

PLEASE BE SURE TO FILL OUT THE FOLLOWING INFORMATION LEGIBLY.

Name:

Current Location:

Phone Number:

Email:

Age:

Next Location

DEPENDENT SUITABILITY SCREENING CHECKLIST

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

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



QR CODE FOR GROUP EMAIL



HOW ARE WE DOING?

Please take a moment to provide feedback on our services by scanning the QR code above.

By providing feedback you assist us with our continuous process improvement, no matter how satisfied or dissatisfied you are. We thank you for taking the time to give your honest feedback.

HM3 Anthony M. Licata

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401-841-6337/6361

PLEASE NOTE

DO NOT SCHEDULE ANY TRAVEL ARRANGEMENTS, HOUSEHOLD GOOD PACK OUTS, OR TRAVEL ALLOWANCES UNTIL ALL MEDICAL SCREENINGS ARE COMPLETE AND YOU AND YOUR FAMILY MEMBERS HAVE BEEN ACCEPTED BY THE GAINING COMMAND. HAVING YOUR ITEMS PICKED UP BEFORE A MEDICAL APPROVAL/DENIAL HAS BEEN WARRANTED, IS NOT RECOMMENDED. PLEASE KEEP IN MIND THAT THIS MAY COMPROMISE YOU IN PAYING FOR YOUR HOUSEHOLD ITEMS TO BE SHIPPED BACK TO THE STATES YOURSELF IF YOU OR YOUR DEPENDENT IS FOUND MEDICALLY UNSUITABLE.

PLEASE READ INFO BELOW!!!

- **1. NAVMED 1300/1 PART I** - MUST HAVE CIVILIAN PRIMARY CARE SIGN OFF UNDER NON-NAVY MTF MEDICAL SCREENER.
- **2. NAVMED 1300/1 PART II** - MUST HAVE A MILITARY DENTAL PROVIDER SIGNATURE WITH A DENTAL CLASS.
- **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.**
- **ONCE ALL OF THE ABOVE IS COMPLETE. PLEASE RETURN THE PACKET TO THE OSS OFFICE, WHERE THE SCREENER WILL SCHEDULE YOUR DEPENDENTS TO GET SEEN AT MEDICAL HOMEPORT FOR THEIR FINAL SIGNATURE.**

OSS SIGNATURE AND DATE: _____

COPY SENT VIA EMAIL
BUMEDINST 1300.2b
Rev. May 2023

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:

- | | | | | |
|--------------------------|---|--|--|--|
| <input type="checkbox"/> | 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.) | | | |
| <input type="checkbox"/> | 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:

- | | | | | |
|--------------------------|---|--|--|--|
| <input type="checkbox"/> | 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 _____ | | | |
| <input type="checkbox"/> | 4. Annual Periodic Health Assessment (PHA) current and documented? Date: _____ | | | |
| <input type="checkbox"/> | 5. Current medical history (DD Form 2807-1) | | | |
| <input type="checkbox"/> | 6. Hearing (Audiogram) | | | |
| <input type="checkbox"/> | 7. Vision Examination | | | |
| <input type="checkbox"/> | 8. G-6P-D Test | | | |
| <input type="checkbox"/> | 9. PPD Test | | | |
| <input type="checkbox"/> | 10. Sickle Cell Trait Test | | | |
| <input type="checkbox"/> | 11. Negative HIV results current to 1 year of transfer
Date Drawn: _____ Roster Number: _____ | | | |
| <input type="checkbox"/> | 12. Blood Type: _____ | | | |
| <input type="checkbox"/> | 13. DNA Testing completed and documented? | | | |
| <input type="checkbox"/> | 14. Required Immunizations (Assignment Specific) | | | |
| <input type="checkbox"/> | 15. Military Dental Records | | | |
| <input type="checkbox"/> | 16. Copies of civilian medical, dental, or mental health care records to include narrative summaries of any inpatient admissions in civilian facilities. | | | |
| <input type="checkbox"/> | 17. Mammogram current and documented. Date: _____ | | | |
| <input type="checkbox"/> | 18. Pregnancy screen (verbal inquiry). (Also, command will refer for pregnancy test 30 days prior to departure date.) | | | |
| <input type="checkbox"/> | Other: | | | |

B. FOR FAMILY MEMBERS:

- | | | | | |
|--------------------------|---|--|--|--|
| <input type="checkbox"/> | 1. Non-Service Treatment Record (medical and dental) and include a completed DD Form 2807-1 | | | |
| <input type="checkbox"/> | 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 | | | |
| <input type="checkbox"/> | 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
<input type="checkbox"/>	1. DD FORM 2792-1 (Required for ALL children birth to 22 nd 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):				
<input type="checkbox"/>	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):				
<input type="checkbox"/>	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):				
<input type="checkbox"/>	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:				
<input type="checkbox"/>	1. Are any of the shaded blocks checked on NAVMED Form 1300/1?			
<input type="checkbox"/>	<input type="checkbox"/> YES (Suitability Inquiry required, proceed to question 2)			
<input type="checkbox"/>	<input type="checkbox"/> NO (Line through question 2 and proceed to section F)			
<input type="checkbox"/>	2. Suitability Inquiry:			
<input type="checkbox"/>	Medical Care:	Date & Time sent: _____	Reply date & time: _____	
	<input type="checkbox"/> Potential need identified	Sent by (Sending SSC): _____	Reply from: _____	
	<input type="checkbox"/> N/A	Sent to (Gaining SSC): _____	Contact #: _____	
			E-Mail: _____	
	Dental Services:	Date & Time sent: _____	Reply date & time: _____	
	<input type="checkbox"/> Potential need identified	Sent by (Sending SSC): _____	Reply from: _____	
	<input type="checkbox"/> N/A	Sent to (Gaining SSC): _____	Contact #: _____	
			E-Mail: _____	
	Special Education Services:	Date & Time sent: _____	Reply date & time: _____	
	<input type="checkbox"/> Potential need identified	Sent by (Sending SSC): _____	Reply from: _____	
	<input type="checkbox"/> N/A	Sent to (Gaining SSC): _____	Contact #: _____	
			E-Mail: _____	
		Sent to (Gaining DoDEA): _____	E-Mail: _____	
Other information:				
F. SUITABILITY SCREENING COORDINATOR: Facility <u>NHCNE NEWPORT 43 SMITH RD NEWPORT RI 02841</u>				
Printed Name: _____		Signature		Date
E-mail: _____				
Phone: 401-841-2105				



When filling out the next part of the packet (DD form 2807)
Please read each bullet thoroughly.

If a bullet applies to you write the bullet with corresponding
number and letter in the blank space at the end of form.

Please include the following information:

1. What is the issue?
2. When did the problem occur? Include year if applicable.
3. Where was the issue treated? Include treatment facility
and location if applicable.
4. Is the issue unresolved? If so, where is the follow-up
treatment being performed?

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 Counseled: _____
			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? <i>Specify below:</i>
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

The public reporting burden for this collection of information is estimated to average 10 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed and completing and reviewing the collection of information. Send comments regarding the burden estimate or burden reduction suggestions to the Department of Defense, Washington Headquarters Services, at wha.mc-alex.esd.mbx.dg-dod-information-collections@mail.mil. Respondents should be aware that notwithstanding any other provision of law, no person shall be subject to any penalty for failing to comply with a collection of information if it does not display a currently valid OMB control number. PLEASE DO NOT RETURN YOUR FORM TO THE ABOVE ORGANIZATION. RETURN COMPLETED FORM AS INDICATED ON PAGE 2

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://dpccd.defense.gov/Privacy/SORNs/index/DOO-wide-SORN-Article-View/Article/570661/a0801-270-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)	6. EXAMINING LOCATION AND ADDRESS (Include ZIP Code)		
b. HOME TELEPHONE (Include Area Code)	NHCNE 43 Smith Rd Newport, RI 02841		
c. EMAIL ADDRESS			

X ALL APPLICABLE BOXES:			7.a. POSITION (Title, Grade, Component)
6.a. SERVICE <input type="checkbox"/> Army <input type="checkbox"/> Coast Guard <input type="checkbox"/> Navy <input type="checkbox"/> Marine Corps <input type="checkbox"/> Air Force	b. COMPONENT <input type="checkbox"/> Regular <input type="checkbox"/> Reserve <input type="checkbox"/> National Guard	c. PURPOSE OF EXAMINATION <input type="checkbox"/> Retention <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Separation <input type="checkbox"/> Medical Board <input type="checkbox"/> Retirement	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	12. (Continued)	YES	NO
10.a. Tuberculosis	<input type="radio"/>	<input type="radio"/>	f. Foot trouble (e.g., pain, corns, bunions, etc.)	<input type="radio"/>	<input type="radio"/>
b. Lived with someone who had tuberculosis	<input type="radio"/>	<input type="radio"/>	g. Impaired use of arms, legs, hands, or feet	<input type="radio"/>	<input type="radio"/>
c. Coughed up blood	<input type="radio"/>	<input type="radio"/>	h. Swollen or painful joint(s)	<input type="radio"/>	<input type="radio"/>
d. Asthma or any breathing problems related to exercise, weather pollens, etc.	<input type="radio"/>	<input type="radio"/>	i. Knee trouble (e.g. locking, giving out, pain or ligament injury, etc.)	<input type="radio"/>	<input type="radio"/>
e. Shortness of breath	<input type="radio"/>	<input type="radio"/>	j. Any knee or foot surgery including arthroscopy or the use of a scope to any bone or joint	<input type="radio"/>	<input type="radio"/>
f. Bronchitis	<input type="radio"/>	<input type="radio"/>	k. Any need to use corrective devices such as prosthetic devices, knee brace(s), back support(s), lifts or orthotics, etc.	<input type="radio"/>	<input type="radio"/>
g. Wheezing or problems with wheezing	<input type="radio"/>	<input type="radio"/>	l. Bone, joint, or other deformity	<input type="radio"/>	<input type="radio"/>
h. Been prescribed or used an inhaler	<input type="radio"/>	<input type="radio"/>	m. Plate(s), screw(s), rod(s) or pin(s) in any bone	<input type="radio"/>	<input type="radio"/>
i. A chronic cough or cough at night	<input type="radio"/>	<input type="radio"/>	n. Broken bone(s) (cracked or fractured)	<input type="radio"/>	<input type="radio"/>
j. Sinusitis	<input type="radio"/>	<input type="radio"/>	13.a. Frequent indigestion or heartburn	<input type="radio"/>	<input type="radio"/>
k. Hay fever	<input type="radio"/>	<input type="radio"/>	b. Stomach, liver, intestinal trouble, or ulcer	<input type="radio"/>	<input type="radio"/>
l. Chronic or frequent colds	<input type="radio"/>	<input type="radio"/>	c. Gall bladder trouble or gallstones	<input type="radio"/>	<input type="radio"/>
11.a. Severe tooth or gum trouble	<input type="radio"/>	<input type="radio"/>	d. Jaundice or hepatitis (liver disease)	<input type="radio"/>	<input type="radio"/>
b. Thyroid trouble or goiter	<input type="radio"/>	<input type="radio"/>	e. Rupture/hernia	<input type="radio"/>	<input type="radio"/>
c. Eye disorder or trouble	<input type="radio"/>	<input type="radio"/>	f. Rectal disease, hemorrhoids or blood from the rectum	<input type="radio"/>	<input type="radio"/>
d. Ear, nose, or throat trouble	<input type="radio"/>	<input type="radio"/>	g. Skin diseases (e.g. acne, eczema, psoriasis, etc.)	<input type="radio"/>	<input type="radio"/>
e. Loss of vision in either eye	<input type="radio"/>	<input type="radio"/>	h. Frequent or painful urination	<input type="radio"/>	<input type="radio"/>
f. Worn contact lenses or glasses	<input type="radio"/>	<input type="radio"/>	i. High or low blood sugar	<input type="radio"/>	<input type="radio"/>
g. A hearing loss or wear a hearing aid	<input type="radio"/>	<input type="radio"/>	j. Kidney stone or blood in urine	<input type="radio"/>	<input type="radio"/>
h. Surgery to correct vision (RK, PRK, LASIK, etc.)	<input type="radio"/>	<input type="radio"/>	k. Sugar or protein in urine	<input type="radio"/>	<input type="radio"/>
12.a. Painful shoulder, elbow or wrist (e.g. pain, dislocation, etc.)	<input type="radio"/>	<input type="radio"/>	l. Sexually transmitted disease (syphilis, gonorrhea, chlamydia, genital warts, herpes, etc.)	<input type="radio"/>	<input type="radio"/>
b. Arthritis, rheumatism, or bursitis	<input type="radio"/>	<input type="radio"/>	14.a. Adverse reaction to serum, food, insect stings or medicine	<input type="radio"/>	<input type="radio"/>
c. Recurrent back pain or any back problem	<input type="radio"/>	<input type="radio"/>	b. Recent unexplained gain or loss of weight	<input type="radio"/>	<input type="radio"/>
d. Numbness or tingling	<input type="radio"/>	<input type="radio"/>	c. Currently in good health (If no, explain in Item 29 on Page 2)	<input type="radio"/>	<input type="radio"/>
e. Loss of finger or toe	<input type="radio"/>	<input type="radio"/>	d. Tumor, growth, cyst, or cancer	<input type="radio"/>	<input type="radio"/>

LAST NAME, FIRST NAME, MIDDLE NAME (SUFFIX)	SOCIAL SECURITY NUMBER	DoD ID NUMBER (If applicable)
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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		YES	NO		
16.a. Dizziness or fainting spells	<input type="radio"/>	<input type="radio"/>	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.	<input type="radio"/>	<input type="radio"/>	
b. Frequent or severe headache	<input type="radio"/>	<input type="radio"/>			b. Inability to perform certain motions	<input type="radio"/>	<input type="radio"/>
c. A head injury, memory loss or amnesia	<input type="radio"/>	<input type="radio"/>			c. Inability to stand, sit, kneel, lie down, etc.	<input type="radio"/>	<input type="radio"/>
d. Paralysis	<input type="radio"/>	<input type="radio"/>			d. Other medical reasons (If yes, give reasons.)	<input type="radio"/>	<input type="radio"/>
e. Seizures, convulsions, epilepsy or fits	<input type="radio"/>	<input type="radio"/>		20. Have you ever been treated in an Emergency Room? (If yes, for what?)	<input type="radio"/>	<input type="radio"/>	
f. Car, train, sea, or air sickness	<input type="radio"/>	<input type="radio"/>			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.)	<input type="radio"/>	<input type="radio"/>
g. A period of unconsciousness or concussion	<input type="radio"/>	<input type="radio"/>		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.)		<input type="radio"/>	<input type="radio"/>
h. Meningitis, encephalitis, or other neurological problems	<input type="radio"/>	<input type="radio"/>			23. Have you ever had any illness or injury other than those already noted? (If yes, specify when, where, and give details.)	<input type="radio"/>	<input type="radio"/>
16.a. Rheumatic fever	<input type="radio"/>	<input type="radio"/>	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.)	<input type="radio"/>		<input type="radio"/>	
b. Prolonged bleeding (as after an injury or tooth extraction, etc.)	<input type="radio"/>	<input type="radio"/>		26. Have you ever been rejected for military service for any reason? (If yes, give date and reason for rejection.)	<input type="radio"/>	<input type="radio"/>	
c. Pain or pressure in the chest	<input type="radio"/>	<input type="radio"/>	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.)		<input type="radio"/>	<input type="radio"/>	
d. Palpitation, pounding heart or abnormal heartbeat	<input type="radio"/>	<input type="radio"/>		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.)	<input type="radio"/>	<input type="radio"/>	
e. Heart trouble or murmur	<input type="radio"/>	<input type="radio"/>	28. Have you ever been denied life insurance?		<input type="radio"/>	<input type="radio"/>	
f. High or low blood pressure	<input type="radio"/>	<input type="radio"/>					
17.a. Nervous trouble of any sort (anxiety or panic attacks)	<input type="radio"/>	<input type="radio"/>					
b. Habitual stammering or stuttering	<input type="radio"/>	<input type="radio"/>					
c. Loss of memory or amnesia, or neurological symptoms	<input type="radio"/>	<input type="radio"/>					
d. Frequent trouble sleeping	<input type="radio"/>	<input type="radio"/>					
e. Received counseling of any type	<input type="radio"/>	<input type="radio"/>					
f. Depression or excessive worry	<input type="radio"/>	<input type="radio"/>					
g. Been evaluated or treated for a mental condition	<input type="radio"/>	<input type="radio"/>					
h. Attempted suicide	<input type="radio"/>	<input type="radio"/>					
i. Used illegal drugs or abused prescription drugs	<input type="radio"/>	<input type="radio"/>					
18. FEMALES ONLY. Have you ever had or do you now have:							
a. Treatment for a gynecological (female) disorder	<input type="radio"/>	<input type="radio"/>					
b. A change of menstrual pattern	<input type="radio"/>	<input type="radio"/>					
c. Any abnormal PAP smears	<input type="radio"/>	<input type="radio"/>					
d. First day of last menstrual period (YYYYMMDD)							
e. Date of last PAP smear (YYYYMMDD)							

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)
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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)
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