Applicant Name _____
(Last, First, Middle Initial)

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

Eating Disorder Treatment Summary Form
OMB No.: 0420-0550
Expiration Date: 03/31/2020

Eating Disorder Treatment Summary Form (Confidential)

The individual listed above has applied to serve as a Peace Corps Volunteer and has reported a history of an eating disorder or disordered eating patterns. The mental health provider who has oversight and management of the applicant's treatment or has access to the applicant's mental health records should complete this form. If you do not have access to appropriate records, please indicate this on the form.

Note to the Mental Health Provider: Please be candid when answering the questions below. During Peace Corps service, a Volunteer may be placed in a community that is very isolated and remote, with the potential for a history of high crime, history of violence, current extreme poverty, and/or inequitable treatment of members of the population. There may also be limited access to Western-trained mental health professionals and little support for existing or new mental health symptoms. Please take these factors into consideration when answering the questions below. This form will also be considered "incomplete" and returned to the applicant if all questions are not answered.

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 105 minutes per applicant and 60 minutes per mental health provider 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,

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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.

Mental Health Provider's Name and Degree (Print):

_____

Date:_____License No.:_____ State:_____

Address:_____ Phone: _____

Do you possess specialty training in care or assessment of eating disorders? ☐ Yes ☐ No

Dates & Frequency of Therapy Sessions

Date of First Session:_____ Frequency of Sessions: _____

Date of Most Recent Session:_____Was this a Final Session: ☐ Yes ☐ No

If marked "Yes," was termination satisfactory and/or mutual? _____

Course of Treatment

Please identify the modality, treatment goals, applicant's reaction to treatment, and any other relevant clinical information.

_____

_____

_____

_____

_____

_____

Please provide the following information based on your treatment and/or clinical assessment of this applicant. Please be as detailed as possible.

A. Past & Current Clinical Disorders (Formerly Axes I, II, and III in DSM-IV-TR)

Please indicate date given and date remitted, if applicable. Please also indicate if no current diagnosis is present or if diagnosis is ongoing.

Mental Disorders:

Diagnosis	Date Given	Date Remitted	Ongoing
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No

General Medical Disorders:

Diagnosis	Date Given	Date Remitted	Ongoing
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No

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B. Past & Current Physical & Mental Health Symptoms

Please be as specific and comprehensive as possible, to include residual symptoms, weight control behavior, and physical concerns that were consequences of behaviors.

Symptom	Onset	Severity	Duration	Date Remitted

Documentation of weight over the past three years:

_____

_____

C. Psychotropic Medications (Current & Previous)

**** If possible, please have the prescribing clinician complete this section. ****

Medication and Dosage	Start Date	End Date	Response to Medication	Recommended Monitoring Plan

Signature:_____Date:_____

Name & Title (Print) _____

D. Past & Current Mental Health/Disordered Eating Hospitalizations & Treatment

Past Treatment? ☐Yes ☐ No Date(s): _____ **From intake to discharge* If "Yes," please describe context/reasons. _____ _____ _____ _____ _____	Current Treatment? ☐ Yes ☐ No Date: _____ **Intake* If "Yes," please describe context/reasons. _____ _____ _____ _____ _____	Hospitalizations? ☐Yes ☐ No Date(s): _____ **From intake to discharge* If "Yes," please describe context/reasons. _____ _____ _____ _____ _____

E. Past & Current Risk Assessment/Information

Suicide Attempt? ☐ Yes ☐ No Date(s): _____ If "Yes," please describe context(s) and reason(s). _____ _____ _____ Rick of Recurrence (Check One): ☐ None/Unlikely ☐ Possible/Likely *Describe:* _____ _____ _____ ☐ I am unable to assess this	Suicide Gesture? ☐ Yes ☐ No Date(s): _____ If "Yes," please describe context(s) and reason(s). _____ _____ _____ Rick of Recurrence (Check One): ☐ None/Unlikely ☐ Possible/Likely *Describe:* _____ _____ _____ ☐ I am unable to assess this	Suicide Ideation? ☐ Yes ☐ No Date(s): _____ If "Yes," please describe context(s) and reason(s). _____ _____ _____ Rick of Recurrence (Check One): ☐ None/Unlikely ☐ Possible/Likely *Describe:* _____ _____ _____ ☐ I am unable to assess this	Self-Injurious Behaviors? ☐ Yes ☐ No Date(s): _____ If "Yes," please describe context(s) and reason(s). _____ _____ _____ Rick of Recurrence (Check One): ☐ None/Unlikely ☐ Possible/Likely *Describe:* _____ _____ _____ ☐ I am unable to assess this

F. Clinical Assessment

Psychological tests/measures administered:
(Please attach pertinent reports or summaries, if any)

1. _____

2._____

To the best of your ability, describe the applicant's ego strength, emotional stability, and flexibility:

_____

_____

_____

_____

To the best of your ability, describe the applicant's coping strategies:

_____

_____

_____

_____

To the best of your ability, describe the applicant's overall functioning (interpersonal and work) and prognosis based on your clinical observations:

_____

_____

_____

_____

What is the applicant's plan for maintaining healthy weight, diet, and exercise while serving in the Peace Corps?

_____

_____

_____

_____

To the best of your ability, rate and describe the applicant's risk of relapse in a stressful overseas environment ***(characterized by isolation, lack of structure, limited social supports, restrictive food environments, and restrictive exercise environments)***:

☐ High/Likely ☐ Possible ☐ Low/Unlikely

_____

_____

_____

_____

G. Recommendations & Follow Up

What specific recommendations for eating disorder support do you have regarding the management of this applicant's condition over the next three years? All recommendations will help determine the best placement for the Peace Corps applicant.

_____

_____

_____

_____

Any other comments or concerns related to the information provided on this form or regarding this applicant?

_____

_____

_____

_____

I certify this information is, in my opinion, an accurate representation of the baseline status of this eating disorder condition for the applicant listed above.

Mental Health Provider's Signature:_____

Date: _____