

Applicant Name \_\_\_\_\_  
(Last, First, Middle Initial)

Date of Birth \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
(Month/Day/Year)

## CERVICAL CANCER (Pap) SCREENING FORM

The United States Preventive Services Task Force (USPTF) recommends cervical cancer screening in all women ages 21-65 years old. The Pap test is typically used to complete this screening. The recommendation for cervical cancer screening applies to all women who have a cervix, regardless of sexual history. Additionally, ongoing cervical cancer screening in women older than 65 years old is recommended in certain circumstances. Individuals with certain medical histories including high-grade precancerous cervical lesions or cervical cancer, women with in utero exposure to diethylstilbestrol (DES), or women who are immunocompromised may need specific screening protocols regardless of age.

The health and safety of volunteers is a priority for the Peace Corps, and Peace Corps follows the recommendations of the American Society for Colposcopy and Cervical Pathology (ASCCP) in determining the appropriate type and timing of cervical cancer screening.

**We request that the Peace Corps invitee and medical provider review, complete, and sign this form.**

### SECTION 1 (to be completed by the Peace Corps Invitee):

**Please CHECK ONLY ONE BOX BELOW.**

I have:

- Undergone cervical cancer screening (Pap test). I will have my medical provider complete Section 2 and submit relevant testing reports for review.
- Discussed cervical cancer screening with my provider and my provider recommends against screening. I will have my medical provider complete Section 2 and submit relevant clinical information for review. (This includes invitees who will be under 21 years old upon entering Peace Corps Service).
- Discussed the indications for cervical cancer screening and risks of forgoing screening with my medical provider and have opted to decline cervical cancer screening because:

\_\_\_\_\_

I will have my provider complete Section 2 indicating that a medical provider has reviewed cervical cancer screening with me. I acknowledge that during Peace Corps service there may be a situation in which a gynecologic exam is medically appropriate and necessary (for example, to evaluate bleeding or concern for infection). If the Peace Corps medical team determines that a gynecologic exam is indicated to appropriately diagnosis and treat me, I agree to undergoing medically necessary and appropriate examination and testing.

Applicant Printed Name \_\_\_\_\_

Applicant Signed Name \_\_\_\_\_ Date \_\_\_\_\_

## 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 an hour and 15 minutes per applicant and 15 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 20<sup>th</sup> Street, NW, Washington, DC, 20526 ATTN: PRA (0420-0550). Do not return the complete form to this address.



**SECTION 2 (to be completed by medical provider)**

**Part A: Results of Cervical Cancer Screening**

Not applicable to my patient

**-or-**

Age of most recent cervical cancer screen \_\_\_\_\_

Date of most recent cervical cancer screen \_\_\_\_\_

**Were any abnormalities detected on the gynecologic physical examination? If so, please detail:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_.

**Results of most recent cervical cancer screen (please include reports):**

No abnormalities or concerns detected. Using ASCCP guidelines, please indicate the type (PAP, PAP with Co-Testing) and timing of the next indicated screening:

\_\_\_\_\_

An abnormality was detected. Please detail findings:

\_\_\_\_\_  
\_\_\_\_\_

**What additional testing and follow-up for this abnormality have been completed to date?**

\_\_\_\_\_  
\_\_\_\_\_

**What additional testing and follow-up will be needed in the next three years?**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**If patient has a history of abnormal cervical screening tests not described above, please detail your patient's history of abnormal results below and include dates of findings and the follow-up and management performed. Please attach reports and relevant clinical documentation.**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**If invitee is >65 years old, do you recommend future cervical cancer screening? If yes, please explain:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_



**Part B: Medical Recommendations against Cervical Cancer Screening**

Not applicable to my patient

-or-

Patient will be under 21 years of age upon entering service and does not have medical conditions that would necessitate screening at this point in her life.

-or-

I recommend against cervical cancer screening at this point in time for the following medical reasons:

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Do you anticipate that during Peace Corps service, cervical cancer screening may be needed? If so, will your patient be able to complete screening with the trained Peace Corps Medical Officer in the local health unit in her country of service? If not, please explain what accommodations may be required to complete the screening.

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**Part C: Patient has declined Cervical Cancer Screening**

Not applicable to my patient

-or-

Please check this box to indicate that you have reviewed the indications for cervical cancer screening and risks of forgoing screening with your patient and your patient understands and has opted to decline cervical cancer screening.

**Part D: Patient has indications for cervical cancer screening that do not fall within guidance provided by USPTF or ASCCP.**

Examples would include individuals with certain medical histories including high-grade precancerous cervical lesions or cervical cancer, women with in utero exposure to diethylstilbestrol (DES), or women who may be immunocompromised (for example, HIV or use of immunosuppressant medications).

Not applicable to my patient

-or-

Applicable to my patient. Details of medical circumstances and specific recommendations for screening during Peace Corps Service include:

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Provider Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Printed Name: \_\_\_\_\_

