratory results are provided and reviewed, in addition to clinically significant abnormal results (include recommendations for follow up).
- ❑ I have performed the physical exam as noted.

(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
Physician Name (Print)

Date

Physician License Number/State

Physician Address and Phone Number

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