Applicant Name _____
(Last, First, Middle Initial)

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

Insulin Dependent Diabetic Supplemental Documentation Form
OMB No.: 0420-0550
Expiration Date: 00/00/0000

INSULIN DEPENDENT DIABETIC SUPPLEMENTAL DOCUMENTATION FORM

Dear Medical Provider:

Your patient has applied to serve as a Peace Corps Volunteer and has reported having insulin dependent diabetes. During Peace Corps service, every Peace Corps Volunteer with diabetes will face dramatic changes to living conditions, diet, and level of physical activity. In order to protect the health of our Volunteers, we ask you to review the issues below with your patient and provide us with your written recommendations.

Considerations for health-care provider:

- Your patient has applied to serve as a Peace Corps Volunteer. During Peace Corps service, most Peace Corps Volunteer 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 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.

Please check each box confirming the corresponding issue has been addressed with the applicant.

☐ I have recently discussed with the applicant insulin strategies and recommendations that can be used when adjusting to a new diet. (Since hypoglycemia is much more threatening in the short term than mild loss of glycemic control, consider instructing your patient to temporarily reduce his/her sliding scale dosing until a better understanding of the local diet is achieved.) **Recommendations**: _____

_____

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☐ I have recently discussed with the applicant insulin strategies and recommendations that can be used during a "sick day," or a day when gastrointestinal issues cause a decreased oral intake or potential for increased fluid losses. **Recommendations**: _____

_____

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_____

For applicants on continuous subcutaneous insulin infusion

☐ I have recently discussed with this applicant recommendation regarding switching to a multiple daily injection (MDI) regimen in the event of an insulin pump failure. **Recommendations**: _____

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OR

☐ N/A Applicant does not require the use of an insulin pump.

☐ I have recently discussed with this applicant recommendations for the proper care and maintenance of all diabetes-related monitors and equipment. Below is a list of the devices and necessary disposables:

Device(s)/Disposables	Manufacturer/Model Number

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 _____