Electrocardiogram (ECG/EKG)
Form OMB No.: 0420-0550
Expiration Date: 03/31/2020

Applicant Name _____
(Last, First, Middle Initial)

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

Electrocardiogram (ECG/EKG) FORM

To the Applicant:

Please submit both a copy of your ECG and this form, completed by your provider. You can electronically upload or fax results. Please do not mail your ECG; due to the government process of irradiating incoming mail, many mailed tracings arrive damaged and uninterpretable.

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 25 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/Privacy Officer, Peace Corps, 1275 First Street, NE, Washington, DC, 20526 ATTN: PRA (0420-0550). Do not return the complete form to this address.

Peace Corps

To the provider:

Please review an ECG that has been performed within the past year on the patient named above and indicate which assessment is relevant to this patient. ***Attach tracing and interpretation.***

☐ This patient's ECG demonstrated normal sinus rhythm with no abnormalities. No further cardiac testing is indicated at present.

☐ If any abnormalities are detected on ECG, please describe the abnormalities and provide explanation as to the likely etiology and additional diagnostics performed or planned to further evaluate the findings. If findings raise concern for possible coronary artery disease, provide further risk assessment and indicate further diagnostics performed or planned. If you have access to prior ECGs, please assess for stability and submit prior tracing(s) as well.

ECG abnormalities: _____

_____

Likely etiology: _____

_____

Additional diagnostic tests performed or planned: _____

_____

Is coronary artery disease on the differential diagnosis for the abnormalities? If so, please provide a coronary artery disease risk assessment and results of any further evaluations performed or details of planned studies: _____

_____

_____

_____

_____

Have prior ECGs been performed on this patient? If so, please comment upon interval findings and submit prior ECGs as well:_____

_____

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 _____