Name: Rank: Age:
Current Duty Station: Next Duty Station:
Phone Number: **Date Orders Received:**
Email:

SUITABILITY SCREENING CHECKLIST

o	IMR - **ACTIVE DUTY MEDICAL SCREENING - APPT. REQUIRED 401-841-6361**
o	KING HALL – **ALL OCS/ODS GO HERE FOR MEDICAL SCREENING**
o	DENTAL- **DENTAL CLASS 1 OR 2 REQUIRED 401-841-2541**
o	LAB- **HIV DRAW MUST BE CURRENT WITHIN 1 YEAR TO TRANSFER. WALK-IN**
o	OPTOMETRY – **MUST BE CURRENT WITHIN 3 YEARS 401-841-3666**
o	AUDIOLOGY- **MUST BE CURRENT WITHIN 5 YEARS WALK-IN**
o	IMMUNIZATIONS- **WALK-IN HAVE A COPY OF ORDERS FOR ALL VACCINES**
o	2792-1 FILLED OUT BY SCHOOL – **REQUIRED FOR ALL CHILDREN AGED FROM BIRTH TO 22 OR HIGH SCHOOL GRADUATION**
o	PCM- **FAMILY MEMBERS SEE PCM/CIVILIAN PHYSICIAN FOR MEDICAL SCREENING**

CHECKED ITEMS MUST BE COMPLETED BEFORE RETURNING TO THE SUITABILITY SCREENING OFFICE

PLEASE FILL OUT ALL YELLOW HIGHLIGHTED PORTIONS. BLUE IS FOR PROVIDER TO COMPLETE

FOR ANY QUESTIONS PLEASE REFER THEM TO THE SUITABILITY SCREENING COORDINATORS.

HM2 CASTANEDA, ISSAC (401) 841-2979
HM3 LLOYD, ERIK /HN SIBLEY, KYLEE (401) 841-6337

OSS/ ODS

KING HALL MEDICAL (401)841-4553

usn.newport.navhlthclinnptri.list.nhcne-suitabilityscreening@mail.mil

QR CODE FOR GROUP EMAIL

PLEASE READ INFO BELOW!!!

EVERY **FAMILY MEMBER** MUST HAVE THE MANDATORY FORMS (FORMS 1-3) COMPLETED:

- **1. NAVMED 1300/1 PART I [ONLY** NAME, SSN (OF SPONSOR), NEXT DUTY STATION FOR PART I**].**
- **2. NAVMED 1300/1 PART II (PAGE 3)-** MUST HAVE A DENTAL PROVIDER SIGNATURE WITH A DENTAL CLASS. **NOTE**: IF CHILD **DOES NOT** HAVE TEETH -AND- IS **UNDER** THE AGE OF 24 MONTHS, A **PEDIATRICIAN** MAY PERFORM AN ORAL DENTAL SCREENING.
- **3. DD 2807-1 REPORT OF MEDICAL HISTORY-** FILL OUT BLOCKS 1-29, WITH EXPLANATIONS OF ALL YES ANSWERS IN BLOCK 29.
- **4. DD FORM 2792-1-** REQUIRED FOR ALL DEPENDENTS AGES **BIRTH TO 21 YEARS OLD** GOING TO OVERSEAS/ REMOTE DUTY LOCATIONS.
- IF PACKAGE IS FILLED OUT BY A CIVILIAN PROVIDER IT WILL NEED TO BE COUNTERSIGNED BY A NAVY MTF PROVIDER FOR MEDICAL AND DENTAL.
- **IF A FAMILY MEMBER IS ENROLLED IN EFMP, PLEASE BRING PAPERWORK** (DD 2792; DD 2792-1; INDIVIDUALIZED EDUCATION PLAN OR INDIVIDUALIZED FAMILY SERVICE PLAN)**.**
- **IF YOU HAVE BEEN REFERRED OR CURRENTLY UNDER THE CARE OF ANY SPECIALIST** (i.e. ORTHOPEDICS, ENDOCRINOLOGY, MENTAL HEALTH, PHYSICAL THERAPY, SPEECH THERAPY, etc.) **PLEASE COMPLETE THE FOLLOW UP APPOINTMENTS AND BRING A COPY OF ALL MEDICAL NOTES/ RECORDS FROM THAT PROVIDER.**

DUE DATE (30 DAYS FROM RECIEPT OF ORDERS): _____

Inquiry Dates:

MEDICAL, DENTAL, AND EDUCATIONAL SUITABILITY SCREENING CHECKLIST AND WORKSHEET

Privacy Act Statement: OPNAVINST 1300.14D authorizes collection of this information. The following information and documents, as applicable, are required to conduct medical, dental, and educational screening to determine suitability for an overseas, remote duty, or operational assignment. Complete and current information is essential for completion of screening. Disclosure is voluntary, however, missing or incomplete information may delay the screening process, result in orders held in abeyance until completion of screening, or affect the amount of leave in transit. Refer to BUMEDINST 1300.2B for implementing guidance.

The Suitability Screening Coordinator (SSC) at the military treatment facility (MTF) can assist in obtaining and completing the required information. The SSC will ensure required information and documents are complete and current before referral to a MTF provider for screening and a suitability recommendation. The SSC will place the completed original from in the individual's Service Treatment Record/Non-Service Treatment Record and retain a copy for audit. Medical, dental, and educational suitability screening is valid for 12 months from the date of completion if there were no significant changes in the medical, dental, or educational status of the service or family member. The service member must notify his or her commanding officer or officer in charge of any change in status (including pregnancy).
Complete one form for each Service and family member screened.

SERVICE MEMBER NAME	GRADE/ RATE	SSN

CURRENT UNIT	TELEPHONE NUMBER
NEXT DUTY STATION LOCATION & UNIT IDENTIFICATION CODE (UIC)	TYPE DUTY CLASSIFICATION CODE (Navy Enlisted Code Only) N/A
FAMILY MEMBER NAME	FAMILY MEMBER PREFIX / Age

	ITEM	SSC Review YES	NO	N/A
A. FOR SERVICE MEMBERS:				
☐	1. Legible copy of orders or an Overseas Screening Notification. (For operational assignments, orders should indicate the platform to which assigned and a description of the duty assignment.)			
☐	2. Each family member name, family member prefix, social security number, address and telephone number, if other than the service member's.			
SERVICE TREATMENT RECORD TO INCLUDE:				
☐	3. All Physical Exams (to include special duty aviation, submarine, radiation, asbestos, etc.) are current and filed in the Service Treatment Record? a. Type of Physical _____ b. Completion Date of Physical _____			
☐	4. Annual Periodic Health Assessment (PHA) current and documented? Date: _____			
☐	5. Current medical history (DD Form 2807-1)			
☐	6. Hearing (Audiogram)			
☐	7. Vision Examination			
☐	8. G-6P-D Test			
☐	9. PPD Test			
☐	10. Sickle Cell Trait Test			
☐	11. Negative HIV results current to 1 year of transfer Date Drawn: _____ Roster Number: _____			
☐	12. Blood Type: _____			
☐	13. DNA Testing completed and documented?			
☐	14. Required Immunizations (Assignment Specific)			
☐	15. Military Dental Records			
☐	16. Copies of civilian medical, dental, or mental health care records to include narrative summaries of any inpatient admissions in civilian facilities.			
☐	17. Mammogram current and documented. Date: _____			
☐	18. Pregnancy screen (verbal inquiry). (*Also, command will refer for pregnancy test 30 days prior to departure date.)*			
☐	Other:			
B. FOR FAMILY MEMBERS:				
☐	1. Non-Service Treatment Record (medical and dental) and include a completed DD Form 2807-1			
☐	2. Copies of civilian medical, dental, or mental health care records to include narrative summaries of any inpatient admissions in civilian facilities. Include a completed DD Form 2807-1			
☐	3. Recommended ACIP and required country specific immunizations (check current country specific immunization requirements issued by the Centers for Disease Control and Prevention (CDC) i.e. yellow fever)			

ITEM	SSC Review		
C. FOR DEPENDENT CHILDREN:	YES	NO	N/A
☐ 1. DD FORM 2792-1 (Required for ALL children birth to 22nd Birthday OR High School Graduation)			
FOR INFANTS AND TODDLERS (Birth to 36 Months) ELIGIBLE TO RECEIVE EARLY INTERVENTION SERVICES AS EVIDENCED BY AN INDIVIDUALIZED FAMILY SERVICE PLAN (IFSP):			
☐ 2. Copy of the current IFSP and, if available, developmental assessments or evaluations.			
FOR PRESCHOOL OR SCHOOL-AGE CHILDREN (Ages 3 to 22nd Birthday or High School Graduation) ELIGIBLE TO RECEIVE SPECIAL EDUCATION AND RELATED SERVICES AS EVIDENCED BY AN INDIVIDUALIZED EDUCATION PROGRAM (IEP):			
☐ 3. Copy of the current IEP and, if available, developmental assessments or evaluations.			
FOR EACH FAMILY MEMBER ENROLLED OR UNDERGOING ENROLLMENT IN THE EXCEPTIONAL FAMILY MEMBER PROGRAM (EFMP):			
☐ 4. Copy of the DD Form 2792 and any EFMP correspondence.			

D. FOR SSC USE ONLY

1. Date suitability screening conducted. Date: _____

E. SUITABILITY INQUIRY:

☐ 1. Are any of the shaded blocks checked on NAVMED Form 1300/1?

☐ YES (Suitability Inquiry required, proceed to question 2)

☐ NO (Line through question 2 and proceed to section F)

☐ 2. Suitability Inquiry:

Medical Care:
- ☐ Potential need identified
- ☐ N/A

Date & Time sent: _____ Reply date & time: _____
Sent by (Sending SSC): _____ Reply from: _____
Sent to (Gaining SSC): _____ Contact #: _____
E-Mail: _____

Dental Services:
- ☐ Potential need identified
- ☐ N/A

Date & Time sent: _____ Reply date & time: _____
Sent by (Sending SSC): _____ Reply from: _____
Sent to (Gaining SSC): _____ Contact #: _____
E-Mail: _____

Special Education Services:
- ☐ Potential need identified
- ☐ N/A

Date & Time sent: _____ Reply date & time: _____
Sent by (Sending SSC): _____ Reply from: _____
Sent to (Gaining SSC): _____ Contact #: _____
E-Mail: _____
Sent to (Gaining DoDEA): _____ E-Mail: _____

Other information:

F. SUITABILITY SCREENING COORDINATOR: Facility NHCNE NEWPORT 43 SMITH RD NEWPORT RI 02841

Printed Name: _____ E-mail: _____ Phone:	Signature	Date

MEDICAL, DENTAL AND EDUCATIONAL SUITABILITY SCREENING FOR SERVICE AND FAMILY MEMBERS

Privacy Act Statement
Authority: 5 U.S.C. 301, Departmental Regulations; and E. O. 9397 (SSN).
Purpose: To identify special, medical, dental or educational needs for the purpose of making a suitability recommendation for an overseas, remote duty, or operational assignment.
Routine uses: This form is completed by a medical treatment facility (MTF)/non-MTF dentist and physician, nurse practitioner, physician assistant, or independent duty corpsman (Service members only). An MTF Medical Screener must counter sign all screenings completed by non-Navy MTF Providers. The MTF Suitability Screening Coordinator (SSC) will place the completed original form in the individual's Service Treatment Record/Non-Service Treatment Record and retain a copy for audit.
Disclosure: Voluntary; however, failure to provide this information may delay the screening process, result in orders held in abeyance until completion of screening or affect the amount of leave in transit.

Refer to BUMEDINST 1300.2B for implementing guidance. ***Complete one form for each Service and family member screened.***

SERVICE MEMBER NAME	GRADE / RATE	AGE	SSN
FAMILY MEMBER NAME	FAMILY MEMBER PREFIX	AGE	SSN

NEXT DUTY STATION LOCATION & UNIT IDENTIFICATION CODE (UIC):	TYPE DUTY CLASSIFICATION CODE: (Navy enlisted only)
	N/A

PART I

SECTION A. Medical Screening. Completed by the medical provider to identify special needs and determine if a Service or family member is suitable for an overseas, remote duty, or operational assignment. *Attach the completed Report of Medical History (DD 2807-1) to this form.*

Yes	No	N/A	ITEM
			1. All current health records (military and civilian) reviewed?
			2. All physical exams (to include special duty, aviation, submarine, radiation, asbestos, etc.) are current and filed in the Service Treatment Record? *a. Type of Physical* _____ *b. Completion date of physical*_____
			3. G-6P-D, PPD and Sickle Cell trait test and Blood Type completed & documented?
			4a. Immunizations are up-to-date and meet destination country requirements?
			4b. Has the individual elected to decline any ACIP recommended immunizations or country required Immunizations? If yes (circle): ACIP Country Specific Date Counselled: _____
			5. Reference audiogram documented on DD 2215?
			6. Latest audiogram (DD 2216) reviewed?
			7. HIV testing completed or drawn?
			8. DNA testing completed and documented?
			9. Are there pending consults or tests that have a bearing on assignment suitability?
			10. Any past limited duty or medical board(s)? *(document on DD 2807-1)*
			11. For Service members:
			a. Annual periodic health assessment current and documented?
			b. Pregnancy screening (verbal inquiry)? *(Also, Command will refer for pregnancy test 30 days prior to departure date)*
			c. If pregnant? (EDC:_____)
			12. For family members, U.S. Preventive Services Task Force screening test recommendations current and documented?
			13. If a Special Duty assignment, is there a condition, which by MANMED, chapter 15, section IV, is disqualifying?
			14. Are there any conditions requiring ongoing care in the following areas? *(document on DD 2807-1)*
			a. Orthopedic conditions (e.g., chronic back, knee, joint pain or weakness)
			b. Cardiovascular conditions (e.g., chest pain/angina, arrhythmia, valve disease, infarction)
			c. Gynecologic/Urologic conditions (e.g., chronic pelvic pain, abnormal PAP, breast mass)
			d. Neurologic conditions (e.g., seizure, pinched nerve, migraine, neuropathy)
			e. Respiratory conditions (e.g., asthma, RAD, chronic sinus, allergies)
			f. Mental health or behavioral conditions (e.g., mood, personality disorder, ADD/ADHD, anxiety, psychosis, autism)
			g. Recurrent or frequent medications not on the standard formulary or require special attention (e.g., injections/infusions every 6-12 months, medication requiring Risk Evaluation and Mitigation Strategies per FD regulations, hormone replacement therapy, or medications requiring close monitoring of therapeutic blood level)? *(list on DD 2807-1)*
			h. Alcohol or substance abuse or dependence
			i. Developmental concerns (e.g., motor, cognitive, communication, social/emotional, or adaptive development)
			j. Specify other conditions or concerns:
			15. For Service/family members requiring medication.
			a. Does the patient's medication maintenance require a dose adjustment?
			b. Should medication use cease, could the underlying condition become life threatening, pose a risk for dangerous or disruptive behavior or result in a limited duty, MEDEVAC, or early return situation?
			c. Are there concerns about medication management capabilities at the gaining MTF/operational platform if the underlying condition is exacerbated?
			d. Has the service/family member registered with the mail order pharmacy program through TRICARE?

Yes	No	N/A	ITEM
			16. For service/family members with underlying medical conditions:
			a. Is there a requirement for special medical supplies, adaptive equipment, assistive technology devices, special accommodations, etc.?
			b. If exposed to a physically or emotionally demanding environment, could the underlying condition become life threatening, pose a risk for dangerous or disruptive behavior, or result in a limited duty or MEDEVAC situation?
			c. Are there any chronic medical or mental health conditions requiring routine or continuing access to care or access to specialized medical care? *(document on DD 2807-1)*
			d. Are there any potential environmental concerns or possible health effects at the gaining location? *(if yes, communicate to family and document on appropriate SF 600)*
			17. For infants and toddlers (birth to 36 months), is the child receiving or undergoing eligibility to receive early intervention services as evidenced by an Individualized Family Service Plan (IFSP)?
			18. For preschool and school age children, is the child receiving or undergoing eligibility to receive special education and/or related services as evidenced by an Individualized Education Program (IEP)?
			19. *Explanation of "yes" responses in shaded boxes (include #):* Are there any concerns about the gaining MTF/operational platform's capabilities to meet the individual's needs? *Specify below:* Navy MTF SSC Name, Signature, Stamp, and Date: _____

Non-Navy Medical Providers: STOP and proceed to SECTION C

SECTION B. Medical and Educational Screening Disposition. Completed by the screening Navy MTF medical provider to determine if a Service or family member is suitable for an overseas, remote duty, or operational assignment.

Yes	No	ITEM
		1. Are any of the above shaded blocks in Section A checked? If "yes", submit a suitability inquiry to the gaining MTF or medical department supporting the overseas/remote duty/operational location to determine local capabilities to provide required support. *(Attach Reply and answer questions 1a and 1b.)* If "no", proceed to question 2.
		a. Does the gaining location have the capabilities to provide the current required medical support?(Service MTFs/TRICARE, etc.)
		b. Does the gaining location have the capabilities to provide the required medical support (diagnostic and therapeutic) if the underlying condition is exacerbated? (To include all Service MTFs/operational platform, TRICARE, etc.)
		2. Is the shaded block of question 18 checked "yes"? If yes, Submit the DD 2792-1 and IEP to the gaining DoDEA Special Education Overseas Screening Coordinator and gaining MTF to determine local capabilities to provide required support. (Attach Reply with POC info and answer question 2a.) If no, proceed to question 3.
		a. Is the DoDEA Special Education Overseas Screening Coordinator recommending travel?

Yes	No	3. IS THE SERVICE/FAMILY MEMBER SUITABLE FOR THE OVERSEAS, REMOTE DUTY OR OPERATIONAL ASSIGNMENT? *(Must be completed by an MTF medical screener. Answered after the inquiry is completed.)*

SECTION C. Contact Information. Completed by the MTF/non-MTF civilian providers who completed PART I. The Navy MTF medical screener shall review and countersign all suitability screenings completed by non-Navy MTF civilian providers, denoting accountability for a complete and thorough suitability screening document review for each Service/family member.

Navy MTF Medical Screener (Signature) _____ Date _____	Non-Navy MTF/Civilian Medical Screener (Signature) _____ Date _____
Printed Name, Rank or Grade _____	Printed Name _____
MTF or Duty Station _____	Address _____
Telephone Number (include area/country code) _____	City, State, and Zip Code _____
DSN Number _____	Telephone Number (include area/country code) _____
Office Hours to contact _____	Office Hours to Contact _____
E-mail Address _____	E-mail Address _____

PART II

SERVICE / FAMILY MEMBER NAME	GRADE / RATE / FAMILY MEMBER PREFIX	SSN

SECTION A. Dental Screening. Completed by a dental officer/privileged dentist prior to an overseas, remote duty, or operational assignment for the purpose of assessing and matching the dental needs of a service/family member to the support capabilities of the gaining medical treatment facility. **NOTE: If child does not have teeth -AND- is under the age of 24 months, a pediatrician may perform an oral dental screening.**

Yes	No	ITEM
		1. All current dental records (military and civilian) reviewed?
		2. All dental examinations are current? (If more than 180 days since last T-1 or T-2 dental exam, a dental officer/privileged dentist must, at a minimum, review the dental record and interval medical and dental history.)
		3. Is a reexamination required by a Navy MTF if examined or treated at a non-Navy facility?
		4. If service/family member is in Dental Class 3 or 4, can dental treatment or examination be completed before the transfer?
		5. Is there a requirement for follow-on care such as orthodontics, implants, specialty prosthetics, etc.?
		6. Are there any chronic dental conditions requiring routine or continuing access to care or access to specialized dental care?
		7. Are there any concerns about the gaining MTF/operational platform's capabilities to meet the individual's needs? *Specify below:*

Navy MTF SSC Name, Signature, Stamp, and Date: _____

8. Specify Dental Class: *(required for service members)* _____

Dental Classifications: (Per DoDI 6025.19)

Normally considered worldwide deployable:

Class 1 - Patients with a current dental examination, who do not require dental treatment or re-evaluation.

Class 2 - Patients with a current dental examination, who require non-urgent dental treatment or re-evaluation for oral conditions unlikely to result in a dental emergency within 12 months.

Normally not considered worldwide deployable:

Class 3 - Patients who require urgent or emergent dental treatment for oral conditions with a high potential to cause a dental emergency in the next 12 months.

Class 4 - Patients who require a dental examination either because: (1) No type 1 (comprehensive) or type 2 (annual or periodic oral) dental examination was completed by a dental officer/privileged dentist within the past 12 months; (2) A patient's dental record does not exist or; (3) The dental record is not held by the responsible dental treatment facility or Medical Department activity.

SECTION B. Dental Screening Disposition. Completed by the screening MTF provider to determine if a service or family member is suitable for an overseas, remote duty, or operational assignment. **Non-Navy Medical Providers: STOP and proceed to SECTION C.**

Yes	No	ITEM
		1. Are any of the above shaded blocks checked? If yes, submit a suitability inquiry to the gaining MTF or medical department supporting the overseas/remote duty/operational location to determine local dental capabilities to provide required support. *(Attach Reply and answer question 2)* If no, proceed to question 3.
		2. Does the gaining MTF/operational platform have the capabilities to provide the current required dental support?

Yes	No	3. IS THE SERVICE/FAMILY MEMBER SUITABLE FOR THE OVERSEAS, REMOTE DUTY OR OPERATIONAL ASSIGNMENT? *(Must be completed by an MTF dental screener. Answered after the inquiry is completed.)*

SECTION C. Contact Information. Completed by the MTF/non-MTF civilian providers who completed PART II. The Navy MTF dental screener shall review and countersign all suitability screenings completed by non-Navy MTF civilian providers, denoting accountability for a complete and thorough suitability screening document review for each Service/family member.

Navy MTF Dental Screener (Signature) Date	Non-Navy Medical Facility/Civilian Dental Screener (Signature) Date
Printed Name, Rank or Grade	Printed Name
MTF or Duty Station	Address
Telephone Number (include area/country code)	City, State, and Zip Code
DSN Number	Telephone Number (include area/country code)
Office Hours to Contact	Office Hours to Contact
E-mail Address	E-mail Address

REPORT OF MEDICAL HISTORY

(This information is for official and medically confidential use only and will not be released to unauthorized persons.)

OMB No. 0704-0413
OMB approval expires
September, 30 2021

PRIVACY ACT STATEMENT

AUTHORITY: 10 U.S.C. 136, Under Secretary Of Defense For Personnel And Readiness; DoD Directive 1145.2, United States Military Entrance Processing Command; DoD Instruction 6130.03, Medical Standards for Appointment, Enlistment, or Induction in the Military Services; and E.O. 9397 (SSN), as amended.
PRINCIPAL PURPOSE(S): The primary collection of this information is from individuals seeking to join the Armed Forces. The information collected on this form is used to assist DoD physicians in making determinations as to acceptability of applicants for military service and verifies disqualifying medical condition(s) noted on the prescreening form (DD 2807-2). An additional collection of information using this form occurs when a Medical Evaluation Board is convened to determine the medical fitness of a current member and if separation is warranted.
ROUTINE USE(S): The Routine Uses are listed in the applicable system of records notice found at: http://dpcld.defense.gov/Privacy/SORNsIndex/DOD-wide-SORN-Article-View/Article/570661/a0601-270-usmepcom-dod/
DISCLOSURE: Voluntary; however, failure by an applicant to provide the information may result in delay or possible rejection of the individual's application to enter the Armed Forces. An applicant's SSN is used during the recruitment process to keep all records together and when requesting civilian medical records. For an Armed Forces member, failure to provide the information may result in the individual being placed in a non-deployable status. The SSN of an Armed Forces member is to ensure the collected information is filed in the proper individual's record.

WARNING: The information you have given constitutes an official statement. Federal law provides severe penalties (up to 5 years confinement or a $10,000 fine or both), to anyone making a false statement.

1. LAST NAME, FIRST NAME, MIDDLE NAME (SUFFIX)	2.a. SOCIAL SECURITY NO.	b. DoD ID NO. *(If applicable)*	3. TODAY'S DATE *(YYYYMMDD)*

4.a. HOME ADDRESS *(Street, Apartment No., City, State, and ZIP Code)*

b. HOME TELEPHONE *(Include Area Code)*

c. EMAIL ADDRESS

5. EXAMINING LOCATION AND ADDRESS *(Include ZIP Code)*

X ALL APPLICABLE BOXES:

6.a. SERVICE
- [ ] Army
- [ ] Coast Guard
- [X] Navy
- [ ] Marine Corps
- [ ] Air Force

b. COMPONENT
- [X] Regular
- [ ] Reserve
- [ ] National Guard

c. PURPOSE OF EXAMINATION
- [ ] Retention
- [ ] Separation
- [ ] Medical Board
- [ ] Retirement
- [X] Other *(Specify)*: OSS

7.a. POSITION *(Title, Grade, Component)*

b. USUAL OCCUPATION

8. CURRENT MEDICATIONS *(Prescription and Over-the-counter)*

9. ALLERGIES *(Including insect bites/stings, foods, medicine or other substance)*

Mark each item "YES" or "NO". Every item marked "YES" must be fully explained in Item 29 on Page 2.

HAVE YOU EVER HAD OR DO YOU NOW HAVE:	YES	NO
10.a. Tuberculosis	○	○
b. Lived with someone who had tuberculosis	○	○
c. Coughed up blood	○	○
d. Asthma or any breathing problems related to exercise, weather, pollens, etc.	○	○
e. Shortness of breath	○	○
f. Bronchitis	○	○
g. Wheezing or problems with wheezing	○	○
h. Been prescribed or used an inhaler	○	○
i. A chronic cough or cough at night	○	○
j. Sinusitis	○	○
k. Hay fever	○	○
l. Chronic or frequent colds	○	○
11.a. Severe tooth or gum trouble	○	○
b. Thyroid trouble or goiter	○	○
c. Eye disorder or trouble	○	○
d. Ear, nose, or throat trouble	○	○
e. Loss of vision in either eye	○	○
f. Worn contact lenses or glasses	○	○
g. A hearing loss or wear a hearing aid	○	○
h. Surgery to correct vision *(RK, PRK, LASIK, etc.)*	○	○
12.a. Painful shoulder, elbow or wrist *(e.g. pain, dislocation, etc.)*	○	○
b. Arthritis, rheumatism, or bursitis	○	○
c. Recurrent back pain or any back problem	○	○
d. Numbness or tingling	○	○
e. Loss of finger or toe	○	○

12. *(Continued)*	YES	NO
f. Foot trouble *(e.g., pain, corns, bunions, etc.)*	○	○
g. Impaired use of arms, legs, hands, or feet	○	○
h. Swollen or painful joint(s)	○	○
i. Knee trouble *(e.g., locking, giving out, pain or ligament injury, etc.)*	○	○
j. Any knee or foot surgery including arthroscopy or the use of a scope to any bone or joint	○	○
k. Any need to use corrective devices such as prosthetic devices, knee brace(s), back support(s), lifts or orthotics, etc.	○	○
l. Bone, joint, or other deformity	○	○
m. Plate(s), screw(s), rod(s) or pin(s) in any bone	○	○
n. Broken bone(s) *(cracked or fractured)*	○	○
13.a. Frequent indigestion or heartburn	○	○
b. Stomach, liver, intestinal trouble, or ulcer	○	○
c. Gall bladder trouble or gallstones	○	○
d. Jaundice or hepatitis *(liver disease)*	○	○
e. Rupture/hernia	○	○
f. Rectal disease, hemorrhoids or blood from the rectum	○	○
g. Skin diseases *(e.g. acne, eczema, psoriasis, etc.)*	○	○
h. Frequent or painful urination	○	○
i. High or low blood sugar	○	○
j. Kidney stone or blood in urine	○	○
k. Sugar or protein in urine	○	○
l. Sexually transmitted disease *(syphilis, gonorrhea, chlamydia, genital warts, herpes, etc.)*	○	○
14.a. Adverse reaction to serum, food, insect stings or medicine	○	○
b. Recent unexplained gain or loss of weight	○	○
c. Currently in good health *(If no, explain in Item 29 on Page 2.)*	●	○
d. Tumor, growth, cyst, or cancer	○	○

LAST NAME, FIRST NAME, MIDDLE NAME (SUFFIX)	SOCIAL SECURITY NUMBER	DoD ID NUMBER *(If applicable)*

Mark each item "YES" or "NO". Every item marked "YES" must be fully explained in Item 29 below.

HAVE YOU EVER HAD OR DO YOU NOW HAVE:	YES	NO
15.a. Dizziness or fainting spells	○	○
b. Frequent or severe headache	○	○
c. A head injury, memory loss or amnesia	○	○
d. Paralysis	○	○
e. Seizures, convulsions, epilepsy or fits	○	○
f. Car, train, sea, or air sickness	○	○
g. A period of unconsciousness or concussion	○	○
h. Meningitis, encephalitis, or other neurological problems	○	○
16.a. Rheumatic fever	○	○
b. Prolonged bleeding *(as after an injury or tooth extraction, etc.)*	○	○
c. Pain or pressure in the chest	○	○
d. Palpitation, pounding heart or abnormal heartbeat	○	○
e. Heart trouble or murmur	○	○
f. High or low blood pressure	○	○
17.a. Nervous trouble of any sort *(anxiety or panic attacks)*	○	○
b. Habitual stammering or stuttering	○	○
c. Loss of memory or amnesia, or neurological symptoms	○	○
d. Frequent trouble sleeping	○	○
e. Received counseling of any type	○	○
f. Depression or excessive worry	○	○
g. Been evaluated or treated for a mental condition	○	○
h. Attempted suicide	○	○
i. Used illegal drugs or abused prescription drugs	○	○
18. FEMALES ONLY. Have you ever had or do you now have:		
a. Treatment for a gynecological (female) disorder	○	○
b. A change of menstrual pattern	○	○
c. Any abnormal PAP smears	○	○
d. First day of last menstrual period *(YYYYMMDD)*		
e. Date of last PAP smear *(YYYYMMDD)*		

	YES	NO
19. Have you been refused employment or been unable to hold a job or stay in school because of:		
a. Sensitivity to chemicals, dust, sunlight, etc.	○	○
b. Inability to perform certain motions	○	○
c. Inability to stand, sit, kneel, lie down, etc.	○	○
d. Other medical reasons *(If yes, give reasons.)*	○	○
20. Have you ever been treated in an Emergency Room? *(If yes, for what?)*	○	○
21. Have you ever been a patient in any type of hospital? *(If yes, specify when, where, why, and name of doctor and complete address of hospital.)*	○	○
22. Have you ever had, or have you been advised to have any operations or surgery? *(If yes, describe and give age at which occurred.)*	○	○
23. Have you ever had any illness or injury other than those already noted? (If yes, specify when, where, and give details.)	○	○
24. Have you consulted or been treated by clinics, physicians, healers, or other practitioners within the past 5 years for other than minor illnesses? *(If yes, give complete address of doctor, hospital, clinic, and details.)*	○	○
25. Have you ever been rejected for military service for any reason? *(If yes, give date and reason for rejection.)*	○	○
26. Have you ever been discharged from military service for any reason? *(If yes, give date, reason, and type of discharge; whether honorable, other than honorable, for unfitness or unsuitability.)*	○	○
27. Have you ever received, is there pending, or have you ever applied for pension or compensation for any disability or injury? *(If yes, specify what kind, granted by whom, and what amount, when, why.)*	○	○
28. Have you ever been denied life insurance?	○	○

29. EXPLANATION OF "YES" ANSWER(S) *(Describe answer(s), give date(s) of problem, name of doctor(s) and/or hospital(s), treatment given and current medical status.)*

NOTE: HAND TO THE DOCTOR OR NURSE, OR IF MAILED MARK ENVELOPE "TO BE OPENED BY MEDICAL PERSONNEL ONLY."

LAST NAME, FIRST NAME, MIDDLE NAME (SUFFIX)	SOCIAL SECURITY NUMBER	DoD ID NUMBER *(If applicable)*

30. EXAMINER'S SUMMARY AND ELABORATION OF ALL PERTINENT DATA *(Physician/practitioner shall comment on all positive answers in questions 10 - 29. Physician/practitioner may develop by interview any additional medical history deemed important, and record any significant findings here.)*

a. COMMENTS

b. TYPED OR PRINTED NAME OF EXAMINER *(Last, First, Middle Initial)*	c. SIGNATURE	d. DATE SIGNED *(YYYYMMDD)*

Fillable

REPORT OF SUITABILITY FOR OVERSEAS ASSIGNMENTS

Supporting Directive OPNAVINST 1300.14D

1. MEMBER'S NAME:	2. DATE:	3. NUMBER OF DEPENDENTS:

4. PRESENT SHIP/STATION:	5. UIC:	6. OVERSEAS LOCATION:	7: UIC:

PART I: COMMAND REVIEW - The purpose of the command review is to determine, via record review and personal interview, member and spouse/family member(s)' suitability for overseas duty/life in the assigned overseas location. Refer to MILPERSMAN 1300-302 and 1300-304. Any questions checked "YES" (with the exception of questions 11, 15, and 16) disqualifies member for overseas assignment. Complete PART I and obtain waiver(s) prior to starting PART II (NAVMED 1300/1).

1. Has the member or any spouse/family member previously been reassigned, prior to normal tour completion, due to their unsuitability?	◯ Yes	◯ No
2. (For Enlisted Personnel) Has member obligated for the prescribed DoD tour? If "NO", member is unsuitable. NAVPERS 1070/613 entries for OBLISERV are prohibited. OBLISERV MUST BE COMPLETED WITHIN 30 DAYS OF RECEIPT OF ORDERS. For SRB issues, see the current NAVADMIN. For PFA see current NAVADMIN and OPNAV instruction. Officers and enlisted who REQUEST to separate/retire, will be held to the DoD tour length.	◯ Yes	◯ No
3. (E-5 and above) Does the member, spouse, or family member have serious problems of indebtedness, credit loss, or other financial problems which have not been reconciled with the creditor(s) or interested parties?	◯ Yes	◯ No
(E-4 and below) Member must complete debt-to-income (DTI) ratio screening per OPNAVINST 1740.5B. Do not calculate the spouse's income unless guaranteed employment at the overseas location has been obtained. Is the DTI ratio 30% or greater.	◯ Yes	◯ No
4. Has the member ever been convicted of a sex offense?** Has the member been convicted of any criminal offense (civilian or military) within the last 24 months or has/had any involvement in an ongoing criminal action? **Information regarding whether a person is a sex offender may be found at Dru Sjodin National Sex Offender Public Website (NSOPW) at www.nsopw.gov.	◯ Yes	◯ No
5. Has the spouse or any family member ever been convicted of a sex offense?** Has the spouse or any family member been convicted of any criminal offense (civilian or military) in the last 24 months or has/had any involvement in an ongoing criminal action? ** Information regarding whether a person is a sex offender may be found at Dru Sjodin National Sex Offender Public Website (NSOPW) at www.nsopw.gov.	◯ Yes	◯ No
6. Does the member have a record of any involvement with illegal drugs or alcohol within the past 24 months? Successful completion of an aftercare program will qualify the member and the question can be answered NO. Waiver of aftercare program does not quality the member; answer YES.	◯ Yes	◯ No
7. Does the spouse/family member have a record of any involvement with illegal drugs or alcohol within the past 24 months?	◯ Yes	◯ No
8. Is the member or spouse/family member involved in an open Family Advocacy Program (FAP) case that is still under investigation or for which treatment was refused or is still ongoing? (If a local FAP representative is not available to provide a status of any FAP issues, then contact the Commander Navy Installation Command (CNIC), Lead of Case Management Section for FAP, at (901) 874-4361, DSN 882-4361, for this endorsement.) If the CO still wishes to request a waiver, then the gaining command and FFSC must support waiver request.	◯ Yes	◯ No
9. Was the member's spouse previously a member of the Armed Forces and the characterization of separation other than "Honorable"? Explain in the remarks section.	◯ Yes	◯ No
10. Has member failed two or more PFAs in a 3-year period? If yes, comply with OPNAVINST 6110.1H and most recent NAVADMIN, which govern Physical Readiness Program.	◯ Yes	◯ No
11. Are any of the member's dependents covered in a custody agreement? If "NO", go to question 12.	◯ Yes	◯ No
a. Does agreement prevent removal of family members from continental United States (CONUS) without prior court approval or agreement between the interested parties? If "NO", go to question 12.	◯ Yes	◯ No
b. Has member obtained prior court approval of requisite agreement from other interested party for removal of family members from CONUS, if required by state law? (Please note: Navy policy does not require a separate agreement if not required by state law.)	◯ Yes	◯ No

Reset Form Print Form

1. MEMBER'S NAME:	2. DATE:

12. Single parents/military couples with family members. Is there any reason why the Family Care Plan cannot be executed or is not in accordance with OPNAVINST 1740.4D?	◯ Yes	◯ No

NOTE: While the unique situation of single parents with dependents is not disqualifying, this fact should be pointed out upon submission of suitability determination.

13. If member is a first-termer and going to an overseas duty station, and has a pre-service moral waiver(s) for drug, alcohol, or criminal conviction, (identified in Section VI remarks of DD 1966 (3-07), Record of Military Processing), then mark block YES.	◯ Yes	◯ No
14. Does member have a history of unsatisfactory or below standard performance (any mark below 3.0) or any NJPs in the last 2 years?	◯ Yes	◯ No
15. Have member and adult dependents received "Level I" Antiterrorism Force Protection (Level III for 0-5/0-6 Commanding Officer Awareness Training), prior to transfer, and recorded on NAVPERS 1070/613?	◯ Yes	◯ No
16. Is dependent spouse a foreign national? If yes, see MILPERSMAN 1300-302 for "Non-US citizen dependents". Case by case coordination for dependents travel documents will be required.	◯ Yes	◯ No

FOR PERSONNEL E-3 AND BELOW: Ensure the members have been counseled that they cannot be assigned accompanied overseas duty. Members will be assigned unaccompanied based on readiness needs. Acquiring family member(s) en route and bringing them without dependent entry approval/command sponsorship will most probably result in return to CONUS at personal expense and servicemembers will complete tour unaccompanied.

1. I have been counseled on the above: ◯ Yes ◯ No

2. MEMBER'S SIGNATURE:	3. DATE:

4. REMARKS:

5. I, _____ , am aware that the failure to divulge disqualifying information or amplifying information (medical, dental, personal) pertaining to the questions on this checklist may ultimately result in disciplinary action punishable under the UCMJ.

6. MEMBER (NAME, RANK/RATE):	6. MEMBER (SIGNATURE)	7. DATE:

8. INTERVIEWER (NAME, RANK/RATE, COMMAND TITLE):	9. INTERVIEWER (SIGNATURE)::	10. DATE:

1. MEMBER'S NAME:	2. DATE:

PART II: RECOMMENDATION OF COMMANDING OFFICER (OR OIC) OF MEDICAL TREATMENT FACILITY.

Based on the information available as a result of screening, approved medical/dental waivers received, and on the capabilities of the Medical/Dental Treatment Facility (MTF/DTF) in the area of assignment to which ordered, the following recommendation is forwarded.

1. Medical, dental, and educational screening was conducted per BUMEDINST 1300.2A.

2. Recommendation is based on a review of NAVMED 1300/1, Parts I and II. One form has been completed for each service and family member screened.

3. If a shaded block is checked on NAVMED 1300/1, coordination is required with the gaining MTF/DTF supporting the overseas, remote duty, or operational location; or with the senior medical department representative of an operational platform. Coordination must indicate whether or not required medical, dental, or educational capabilities are available.

4. Family member screening is not required if an unaccompanied tour of 24 months or less (exception: screening is required for Diego Garcia/ Souda Bay, Crete).

5. Do not forward sensitive medical or personal information with this form.

The following recommendation(s) are made based on a review of each NAVMED 1300/1, Parts I and II, and if required, the response from the gaining MTF/DTF or senior medical department representative of the gaining command:

1. SERVICEMEMBER IS SUITABLE FOR THIS ASSIGNMENT. ◉ Yes ○ No

FAMILY MEMBERS SUITABILITY FOR THIS ASSIGNMENT.

2. NAME: ○ Yes ○ No	3. NAME: ○ Yes ○ No
4. NAME: ○ Yes ○ No	5. NAME: ○ Yes ○ No
6. NAME: ○ Yes ○ No	6. NAME: ○ Yes ○ No

The following family member(s) were referred for Exceptional Family Member Program (EFMP) enrollment (DO NOT DELAY SCREENING FOR EFM DETERMINATION):

8. NAME (s):

9. NAME OF CO/OIC OR DESIGNEE OF MEDICAL TREATMENT FACILITY:	10. DATE:	9. SIGNATURE OF CO/OIC OR DESIGNEE OF MEDICAL TREATMENT FACILITY:

1. MEMBER'S NAME:	2. DATE:

PART III: CMC/COB/SEA ENDORSEMENT

1. On the basis of all available information, I endorse ☐ / I do not endorse ☐ the member's orders for the overseas assignment.

2. CMC/COB/SEA (NAME AND RANK):	3. SIGNATURE OF CMC/COB/SEA:	4. DATE:

PART IV: COMMANDING OFFICER'S ENDORSEMENT

1. On the basis of all available information, I endorse ☐ / I do not endorse ☐ the member's orders for the overseas assignment.

2. COMMANDING OFFICER (NAME AND RANK):	3. SIGNATURE OF COMMANDING OFFICER:	4. DATE:

5. REMARKS:

If the Commanding Officer still feels member should be considered for overseas assignment, submit waiver (non-medical/dental) request per MILPERSMAN 1300-304.

PRIVACY STATEMENT: THE AUTHORITY TO REQUEST THIS INFORMATION IS CONTAINED IN 5 USC 301 DEPARTMENTAL REGULATIONS. THE INFORMATION WILL BE USED TO ASSIST OFFICIALS AND EMPLOYEES OF THE DEPARTMENT OF THE NAVY IN DETERMINING YOUR FUTURE DUTY ASSIGNMENT.

COMPLETION OF THE FORM IS MANDATORY EXCEPT FOR DUTY AND HOME PHONE NUMBERS, OR FAILURE TO PROVIDE REQUIRED INFORMATION MY RESULT IN DELAY IN RESPONSE TO OR DISAPPROVAL OF YOUR REQUEST.

Reset Form Print Form