**Applicant Name** _____
(Last, First, Middle Initial)

**Date of Birth**_____/_____/_____
(Month/Day/Year)

**Diabetes Evaluation Form**
**OMB No.: 0420-0550**
**Expiration Date: 00/00/0000**

# DIABETES EVALUATION FORM

The individual listed above has applied to serve as a Peace Corps Volunteer and has reported having diabetes type 1 or type 2. This form must be completed by the health-care provider (MD or DO) who provides or provided medical oversight and management of this condition.

**Considerations for 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.

**I. Current diabetic status**

Diabetes diagnosis: ☐ Type 1 ☐ Insulin Dependent Type 2 ☐ Non-Insulin Dependent Type 2

Date of diagnosis: _____

What have you defined as this patient's optimal A1C goal? _____

☐ If this target has been met, please indicate approximate date achieved: _____

☐ If this target has not yet been met, please indicate current A1C and detail the ongoing plans to further optimize diabetic control:

_____

_____

_____

_____

Has your patient experienced hypoglycemia or symptomatic hyperglycemia over the past two years? If so, please detail episodes and required management.

_____

_____

_____

_____

**II. Diabetes-related medical conditions & complications:**

Please provide objective findings and a risk assessment summary for each diabetes-related condition, including the date of diagnosis, related diagnostic testing, current status of the condition and management plan, recommendations for ongoing care and monitoring while in Peace Corps service, and note any additional providers or specialists who are involved in the co-management of the condition. **You may also provide a copy a comprehensive summary from your electronic medical record.**

a) Cardiac status and a coronary artery disease risk assessment:

_____

_____

_____

b) Peripheral-vascular status:

_____

_____

_____

c) Impaired renal function:

_____

_____

_____

d) Neuropathy:

_____

_____

_____

e) Retinopathy:

_____

_____

_____

f) Other related conditions:

_____

_____

_____

**III. Diabetes medications**

Please list current medication regimen and all medications prescribed in the last two years.

| Medication (name) | Start Date | Stop Date | Dose | Route | Frequency |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

Does this person use an insulin pump? ☐ Yes ☐ No

**IV. Your patient in the Peace Corps environment**

Please document this patient's understanding of the disease and demonstrated ability to monitor and care for themselves independently in a resource-limited health-care environment: _____

_____

_____

Are there any functional limitations or restrictions or any specific accommodations that will need to be made to help your patient successfully and healthfully complete his or her Peace Corps service? ☐ Yes ☐ No

If "Yes," please describe the limitations, restrictions, or recommended accommodations:

_____

_____

_____

_____

**V. Additional information requested (please submit as attachments to this form)**

☐ If your patient routinely monitors glucose levels, provide a copy of the glucose log for the 30 days prior to your most recent visit with the patient.

☐ Provide the patient's two most recent hemoglobin A1C laboratory reports. For our review process, one must be performed within the last three months.

☐ Provide reports of any additional diabetes-related testing performed **in the past 12 months** (urinary albumin-to-creatinine ratio, lipid panel, etc.).

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

## 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 _____