

Guide to Completing the Report of Physical Examination

Getting it right the first time: Answers to commonly asked questions.

Page 4: Measurements and Other Findings

- 1) **Hearing:** Please ask the doctor to note either normal or abnormal after performing the following whisper test:
 - The doctor stands at arms-length behind you.
 - Cover your right ear.
 - Ask doctor to whisper 2-3 numbers towards your left ear.
 - Repeat what you heard the doctor say.
 - Repeat test covering the left ear.
 - Your hearing is normal if you respond correctly each time.

Page 4: Clinical Examination

- 1) **Please document either *normal* or *abnormal* to all applicable questions.** The only questions that may not be applicable are the gender and age-specific questions, 12 and 15.

Page 4: Laboratory Evaluation

- 1) **Tuberculin Test:** If you choose to submit results from the *PPD* test, please submit them in mm of induration (in number terms). Do not report “negative” as negative means different things to different doctors.
- 2) **Lab Reports:** Please ask the doctor for a copy of all lab results for the 8 lab tests listed under *Other Required Lab Tests*.

Page 5: Immunizations Required for Medical Qualification

You must provide documentation that you have had all these immunizations in the noted timeframes (where applicable) even if your doctor feels they are unnecessary.

Page 5: Immunization History

Please provide documentation for all immunizations in this section that you have previously had. Peace Corps will provide all other immunizations needed once you become a Peace Corps Volunteer.

Page 6: Signature

This form must be signed or co-signed by an MD (Medical Doctor) or DO (Doctor of Osteopathy).



Peace Corps Report of Physical Examination

Name (Last, First, Middle Initial) _____ Sex M F Social Security Number _____ Date of Birth (MO / DAY / YR) _____ / _____ / _____

Current Address Until _____ / _____ / _____ Home/Permanent Address _____

Telephone No. (_____) _____ Telephone No. (_____) _____

Email _____

All sections must be completed **THIS SECTION TO BE COMPLETED BY APPLICANT**

IV. Health History

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 6 (Summary and Comments) or additional pages if necessary, identified with the applicant's name and social security number.

Symptoms or problems	No	Yes	Yes	Physician comments
		(Resolved)	(Current)	
Frequent or severe headaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Fainting spells, blackouts or seizures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Vision problems (e.g., eye injuries, disorders, inflammation)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Hearing problems/loss	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Persistent cough	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Chest pain or chest pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Shortness of breath or wheezing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Repeated episodes of indigestion, heartburn, or stomach pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Frequent diarrhea or constipation (such as colitis, irritable bowel syndrome)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Frequent or bloody stools (such as Crohns disease)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Frequent or painful urination	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Blood in urine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Repeated episodes of back or neck pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Muscle, bone, or joint injuries	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Painful or swollen joints	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Breast lump or mass or nipple discharge	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Skin problems (e.g., eczema, dermatitis, psoriasis)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Change in color or size of a mole or other growth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
A sore that does not heal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Frequent sadness or feelings of depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Frequent or severe nervousness or anxiousness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Frequent sleeplessness or insomnia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Use of cigarettes or other tobacco products	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Chest palpitations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Easy bleeding or bruising	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Swollen glands in neck	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Swelling in arms or legs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
(Females) Gynecologic symptoms or disorders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
(Males) Lumps in testicles	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
(Males) Difficulty starting urine stream or a decreased urine stream	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Other (please specify) _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Traumatic injuries (including accidents motor vehicle, sports related, please specify) _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Hospitalizations (please specify) _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Surgeries (please specify) _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

Name of surgery _____ Date of surgery _____

B. Family history

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

- | | |
|--|--|
| <input type="checkbox"/> Alcoholism _____ | <input type="checkbox"/> Cardiovascular disease _____ |
| <input type="checkbox"/> Diabetes _____ | <input type="checkbox"/> Mental illness _____ |
| <input type="checkbox"/> Cancer _____ | <input type="checkbox"/> Kidney Disease _____ |
| <input type="checkbox"/> High blood pressure _____ | <input type="checkbox"/> Sudden death of a relative under age of 50 _____
(Other than trauma) |
| <input type="checkbox"/> None | <input type="checkbox"/> Other (specify) _____ |

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

Please note, whenever possible, Peace Corps provides a generic equivalent and does not provide medications/supplements considered not medically necessary.

Name	Start Date	Dose	Frequency	Condition Being Treated

None

D. Allergies and hypersensitivities

List Allergies	Medications, foods, and insect stings	Description of Reaction	Treatment	Did treatment require an ER visit?	Date of last reaction
				<input type="checkbox"/> yes <input type="checkbox"/> no	
				<input type="checkbox"/> yes <input type="checkbox"/> no	
				<input type="checkbox"/> yes <input type="checkbox"/> no	
				<input type="checkbox"/> yes <input type="checkbox"/> no	
				<input type="checkbox"/> yes <input type="checkbox"/> no	
				<input type="checkbox"/> yes <input type="checkbox"/> no	

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 withholding or providing 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

V. Measurements and Other Findings

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

VI. Clinical Examination

All Sections MUST be completed by examining physician

Check each item in appropriate column.

All systems must be examined.

Prior to this visit have you provided medical care to this applicant?

yes no

If yes, how many times in the past 12 months have you seen this applicant?

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

Normal Abnormal

- | | | |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | 1. Head and neck _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | 2. Nose, sinuses _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | 3. Mouth and throat _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | 4. Thyroid _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | 5. Ears _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | 6. Eyes (include fundoscopic exam) _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | 7. Lungs and chest _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | 8. Breasts _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | 9. Cardiac (rate, rhythm, heart sounds) _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | 10. Peripheral pulses _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | 11. Abdomen _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | 12. Prostate exam (men over 50 only) _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | 13. Anus and rectum _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | 14. Genitalia (include hernia) _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | 15. Pelvic exam (females only) _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | 16. Spine _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | 17. Musculoskeletal _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | 18. Neurologic _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | 19. Skin, lymphatics _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | 20. Identifying marks, scars, tattoos _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | 21. Psychiatric (specify any significant cognitive or behavioral observations) _____ |

VII. Laboratory Evaluation

Abnormal lab results require an explanation, a treatment plan or, if chronic abnormality, historical results with a plan for follow up.

PAP Smear cytology results

Date _____

Lab report performed no more than 1 year prior to the physical exam **MUST** be attached

Tuberculin Test

TB test performed no more than 6 months prior to physical exam

PPD

Date read _____

Size of induration must be recorded in box below.

Do not report "Negative"

mm of induration

OR

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

negative positive

Other Required Lab Tests

Lab report performed no more than 6 months prior to the physical exam **MUST** be attached

HIV (bloodwork or rapid oral test)

CBC

Hepatitis B surface Antibody

Hepatitis B surface Antigen

Hepatitis B core Antibody

Hepatitis C Antibody

G6PD titer

Urinalysis

VIII. Immunizations Required for Medical Qualification:

Physician - Initial & Date Administration

Type of Immunization	Date of Immunization	Physician Initials
1. Td or Tdap Booster (within 5 years of the Report of Medical Examination)		
2. Polio Booster (after age 18 or documentation by physician of having had the disease)		
3. MMR#1		
4. MMR#2 Booster		
<p>If born before 1957, may instead provide documentation of one measles-containing vaccine, documentation of physician-diagnosed measles, or documentation of titers demonstrating immunity to all 3 diseases.</p> <p>If born 1957 or after, may instead provide documentation of titers demonstrating immunity to all 3 diseases.</p>		
5. Varicella #1		
6. Varicella #2		
<p>If born before 1980, may instead provide documentation of physician-diagnosed chicken-pox or herpes zoster.</p> <p>If born 1980 or after, may instead provide titers demonstrating immunity to varicella.</p>		

Immunization History: Do NOT Give These Immunizations.

Has the applicant received the following immunizations?

If yes to any of the following, please attach copy of the immunization records.

	Yes	No
1. Yellow Fever	<input type="checkbox"/>	<input type="checkbox"/>
2. Hep B Series	<input type="checkbox"/>	<input type="checkbox"/>
3. Hep A Series	<input type="checkbox"/>	<input type="checkbox"/>
4. Typhoid	<input type="checkbox"/>	<input type="checkbox"/>
5. Rabies Pre-Exposure	<input type="checkbox"/>	<input type="checkbox"/>
6. Meningococcal	<input type="checkbox"/>	<input type="checkbox"/>
7. Japanese Encephalitis	<input type="checkbox"/>	<input type="checkbox"/>
8. Tick-borne Encephalitis	<input type="checkbox"/>	<input type="checkbox"/>
9. Influenza	<input type="checkbox"/>	<input type="checkbox"/>
10. Pneumococcal	<input type="checkbox"/>	<input type="checkbox"/>
11. Other (please specify)	<input type="checkbox"/>	<input type="checkbox"/>

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

Mammogram (females only)

(Attach radiology report performed no more than 1 year prior to physical exam)

Tests for Applicants 50 Years and Older.

Colorectal Screening (any ONE test) *(Results must be attached)*

- Colonoscopy *(within 10 years)*
- Flexible Sigmoidoscopy *(within 5 years)*
- Double Contrast Barium Enema *(within 5 years)*
- CT Colonography "Virtual Colonoscopy" *(within 5 years)*
- Stool DNA Testing *(within 1 year)*
- Fecal Immunochemical Test (FIT) *(within 1 year)*
- Fecal Occult Blood Test (FOBT)x3 - Stool for occult blood *(within 1 year)*

ECG Interpretation

(ECG tracing performed no more than 1 year prior to the physical exam MUST be faxed to Peace Corps at 202.692.1561)

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 all Active and Chronic Conditions	Recommendations & Comments
1 _____	_____
2 _____	_____
3 _____	_____
4 _____	_____
5 _____	_____
6 _____	_____

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

(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.)

* Important * Medical examination is complete only when:

- Applicant has signed and dated statement on page 3.
- Physician has signed and dated page 6.
- Physician has initialed all documented immunizations on page 5.
- Required lab reports are attached.
- PAP, ECG tracing and mammography report are attached (when indicated).

Physician Signature/Title

Physician Name (Print)

Date Physician License Number/State

Physician Address and Phone Number

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