Peace Corps

Physical Exam Instructions for the Health-Care Provider

1. Review the patient's Peace Corps Health History Form.
2. Perform the physical examination and document your findings.
3. Order the required laboratory tests and comment on any abnormal results. Tests must be performed within six months of the physical exam. Required lab tests:

- ☐ HIV – Serum or rapid oral test
- ☐ CBC with differential
- ☐ Hepatitis B surface antibody – We do not accept Hepatitis B core antibody
- ☐ Hepatitis B surface antigen – We do not accept Hepatitis Be tests
- ☐ Hepatitis C antibody
- ☐ Basic metabolic panel
- ☐ If BMI is greater than or equal to 30: TSH, lipid profile, A1C or fasting blood glucose, AST, & ALT
- ☐ TB Screening
  Option 1: Skin test result must be documented in millimeters of induration ("negative" is not accepted) Option 2: Interferon gamma releasing assay

If you have questions, please contact the Peace Corps Medical Office at 202-692-1504 pre-serviceunit@peacecorps.gov.

Most Peace Corps Volunteers face dramatic changes to living conditions, diet, and level of physical activity. They typically serve in remote and resource-limited communities. It is common for Volunteers 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.

The Peace Corps will assume primary responsibility for Volunteers' medical care for the duration of service. However, 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.

Peace Corps must fully and accurately understand the current health of potential Volunteers and assess whether we can appropriately support and accommodate your patient's individualized health care needs.

PRIVACY ACT NOTICE

Authority: This information is collected under the authority of the Peace Corps Act, 22 U.S.C. 2501 et seq.

Purpose: 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.

Routine Uses: This information may be used for the routine uses described in the Privacy Act, 5 U.S.C. 552a(b), and the Peace Corps' Routine Uses A through N, as listed on the Peace Corps' Privacy Program webpage, and listed in System of Records PC-17, "Volunteer Applicant and Service Records System." 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.

Applicable SORN: System of Records PC-17, Volunteer Applicant and Service Records System.

Disclosure: 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.

BURDEN STATEMENT

Public reporting burden for this collection of information is estimated to average 90 minutes per applicant and 45 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/Privacy Officer, Peace Corps, 1275 First Street, NE, Washington, DC, 20526 ATTN: PRA (0420-0550). Do not return the complete form to this address.

*Applicant Name (Last, First)*_____ *Date of Exam (M/D/Y):* _____

I. Vital signs and measurements

Height	_____feet_____inches	Gross Vision	Right 20/ ___
Weight	_____lbs.		Left 20/ ____
BMI	_____		Both Eyes 20/ __
Blood Pressure	_____		With vision correction? ☐ Yes ☐ No
Pulse	_____		

II. Clinical examination

All sections MUST be completed by examining provider	Normal	Abnormal	Describe each abnormality in detail. Enter pertinent item number before each comment. Use additional sheets if necessary.
1. General/Constitution	☐	☐	
2. Skin	☐	☐	
3. Eyes (include funduscopic exam)	☐	☐	
4. Ears/Nose/Throat	☐	☐	
5. Head/Neck/Thyroid	☐	☐	
6. Lungs/Thorax	☐	☐	
7. Breasts	☐	☐	
8. Cardiovascular	☐	☐	
9. Peripheral pulses	☐	☐	
10. Abdomen	☐	☐	
11. Male Genitalia/ Prostate (men over 50 only)	☐	☐	
12. Anus/Rectum	☐	☐	
13. Spine/Back/Musculoskeletal	☐	☐	
14. Lymphatic	☐	☐	
15. Neurological	☐	☐	
16. Female Gynecologic	☐	☐	
17. Psychiatric (including any cognitive or behavioral observations)	☐	☐	
18. Identifying marks, scars, tattoos	Yes ☐	No ☐	

III. Allergies

Drug or Other Allergies	Describe severity of reaction	Requires emergency epinephrine
		☐ Yes ☐ No
		☐ Yes ☐ No
		☐ Yes ☐ No
		☐ Yes ☐ No

IV. Medications

Prescription, over the counter, vitamins, and herbal medications	Start date	Dose	Frequency

V.Required laboratory tests

Please refer to page one to order required laboratory tests. Tuberculin skin test

Date read: _____

Results:_____(millimeters)

Assessment and plan

List all active and/or chronic conditions and current status.	Treatment plan and specific follow-up recommendations for the next three years. Use additional sheets if necessary.
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____
5. _____	_____

Are there any functional and/or environmental limitations? Please specify:

_____

_____

Are there any medical concerns about the applicant that might limit his/her assignment in a specific geographic area (e.g., mountainous terrain, high altitude, sun exposure, harsh environmental or climatic conditions)?

Please specify: _____

_____

_____

Understanding that health-care resources in some host countries may be very limited and potentially hours away from his/her living or working site, do you have any concerns about this applicant serving safely in the Peace Corps?

Please specify: _____

_____

_____

Prior to this visit have you provided medical care to this applicant? ☐ Yes ☐ No

Signatures

Provider Signature and Title_____

Provider Name (Print)_____Date_____

Provider License Number/State_____

Provider Address and Phone Number_____

_____

If exam was completed by other than MD, DO, or NP licensed to practice independently, this form must be signed or co- signed by a licensed MD or DO.

Co-signature, if required in your state _____

Co-signatory License Number/State _____

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- ☐ Hepatitis C antibody
- ☐ Basic metabolic panel
- ☐ Glucose-6-phosphate dehydrogenase (G6PD) – Required for service in malaria-endemic countries Qualitative or quantitative tests accepted
- ☐ If BMI is greater than or equal to 30: TSH, lipid profile, A1C or fasting blood glucose, AST, & ALT
- ☐ TB Screening
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13. Spine/Back/Musculoskeletal	☐	☐	
14. Lymphatic	☐	☐	
15. Neurological	☐	☐	
16. Female Gynecologic	☐	☐	
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Please specify: _____

_____

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Prior to this visit have you provided medical care to this applicant? ☐ Yes ☐ No

Signatures

Provider Signature and Title_____

Provider Name (Print)_____Date_____

Provider License Number/State_____

Provider Address and Phone Number_____

_____

If exam was completed by other than MD, DO, or NP licensed to practice independently, this form must be signed or co- signed by a licensed MD or DO.

Co-signature, if required in your state _____

Co-signatory License Number/State _____