

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

(Last, First, Middle Initial)

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

(Month / Day / Year)

**Guide to Completing the Report of  
Physical Examination**  
OMB No.: 0420-0549  
Expiration Date: 00/00/0000

## GUIDE TO COMPLETING THE REPORT OF PHYSICAL EXAMINATION

### Considerations for the health-care provider:

- Your patient has applied to serve as a Peace Corps Volunteer. During Peace Corps service, most Peace Corps Volunteers face dramatic changes to living conditions, diet, and level of physical activity. Furthermore, they typically serve in remote and resource-limited environments where they are expected to live and work in conditions that parallel those in their local community. It is not uncommon for Volunteers to need to be able 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. Additionally, they may face unpredictable housing conditions, extremes of climate, unreliable transportation, the need for heightened awareness of personal safety, and increased attention to safe food and drinking water.
- When Volunteers serve with the Peace Corps, the Office of Health services providers assume primary responsibility for their medical care during the duration of their service. However, it must be recognized that 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.
- In order to help Peace Corps fully and accurately understand the current health of potential Volunteers and assess whether the Peace Corps can appropriately support and accommodate individualized health care and support needs of your patient, we ask you to review the issues below with your patient and provide us with your written assessment of your patient's medical conditions, functional limitations, and anticipated support needs.

### Instructions to the health care provider:

- Please begin your examination with the review of the Peace Corps candidate's Health History Form and any other additional history they provide.
- Please perform the assigned complete physical examination documenting your findings and complete the requested laboratory tests.
- Please comment on any abnormal laboratory results.

## 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 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 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.



## I. Vital signs and measurements

Height (feet/inches)	Weight (lbs.)	BMI	Blood Pressure	Pulse
<b>Gross Vision</b>	Right 20/ _____	Left 20/ _____	With vision correction? Yes <input type="checkbox"/> No <input type="checkbox"/>	

## II. Clinical examination All sections MUST be completed by examining provider.

Please check either normal or abnormal for all applicable questions.	Normal	Abnormal	Describe each abnormality in detail. Enter pertinent item number before each comment. Use additional sheets if necessary.
1. General/Constitution	<input type="checkbox"/>	<input type="checkbox"/>	
2. Skin	<input type="checkbox"/>	<input type="checkbox"/>	
3. Eyes (include funduscopic exam)	<input type="checkbox"/>	<input type="checkbox"/>	
4. Ears/Nose/Throat	<input type="checkbox"/>	<input type="checkbox"/>	
5. Head/Neck/Thyroid	<input type="checkbox"/>	<input type="checkbox"/>	
6. Lungs/Thorax	<input type="checkbox"/>	<input type="checkbox"/>	
7. Breasts	<input type="checkbox"/>	<input type="checkbox"/>	
8. Cardiovascular	<input type="checkbox"/>	<input type="checkbox"/>	
9. Peripheral pulses	<input type="checkbox"/>	<input type="checkbox"/>	
10. Abdomen	<input type="checkbox"/>	<input type="checkbox"/>	
11. Male Genitalia/ Prostate (men over 50 only)	<input type="checkbox"/>	<input type="checkbox"/>	
12. Anus/Rectum	<input type="checkbox"/>	<input type="checkbox"/>	
13. Spine/Back/Musculoskeletal	<input type="checkbox"/>	<input type="checkbox"/>	
14. Lymphatic	<input type="checkbox"/>	<input type="checkbox"/>	
15. Neurological	<input type="checkbox"/>	<input type="checkbox"/>	
16. Female Gynecologic	<input type="checkbox"/>	<input type="checkbox"/>	
17. Psychiatric (including any cognitive or behavioral observations)	Y <input type="checkbox"/>	N <input type="checkbox"/>	
18. Identifying marks, scars, tattoos	Y <input type="checkbox"/>	N <input type="checkbox"/>	



### III. Allergies

Drug or Other Allergies	Describe severity of reaction	Requires emergency epinephrine
		Yes <input type="checkbox"/> No <input type="checkbox"/>
		Yes <input type="checkbox"/> No <input type="checkbox"/>
		Yes <input type="checkbox"/> No <input type="checkbox"/>
		Yes <input type="checkbox"/> No <input type="checkbox"/>
		Yes <input type="checkbox"/> No <input type="checkbox"/>

### IV. Medications

Please review the applicants Medication Verification Form and document any changes below to provide a complete list of current medications (include prescription, over the counter, vitamins, and herbal). Use additional sheets if necessary.

*Note: The Peace Corps does not provide homeopathic or naturopathic (herbal remedies) or vitamin treatments other than multivitamins.*

Medication	Start date	Dose	Frequency

### V. Laboratory evaluation

Please attach original lab reports. Abnormal results require an explanation for the abnormality, a treatment plan, and, if chronic, historical results with a plan for follow-up.

Tuberculin test and lab tests must be performed **within six months** of the physical exam.

#### Tuberculin Test

Tuberculin skin test

Date read: \_\_\_\_\_

Results: \_\_\_\_\_ mm of induration

**OR**

Interferon gamma releasing assay (QuantIFERON® - TB Gold/ T SPOT. TB)

Results:  negative     positive     equivocal (must repeat)

#### Required Lab Tests

HIV (bloodwork or rapid oral test)

CBC with differential

Hepatitis B surface antibody

Hepatitis B surface antigen

Hepatitis C antibody

Basic metabolic panel

G6PD



---

## VI. 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 to a specific geographic area (e.g., mountainous terrain, high altitude, sun exposure, harsh environmental or climatic conditions, etc.)?

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 candidate?  Yes  No

---

## 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 \_\_\_\_\_

