

Applicant Name _____

(Last, First, Middle Initial)

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

**Low Body Mass Index
Evaluation Form**
OMB No.: 0420-0550
Expiration Date: 1/31/2014

LOW BODY MASS INDEX EVALUATION FORM

The individual listed above has applied to serve as a Peace Corps Volunteer and has reported a weight and height indicating a low Body Mass Index (BMI). In cases where the applicant's Body Mass Index (BMI) is low, the Peace Corps requires additional information.

Note to the Provider: Please be candid and answer all questions. There are many assignments where a Peace Corps Volunteer will need considerable flexibility and physical endurance to adapt to unpredictable housing conditions, climate extremes, or unreliable transportation. The Volunteer will also need heightened awareness of personal safety and increased attention to safe food and drinking water. The food may be very different than food available in the United States, and there may be limited options to control food offerings. *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. Medical care and resources compared to U.S. health care standards are limited and specialty physicians may be nonexistent. The most accurate representation of this reported BMI 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.**

Current BMI: _____

Your clinical assessment of this BMI: _____

Any concerns related to the BMI? _____

Are there any associated symptoms (such as amenorrhea)? _____

Is there a known diagnosis related to this low BMI? _____

If there is a need for baseline testing, please provide all results from these tests (list tests performed): _____

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 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:

I certify this information with regard to Body Mass Index is complete and accurate for the applicant listed above.

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

Physician Name (Print) _____ Date _____

Physician License Number/State _____

Physician Address _____

