Applicant Name _____
(Last, First, Middle Initial)

Date of Birth_____/_____/_____ Medical Case Number:_____
(Mo/Day/Year)

Med.UnderactiveThyroid
OMB No.: 0420-0550
Expiration Date: 1/31/2014

DISEASE DIAGNOSIS EVALUATION FORM

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

Note to the Health Care Provider: Please be candid when answering the questions below, and answer all questions completely. There are many assignments where the Volunteer will need considerable flexibility and physical endurance to adapt to unpredictable housing conditions, climate extremes, and unreliable transportation and to exhibit a heightened awareness of personal safety and increased attention to safe food and drinking water. *Walking long distances on rough terrain and use of squat toilets is not uncommon.* During Peace Corps service there may be limited access to Western-trained health professionals, while medical care and resources compared to U.S. health care standards are limited. Access to specialty physicians also might be nonexistent. The most accurate representation of this condition is critical in order 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.**

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 75 minutes per applicant and 30 minutes per physician 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 - 0550). Do not return the completed form to this address.

Medical Case Number: ____________

Diagnosis: ____________

Date of diagnosis: ____________

Etiology: ____________

Date of last visit to health care provider for this condition (other than the date of the visit to fill out this form): ____________

Date and Type of Surgery: ____________ ☐ N/A

Recommendation for future surgery (type and reason): ____________

____________ ☐ N/A

List any associated medical conditions or complications associated with this condition: ____________

____

____

____________ ☐ N/A

List ALL signs and symptoms that have occurred in the past two years:

Signs and Symptoms	Required Hospitalization?	Severity	Frequency	Date of last occurrence	Ongoing?
	☐ Y ☐ N	☐ Mild ☐ Moderate ☐ Severe	☐ Daily ☐ Once or more a week ☐ Once or more a month ☐ Very rarely		☐ Y ☐ N
	☐ Y ☐ N	☐ Mild ☐ Moderate ☐ Severe	☐ Daily ☐ Once or more a week ☐ Once or more a month ☐ Very rarely		☐ Y ☐ N
	☐ Y ☐ N	☐ Mild ☐ Moderate ☐ Severe	☐ Daily ☐ Once or more a week ☐ Once or more a month ☐ Very rarely		☐ Y ☐ 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
			☐ Y ☐ N			
			☐ Y ☐ N			
			☐ Y ☐ N			

List all laboratory or radiologic testing done <u>in the past 12 months</u>* specific for this condition (all results need to be attached):

____

____

*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 the current baseline for this applicant with regard to this condition.***

Medical Case Number: _____

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

☐ NO ☐ YES

If "Yes" is marked, describe limitations or restrictions: _____

_____

_____

What specific recommendations for medical care do you have regarding the management of this condition over the next three years? **All recommendations will help determine the Volunteer's placement with regards to each country's specific ability to provide specialized support:** _____

_____

_____

_____

_____

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

☐ I have no concerns. This applicant, with regards to the diagnosis of **Underactive Thyroid**, 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 Peace Corps service due to the diagnosis of **Underactive Thyroid**. 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:

☐ I do not believe that this applicant is or will be able to complete 27 months of Peace Corps service without disruption due to this diagnosis.

I certify this information is, in my opinion, an accurate representation of the baseline status on the condition of **Underactive Thyroid** for the applicant listed above.

Physician Signature/Title (MD or DO as required by state law)_____

Physician Name_____

Date_____Physician License Number/State_____

Physician Address_____