Applicant Name _____
(Last, First, Middle Initial)

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

Colon Cancer Screening Form
OMB No.: 0420-0550
Expiration Date: 00/00/0000

COLON CANCER SCREENING FORM

The United States Preventive Services Task Force (USPSTF) guidelines recommend screening for colorectal cancer using either fecal occult blood testing, sigmoidoscopy, or colonoscopy in adults, beginning at age 50 and continuing until age 75. The frequency of screening depends on the screening test used and results of an individual's prior screening.

The Peace Corps is unable to provide routine colon cancer screening and recommends that you discuss your options with your health-care provider, i.e., performing colon cancer screening before or after your Peace Corps service.

Instructions to Peace Corps Applicant:

After discussing colon cancer screenings with your physician, please attest to your understanding of the following by marking the box next to each statement and signing below.

☐ I understand that the Peace Corps is unable to provide routine colon cancer screening at any point during my service.

☐ I understand that foregoing or delaying routine screening colon cancer assessment may increase risk of delayed diagnosis of colorectal cancer, which could cause adverse health consequences, including death.

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 20th Street, NW, Washington, DC, 20526 ATTN: PRA (0420-0550). Do not return the complete from to this address.

Instructions to the physician: Please complete the following review of your patient's colorectal cancer screening history, submit documentation of testing results, and provide recommendations for future screenings. **Attach all results.**

The above-named patient has had the following:

☐ Fecal occult blood testing with immunochemical testing on a single sample ***within the past year*****,** which required no follow-up testing for abnormalities

☐ Fecal occult blood testing on three distinct specimens ***within the past year***, which required no follow-up testing for abnormalities

☐ Flexible sigmoidoscopy test ***within the past five years***, which required no follow-up testing for abnormalities

☐ Colonoscopy test ***within the past 10 years***, which required no follow-up testing for abnormalities

☐ **Abnormal colorectal screening results**. The details of the abnormalities, subsequent evaluations, and recommendations for ongoing management include the following: _____

_____

_____

_____

_____

Please indicate when the patient's next colon cancer screening is due: _____

Given the unique circumstances of the Peace Corps environment, we are unable to provide routine colon cancer screening during a Volunteer's service tenure, regardless of whether a Volunteer is in-country or on leave elsewhere. Please select which of the following statements is relevant to your patient:

☐ The aforementioned patient IS NOT due for colorectal cancer screening within the next three years.

☐ The aforementioned patient IS due for colorectal cancer screening within the next three years. I feel that completing screening at the recommended time intervals should be a priority for this patient and do not recommend any delays in the recommended screening intervals.

☐ The aforementioned patient IS due for colorectal cancer screening in the next three years, though based on this individual's personal and health circumstances, I think it is reasonable to either complete the screening early (before the patient leaves for Peace Corps service) or delay until the patient returns after completion of Peace Corps service. The specific screening plan my patient and I have agreed to is as follows:

_____

_____

_____

_____

Please confirm the following statement and sign to attest to your above assessment of your patient's colorectal cancer screening history and anticipated future screening needs.

☐ I have discussed with the above-named person that foregoing a routine screening colon cancer assessment at the recommended intervals may increase risk of delayed diagnosis of colon cancer, which could cause adverse health consequences, including death.

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 _____