

FOR USE OF THIS FORM, SEE USMEPCOM REG 680-3	REQUEST FOR EXAMINATION THE INFORMATION PROVIDED CONSTITUTES AN OFFICIAL STATEMENT	FOR OFFICIAL USE ONLY
PRIVACY ACT STATEMENT AUTHORITY: Sections 505, 508, 510, and 3012 of Title 10 U.S. Code and Executive Order 9397. PRINCIPAL PURPOSE: To request administration of enlistment aptitude and/or medical qualification examinations. Social Security Number is used to positively identify examination results. ROUTINE USE: Record is maintained with other enlistment processing records. DISCLOSURE: Voluntary; refusal to provide required data could result in denial of enlistment.		
A. SERVICE PROCESSING FOR	B. PRIOR SERVICE [] YES [] NO	C. SELECTIVE SERVICE CLASSIFICATION
D. SELECTIVE SERVICE REGISTRATION NUMBER		
1. SOCIAL SECURITY NUMBER	2. NAME (Last, First, Middle Name (and Maiden, if any), Jr., Sr., etc.)	
3. CURRENT ADDRESS (Street, City, County, State, Country, ZIP Code)	4. HOME OF RECORD ADDRESS (Street, City, County, State, Country, ZIP Code)	
5. CITIZENSHIP (X One)	6. SEX (X One)	7.a. RACIAL CATEGORY (X one or more)
a. U.S. AT BIRTH (If this box is marked, also X (1) or (2))	a. MALE	(1) AMERICAN INDIAN/ ALASKA NATIVE
(1) NATIVE BORN	b. FEMALE	(4) NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER
(2) BORN ABROAD OF U.S. PARENT(S)	8. MARITAL STATUS (Specify)	(2) ASIAN
b. U.S. NATURALIZED	9. NUMBER OF DEPENDENTS	(3) BLACK OR AFRICAN AMERICAN
c. U.S. NON-CITIZEN NATIONAL	7.b. ETHNIC CATEGORY (X One)	(5) WHITE
d. IMMIGRANT ALIEN (Specify)	(1) HISPANIC OR LATINO	(6) DECLINE TO RESPOND
e. NON-IMMIGRANT FOREIGN NATIONAL (Specify)	(2) NOT HISPANIC OR LATINO	(3) DECLINE TO RESPOND
f. ALIEN REGISTRATION NUMBER (As applicable)	10. DATE OF BIRTH (YYYYMMDD)	11. RELIGIOUS PREFERENCE (Optional)
12. EDUCATION (Yrs/Highest Ed Gr Completed)	13. PROFICIENT IN FOREIGN LANGUAGE (X One) (If Yes, specify)	1st 2nd
14. VALID DRIVER'S LICENSE (X One) [] YES [] NO (If Yes, list State, number, and expiration date)	15. PLACE OF BIRTH (City, State, and Country)	
16. APTITUDE: a. ASVAB REQUIRED TO ENLIST? (X One) [] YES [] NO	c. TEST TYPE [] INITIAL [] 1ST RETEST [] 6 MONTH RETEST	e. PREVIOUS TEST VERSIONS 1. 2.
b. ENLIST UNDER STUDENT TEST SCORES? (X One) [] YES [] NO	d. RETEST [] SPECIAL [] 2ND RETEST [] IMMEDIATE RETEST AUTHORIZED	f. PREVIOUS TEST DATES (YYYYMMDD) 1. 2.
17.a. RECRUITER ID/SSN	b. STATION ID	18. TEST ADMINISTRATOR SSN/ID
19. TEST ADMINISTRATOR SIGNATURE		20. MEDICAL: a. MEPS MEDICAL EXAM REQUIRED TO ENLIST? (X One) [] YES [] NO
b. EXAM TYPE [] FULL [] SPECIAL [] RE-EXAM [] INSPECT [] CONSULT [] OTHER	c. DATE LAST FULL MEDICAL EXAM (YYYYMMDD)	
21. APPLICANT'S SIGNATURE	22. MIRS CODING	
	WKID	ST
	DATE	INT
	DATE	INT
23. APPLICANT CERTIFICATION IN PRESENCE OF TEST ADMINISTRATOR I certify that I am the person identified on this form:	Photo ID? (X One) [] YES [] NO	24. RIGHT THUMBPRINT
(Signature of Applicant)	If yes, type/organization _____ ID Number _____	RIGHT THUMBPRINT, FIRST ATTEMPT (AFFIX THUMBPRINT WITH THUMBNAIL POINTED TO THE LEFT)
25. APPLICANT CERTIFICATION IN PRESENCE OF RECRUITING PERSONNEL I certify that I am the person identified on this form and that the information about me shown there, including my Social Security Number is all true and correct to the best of my knowledge. I also certify that:	a. <input type="checkbox"/> I have never been tested ANYTIME or ANYWHERE with the ASVAB either for enlistment purposes or as a student under the ASVAB testing program.	IF SECOND ATTEMPT IS REQUIRED, TURN FORM OVER (TOP OF FORM ON THE BOTTOM) AFFIX RIGHT THUMBPRINT ON UPPER RIGHT CORNER, THUMBNAIL POINTED TO THE LEFT
b. <input type="checkbox"/> I was tested with the ASVAB on or about _____ at _____ (Most Recent Date Tested) (School, City, and State)	c. <input type="checkbox"/> Request for student test scores (high school look-up) _____ at _____ (Most Recent Date Tested) (School, City, and State)	
d. <input type="checkbox"/> Yes, I want to keep my AFQT scores from the student test listed in "c" above.	e. Current or last high school attended _____ / _____ (High School) OR (13 Digit Code)	
f. _____ / _____ / _____ (Signature of Applicant) (Social Security Number) (Date)		
MEDICAL RECORDS RELEASE AUTHORITY: I request and authorize individuals/organizations listed below to release to the MEPS a complete transcript of my medical records. This release is for the purpose of further evaluation of my medical acceptability under military medical fitness standards. The medical records are to be obtained by this examinee at no cost to the Government and made available for review during the pre-enlistment physical.		
26. APPLICANT'S CURRENT MEDICAL INSURER NAME (If none, sign your complete name to affirm that you have no current medical insurer):	27. APPLICANT'S CURRENT MEDICAL PROVIDER NAME (If none, sign your complete name to affirm that you have no current medical provider):	
28. MEDICAL INSURER ADDRESS (Street, City, State, Country, ZIP Code)	29. MEDICAL PROVIDER ADDRESS (Street, City, State, Country, ZIP Code)	
30. CERTIFICATION BY RECRUITING PERSONNEL I certify that I have properly identified this applicant in accordance with my service directives, have reviewed for completeness and accuracy the information provided on this form, and have witnessed the applicant's signature:		APPLICANT SSN
(Signature of Recruiter (or rep, if auth))	(Printed/Typed Name of Recruiter or Rep)	(Date)
(Printed/Typed Name of Recruiter (if not recorded above))		
(Recruiter ID/SSN)	(Local Recruiting Activity)	(Bn, NRD, Sq or RS Location)