Applicant Name _____
(Last, First, Middle Initial)

Date of Birth_____/_____ /_____
(Month/Day/Year)

Functional Abilities Evaluation
OMB No.: 0420-0550
Expiration Date: 00/00/0000

FUNCTIONAL ABILITIES EVALUATION

Your patient has applied to serve with the Peace Corps and has reported a **functional ability limitation**. This form must be completed by the health-care provider who can assess the reported functional ability limitation.

Considerations for the health-care provider:

- Your patient has applied to serve as a Peace Corps Volunteer. During Peace Corps service, most Peace Corps Volunteers face dramatic changes to living conditions, diet, and level of physical activity. Furthermore, they typically serve in remote and resource-limited environments where they are expected to live and work in conditions that parallel those in their local community. It is not uncommon for Volunteers to need to be able to use squat toilets, ambulate for miles on uneven terrain daily, haul water over some distance, and sleep on bedding that does not meet typical U.S. comfort standards. Additionally, they may face unpredictable housing conditions, extremes of climate, unreliable transportation, the need for heightened awareness of personal safety, and increased attention to safe food and drinking water.
- When Volunteers serve with the Peace Corps, the Office of Health services providers assume primary responsibility for their medical care during the duration of their service. However, it must be recognized that given the resource limitations of countries in which Volunteers serve, there may be limited access to Western trained health professionals. Medical care and resources comparable to U.S. health-care standards are limited and, in the case of specialty physicians, is mostly non-existent.
- In order to help the Peace Corps fully and accurately understand the current health of potential Volunteers and assess whether the Peace Corps can appropriately support and accommodate individualized health care and support needs of your patient, we ask you to review the issues below with your patient and provide us with your written assessment of your patient's medical conditions, functional limitations, and anticipated support needs.

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 service 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 or failure to disclose relevant information may 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 U.S.C. 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, licensed clinical social worker 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 complete from to this address.

Functional Ability Limitation (please check)	Reason for Functional Ability Limitation (if known)
☐ Cannot walk distances greater than two miles on rough or uneven terrain on a daily basis	
☐ Cannot climb at least two flights of stairs carrying groceries or luggage without difficulty on a daily basis	
☐ Cannot tolerate riding in a vehicle on rough roads on a daily basis	
☐ Cannot hold a squat position for several minutes to use a squat commode or toilet	
☐ Cannot independently lift or manage their luggage or other supplies during service (up to a weight of 50 pounds)	
☐ Cannot, **for medical reasons**, live in extreme heat, extreme cold, constant dampness, or constant dust (circle all that apply)	
☐ Cannot, for **medical reasons**, live in altitudes above 5,000 feet	

List all laboratory and radiologic testing and consultative evaluations (such as physical therapy or other specialist evaluations) done **in the past 12 months*** that can be used to objectively assess this functional ability limitation. Attach all results and notes. _____

_____

_____

_____

If no laboratory and radiologic testing or consultative evaluations have been done in the past 12 months, **please indicate what additional testing or evaluations you are planning to complete or arrange for your patient to provide objective baseline assessment with regard to this functional ability limitation**.

_____

_____

_____

_____

What specific recommendations do you have for the management of this applicant's functional ability limitation(s) over the next three years? All recommendations will help determine appropriate Volunteer placement and worksite.

_____

_____

_____

_____

Will your patient require any specific accommodations or support devices while in service? If yes, please detail:

_____

_____

_____

_____

Closing Signatures

Provider Signature/Title_____

Provider Name (Print) _____ Date _____

Provider License Number/State _____

Provider Address and Phone Number_____

_____

If evaluation completed by other than MD, DO, or NP licensed to practice independently, must be signed or co-signed by a licensed MD or DO.

Co-signature, if required in your state _____

License Number _____