INSTRUCTIONS FOR COMPLETING DD FORM 2807-2, ACCESSIONS MEDICAL PRESCREEN REPORT

1. This form is to be completed by each individual who requires medical processing in accordance with Department of Defense Instruction (DODI) 6130.03, "Physical Standards for Appointment, Enlistment, or Induction" and DODI 1304.02, "Accession Processing Data Collection Forms." This form must be completed by the applicant with the assistance of the recruiter, parent(s), or guardian, as needed.

2. Replaces the existing medical prescreen form (DD Form 2807-2, AUG 2011). Additional questions have been added to improve its usefulness to the accessions medical pre-screening process. The questions are intended to provide the U.S. Military Entrance Processing Command (USMEPCOM) with health history information necessary to identify conditions commonly related to medical causes for separation during basic and follow-on training (per P.L. 105-85, Div. A, Title V, S 532).

3. Use of medical history information facilitates efficient, timely, and accurate medical processing of individuals applying for Service in the United States Armed Forces or United States Coast Guard. Positive responses do not automatically result in disqualification but are necessary to prompt further explanation that will be used to determine medical qualification. Medical history information assists USMEPCOM medical personnel in the medical prescreening of applicants. Accurate responses to all questions are critical and all positive responses must be fully explained. Applicant responses to questions may be verified using electronically obtained medical history by the USMEPCOM. Medical history information will be used by the Department of Defense for continuity of care purposes if and when an applicant accesses into the Armed Forces or Coast Guard. Supporting medical information in the form of historical medical records may also be attached to the Service member's medical record. Medical history information collected by the USMEPCOM during accession medical processing will serve as the foundation for a Service member's lifecycle medical treatment record.

4. The completed DD Form 2807-2 along with all substantiating and supporting medical documents must be delivered to USMEPCOM for review prior to scheduling the applicant for medical examination. All documents must be submitted for review in accordance with standards below. After review, the Military Entrance Processing Station (MEPS) will notify the Recruiting Service of the applicant's status.

- 1 processing day prior for applicants with no positive medical history (all items marked "NO" with the exception of items 9 (glasses/contacts), 11 (defective color vision), and 20 (braces) which can be "YES").

- 2 processing days prior; for applicants with ANY positive medical history (other than those noted above) and 5 OR LESS single-sided pages of supporting medical documents.

- 3 processing days prior; for applicants with ANY positive medical history (other than those noted above) and MORE THAN 5 single-sided pages of supporting medical documents.

Secure electronic submission is preferable; if not feasible bring/mail to the nearest MEPS which can be found at http://www.mepcom.army.mil/battalions/index.html. All supporting medical documentation must be present with the DD Form 2807-2 to meet the above timeframes for review. After review by a USMEPCOM provider, appropriate processing notification will be made.

5. If an applicant has been seen by any Health Care Provider (HCP) and/or has been hospitalized for any reason, medical records/documentation must be obtained and submitted along with a medical release to USMEPCOM. Provide all medical documents via secure electronic submission (if possible) to the nearest MEPS. If hand-carried or mailed, ensure they are sealed in an envelope marked: "CONFIDENTIAL: MEPS MEDICAL DEPARTMENT".

a. If the applicant was evaluated and/or treated on an out-patient basis, obtain a copy of actual treatment records of the private medical doctor/HCP including:

(1) office or clinic assessment and progress notes, including the initial assessment documents, subsequent evaluation and treatment documents, and record of date when released from care to full, unrestricted activity;
(2) emergency room (ER) report(s);
(3) study reports (e.g. x-ray, magnetic resonance imaging (MRI), Computerized Tomography (CT), etc.);
(4) procedure reports (e.g., arthroscopy, electroencephalogram (EEG; brain wave test), echocardiogram (ultrasound of the heart), etc.);
(5) pathology reports (e.g., tissue specimens sent to lab for microscopic diagnosis, abnormal PAP smear cytology, etc.);
(6) specialty consultation records (e.g., neurologist, cardiologist, OB/GYN, gastroenterologist, orthopedic surgeon, pulmonologist, allergist, etc.).

b. If the applicant was hospitalized, obtain a copy of the inpatient hospital record, to include (if any): ER report, admission history and physical, study reports, procedure reports, operative report (example: surgery to bone or joint), pathology report, specialty consultation reports, and discharge summary.

c. If an applicant has been diagnosed or treated for any attention disorder (Attention Deficit Disorder (ADD), Attention Deficit Hyperactivity Disorder (ADHD), etc.), academic skills or perceptual defect, or had an Individualized Education Plan or 504 Plan, call/contact the MEPS medical department for additional instructions.

d. Obtain any and all documents relating to any evaluation, treatment or consultation with a psychiatrist, psychologist counselor, or therapist, on an inpatient or out-patient basis for any reason, including but not limited to counseling or treatment for adjustment or mood disorder, family or marriage problems, depression, treatment or rehabilitation for alcohol, drug, or substance abuse.

6. MEPS Chief Medical Officers (CMOs) may locally modify the above instructions and instruct recruiters on what supporting medical documents they require to complete the DD Form 2807-2 medical prescreen review, if doing so enhances the efficiency of medical processing and is consistent with DODI 6130.03 and USMEPCOM guidance.

7. If all attempts to obtain required substantiating and supporting medical documents fail, the recruiter must contact the MEPS medical department for guidance prior to submitting an incomplete medical prescreen packet.

ACCESSIONS MEDICAL PRESCREEN REPORT

OMB No. 0704-0413
OMB approval expires
Oct 31, 2017

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 this burden estimate or any other aspect of this collection of information, including suggestions for reducing the burden, to the Department of Defense, Washington Headquarters Services, Executive Services Directorate, Directives Division, 4800 Mark Center Drive, Alexandria, VA 22350-3100 (0704-0413). 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 ADDRESS.**

PRIVACY ACT STATEMENT

AUTHORITY: 10 U.S.C. 504, 505, 507, 532, 978, 1201, 1202, and 4346; and E.O. 9397 (SSN).
PRINCIPAL PURPOSE(S): To obtain medical data for determination of medical fitness for enlistment, induction, appointment and retention for applicants and members of the Armed Forces. The information will also be used for medical boards and separation of Service members from the Armed Forces.
ROUTINE USE(S): DoD Blanket Routine Uses found at http://dpcld.defense.gov/Privacy/SORNsIndex/BlanketRoutineUses.aspx apply to the use of this data.
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. For an Armed Forces member, failure to provide the information may result in the individual being placed in a non-deployable status.

WARNING: The information you have given constitutes an official statement. Federal law provides severe penalties (up to 5 years confinement or $10,000 fine, or both), to anyone making a false statement. If you are selected for enlistment, commission or entrance into a commissioning program based on a false statement, you may be subject to prosecution under the Uniform Code of Military Justice or to administrative separation proceedings for discharge, and could receive a less than honorable discharge."

SECTION I - APPLICANT

1. LAST NAME - FIRST NAME - MIDDLE INITIAL (SUFFIX)	2. AGE	3. DATE OF BIRTH *(YYYYMMDD)*	4. SOCIAL SECURITY NUMBER

5. HEIGHT *(inches)*	6. WEIGHT *(lbs.)*	7. MAX WEIGHT *(lbs.)*	8. SERVICE AND COMPONENT *(X as applicable)*			9. DATE *(YYYYMMDD)*
			☐ Army	☐ USMC	☐ Regular	
			☐ Navy	☐ USCG	☐ Reserve Component	
			☐ USAF	☐ Other: NROTC	☐ National Guard	

10. PURPOSE OF EXAMINATION *(X as applicable)*		11. POSITION *(If a current Federal Employee) (Job Title, Grade, Component)*	12. USUAL OCCUPATION
☐ Enlistment	☐ U.S. Service Academy	N/A	N/A
☐ Commission	☐ ROTC Scholarship		
☐ Retention	☐ Other *(Specify)* New Student Indoctrination		

SECTION II - MEDICAL HISTORY. Initial each item "Yes" or "No". All "Yes" items must be fully explained in Section III (Pages 4 and 5).

CURRENTLY HAVE OR ANY HISTORY OF:	YES	NO
EYES		
1. Double vision		
2. Detached retina or surgery to repair a detached retina		
3. Cataracts or surgery for cataracts		
4. Eye surgery to improve vision (RK, PRK, LASIK, etc.)		
5. Night blindness		
6. Glaucoma		
7. Strabismus or "lazy eye" or any surgery to correct these		
8. Any other eye condition, injury or surgery		
VISION		
9. Worn/wear contact lenses or glasses (Bring your contact lens kit and solution so you can remove contacts during vision testing, or for best results remove 72 hours prior. Bring your eyeglasses no matter how old they are.)		
10. Loss of vision in either eye		
11. Color vision deficiency or color blindness		
EARS		
12. Perforated ear drum or tubes in ear drum(s)		
13. Ear surgery, to include mastoidectomy or repair of perforated ear drum		
14. Loss of balance or vertigo		
HEARING		
15. Hearing loss or wear a hearing aid		
NOSE, SINUSES, MOUTH, AND LARYNX		
16. Ear, nose, or throat trouble including tonsillectomy		
17. Chronic sinus infections or recurrent nose bleeds		
18. Absence of, or disturbance of sense of smell		
19. Any surgery of your face, mandible or jaw		
DENTAL		
20. Do you wear dental braces or plan to wear braces? (If so, your orthodontist must submit a letter stating that active orthodontic treatment will be completed prior to active duty date: release form/ sample format can be found in the Recruiter's Medical Guide.)		
21. Tooth or gum problems (other than cavities)		

CURRENTLY HAVE OR ANY HISTORY OF:	YES	NO
LUNGS, CHEST WALL, PLEURA, AND MEDIASTINUM		
22. Asthma		
23. Wheezing		
24. Shortness of breath		
25. Bronchitis		
26. Other breathing problems worsened by exercise, weather, pollens, etc.		
27. Used inhaler(s) or steroids for breathing problem(s)		
28. Chronic cough or frequent coughing at night		
29. Collapsed lung or other lung condition		
30. History of chest, chest wall, or breast surgery		
HEART		
31. Heart murmur, valve problem or mitral valve prolapse		
32. Palpitation, pounding heart or abnormal heartbeat		
33. Heart surgery		
34. Pain or pressure in the chest		
35. An abnormal electrocardiogram (EKG)		
36. Any other heart problems		
ABDOMINAL ORGANS AND GASTROINTESTINAL SYSTEM		
37. Stomach, esophageal or intestinal ulcer		
38. Difficulty swallowing		
39. Frequent indigestion or heartburn		
40. Gall bladder trouble or gallstones		
41. Jaundice (except neonatal) or hepatitis (liver disease)		
42. Rupture/hernia		
43. Surgery to remove or repair a portion of the intestine or spleen (other than the appendix)		
44. Chronic or recurrent intestinal problem of the small or large bowel such as Irritable Bowel Syndrome, Crohn's disease, Ulcerative Colitis, or Celiac disease		
45. Rectal disease, hemorrhoids, or blood from the rectum		
46. Hemorrhoid surgery		
47. Bariatric surgery (weight loss surgery)		

LAST NAME - FIRST NAME - MIDDLE INITIAL (SUFFIX)	SOCIAL SECURITY NUMBER *(Last 4)*

SECTION II - MEDICAL HISTORY *(Continued)*. Initial each item "Yes" or "No". All "Yes" items must be fully explained in Section III.

CURRENTLY HAVE OR ANY HISTORY OF:	YES	NO
FEMALES ONLY:		
48. A change of menstrual pattern (other than pregnancy)		
49. Pregnancy, abortion or miscarriage		
50. Any abnormal PAP smear(s)		
51. Date of last PAP smear *(YYYYMMDD)*		
52. Diagnosed with endometriosis or ovarian cysts		
53. Evaluation, treatment or surgery for any other gynecological (female) disorder		
54. Sexually transmitted disease (syphilis, gonorrhea, chlamydia, genital warts, herpes, etc.)		
55. First day of last menstrual period *(YYYYMMDD)*		
MALES ONLY:		
56. Missing a testicle, testicular implant, or undescended testicle		
57. Variocele, hydrocele, or any scrotal mass, swelling or pain		
58. Prostate problems		
59. Sexually transmitted disease (syphilis, gonorrhea, chlamydia, genital warts, herpes, etc.)		
URINARY SYSTEM		
60. Missing a kidney		
61. Kidney stone, infection or disease		
62. Kidney or urinary tract surgery of any kind		
63. Blood or protein in urine		
64. Painful or difficult urination		
65. Bedwetting or treatment for bedwetting (after childhood)		
66. Hernia		
SPINE AND SACROILIAC JOINTS		
67. Recurrent back pain or back problem		
68. Herniated disk		
69. Recurrent neck pain		
70. Back or neck surgery		
71. Abnormal curvature of your spine (any part)		
UPPER EXTREMITIES		
72. Painful shoulder, elbow, wrist, hand or fingers		
73. Dislocated shoulder, elbow, wrist, hand or fingers		
LOWER EXTREMITIES		
74. Foot trouble (e.g., pain, corns, bunions, warts, ingrown toenails, etc.)		
75. Knee trouble (e.g., locking, giving out, or ligament injury, etc.)		
76. Painful hip, knee, ankle, foot or toes		
77. Dislocated hip, knee, ankle, foot or toes		
MISCELLANEOUS CONDITIONS OF THE EXTREMITIES		
78. Bone, joint, or other orthopedic deformity		
79. Loss of finger or toe, or extra finger or toe		
80. Loss of the ability to fully flex (bend) or fully extend a finger, toe, or other joint		
81. Impaired use of arms, hands, legs, or feet (any reason)		
82. Arthritis, rheumatism, or bursitis		
83. Any swollen joint(s)		
84. Surgery on any joint/bone (including arthroscopy)		
85. Plate(s), screw(s), rod(s) or pin(s) in any bone		
86. Pain or swelling at the site of an old fracture		
87. Any need to use corrective devices such as prosthetic devices, knee brace(s), back support(s), lifts or orthotics		
88. Any other orthopedic, muscle, or sports injury problems		
VASCULAR		
89. High or low blood pressure		
90. Raynaud's phenomenon or disease		
91. Deep Vein Thrombosis (blood clot; leg or elsewhere)		
92. Pulmonary embolism (blood clot in lung)		

CURRENTLY HAVE OR ANY HISTORY OF:	YES	NO
SKIN AND CELLULAR		
93. Acne or psoriasis		
94. Eczema		
95. Atopic dermatitis		
96. Large or painful scars		
97. Any other skin problems		
BLOOD AND BLOOD FORMING TISSUES		
98. Anemia		
99. Blood clots requiring blood thinner medicine		
100. Absence or removal of the spleen		
101. Prolonged bleeding (after an injury or tooth extraction)		
102. Any other blood or circulation problems		
SYSTEMIC		
103. Adverse reaction to medication (describe reaction in Section III)		
104. Adverse reaction to serum, insect stings, or tree nuts		
105. Allergy to common foods (milk, eggs, fish, meat, etc.)		
106. Allergy to wool, latex, or other material		
107. Tuberculosis or lived with someone who had tuberculosis		
108. Positive test for tuberculosis (PPD or blood test)		
109. Malaria		
110. Disorder(s) of your immune system (including HIV)		
111. Car, train, sea, or air sickness		
ENDOCRINE AND METABOLIC		
112. Thyroid trouble or goiter		
113. High or low blood sugar		
114. Diabetes or told that you should be tested for diabetes		
NEUROLOGIC		
115. Cerebrovascular incident (stroke)		
116. Frequent or severe headaches, including migraines		
117. Taking medication to prevent headaches		
118. Lost time from work or school due to frequent or severe headaches		
119. A skull fracture		
120. A head injury, memory loss, or amnesia		
121. A period of unconsciousness or concussion		
122. Loss of memory or amnesia, or neurological symptoms		
123. Paralysis		
124. Meningitis, encephalitis, or other neurological problems		
125. Seizures, convulsions, epilepsy or fits		
126. Dizziness or fainting spells		
127. Any other neurologic problems		
SLEEP DISORDERS		
128. Sleepwalking or narcolepsy		
129. Frequent trouble sleeping		
130. Sleep apnea or severe snoring		
LEARNING, PSYCHIATRIC, AND BEHAVIORAL		
131. Evaluated or treated for Attention Deficit Disorder (ADD) or Attention Deficit Hyperactivity Disorder (ADHD)		
132. Taken (or taking) medication, drugs, or any substance to improve attention, behavior, or physical performance		
133. Diagnosed with a learning disorder, to include dyslexia		
134. Received counseling of any type		
135. Seen a psychiatrist, psychologist, social worker, counselor or other professional for any reason (inpatient or out-patient) including counseling or treatment for school, adjustment, family, marriage, divorce, depression, anxiety, or treatment of alcohol, drug or substance abuse (Applicant or recruiter will request sealed medical supporting documents from health care providers marked "CONFIDENTIAL: MEPS MEDICAL DEPARTMENT" and submit directly to MEPS medical personnel.)		

LAST NAME - FIRST NAME - MIDDLE INITIAL (SUFFIX)	SOCIAL SECURITY NUMBER *(Last 4)*

SECTION II - MEDICAL HISTORY *(Continued)*. Initial each item "Yes" or "No". All "Yes" items must be fully explained in Section III.

CURRENTLY HAVE OR ANY HISTORY OF:	YES	NO
LEARNING, PSYCHIATRIC, AND BEHAVIORAL *(Continued)*		
136. Been expelled or suspended from school		
137. Been kicked out or removed from your home		
138. Been arrested or other encounters with law enforcement		
139. Been evaluated or treated, either with medication or counseling, for a mental condition, depression or excessive worry		
140. Nervous trouble of any sort (anxiety or panic attacks)		
141. Anorexia, bulimia, or other eating disorder		
142. Habitual stammering or stuttering		
143. Have you ever purposely cut or harmed yourself		
144. Have you ever attempted or considered suicide		
145. Used illegal drugs or abused prescription drugs		
146. Have you been evaluated, treated, or hospitalized for substance abuse, addiction or dependence (including illegal drugs, prescription medications or other substances)		
147. Have you been evaluated, treated, or hospitalized for alcohol abuse, dependence, or addiction		
148. Post-traumatic Stress Disorder or excessive stress requiring counseling and/or medication following a traumatic experience		
149. Any other learning, psychiatric, or behavioral problems		
TUMORS AND MALIGNANCIES		
150. Tumor, growth, cyst, or cancer of any type		
MISCELLANEOUS		
151. Cold injury, frostbite or cold intolerance		
152. Heat injury, heat stroke or heat intolerance		
SUPPLEMENTAL QUESTIONS		
153. Are you taking any medications, to include over the counter medications (OTCs), vitamin, herbal, or nutritional supplements (If "yes", list all in Section III.)		

CURRENTLY HAVE OR ANY HISTORY OF:	YES	NO
SUPPLEMENTAL QUESTIONS *(Continued)*		
154. Any recent unexplained gain or loss of weight		
155. Artificial or replacement body part (eye, bone, palate, hip, knee, joint, leg, arm, etc.)		
156. Have you ever had any illness or injury other than those already noted? (If "yes", specify when, where and give details in Section III.)		
157. Have you ever been treated in an Emergency Room? (If "yes", explain in Section III.)		
158. Have you ever been a patient in any type of hospital (including being kept overnight)? (If "yes", specify when, where, why, and name of doctor and complete address of hospital in Section III.)		
159. Have you ever had, or have you been advised to have any operations or surgery? (If "yes", describe and give age at which occurred in Section III.)		
160. Have you ever been rejected for military Service for any reason? (If "yes", give date and reason in Section III.)		
161. Have you ever been discharged from the military Service for any reason? (If "yes", give date, reason, and type of discharge, whether honorable, other than honorable, for unfitness or unsuitability in Section III.)		
162. Have you ever been refused employment or been unable to hold a job or stay in school because of any of the following: (If "yes", answer a - d below and give reasons in Section III.)		
a. Sensitivity to chemicals, dust, sunlight, etc.		
b. Inability to perform certain motions		
c. Inability to stand, sit, kneel, lie down, etc.		
d. Other medical reasons		
163. Applied for and/or received disability evaluation and/or compensation for an injury or other medical conditions (If "yes", provide details in Section III.)		
164. Have you ever been denied life insurance? (If "yes", provide reason(s) in Section III.)		

SECTION III - APPLICANT COMMENTS. Explain all "Yes" answers to questions 1 - 164 above.

Begin with the Item Number. Describe answer(s) fully: provide date(s) of problem(s)/condition(s); provide names of Health Care Providers (HCPs), Clinic(s) and/or Hospital(s) along with the City and State; explain what was done (e.g., evaluation and/or treatment); and describe your current medical status. Attach additional sheet(s) if necessary and sign and date each additional page. Obtain and attach copies of applicable medical evaluation and treatment records.

LAST NAME - FIRST NAME - MIDDLE INITIAL (SUFFIX)	SOCIAL SECURITY NUMBER *(Last 4)*

SECTION III - APPLICANT COMMENTS *(Continued)*.

SECTION IV - HEALTH CARE PROVIDER/INSURANCE CARRIER CONTACT INFORMATION:

Current Primary Care Physician(s)/Practitioner(s) and/or Clinic(s) where care is received and Current/Previous Insurance Carrier(s) information. Attach additional sheets if necessary.

1. CURRENT PRIMARY CARE PHYSICIAN(S)/PRACTITIONER(S) AND/OR CLINIC(S)

a. NAME(S)	b. ADDRESS *(Include ZIP Code)*	c. TELEPHONE *(Include Area Code)*

2. PREVIOUS PRIMARY CARE PHYSICIAN(S)/PRACTITIONER(S) AND/OR CLINIC(S)

a. NAME(S)	b. ADDRESS *(Include ZIP Code)*	c. TELEPHONE *(Include Area Code)*

3. CURRENT INSURANCE AND/OR PHARMACY BENEFIT MANAGER(S)

a. NAME(S)	b. ADDRESS *(Include ZIP Code)*	c. TELEPHONE *(Include Area Code)*

4. PREVIOUS INSURANCE AND/OR PHARMACY BENEFIT MANAGER(S)

a. NAME(S)	b. ADDRESS *(Include ZIP Code)*	c. TELEPHONE *(Include Area Code)*

LAST NAME - FIRST NAME - MIDDLE INITIAL (SUFFIX)	SOCIAL SECURITY NUMBER *(Last 4)*

SECTION V - APPLICANT VALIDATION, AUTHORIZATION AND SIGNATURE

STOP AND READ: THE FOLLOWING STATEMENTS APPLY TO SIGNATURES IN SECTION V (BELOW)

I (we) , the undersigned:

Certify the information on this form is true and complete to the best of my knowledge and belief, and no person has advised me to conceal or falsify any information about my physical and mental history.

Authorize and understand that a physical examination is part of the accession evaluation, may require several visits to the Military Entrance Processing Station (MEPS), and that I will have blood work and/or other medical tests, procedures and/or specialty consultations performed as part of my processing. I understand that the results of the examination, tests, and consults will be reviewed and considered as part of my application file and are not performed as part of an individual healthcare treatment plan. The MEPS medical staff are not my healthcare providers. If I do not receive notice of an abnormal test or consult, I am not to assume that the results are normal. Furthermore, if any test or consult results are abnormal, I am responsible for obtaining those results from the MEPS and for any necessary follow-up evaluations and/or treatment. If I am notified to return to the MEPS to discuss medical results, it is my responsibility to take quick action to return to the MEPS to speak with the Chief Medical Officer (CMO). Any concerns that I have about my health and healthcare are my responsibility to address with my personal healthcare provider(s).

Understand that I must provide required documentation regarding my health history which, upon my accession, will become part of my Service member lifecycle medical treatment record.

Authorize the Department of Defense (DoD) to request holders of medical/behavioral health data (including but not limited to healthcare providers, clinics, hospitals, insurance companies, pharmacy benefit managers, pharmacies, health information exchanges, and federal and state agencies) to release to the DoD medical authority a complete transcript of my health data for purposes of processing my application for Military Service. I also authorize holders of my health data to report to the DoD whether any data they hold or have held about me has been amended or restricted. I agree that all personal information or data disclosed by myself or others on my behalf with my consent during this process may be further disseminated as needed during the accession process and that my medical information is no longer protected by federal Health Insurance Portability and Accountability Act (HIPAA) Privacy Rules.

Authorize release of records and information relating to grades, performance, individual education plans, and disciplinary proceedings. Under the Family Educational Rights and Privacy Act (FERPA) USMEPCOM is authorized to receive all my education/disciplinary records for evaluation of my acceptability for Service in the Armed Forces.

Understand that I have the right to refuse to sign this authorization but also understand that failure to do so may cause me to be found disqualified for further processing.

Understand this authorization will expire two years from the date of the signature below or sooner if written request is received by USMEPCOM Staff Judge Advocate's Office. I have the right to revoke this authorization in writing, except to the extent that the DoD has acted in reliance on this information.

1. APPLICANT	
a. SIGNATURE	b. DATE SIGNED *(YYYYMMDD)*

2. PARENT OR GUARDIAN SIGNATURE IS MANDATORY FOR MINOR APPLICANT, SIGNATURE IS OPTIONAL IF APPLICANT IS OF AGE		
a. NAME *(Last, First, Middle Initial)*	b. SIGNATURE	c. DATE SIGNED *(YYYYMMDD)*

3. RECRUITING REPRESENTATIVE: *(If a representative was used)* I certify all information is complete and true to the best of my knowledge.			
a. NAME *(Last, First, Middle Initial)*	b. RECRUITER IDENTIFICATION NUMBER	c. SIGNATURE	d. DATE SIGNED *(YYYYMMDD)*

LAST NAME - FIRST NAME - MIDDLE INITIAL (SUFFIX)	SOCIAL SECURITY NUMBER *(Last 4)*

SECTION VI - MEDICAL PROVIDER'S SUMMARY AND DESCRIPTION OF PERTINENT INFORMATION:

Review and comment on all medical records, electronically provided medical history information, and other electronic data available in the Department of Defense Accessions Processing System. Medical providers may also develop any additional medical history deemed important and record significant findings here or by interview and document them on DD Form 2808, "Report of Medical Examination".
Attach additional sheet(s) if necessary.

COMMENTS:

SECTION VII - MEDICAL PROVIDER'S PRESCREEN DETERMINATION BASED ON AVAILABLE INFORMATION:

1.a. DATE *(YYYYMMDD)*	b. MEDICAL PROCESSING STATUS						c. IF NOT WITHIN STANDARDS:				d. PROVIDER INITIALS
	PA	PRW	PH	RJ	METR	PNJ	ICD	CONDITION	PULHES	SMWRA INPUT	

KEY:
PA = Processing Authorized; PRW = Processing Requested by SMWRA; PH = Processing Hold; RJ = Return Justified; METR = Medical Evaluation and/or Treatment Records; PNJ = Processing Not Justified; ICD = International Classification of Disease Code; PULHES = P (Physical Capacity), U (Upper Extremities), L (Lower Extremities), H (Hearing), E (Eyes), S (Psychiatric); SMWRA = Service Medical Waiver Review Authority.

2. *FOR MEPS USE ONLY:

ON EXAM:	a. PSN COMP	b. PSN INCOM	c. NPS	d. *AE	e. *RE	f. *ME	g. *OE	h. DATE *(YYYYMMDD)*	i. PROVIDER INITIALS

KEY:
PSN = Prescreen; COMP = Complete; INCOM = Incomplete; NPS = Not Prescreened; AE = Applicant Error; RE = Recruiter Error; ME = MEPS Error; OE = Other Source of Error.

3. AUTHORIZING MEDICAL PROVIDER			4. NUMBER OF ADDITIONAL SHEETS SUBMITTED
a. NAME *(Last, First, Middle Initial)*	b. SIGNATURE	c. DATE SIGNED *(YYYYMMDD)*	