Applicant Name ______________________________
(Last, First, Middle Initial)

Date of Birth_____/_____/_____ Application Case ID: ______________________
(Mo/Day/Year)

Form Name
OMB No.:
Expiration Date:

MENTAL HEALTH TREATMENT SUMMARY FORM
(CONFIDENTIAL)

The individual listed above has applied to serve as a Peace Corps Volunteer and has reported a history of a mental health condition, mental health counseling, or use of medication for mental health. The mental health provider who has oversight and management of the applicant's treatment, or has access to the applicant's mental health records, should complete this mental health treatment summary. If you do not have access to the appropriate records, please indicate this on the form.

Note to the Mental Health Provider: Please be candid when answering the questions below. During Peace Corps service, a Volunteer may be placed in a community that is very isolated and remote. It may have a history of violence or high crime, or extreme poverty, or inequitable treatment. There may be limited access to Western-trained mental health professionals and little support for existing or new mental health symptoms. **Please answer all questions or the form will be considered incomplete and returned to the applicant.**

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 552a, 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 members 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 105 minutes per applicant and 60 minutes per mental health provider 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.

Application Case ID: ____________

Mental Health Provider's Name:______________________________Date: __________

Professional degree:____________________ License No.:______________ State: ______

Address:____Tel: ______________

1. Dates and Frequency of Therapy Sessions:

Date of First Session: ____________________ Frequency of Sessions:______________

Date of Last Session: ____________________ Was this a Final Session? ☐ Y ☐ N

If yes, was termination satisfactory and/or mutual? ______________________________

Please provide the following information based on your treatment and clinical assessment of this applicant. Please be as detailed as possible. Continue on the reverse side of this page, if necessary.

2. Diagnoses [DSM IV Codes] (List all diagnoses)

Working Diagnoses	Date Given	Date Resolved	Current Diagnosis
Axis I:	(MM/YY)________	(MM/YY)________ ☐ ongoing	Axis I:
Axis II:			Axis II:
Axis III:			Axis III:
Axis IV:			Axis IV:
Axis V:			Axis V:

3. Presenting Problem and Precipitating Factors:

4. Symptoms: *Please be as specific and comprehensive as possible.*

Symptom	Onset	Severity	Duration	Date remitted

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5. Course of Treatment: ____

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6. Psychotropic Medications: *Current and Previous*

Please have the prescribing professional complete this portion.

Medication and Dosage: ____

Start Date______________________ End Date: ______________________

Response to Medication: ____

Recommended Monitoring Plan: ____

Medication and Dosage: ____

Start Date______________________ End Date: ______________________

Response to Medication: ____

Recommended Monitoring Plan: ____

Medication and Dosage: ____

Start Date______________________ End Date: ______________________

Response to Medication: ____

Recommended Monitoring Plan: ____

Signature and title if different from the person completing the rest of this form: ______________________

Name and title______________________Date ______________________

7. Mental Health History

Previous Counseling ☐ N/A If yes, describe:	Dates if known	DSM Diagnosis if known
Psychiatric Hospitalizations ☐ N/A If yes, describe:	Dates if known	Location

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Suicide Attempt(s) dates)	Suicidal Gestures (dates)	Suicide Ideation (dates)
☐ N/A If yes, describe:	☐ N/A If yes, describe:	☐ N/A If yes, describe:
Risk of recurrence?	Risk of recurrence?	Risk of recurrence?
☐ None or unlikely	☐ None or unlikely	☐ None or unlikely
☐ Possible or likely (describe):	☐ Possible or likely (describe):	☐ Possible or likely (describe):
☐ I am unable to asses this	☐ I am unable to asses this	☐ I am unable to asses this

8. Level of Functioning

History	Interpersonal (describe):	Work (describe):	School (describe):
Current	Interpersonal (describe):	Work (describe):	School (describe):

9. Prognosis: ____

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10. Risk of Exacerbation or Recurrence: ***Please consider issues of isolation, lack of structure, and lack of social support in an austere environment overseas,*** ____

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11. Additional Comments: ____

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Application Case ID: ______

12. Recommendations and Follow Up: What specific recommendations for mental health support do you have regarding the management of this condition over the next three years? **All recommendations will help determine the best placement for the applicant as a Peace Corps Volunteer.** Do you have any concerns that would prevent this applicant from completing 27 months of service without disruption due to a mental health condition? 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 mental health conditions, is healthy enough to complete 27 months of uninterrupted Peace Corps service provided these recommendations can be accommodated.

☐ I am unsure that this applicant can, due to a mental health condition, complete 27 months of uninterrupted Peace Corps service. I recommend a period of stabilization for this condition and an updated assessment at a future date. Describe and include length of time for stabilization: ______

______

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☐ I do not believe this applicant is or will be able to complete 27 months of Peace Corps service due to his/her mental health condition.

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

Mental Health Professional Signature/Title ______

Mental Health Professional Name (Print) ______

Date ______