## NAVY MEDICINE READINESS TRAINING UNIT BANGOR MEDICAL READINESS DEPARTMENT (MRRS)

<u>Laboratory:</u>				\TE	ERECEIVED:		_
		HIV WITHIN 18 MONTHS OF NLT	DA	TE	RETURNED:		_
<b>IMMUNIZATIONS</b>	(Over	seas):					
		CHECK REQUIREMENTS IF GOING OVERSEAS			<u>Height:</u>		
OPTOMETRY:		EYE EXAM WITHIN 2 YEARS OF NLT			<u>Weight:</u>		
<u>AUDIOLOGY:</u>		WITHIN 6 MONTHS OF NLT IF IN HEARING CONSERVATION	N PROGRAM		<u>Blood Pressure</u>	<u>:</u>	
READINESS APPO	INTMI						
		DENTAL EXAM WITHIN PAST YEAR			<u>Pulse:</u>		
		CLASS 2 PHA / PDHA UP TO DATE	<u>Decision</u>	<u>}</u>	'es (✔) / No (X)	<u>IC</u>	<u>D-10 Code</u>
		PAP SMEAR NOT DUE PRIOR TO NLT	Approved				
			Not				
		ATE (SUB/NFD/DIVE/NSW):	Approved				
		S TO SEE IF YOU REQUIRE A PHYSICAL TO TRANSFER. E IT IS UP TO DATE PRIOR TO RETURNING THIS PACKET TO	MRRS, IF NOT	su	RE ASK MRRS)		

Name:		
Rate/Rank:	DoD Number:	
Current command:		
Operational Command /	NLT Date:	

Upon receipt of your orders you have 30 days to complete the screening process. Failure to show up in a timely manner after your orders post falls on <u>YOU</u>, medical cannot guarantee you an appointment prior to your NLT date.

If you have chronic medical needs you may need an inquiry sent to your gaining command to ensure they can accommodate medical necessities/appointments. This can sometimes take an additional 2-4 weeks, please let the corpsman know if this may apply to you and plan your time accordingly.

**\*DO NOT** plan / ship household goods until you have completed your screening and have been <u>approved</u> for transfer.

A good contact number with a proper voicemail set up is:

When completed please give 1-2 business days turnaround to have your 1300/16 form signed by NBHC Bangor Administration. We will call the above number when completed, please ensure the number is correct with voicemail set up and <u>NOT full</u>. When you pick up your 1300/16 from MRRS there will be a logbook to sign acknowledging receipt of your 1300/16.

If you have any questions throughout the screening process please call: MRRS: (360) 315-4319 or 4352

I,

, understand and acknowledge the above information given to me.

REPORT OF MEDICAL HISTORY (This information is for official and medically confidential use only and will not be released to unauthorized persons.)							
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 whs.mc-alex.esd.mbx.dd-dod-information-collections@mail.mii. 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.							
AUTHORITY: 10 U.S.C. 136, Under Secretary Of Defense For Personnal And Medical Standards for Appointment, Enlistment, or Induction in the Military Ser PRINCIPAL PURPOSE(S): The primary collection of this information is from in making determinations as to acceptability of applicants for military service and information using this form occurs when a Medical Evaluation Board is conven ROUTINE USE(S): The Routine Uses are listed in the applicable system of rer a0601-270-usmepcom-dod/ DISCLOSURE: Voluntary; however, failure by an applicant to provide the infor SSN is used during the recruitment process to keep all records together and w individual being placed in a non-deployable status. The SSN of an Armed Forc WARNING: The information you have given constitutes an	I Readiness; vices; and E ndividuals sei verifies disqued to determ cords notice f rmation may i then requesti ses member i	9397 (SSN), as amended. ng to join the Armed Forces. The information collected on this form is used ifying medical condition(s) noted on the prescreening form (DD 2807-2). An the medical fitness of a current member and if separation is warranted. and at: http://dpcld.defense.gov/Privacy/SORNsIndex/DOD-wide-SORN-Artic ult in delay or possible rejection of the individual's application to enter the A civilian medical records. For an Armed Forces member, failure to provide to o ensure the collected information is filed in the proper individual's record.	to assist DoD physicians in additional collection of cle-View/Article/570661/ rmed Forces. An applicant's te information may result in the				
\$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)	5. EXAMINING LOCATION AND ADDRESS (Include ZIP Cod	) (e)				
b. HOME TELEPHONE (Include Area Code) c. EMAIL ADDRESS		enander ander sollen a Enander ander sollen der sole ener Sale finder ander					
X ALL APPLICABLE BOXES:		7.a. POSITION (Title, Grade, C	omponent)				
	OSE OF E	AMINATION					
Army Guard Regular Navy Reserve	en lines for lines for a f	b. USUAL OCCUPATION	or other substance)				
Mark each item "YES" or "NO". Every item marked "YE	S" must	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	0 0	f. Foot trouble (e.g., pain, corns, bunions, etc.)	0 0				
b. Lived with someone who had tuberculosis	0 0	g. Impaired use of arms, legs, hands, or feet	0 0				
c. Coughed up blood	0 0	h. Swollen or painful joint(s)	0 0				
d. Asthma or any breathing problems related to exercise, weather, pollens, etc.	0 0	i. Knee trouble (e.g., locking, giving out, pain or ligament injur)					
e. Shortness of breath	0 0	j. Any knee or foot surgery including arthroscopy or the use of a to any bone or joint Any bone or joint					
f. Bronchitis	0 0	k. Any need to use corrective devices such as prosthetic devices, brace(s), back support(s), lifts or orthotics, etc.					
g. Wheezing or problems with wheezing	0 0	I. Bone, joint, or other deformity	0 0				
h. Been prescribed or used an inhaler i. A chronic cough or cough at night		<ul> <li>m. Plate(s), screw(s), rod(s) or pin(s) in any bone</li> <li>n. Broken bone(s) (cracked or fractured)</li> </ul>					
i. Sinusitis	0 0	13.a. Frequent indigestion or heartburn	0 0				
k. Hay fever	00	b. Stomach, liver, intestinal trouble, or ulcer	0 0				
I. Chronic or frequent colds	0 0	c. Gall bladder trouble or gallstones	0 0				
11.a. Severe tooth or gum trouble	0 0	d, Jaundice or hepatitis (liver disease)	0 0				
b. Thyroid trouble or goiter	0 0	e. Rupture/hernia	0 0				
c. Eye disorder or trouble	0 0	f. Rectal disease, hemorrhoids or blood from the rectum					
d. Ear, nose, or throat trouble	0 0	g. Skin diseases (e.g. acne, eczema, psoriasis, etc.)	0 0				
e. Loss of vision in either eye	0 0	h. Frequent or painful urination	0 0				
f. Worn contact lenses or glasses	0 0	i. High or low blood sugar	0 0				
g. A hearing loss or wear a hearing aid	0 0	j. Kidney stone or blood in urine	0 0				
h. Surgery to correct vision (RK, PRK, LASIK, etc.)	0 0	k Sugar or protein in urine	0 0				
12.a. Painful shoulder, elbow or wrist (e.g. pain, dislocation, etc.)	0 0	<ol> <li>Sexually transmitted disease (syphilis, gonorrhea, chlamydia, ge warts, herpes, etc.)</li> </ol>					
b. Arthritis, rheumatism, or bursitis	0 0	14.a. Adverse reaction to serum, food, insect stings or med					
c. Recurrent back pain or any back problem	0 0	b. Recent unexplained gain or loss of weight	0 0				
d. Numbness or tingling	0 0	c. Currently in good health (If no, explain in Item 29 on F	0 0				
e. Loss of finger or toe	0 0	d. Tumor, growth, cyst, or cancer	0 0				

DD FORM 2807-1 OCT 2018

DoD exception to SF 93 approved by ICMR, August 3, 2000. PREVIOUS EDITION IS OBSOLETE. Page 1 of 3 Pages Adobe Professional XI

Mark ach 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         156. Diszines of faining splish       0       0       1. Invey you been rotised employment to been unable to not a pob       0         2. A bed ipily:       0       0       0. Inability to perform orbitals, duit, kundlip, tec.       0         3. Battines, convulsions, epilepsy or fits       0       0. Inability to perform and notices, duit, kundlip, tec.       0         4. Cherr metalo area.on arise, or arise data molecular acaona (l/ysst, you ever bear data).       0       0       0. Inability to perform and notices, duit, kundlip, tec.       0         5. Batterise, convulsions, onlines or oncusion       0       0. Inability to stand, sit, kneel, line down, etc.       0         6. Rohemingto, extension and problems       0       0. Painor of stand and in Emergenzy Room?       0         7. Namingtis, acceptatis, or other neurological problems       0       0       10. Have you ever that and on the metry Room?       0         8. Relemants       0       0       10. Have you ever that accept when, when, with y and an give data).       0         9. Paintoin of the work data was an injury or onb extraction, etc.       0       0       0       0         9. Been sequesticati fever       0       0       0	LAS	TNAME, FIRST NAME, MIDDLE NAME (SUFFIX)			OCIAL SECURI	TY NUMBER	DoD ID NUMBER (If applica	able)	
HAVE YOU EVER HAD OR DO YOU NOW HAVE:       YES NO       YES         15.a. Dizziness or fainting spells       O       O         b. Frequent or severe headache       O       O         c. A head injury, memory loss or amnesia       O       O         d. Paralysis       O       O         e. Seizures, convulsions, epilepsy or fits       O       O         f. Car, train, sea, or air sickness       O       O         g. A period of unconsciousness or concussion       O       O         h. Mainingits, encephalitis, or other neurological problems       O       O         d. Pariorged bleeding (as after an injury or tooth extraction, etc.)       O       O         e. Prolonged bleeding (as after an injury or tooth extraction, etc.)       O       O         f. High or low blood pressure       O       O       O         d. Papilitation, pounding heart or abnormal heartbeat       O       O         e. Loss of memory or amnesia, or neurological symptoms       O       O         d. Lass for memory or amnesia, or neurological symptoms       O       O         e. Received counseling of any type       O       O       O         e. Habit Line or word any structure       O       O       O         b. Habitust atammering or stutering       O <th></th> <th></th> <th></th> <th></th> <th></th> <th></th> <th></th> <th></th> <th></th>									
15.a.       Dizziness or fainting spells       10.         16.       Frequent or severe headache       0         16.       Frequent or severe headache       0         16.       Prequent or severe headache       0         17.       Prozingysis       0         18.       Bayistic convulsions, epilepsy or fits       0         19.       A period of unconsciousness or concussion       0         16.       A period of unconsciousness or concussion       0         16.       A period of unconsciousness or concussion       0         16.       Rheumatic fever       0         17.       Nervois pressure in the chest       0         19.       Have you ever had, or have you ever had, or have you been advised to have any operations or surgery? (If yes, describe and give age at which occurred.)         17.       Nervois workies and fine an injury or tooth extraction, etc.)       0         19.       Have you ever had, or have you ever had, or have you been advised to have any operations or surgery? (If yes, describe and give age at which occurred.)         17.       Nervois workies and fine an injury or tooth extraction, etc.)       0         19.       Have you ever had any illness or injury other than those already noted? (If yes, specify when, where, and give details.)         17.       Nervois worki (antrice) and any type </th <th>Mari</th> <th>k each item "YES" or "NO". Every item marked "YES" r</th> <th>must b</th> <th>e full</th> <th>xplained in It</th> <th>em 29 below.</th> <th></th> <th>5</th> <th>63</th>	Mari	k each item "YES" or "NO". Every item marked "YES" r	must b	e full	xplained in It	em 29 below.		5	63
b. Frequent or severe headache       or stay in school because of:       or stay in school because of:         c. A head injury, memory loss or amnesia       or       a. Sensitivity to chemicals, dust, sunlight, etc.       or         d. Paralysis       or       is chemicals, dust, sunlight, etc.       or         e. Seizures, convulsions, epilepsy or fits       or       is chemicals, dust, sunlight, etc.       or         g. A period of unconsciousness or concussion       or       or       d. Other medical reasons (If yes, give reasons.)       or         16.a. Rheumatic fever       or       or       flips, forward?       or         b. Prolonged bleeding (as after an injury or tooth extraction, etc.)       or       operations or surgery? (If yes, forward?)       or         c. Pain or pressure in the chest       operations or surgery? (If yes, describe and give age at which operations or surgery? (If yes, describe and give age at which occurred.)       occurred.)         17.a. Nervous trouble or anurmur       operations or surgery? (If yes, specify when, where, why, and name of doctor and complete address or flooptial.)       occurred.)         c. Loss of memory or anmesia, or neurological symptoms       occurred.)       occurred.)       occurred.)         c. Loss of memory or anmesia, or neurological symptoms       occurred.)       octher practicons sy the on white past 5 years for other practicons sy the onorelate address or for gindice address or or tot	HAV	E YOU EVER HAD OR DO YOU NOW HAVE:	YES	NO				YES	NO
<ul> <li>a. Sensitivity to chemicals, dust, sunlight, etc.</li> <li>b. Inability to chemicals, dust, sunlight, etc.</li> <li>c. A hadd injury, memory loss or amnesia</li> <li>d. Paralysis</li> <li>e. Soizures, convulsions, epilepsy or fits</li> <li>f. Car, train, sea, or air sickness</li> <li>g. A period of unconsciousness or concussion</li> <li>h. Meningitis, encephalitis, or other neurological problems</li> <li>h. Prolonged bleeding (as after an injury or tooth extraction, etc.)</li> <li>c. Pain or pressure in the chest</li> <li>d. Paipitation, pounding heart or abnormal heartbeat</li> <li>e. Heart trouble or murmur</li> <li>c. Loss of memory or annesia, or neurological symptoms</li> <li>d. Frequent trouble sleeping</li> <li>e. Received counseling of any type</li> <li>g. Been evaluated for a mental condition</li> <li>h. Attempted suicide</li> <li>i. Used illegal drugs or abused prescription drugs</li> <li>g. Any abnormal PAP smears</li> <li>d. Any abnormal PAP smears</li> <li>d. First day of last ther smears</li> <li>d. First day of last ther smears</li> <li>d. First day of last thenstrual pattern</li> <li>d. Anay abnormal PAP smears</li> <li>d. Anay abnormal PAP smears</li> <li>d. First day of last thenstrual pattern</li> <li>d. S. EXPLANATION OF "YES" ANSWER(S) (Describe answer(s), give date(s) of problem, name of doctor is and current medical</li> </ul>	15.a.	Dizziness or fainting spells	0	0	19. Have you	been refused employ	yment or been unable to hold a job		
d. Paralysis       D       b. Inability to perform certain motions         e. Seizures, convulsions, epilepsy or fits       D       D         f. Car, train, sea, or air sickness       D       D         g. A period of unconsciousness or concussion       D       D         h. Meningitis, encephalitis, or other neurological problems       D       D         16.a. Rheumatic fever       D       D         b. Prolonged bleeding (as after an injury or tooth extraction, etc.)       D       D         c. Pain or pressure in the chest       D       D         d. Paintation, pounding heart or abnormal heartbeat       D       D         e. Heart trouble or murmur       D       Depressure in the chest       D         d. Paintation, pounding heart or abnormal heartbeat       D       D         b. Habitual stammering or stuttering       D       D         c. Loss of memory or annesia, or neurological symptoms       D       D         d. Frequent trouble sleeping       D       D       D         f. Depression or excessive worry       D       D       D         g. Been evaluated or treated for a mental condition       D       D       D         h. Habitual stammering or abused prescription drugs       D       D       D         g. B	b.	Frequent or severe headache	0	0	or stay in s	school because of:			
e. Seizures, convulsions, epilepsy or fits       C         f. Car, train, sea, or air sickness       C         g. A period of unconsciousness or concussion       C         h. Meningitis, encephalitis, or other neurological problems       C         h. Meningitis, encephalitis, or other neurological problems       C         b. Prolonged bleeding (as after an injury or tooth extraction, etc.)       C         c. Pain or pressure in the chest       C         d. Palpitation, pounding heart or abnormal heartbeat       C         e. Heat trouble or numur       C         f. High or low blood pressure       C         b. Habitual stammering or stuttering       C         c. Loss of memory or annesia, or neurological symptoms       C         d. Frequent trouble sleeping       C         e. Received counseling of any type       C         f. Depression or excessive worry       C         g. Been evaluated or treated for a mental condition       C         h. Attempted suicide       C         l. Used illegial drugs or abused prescription drugs       C         a. Treatment for a synecological (female) disorder       C         g. Anay abormal PAP smears       C         g. Anay on and PAP smears       C         g. Fist day of last PAP smeary (YYYYMMDD)       C <td>C.</td> <td>A head injury, memory loss or amnesia</td> <td>0</td> <td>0</td> <td>a. Sensit</td> <td>ivity to chemicals, du</td> <td>ust, sunlight, etc.</td> <td>0</td> <td>0</td>	C.	A head injury, memory loss or amnesia	0	0	a. Sensit	ivity to chemicals, du	ust, sunlight, etc.	0	0
f. Car, train, sea, or air sickness       0         g. A period of unconsciousness or concussion       0         h. Meningitis, encephalitis, or other neurological problems       0         16.a. Rheumatic fever       0         b. Prolonged bleeding (as after an injury or tooth extraction, etc.)       0         c. Pain or pressure in the chest       0         d. Palpitation, pounding heart or abnormal heartbeat       0         e. Heart trouble or murmur       0         f. High or low blood pressure       0         17.a. Nervous trouble of any sort (anxiety or panic attacks)       0         b. Habitual stammering or stuttering       0         c. Loss of memory or annesia, or neurological symptoms       0         d. Depression or excessive worry       0         g. Been evaluated or treated for a mental condition       0         h. Attempted suicide       0         i. Used illegal drugs or abused prescription drugs       0         b. A change of menstrual pattern       0         c. Any abnormal PAP smears       0         d. First day of last menstrual pattern       0         e. Taestment for a gynecological (YYYMMDD)       2         b. Achange of menstrual pattern       0         c. Any abnormal PAP smears       0         d. Firs	d.	Paralysis	0	0	b. Inabili	ty to perform certain	motions	0	0
g. A period of unconsciousness or concussion       0         h. Meningitis, encephalitis, or other neurological problems       0         16.a. Rheumatic fever       0         b. Prolonged bleeding (as after an injury or tooth extraction, etc.)       0         c. Pain or pressure in the chest       0         d. Palpitation, pounding heart or abnormal heartbeat       0         e. Heart trouble or murmur       0         f. High or low blood pressure       0         c. Loss of memory or amnesia, or neurological symptoms       0         d. Frequent trouble sleeping       0         e. Received counseling of any type       0         f. Depression or excessive worry       0         g. Been evaluated or treated for a mental condition       0         h. Attempted suicide       0         l. Used illegal drugs or abused prescription drugs       0         g. Frequent troub as or bused prescription drugs       0         g. A change of menstrual pattern       0         g. A prisol dist PAP smears       0         g. First day of last menstrual pattern       0         g. Anage of menstrual pattern       0         g. A change of menstrual pattern       0         g. A precological (female) disorder       0         g. A panormal PAP smears	e,	Seizures, convulsions, epilepsy or fits	0	0	c. Inabilit	y to stand, sit, kneel	, lie down, etc.	0	0
<ul> <li>h. Meningitis, encephalitis, or other neurological problems</li> <li>if the y for what??)</li> <li>if the y for what</li></ul>	f.	Car, train, sea, or air sickness			d. Other	medical reasons (If )	yes, give reasons.)	0	0
h. Meningitis, encephalitis, or other neurological problems       If yes, for Whitt?)         16.a. Rheumatic fever       If yes, for Whit?)         16.a. Rheumatic fever       If yes, for Whit?)         17.a. Nervous trouble or murmur       If yes, for Whit?)         17.a. Nervous trouble of any sort (anxiety or panic attacks)       If yes, yee of yee, why, and name of doctor and complete address of hospital.)         17.a. Nervous trouble of any sort (anxiety or panic attacks)       If yes, yee of yee, why, and name of doctor and give age at which occurred.)         17.a. Nervous trouble of any sort (anxiety or panic attacks)       If yes, yee of yee, yee, yee of yee, yee, yee of yee, and give details.)         17.a. Nervous trouble of any sort (anxiety or panic attacks)       If yee, yee one one advised to have any operations or surgery? (if yee, specify when, where, and give details.)         a. Loss of memory or annesia, or neurological symptoms       If yee you consulted or been treated by clinics, physicians, healers, or other practitioners within the past 5 years for other than minor illnesses? (if yee, give complete address of doctor, hospital., clinic, and details.)         16. Depressive or excessive worry       If yee, give date and reason for rejection.)         17. Been evaluated or treated for a mental condition       If yee, give date and reason for rejection.)         18. FEMALES ONLY. Have you ever had or do you now have:       If yee, yee date and reason for any treasor? (if yee, give date for any or complete discharge; whethet honorable, for unfitness or or unsuitability.) </td <td>g.</td> <td>A period of unconsciousness or concussion</td> <td>0</td> <td>0</td> <td></td> <td></td> <td>an Emergency Room?</td> <td>0</td> <td>0</td>	g.	A period of unconsciousness or concussion	0	0			an Emergency Room?	0	0
b. Prolonged bleeding (as after an injury or tooth extraction, etc.)       0         c. Pain or pressure in the chest       0         d. Palpitation, pounding heart or abnormal heartbeat       0         e. Heart trouble or murmur       0         f. High or low blood pressure       0         17.a. Nervous trouble of any sort (anxiety or panic attacks)       0         b. Habitual stammering or stuttering       0         c. Loss of memory or annesia, or neurological symptoms       0         d. Frequent trouble sleeping       0         e. Received counseling of any type       0         g. Been evaluated or treated for a mental condition       0         h. Attempted suicide       0         i. Used illegal drugs or abused prescription drugs       0         i. Breenvaluated or treated for a mental condition       0         b. A change of menstrual pattern       0         c. Any abnormal PAP smears       0         d. First day of last menstrual period (YYYYMMDD)       28. Have you ever been discharged from specify when, where, and yike date in surance?         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	h.	Meningitis, encephalitis, or other neurological problems	10.77	100700	(If yes, for	what?)		0	0
b. Prolonged bleeding (as after an injury or tooth extraction, etc.)       O         c. Pain or pressure in the chest       O         d. Palpitation, pounding heart or abnormal heartbeat       O         e. Heart trouble or mumur       O         f. High or low blood pressure       O         17.a. Nervous trouble of any sort (anxiety or panic attacks)       O         b. Habitual stammering or stuttering       O         c. Loss of memory or amnesia, or neurological symptoms       O         d. Frequent trouble seleping       O         e. Received counseling of any type       O         g. Been evaluated or treated for a mental condition       O         h. Attempted suicide       O         i. Used illegal drugs or abused prescription drugs       O         s. A change of mentrul patterm       O         a. Treatment for a gynecological (female) disorder       O         d. First day of last mentrul patterm       O         e. Any abnormal PAP smears       O         d. First day of last mentrul patterm       O         e. Any abnormal PAP smear (YYYYMMDD)       28. Have you ever been denied life insurance?         e. Any abnormal PAP smear (YYYYMMDD)       28. Have you ever been denied life insurance?         e. ExpLaNATION OF "YES" ANSWER(S) (Describe answer(s), give date(s) of problem, name of doctor(s)	16.a.	Rheumatic fever	0	0	21. Have you	ever been a patient i	n any type of hospital? (If yes,		
d. Palpitation, pounding heart or abnormal heartbeat       0         d. Palpitation, pounding heart or abnormal heartbeat       0         e. Heart trouble or murmur       0         f. High or low blood pressure       0         17.a. Nervous trouble of any sort (anxiety or panic attacks)       0         b. Habitual stammering or stuttering       0         c. Loss of memory or annesia, or neurological symptoms       0         d. Frequent trouble sleeping       0         e. Received counseling of any type       0         f. Depression or excessive worry       0         g. Been evaluated or treated for a mental condition       0         h. Attempted suicide       0         i. Used illegal drugs or abused prescription drugs       0         g. A change of menstrual pattern       0         g. Any abnormal PAP smears       0         g. Date of last PAP smear (YYYYMMDD)       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	b.	Prolonged bleeding (as after an injury or tooth extraction, etc.)	1.20		specify wh	en, where, why, and		0	0
e. Heart trouble or murmur       0       22. Have you ever had, or have you been advised to have any operations or surgery? (If yes, describe and give and give age at which occurred.)         17.a. Nervous trouble of any sort (anxiety or panic attacks)       0         b. Habitual stammering or stuttering       0         c. Loss of memory or amnesia, or neurological symptoms       0         d. Frequent trouble sleeping       0         e. Received counseling of any type       0         f. Depression or excessive worry       0         g. Been evaluated or treated for a mental condition       0         h. Attempted suicide       0         i. Used illegal drugs or abused prescription drugs       0         18. FEMALES ONLY. Have you ever had or do you now have:       0         a. Treatment for a gynecological (female) disorder       0         b. A change of menstrual pattern       0         c. Any abnormal PAP smears       0         d. First day of last menstrual period (YYYYMMDD)       2         e. Date of last PAP smear (YYYYMMDD)       2         e. Date of last PAP smear (YYYYMMDD)       2         e. Date of last PAP smear(YYYYMMDD)       2         e. Date of last PAP smear(YYYYMMDD)       2         e. Date of last PAP smear(YYYYMMDD)       2         e. Date of last PAP smear(YYYYMMDD) <td>C.</td> <td>Pain or pressure in the chest</td> <td>0</td> <td>0</td> <td>address of</td> <td>nospital.)</td> <td></td> <td></td> <td></td>	C.	Pain or pressure in the chest	0	0	address of	nospital.)			
f. High or low blood pressure       O         17.a. Nervous trouble of any sort (anxiety or panic attacks)       O         b. Habitual stammering or stuttering       O         c. Loss of memory or amnesia, or neurological symptoms       O         d. Frequent trouble sleeping       O         e. Received counseling of any type       O         f. Depression or excessive worry       O         g. Been evaluated or treated for a mental condition       O         h. Attempted suicide       O         i. Used illegal drugs or abused prescription drugs       O         g. Achange of menstrual pattern       O         c. Any abnormal PAP smears       O         d. First day of last menstrual period (YYYYMMDD)       Zf. Have you ever been denied life insurance?         e. Date of last PAP smear (YYYYMMDD)       Z8. Have you ever been denied life insurance?	d.	Palpitation, pounding heart or abnormal heartbeat		10177	22. Have you	ever had, or have yo	u been advised to have any		
1. High dribb blodd pressure       0       0         17.a. Nervous trouble of any sort (anxiety or panic attacks)       0       0         b. Habitual stammering or stuttering       0       0         c. Loss of memory or amnesia, or neurological symptoms       0       0         d. Frequent trouble sleeping       0       0         e. Received counseling of any type       0       0         f. Depression or excessive worry       0       0         g. Been evaluated or treated for a mental condition       0       0         h. Attempted suicide       0       0         i. Used illegal drugs or abused prescription drugs       0       0         8. FEMALES ONLY. Have you ever had or do you now have:       0         a. Treatment for a gynecological (female) disorder       0         b. A change of menstrual pattern       0         c. Any abnormal PAP smears       0         d. First day of last menstrual period (YYYYMMDD)       28. Have you ever been denied life insurance?         e. Date of last PAP smear (YYYYMMDD)       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			0	- with the	operations	or surgery? (If yes,		0	0
b. Habitual stammering or stuttering       Image: already noted? (If yes, specify when, where, and give details.)         c. Loss of memory or annesia, or neurological symptoms       Image: already noted? (If yes, specify when, where, and give details.)         d. Frequent trouble sleeping       Image: already noted? (If yes, specify when, where, and give details.)         e. Received counseling of any type       Image: already noted? (If yes, specify when, where, and give details.)         f. Depression or excessive worry       Image: already noted? (If yes, specify when, where, and give details.)         g. Been evaluated or treated for a mental condition       Image: already noted? (If yes, specify when, where, and details.)         i. Used illegal drugs or abused prescription drugs       Image: already noted? (If yes, specify when, where, and give details.)         i. Used illegal drugs or abused prescription drugs       Image: already noted? (If yes, give date, creason, and type of discharge; whether honorable, other than honorable, for unfitness or unsuitability.)         b. A change of menstrual pattern       Image: already of last menstrual period (YYYYMMDD)         e. Date of last PAP smear (YYYYMMDD)       Image: already or last period (YYYYMMDD)         e. Date of last PAP smear (YYYMMDD)       Image: already or last menstrual given and current medical         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			0.000		occurred.)			16	
B. Habitual stammering or stuttering       O       O       Calledy fided? (if yes, specify when, where, and give details.)         c. Loss of memory or annesia, or neurological symptoms       O       O         d. Frequent trouble sleeping       O       O         e. Received counseling of any type       O       O         f. Depression or excessive worry       O       O         g. Been evaluated or treated for a mental condition       O       O         h. Attempted suicide       O       O         i. Used illegal drugs or abused prescription drugs       O       O         a. Treatment for a gynecological (female) disorder       O       O         b. A change of menstrual pattern       O       O         c. Any abnormal PAP smears       O       O         d. First day of last menstrual period (YYYYMMDD)       Z8. Have you ever been denied life insurance?       O         g. Bate of last PAP smear (YYYYMMDD)       Z8. Have you ever been denied life insurance?       O			0	and a set				0	0
d. Frequent trouble sleeping       O       A 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.)         e. Received counseling of any type       O       O         f. Depression or excessive worry       O       O         g. Been evaluated or treated for a mental condition       O       O         h. Attempted suicide       O       O         i. Used illegal drugs or abused prescription drugs       O       O         8. FEMALES ONLY. Have you ever had or do you now have:       C       C         a. Treatment for a gynecological (female) disorder       O       O         b. A change of menstrual pattern       O       O       C         c. Any abnormal PAP smears       O       O       C         d. First day of last menstrual period (YYYYMMDD)       Z8. Have you ever been denied life insurance?       O         e. Date of last PAP smear (YYYYMMDD)       Z8. Have you ever been denied life insurance?       O         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		and the second		1121	already no	ted? (If yes, specify	when, where, and give details.)	<u> </u>	
a. Trequent double steeping       0			0	10000	24. Have you	consulted or been tre	eated by clinics, physicians,		
f. Depression or excessive worry       0         g. Been evaluated or treated for a mental condition       0         h. Attempted suicide       0         i. Used illegal drugs or abused prescription drugs       0         18. FEMALES ONLY. Have you ever had or do you now have:       0         a. Treatment for a gynecological (female) disorder       0         b. A change of menstrual pattern       0         c. Any abnormal PAP smears       0         d. First day of last menstrual period (YYYYMMDD)       27. Have you ever been denied life insurance?         e. Date of last PAP smear (YYYYMMDD)       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				100	other than	minor illnesses? (If	yes, give complete address	0	0
g. Been evaluated or treated for a mental condition       0         h. Attempted suicide       0         i. Used illegal drugs or abused prescription drugs       0         ii. Used illegal drugs or abused prescription drugs       0         iii. FEMALES ONLY. Have you ever had or do you now have:       0         iii. Treatment for a gynecological (female) disorder       0         iii. Any abnormal PAP smears       0         iii. First day of last menstrual period (YYYYMMDD)       27. Have you ever been denied life insurance?         iii. First day of last PAP smear (YYYYMMDD)       28. Have you ever been denied life insurance?	e.	Received counseling of any type	0		of doctor, i	hospital, clinic, and	details.)	15.1	
g. been evaluated of readed for a membral conduction       0       0       reason? (If yes, give date and reason for rejection.)         h. Attempted suicide       0       0       0         i. Used illegal drugs or abused prescription drugs       0       0         18. FEMALES ONLY. Have you ever had or do you now have:       0       0         a. Treatment for a gynecological (female) disorder       0       0         b. A change of menstrual pattern       0       0         c. Any abnormal PAP smears       0       0         d. First day of last menstrual period (YYYYMMDD)       27. Have you ever been denied life insurance?       0         e. Date of last PAP smear (YYYYMMDD)       28. Have you ever been denied life insurance?       0         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	1000	A second from the second se	0	1.	25 Have you	aver been rejected fr	or military service for any		
i. Used illegal drugs or abused prescription drugs       O         ii. Used illegal drugs or abused prescription drugs       O         iii. FEMALES ONLY. Have you ever had or do you now have:       Image: constraint of the prescription drugs of the prescrugs of the prescription drugs of the prescr	1.1.1			10023-0011				0	0
18. FEMALES ONLY. Have you ever had or do you now have:       reason? (If yes, give date, reason, and type of discharge; whether honorable, other than honorable, for unfitness or unsuitability.)         a. Treatment for a gynecological (female) disorder       0         b. A change of menstrual pattern       0         c. Any abnormal PAP smears       0         d. First day of last menstrual period (YYYYMMDD)       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.)         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		the second second statement and because the second							
a. Treatment for a gynecological (female) disorder       O         b. A change of menstrual pattern       O         c. Any abnormal PAP smears       O         d. First day of last menstrual period (YYYYMMDD)       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.)         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	i.	Used illegal drugs or abused prescription drugs	0	0					
b. A change of menstrual pattern       O       O         c. Any abnormal PAP smears       O       O         d. First day of last menstrual period (YYYYMMDD)       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.)         e. Date of last PAP smear (YYYYMMDD)       28. Have you ever been denied life insurance?       O         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					whether ho	onorable, other than	honorable, for unfitness or	0	0
c. Any abnormal PAP smears       O       applied for pension or compensation for any disability or injury? (If yes, specify what kind, granted by whom, and what amount, when, why.)         e. Date of last PAP smear (YYYYMMDD)       28. Have you ever been denied life insurance?       O         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	100		0	-	unsuitabilit	y.)		2.0	
d. First day of last menstrual period (YYYYMMDD)       or injury? (If yes, specify what kind, granted by whom, and what amount, when, why.)         e. Date of last PAP smear (YYYYMMDD)       28. Have you ever been denied life insurance?       O         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       O		and the second			27. Have you	ever received, is the	re pending, or have you ever		
e. Date of last PAP smear (YYYYMMDD)  28. Have you ever been denied life insurance?  O  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		A Weather a construction of the second state of the second state of the second state of the second state of the	0	0	or injury?	(If yes, specify what	kind, granted by whom,	0	0
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							- 1		
					Participation and the second	And a state of the state of the second state of the state of the		<u> </u>	0
NOTE: HAND TO THE DOCTOR OR NURSE, OR IF MAILED MARK ENVELOPE "TO BE OPENED BY MEDICAL PERSONNEL ONLY." DD FORM 2807-1 OCT 2018 Page 2 of 3 Pa			MARK	ENV	OPE "TO BE	OPENED BY MED	And the second sec	100	

<ul> <li>10. EXAMINER'S SUMMARY AND ELABORATION OF ALL PERTINENT DATA (Physicial/practitioner shall commend in al possible answers in questions 10 - all possible answers 10 - all possible and 10 - all possible answers 10 - all possible answers 10 - all possible and 10 - all po</li></ul>	LAST NAME, FIRST NAME, MIDDLE NAME (SUFFIX)	SOCIAL SECURITY NUMBER	DoD ID NUMBER (If applicable)
<ul> <li>a. COMMENTS</li> <li>See Block 29</li> <li>b. TYPED OR PRINTED NAME OF EXAMINER (Last, First Model Invite)</li> <li>a. SIGNATURE</li> </ul>			
s. COMMENTS See Block 29	30. EXAMINER'S SUMMARY AND ELABORATION OF ALL PERTIN	IENT DATA (Physician/practitioner shall comm	nent on all positive answers in
See Block 29	significant findings here.)	wany additional medical history deemed impo	nani, and record any
<ul> <li>b. TYPED OR PRINTED NAME OF EXAMINER (Last: First: Mode Initial 6. SIGNATURE 4. DATE SIGNED</li> </ul>	a. COMMENTS		
b. TYPED OR PRINTED NAME OF EXAMINER (Last. Frid, Middle Initial) C. SIGNATURE	See Block 29		
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(YYYMMDD)	b. TYPED OR PRINTED NAME OF EXAMINER (Last, First, Middle Initial)	c. SIGNATURE	d. DATE SIGNED
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### 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, media	al, dental or edu	ucational needs	for the purpose	of making a suitability	recommendation for	an overseas,	remote duty, o	r
operationa	l 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 IDENT	FIFICATION CODE (UIC):	TYPE DUTY CL	ASSIFICATION CODE: (Navy enlisted only)				

## DADTI

			PARTI
SECTIO	ON A.	Medica	I Screening. Completed by the medical provider to identify special needs and determine if a Service or family member is
uitable	e for an	overse	as, 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?
and a second			14. Are there any conditions requiring ongoing care in the following areas? ( <i>document on DD 2807-1</i> )
			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)
12 12 15 15 15 15 15 15 15 15 15 15 15 15 15		-	f. Mental health or behavioral conditions (e.g., mood, personality disorder, ADD/ADHD, anxiety, psychosis, autism)
			<ul> <li>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)? (<i>list on DD 2807-1</i>)</li> </ul>
			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 underlyin condition is exacerbated?
			d. Has the service/family member registered with the mail order pharmacy program through TRICARE?

NAVMED 1300/1 (Rev. 1-2016), Part I - Front

Yes	No	N/A		ITEM						
			16. For service/family members with underlying me							
		<ul> <li>a. Is there a requirement for special medical supplies, adaptive equipment, assistive technology devices, special accommodations, etc.?</li> <li>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?</li> </ul>								
			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?							
			<ul> <li>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)</li> </ul>							
			<ul> <li>d. Are there any potential environmental concerns or possible health effects at the gaining location? (<i>if yes, communicate to family and document on appropriate SF 600</i>)</li> </ul>							
			17. For infants and toddlers (birth to 36 months), is services as evidenced by an Individualized Family 5	the child receiving or undergoing eligibility to receive early intervention Service Plan (IFSP)?						
			<ol> <li>For preschool and school age children, is the chandle and/or related services as evidenced by an Individuation</li> </ol>	nild receiving or undergoing eligibility to receive special education alized Education Program (IEP)?						
			19. Explanation of "yes" responses in shaded boxe	s (include #):						
			Are there any concerns about the gaining MTF/oper	ational platform's capabilities to meet the individual's needs? Specify below:						
			Navy MTF SSC Name, Signature, Stamp, and Date:							
			oviders: STOP and proceed to SECTION C							
			and Educational Screening Disposition. Comple ble for an overseas, remote duty, or operational assig	ted by the screening Navy MTF medical provider to determine if a Service or						
Yes	No	13 Suita	bie for all overseas, remote duty, or operational assig	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.									
	1.185	a. Does the gaining location have the capabilities to provide the current required medical support?(Service MTFs/TRICARE, etc.)								
			underlying condition is exacerbated? (To include all	ovide the required medical support (diagnostic and therapeutic) if the Service MTFs/operational platform, TRICARE, etc.)						
		If ye	e shaded block of question 18 checked "yes"? s, Submit the DD 2792-1 and IEP to the gaining DoDEA ies to provide required support. (Attach Reply with POC	Special Education Overseas Screening Coordinator and gaining MTF to determine local C info and answer question 2a.) If no, proceed to question 3.						
		a. I	s the DoDEA Special Education Overseas Screening Coord	dinator recommending travel?						
Y	es			R SUITABLE FOR THE OVERSEAS, REMOTE DUTY OR OPERATIONAL by an <u>MTF</u> medical screener. Answered after the inquiry is completed.)						
review	and con	untersig		ian providers who completed PART I. The Navy MTF medical screener shall TF civilian providers, denoting accountability for a complete and thorough						
Navy	MTF M	edical S	creener (Signature) Date	Non-Navy MTF/Civilian Medical Screener (Signature) Date						
		e, Rank BANG	or Grade	Printed Name						
	or Duty			Address						
(360) 315-4346										
Telephone Number (include area/country code)				City, State, and Zip Code						
DSN	Numbei			Telephone Number (include area/country code)						
Office	Hours	to conta	ct	Office Hours to Contact						
E-mai	I Addre	SS		E-mail Address						
		-								

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SERVIC	PART II						
	CE / FA	MILY MEMBER N	AME		ATE / FAMILY MEMBER PREFIX		
the purp	pose of	assessing and ma	atching the dental r	needs of a service/fam	dentist prior to an overseas, remote duty, or operational assignment for ily member to the support capabilities of the gaining medical treatment <b>24 months, a pediatrician may perform an oral dental screening.</b>		
Yes	No				ITEM		
				y and civilian) reviewe			
					days since last T-1 or T-2 dental exam, a dental officer/privileged nd interval medical and dental history.)		
			,		d or treated at a non-Navy facility?		
					dental treatment or examination be completed before the transfer?		
		5. Is there a requ	irement for follow-	on care such as ortho	dontics, implants, specialty prosthetics, etc.?		
S alte		,		1 0	e or continuing access to care or access to specialized dental care?		
		7. Are there any	concerns about the	e gaining MTF/operati	onal platform's capabilities to meet the individual's needs? Specify below:		
		Navy MTF SSC Na	ime, Signature, Star	mp, and Date:			
	cify De	ntal Class: (require	d for service mem	bers)			
		sifications: (Per D nsidered worldwi					
Class	1 - Pat 2 - Pat	tients with a curren	t dental examination t dental examination		dental treatment or re-evaluation. rgent dental treatment or re-evaluation for oral conditions unlikely to result in		
			dwide deployable		oral conditions with a high potential to cause a dental emergency in the next		
Class	4 - Patexa	amination was com	pleted by a dental	officer/privileged dent	No type 1 (comprehensive) or type 2 (annual or periodic oral) dental ist within the past 12 months; (2) A patient's dental record does not exist or		
ECTIO	. ,				atment facility or Medical Department activity. In MTF provider to determine if a service or family member is suitable for an		
versea	s, remo	ote duty, or operation	onal assignment.	Non-Navy Medical Pr	oviders: STOP and proceed to SECTION C.		
Yes	No		a above shaded b		ITEM		
<ol> <li>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)     </li> </ol>							
		If yes, su loca	bmit a suitability inc	quiry to the gaining MT cal dental capabilities f	F or medical department supporting the overseas/remote duty/operational		
		If yes, su loca If no, pro	bmit a suitability industrian to determine loc ceed to question 3.	quiry to the gaining MT cal dental capabilities f	F or medical department supporting the overseas/remote duty/operational		
Y	/es	If yes, su loca If no, pro	bmit a suitability induction to determine loc ceed to question 3. ining MTF/operation 3. IS THE SERV	quiry to the gaining MT cal dental capabilities f phal platform have the ICE/FAMILY MEMBEI	F or medical department supporting the overseas/remote duty/operational to provide required support. (Attach Reply and answer question 2)		
SECTIC review a	ON C. and cor	If yes, su loca If no, pro 2. Does the ga No Contact Informati untersign all suitab	brit a suitability indition to determine loc seed to question 3. ining MTF/operation 3. IS THE SERVI ASSIGNMENT? ( on. Completed by ility screenings cor	quiry to the gaining MT cal dental capabilities f onal platform have the ICE/FAMILY MEMBEI (Must be completed b the MTF/non-MTF civ	F or medical department supporting the overseas/remote duty/operational to provide required support. (Attach Reply and answer question 2) capabilities to provide the current required dental support?		
SECTIC review a suitabili	ON C. and cou	If yes, su loca loca lf no, prod 2. Does the ga No Contact Informati untersign all suitab ening document re	brit a suitability indition to determine loc ceed to question 3. ining MTF/operation 3. IS THE SERVI ASSIGNMENT? ( ion. Completed by ility screenings conview for each Service)	quiry to the gaining MT cal dental capabilities f onal platform have the ICE/FAMILY MEMBER (Must be completed b the MTF/non-MTF cis mpleted by non-Navy I vice/family member.	F or medical department supporting the overseas/remote duty/operational to provide required support. (Attach Reply and answer question 2) capabilities to provide the current required dental support? R SUITABLE FOR THE OVERSEAS, REMOTE DUTY OR OPERATIONAL by an <u>MTF</u> dental screener. Answered after the inquiry is completed.) vilian providers who completed PART II. The Navy MTF dental screener shall MTF civilian providers, denoting accountability for a complete and thorough		
SECTIC review a suitabili	ON C. and cou	If yes, su loca If no, pro 2. Does the ga No Contact Informati untersign all suitab	brit a suitability indition to determine loc ceed to question 3. ining MTF/operation 3. IS THE SERVI ASSIGNMENT? ( ion. Completed by ility screenings conview for each Service)	quiry to the gaining MT cal dental capabilities f onal platform have the ICE/FAMILY MEMBEI (Must be completed b the MTF/non-MTF civ mpleted by non-Navy I	F or medical department supporting the overseas/remote duty/operational to provide required support. ( <i>Attach Reply and answer question 2</i> ) capabilities to provide the current required dental support? R SUITABLE FOR THE OVERSEAS, REMOTE DUTY OR OPERATIONAL by an <u>MTF</u> dental screener. Answered after the inquiry is completed.) vilian providers who completed PART II. The Navy MTF dental screener shall		
SECTIC eview a suitabili Navy N	ON C. and cou ity scree	If yes, su loca loca lf no, prod 2. Does the ga No Contact Informati untersign all suitab ening document re	brit a suitability indition to determine loc ceed to question 3. ining MTF/operation 3. IS THE SERVI ASSIGNMENT? ( ion. Completed by ility screenings conview for each Service)	quiry to the gaining MT cal dental capabilities f onal platform have the ICE/FAMILY MEMBER (Must be completed b the MTF/non-MTF cis mpleted by non-Navy I vice/family member.	F or medical department supporting the overseas/remote duty/operational to provide required support. (Attach Reply and answer question 2) capabilities to provide the current required dental support? R SUITABLE FOR THE OVERSEAS, REMOTE DUTY OR OPERATIONAL by an <u>MTF</u> dental screener. Answered after the inquiry is completed.) vilian providers who completed PART II. The Navy MTF dental screener shall MTF civilian providers, denoting accountability for a complete and thorough		
Navy M Printec	ON C. and cou ity scree	If yes, su loca loca lf no, prod 2. Does the ga No Contact Informat untersign all suitab ening document re- intal Screener (Sign , Rank or Grade	brit a suitability indition to determine loc ceed to question 3. ining MTF/operation 3. IS THE SERVI ASSIGNMENT? ( ion. Completed by ility screenings conview for each Service)	quiry to the gaining MT cal dental capabilities f onal platform have the ICE/FAMILY MEMBER (Must be completed b the MTF/non-MTF cis mpleted by non-Navy I vice/family member.	F or medical department supporting the overseas/remote duty/operational to provide required support. (Attach Reply and answer question 2) capabilities to provide the current required dental support? R SUITABLE FOR THE OVERSEAS, REMOTE DUTY OR OPERATIONAL by an <u>MTF</u> dental screener. Answered after the inquiry is completed.) rilian providers who completed PART II. The Navy MTF dental screener shal MTF civilian providers, denoting accountability for a complete and thorough Non-Navy Medical Facility/Civilian Dental Screener (Signature) Date		
SECTIO review a suitabili Navy M Printec MTF or	ON C. and con ity scree MTF De d Name	If yes, su loca loca lf no, prod 2. Does the ga No Contact Informat untersign all suitab ening document re- intal Screener (Sign , Rank or Grade	brit a suitability indition to determine loc ceed to question 3. ining MTF/operation 3. IS THE SERVI ASSIGNMENT? ( ion. Completed by ility screenings conview for each Serv ature)	quiry to the gaining MT cal dental capabilities f onal platform have the ICE/FAMILY MEMBER (Must be completed b the MTF/non-MTF cis mpleted by non-Navy I vice/family member.	F or medical department supporting the overseas/remote duty/operational to provide required support. (Attach Reply and answer question 2) capabilities to provide the current required dental support? R SUITABLE FOR THE OVERSEAS, REMOTE DUTY OR OPERATIONAL by an <u>MTF</u> dental screener. Answered after the inquiry is completed.) rilian providers who completed PART II. The Navy MTF dental screener shal MTF civilian providers, denoting accountability for a complete and thorough Non-Navy Medical Facility/Civilian Dental Screener (Signature) Printed Name		
SECTIO review a suitabili Navy M Printec MTF or	ON C. and con ity scree MTF De d Name	If yes, su loca If no, prov 2. Does the ga No Contact Informat untersign all suitab ening document re intal Screener (Sign , Rank or Grade Station	brit a suitability indition to determine loc ceed to question 3. ining MTF/operation 3. IS THE SERVI ASSIGNMENT? ( ion. Completed by ility screenings conview for each Serv ature)	quiry to the gaining MT cal dental capabilities f onal platform have the ICE/FAMILY MEMBER (Must be completed b the MTF/non-MTF cis mpleted by non-Navy I vice/family member.	F or medical department supporting the overseas/remote duty/operational to provide required support. (Attach Reply and answer question 2)         capabilities to provide the current required dental support?         R SUITABLE FOR THE OVERSEAS, REMOTE DUTY OR OPERATIONAL by an <u>MTF</u> dental screener. Answered after the inquiry is completed.)         vilian providers who completed PART II. The Navy MTF dental screener shall         MTF civilian providers, denoting accountability for a complete and thorough         Non-Navy Medical Facility/Civilian Dental Screener (Signature)         Date         Address		
SECTIO eview a suitabili Navy M Printec MTF of Teleph	ON C. and con ity scree MTF De d Name	If yes, su loca If no, prov 2. Does the ga No Contact Informat untersign all suitab ening document re intal Screener (Sign , Rank or Grade Station	brit a suitability indition to determine loc ceed to question 3. ining MTF/operation 3. IS THE SERVI ASSIGNMENT? ( ion. Completed by ility screenings conview for each Serv ature)	quiry to the gaining MT cal dental capabilities f onal platform have the ICE/FAMILY MEMBER (Must be completed b the MTF/non-MTF cis mpleted by non-Navy I vice/family member.	F or medical department supporting the overseas/remote duty/operational to provide required support. (Attach Reply and answer question 2)         capabilities to provide the current required dental support?         R SUITABLE FOR THE OVERSEAS, REMOTE DUTY OR OPERATIONAL by an <u>MTF</u> dental screener. Answered after the inquiry is completed.)         vilian providers who completed PART II. The Navy MTF dental screener shall         MTF civilian providers, denoting accountability for a complete and thorough         Non-Navy Medical Facility/Civilian Dental Screener (Signature)         Date         Address		
BECTIC eview a suitabili Navy M Printec MTF of Teleph DSN N	MTF De d Name	If yes, su loca If no, prov 2. Does the ga No Contact Informat untersign all suitab ening document re intal Screener (Sign , Rank or Grade Station	brit a suitability indition to determine loc ceed to question 3. ining MTF/operation 3. IS THE SERVI ASSIGNMENT? ( ion. Completed by ility screenings conview for each Serv ature)	quiry to the gaining MT cal dental capabilities f onal platform have the ICE/FAMILY MEMBER (Must be completed b the MTF/non-MTF cis mpleted by non-Navy I vice/family member.	F or medical department supporting the overseas/remote duty/operational to provide required support. (Attach Reply and answer question 2)         capabilities to provide the current required dental support?         R SUITABLE FOR THE OVERSEAS, REMOTE DUTY OR OPERATIONAL by an <u>MTF</u> dental screener. Answered after the inquiry is completed.)         villan providers who completed PART II. The Navy MTF dental screener shall         MTF civilian providers, denoting accountability for a complete and thorough         Non-Navy Medical Facility/Civilian Dental Screener (Signature)         Date         Printed Name         Address         City, State, and Zip Code		
SECTIC eview a suitabili Navy M Printec MTF of Teleph DSN N Office	MTF De d Name	If yes, su loca lf no, prod 2. Does the ga No Contact Informat untersign all suitab ening document re- intal Screener (Sign , Rank or Grade Station imber (include areau o Contact	brit a suitability indition to determine loc ceed to question 3. ining MTF/operation 3. IS THE SERVI ASSIGNMENT? ( ion. Completed by ility screenings conview for each Serv ature)	quiry to the gaining MT cal dental capabilities f onal platform have the ICE/FAMILY MEMBER (Must be completed b the MTF/non-MTF cis mpleted by non-Navy I vice/family member.	F or medical department supporting the overseas/remote duty/operational to provide required support. (Attach Reply and answer question 2)         capabilities to provide the current required dental support?         R SUITABLE FOR THE OVERSEAS, REMOTE DUTY OR OPERATIONAL by an <u>MTF</u> dental screener. Answered after the inquiry is completed.)         ilian providers who completed PART II. The Navy MTF dental screener shall         MTF civilian providers, denoting accountability for a complete and thorough         Non-Navy Medical Facility/Civilian Dental Screener (Signature)         Date         Printed Name         Address         City, State, and Zip Code         Telephone Number (include area/country code)		

# MEDICAL, DENTAL, AND EDUCATIONAL SUITABILITY SCREENING CHECKLIST AND WORKSHEET

Privacy Act Statement: OPNAVINST 1300.14D authorizes collection of conduct medical, dental, and educational screening to determine suitabil information is essential for completion of screening. Disclosure is volunta orders held in abeyance until completion of screening, or affect the amou	this informati ity for an ove ary, however int of leave in	on. The following information and documents, as a rseas, remote duty, or operational assignment. Co , missing or incomplete information may delay the transit. Refer to BUMEDINST 1300.28 for implement	applicable, a omplete and screening pr nenting guid:	are requi current rocess, r ance.	red to result in	
The Suitability Screening Coordinator (SSC) at the military treatment faci ensure required information and documents are complete and current be will place the completed original from in the individual's Service Treatmen educational suitability screening is valid for 12 months from the date of co of the service or family member. The service member must notify his or h <i>Complete one form for each Service and family member screened</i> .	fore referral t t Record/No ompletion if t	o a MTF provider for screening and a suitability rec n-Service Treatment Record and retain a copy for a here were no significant changes in the medical, do	commendatio audit. Medic ental, or edu	on. The cal, denta icational	SSC al, and status	
SERVICE MEMBER NAME	GRADE	/RATE DOD ID				
CURRENT UNIT		(TELEPHONE NUMBER)				
NEXT DUTY STATION LOCATION & UNIT IDENTIFICATION CODE (U	IIC}	(TYPE DUTY CLASSIFICATION CODE (Navy B	Enlisted Cod	le Only}		
FAMILY MEMBER NAME		FAMILY MEMBER PREFIX	Age			
ITEM				C Revie	W	
A. FOR SERVICE MEMBERS:			YES	NO	N/A	
1. Legible copy of orders or an Overseas Screening Notification						
indicate the platform to which assigned and a description of the 2. Each family member name, family member prefix, social sect	duty assign	ment.)		+		
than the service member's.						
SERVICE TREATMENT RECORD TO INCLUDE:						
3. All Physical Exams (to include special duty aviation, submaring the Service Treatment Record?	ne, radiation	, asbestos, etc.) are current and filed in				
a. Type of Physical:	b. Complet	ion Date of Physical;				
4. Annual Periodic Health Assessment (PHA) current and						
5. Current medical history (DD Form 2807-1)						
6. Hearing (Audiogram) Date:						
7. Vision Examination Date:						
8. G6PD Test Date:						
9. PPD Test Date:						
10. Sickle Cell Trait Test Date:						
11. Negative HIV results current to 1 year of transfer Date Drawn:						
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 reco admissions in civilian facilities.	ords to incluc	le narrative summaries of any inpatient				
17. Mammogram current and documented. Date:	17. Mammogram current and documented. Date:					
18. Pregnancy screen (verbal inquiry). (Also, command will refe	r for pregna	ncy test 30 days prior to departure date.)				
Other:						
B. FOR FAMILY MEMBERS:				1	1	
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 reco admissions in civilian facilities. Include a completed DD Form 2		e narrative summaries of any inpatient				
3. Recommended ACIP and required country specific immuniza requirements issued by the Centers for Disease Control and Pr	ations (checl					
	0/ 11001101			1	1	

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ITEM SS									
						I N/A			
	1. DD FORM 2792-1 (Required for ALL children birth to 22 <sup>rr0</sup> 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):								
	-	f available, developmental assessments or evaluations							
	FOR PRESCHOOL OR SCHOOL-AGE CHILDREN (Ages 3 to 22" <sup>0</sup> Birthday or High School Graduation) ELIGIBLE TO RECEIVE SPECIAL EDUCATION AND RELATED SERVICES AS EVIDENCED BY AN INDIVIDUALIZED EDUCATION PROGRAM (IEP):								
		available, developmental assessments or evaluations.							
FOR		ED OR UNDERGOING ENROLLMENT IN THE EXCE		PROGR		-MP):			
	4. Copy of the DD Form 2792 and	any EFMP correspondence.							
	OR SSC USE ONLY								
	ate suitability screening conducted	I. Date:							
	1. Are any of the shaded blocks	checked on NAVMED Form 1300/1?							
		required, proceed to question 2)							
		tion 2 and proceed to section F)							
(in (i)									
	2. Suitability Inquiry:	Date & Time sent:	Renly date & time <sup>.</sup>						
	Potential need identified	Sent by (Sending SSC):							
	N/A	Sent to (Gaining SSC):							
			E-Mail:						
	Dental Services:	Date & Time sent:							
	Potential need identified	Sent by (Sending SSC):				-			
	N/A	Sent to (Gaining SSC):							
			E-Mail:						
	Special Education Services:	Date & Time sent:	Reply date & time:						
	Potential need identified	Sent by (Sending SSC):	Reply from:						
	N/A	Sent to (Gaining SSC):	Contact#:						
			E-Mail:						
		Sent to (Gaining DoDEA):	E-Mail:						
Othe	er information:								
8						7			
F. S	UITABILITY SCREENING COORDI	NATOR FACILITY:							
		Signature	Date						
Print	ed Name:								
E-ma	ail:								
Pho	ne:								
L									

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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.			
<ol> <li>If a shaded block is checked on NAVMED 1300/1, coord operational location; or with the senior medical department required medical, dental, or educational capabilities are available.</li> </ol>	representative		
<ol> <li>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).</li> </ol>			
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. C Yes C No			
FAMILY MEM	BERS SUITABI	LITY FOR THIS AS	SSIGNMENT.
2. NAME:	C N	3. NAME:	
2. NAME: CYes	( No	o. To IME.	(Yes No
4. NAME: CYes	( No	5. NAME:	(Yes (No
6. NAME: Yes	( No	7. NAME:	C Yes C No
( res			(Yes No
The following family member(s) were referred for Exce FOR EFM DETERMINATION):	ptional Family	Member Program	I (EFMP) enrollment (DO NOT DELAY SCREENING
8. NAME (s):			
9. NAME OF CO/OIC OR DESIGNEE OF MEDICAL	10. DATE:		9. SIGNATURE OF CO/OIC OR DESIGNEE OF
TREATMENT FACILITY:			MEDICAL TREATMENT FACILITY:
NAVPERS 1300/16 (rev. 11-09)		IAL USE ONLY	PAGE 3 OF

PRIVACY SENSITIVE