

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

(Last, First, Middle Initial)

Date of Birth \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Transfer of Care Form  
OMB No.: 0420-0550  
Expiration Date: 00/00/0000

## TRANSFER OF CARE FORM – REQUEST FOR INFORMATION

### Note to the health-care provider:

- Peace Corps physicians will be assuming responsibility for the health care of your patient, <<NAME OF PERSON>>, for the period <<INSERT PERIOD OF SERVICE>> for Peace Corps service in <<COUNTRY INVITED>>.
- Peace Corps Volunteers typically live in remote settings that are hours away from rudimentary health-care services; in the closest major cities, health resources are usually limited.
- The health-care professionals in the Peace Corps Office of Health Services need a complete and clear understanding of your patient's <<BODY SYSTEM>> conditions.
  - <<LIST CONDITIONS FOR BODY SYSTEM>>
    - ONLY SELECT CONDITIONS
- **Please provide a signed written narrative or copies of documents from the medical record detailing the information requested below.**

Please provide medical management information for the condition(s) listed above:

1. How and when was the diagnosis established? Please include copies of the results of the original objective testing or provide a detailed written narrative, as well as the ICD-10 code(s).
2. What is the current treatment, if any? Please indicate if there were any previous treatments that failed or were not tolerated. What are the current signs and/or symptoms, if any?
3. What physical limitations, if any, exist (i.e. activity, altitude, other environmental restrictions)?
4. What is the likelihood of significant progression of this condition over the next three years?
5. What clinical follow-up is indicated for this condition (i.e., specific diagnostic studies, consultant follow-up) over the next three years? If follow-up diagnostic studies are indicated, please include copies of the most recent of these studies to serve as a baseline.

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