

REPORT OF MEDICAL EXAMINATION/TREATMENT

(For use of this form, see USMEPCOM Reg 40-1)

FOR OFFICIAL USE ONLY

Page ____ of ____

TO: (Applicant's physician or hospital)

FROM: (Name of applicant)

DATE:

I wish to join a branch of the Armed Forces of the United States, but cannot do so until I have demonstrated I am physically and mentally qualified. You have records that will help me provide part of the necessary information. It is my responsibility to obtain accurate information about significant items in my medical history. Before I can join, I need copies of the records pertaining to:

Please forward copies from my medical history file concerning the medical condition identified in section above. The copies of my medical history file must include the following:

- 1) Inclusive dates of treatment (including emergency room visits)
- 2) Duration of hospitalization (if applicable)
- 3) Diagnosis
- 4) Significant findings
- 5) Results of laboratory tests and x-rays
- 6) Therapy
- 7) Current status of condition
- 8) Prognosis. If currently under observation, approximately how much longer will it be necessary?
- * 9) High blood pressure
- * 10) Rapid pulse rate
- * 11) Seizures

*** NOTE: In cases where a history of high blood pressure, rapid pulse rate, or seizures exist, additional information is required. SEE BACK OF FORM.**

I request and authorize you to release to the military entrance processing station (MEPS), a complete transcript of my medical records, to include the above information. This release is for purposes of further evaluation of my medical acceptability under military medical fitness standards. I have also signed DD Form 2005, Privacy Act Statement - Health Care Records, which serves as the authority for collection of my social security number on this form. The above information and record are to be obtained by the examinee at no cost to the Government.

SIGNATURE OF APPLICANT

APPLICANT'S SOCIAL SECURITY NUMBER

DATE:

* If high blood pressure or tachycardia exist, provide the following information at 1 hour intervals.

DATE/TIME _____ B/P _____ PULSE _____

DATE/TIME _____ B/P _____ PULSE _____

DATE/TIME _____ B/P _____ PULSE _____

* If a history of seizures exists, records must show the following, as a minimum.

- a) Date of onset
- b) Type of seizure
- c) Frequency of seizure
- d) Date of last seizure
- e) Type of anticonvulsive medications used
- f) Date anticonvulsive medications were discontinued

Anything the physician wishes to add about the ability to undertake rigorous military training, including physical exertion and periods of stress, type or print below. (ATTACH A CONTINUATION SHEET IF ADDITIONAL SPACE IS NEEDED.)

Enclosed are the requested copies of the medical history file pertaining to the medical condition of the applicant.

PRINT or TYPE name of physician _____

Degree (s) _____

Address _____

Signature _____

Date _____

Please mail the completed form along with copies of medical history in the enclosed envelope.