



Peace Corps

DIABETES DIAGNOSIS FORM

The individual listed above has applied to serve as a Peace Corps Volunteer and has reported having ***Diabetes Type 1 or Type 2***. This form must be completed by the Health Care Provider (MD or DO) who provides or provided medical oversight and management of this condition.

Note to the Provider: Please be candid when answering the questions below, and consider that there are many assignments where the Volunteer may be isolated or exposed to violence and crime, extreme poverty, or inequitable treatment. *Walking long distances on rough terrain and use of squat toilets is not uncommon.* There may also be limited access to western-trained medical professionals. There are many assignments where the Volunteer will need considerable flexibility and physical endurance to adapt to unpredictable housing conditions, extreme changes in climate, and unreliable transportation and to exhibit the need for heightened awareness of personal safety and increased attention to safe food and drinking water. The most accurate medical representation of this condition is critical for the Peace Corps to make appropriate medical decisions for qualification and placement. **Please answer all questions or the form will be considered incomplete and returned to the applicant.**

Diabetes diagnosis:	<input type="checkbox"/> Type 1	<input type="checkbox"/> Type 2
Date of diagnosis:	_____	
Etiology:	_____ _____	
List any associated medical conditions or complications associated with this condition:	<input type="checkbox"/> N/A	

Burden Statement:

Public reporting burden for this collection of information is estimated to average 30 per applicant and 75 minutes per mental health professional per 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.

(Include any conditions, such as neuropathy, ophthalmology conditions or other problems, such as altered kidney function)* Any other body involvement will require an evaluation by a specialist for that body system.

Date condition stabilized with normal blood sugars:

This condition is not yet stable and still requires ongoing monitoring and adjustments. Describe:

This person uses an insulin pump to manage his/her condition **No** **Yes**

Name and model of insulin pump:

Expected date that insulin pump will need to be replaced or serviced:

(If yes, applicant must complete the information in the box below)

Please note that, if you are cleared for Peace Corps service, you will be responsible for bringing an insulin pump, and ensuring that the pump can last throughout the entire length of Peace Corps service.

Candidate Signature: I understand that I will need to bring an insulin pump that is expected to last throughout my Peace Corps service.

The provider should complete the sections below:

Document this patient's understanding of the disease and demonstrated ability to monitor and care for himself/herself independently in an overseas environment:

Document the patient's current cardiac status. If the patient is 40 or older, include a current EKG tracing with a detailed interpretation:

Document the current peripheral-vascular status:

List ALL of the signs and symptoms that have occurred in the past two years: (include episodes of high/low blood sugar that required a medical intervention or involved a change in consciousness)

Signs and Symptoms	Was this life threatening?	Severity (circle one)			Frequency (circle one)				Date of last occurrence	Ongoing?
		Mild	Moderate	Severe	Daily	once or more a week	once or more a month	Very rarely		
	<input type="radio"/> Y <input type="radio"/> N				<input type="radio"/> Daily <input type="radio"/> once or more a week <input type="radio"/> once or more a month <input type="radio"/> Very rarely				<input type="radio"/> Y <input type="radio"/> N	
	<input type="radio"/> Y <input type="radio"/> N				<input type="radio"/> Daily <input type="radio"/> once or more a week <input type="radio"/> once or more a month <input type="radio"/> Very rarely				<input type="radio"/> Y <input type="radio"/> N	
	<input type="radio"/> Y <input type="radio"/> N				<input type="radio"/> Daily <input type="radio"/> once or more a week <input type="radio"/> once or more a month <input type="radio"/> Very rarely				<input type="radio"/> Y <input type="radio"/> N	

List all medications prescribed in the last two years for this condition, either daily or as needed: It is important we know all medications and changes, especially medication or dosage changes in the last six months.

Medication (name)	Start Date	Stop Date	Ongoing?	Strength	Dose	Frequency
			<input type="radio"/> Y <input type="radio"/> N			
			<input type="radio"/> Y <input type="radio"/> N			
			<input type="radio"/> Y <input type="radio"/> N			

List all laboratory or radiologic testing done ***in the past 12 months**** that specific to this condition (Please attach all results):

****If no laboratory or radiologic testing has been done in the past 12 months, please provide appropriate baseline testing results that would demonstrate to the Peace Corps medical officer the current medical baseline for this applicant. These should have been completed within the past three months:***

- FBS
- BUN
- Creatinine
- Urinalysis
- Glycohemoglobin (HgA1C) on two measurements at least two months apart

Are there any functional limitations or restrictions due to this condition?

NO YES

If “Yes” please describe the limitations or restrictions:

What specific recommendations do you have for the management for this condition over the next three years? **All recommendations will help determine the appropriate Volunteer placement and worksite.**

Do you have any concerns that would prevent this applicant from completing 27 months of Peace Corps service without disruption due to diabetes? NOTE: Peace Corps service may be in areas that are isolated or have limited access to Western-trained providers and health care systems. Please check one box below.

I have no concerns. This applicant, with regard to diabetes, is healthy enough to complete 27 months of uninterrupted Peace Corps service provided the above recommendations can be accommodated.

I am unsure that this applicant can complete 27 months of uninterrupted service due to diabetes. I recommend a period of stabilization for this condition and an updated assessment at a later date. (Describe and include length of time for stabilization)

I do not believe that this applicant can complete 27 months of Peace Corps service without disruption due to diabetes.

I certify this information is, in my opinion, an accurate representation of the baseline status of diabetes for the applicant listed above.

Physician Signature/Title (MD or DO)

Physician Name (Print)

Date

Physician License Number/State

Physician Address
