

OSS PROCESS

Upon review of your documents, you will be contacted to schedule an appointment with provider. If your documents are incomplete and/or missing requirements, you will be informed of what is incomplete. Once all of your documents are completed the corpsman will book an appointment for you to be screened by our medical provider. (This appointment will also be over the phone.) DUE TO HIGH LEVELS OF PCS ensure you turn in packet in a timely manner. If you are suitable for transfer you may pick up your paperwork in person or through DoD SAFE. If you prefer to have it sent through DoD SAFE please refer to the PowerPoint on the website for instructions. If the medical provider has to send a message to the gaining command for further review, then you will contact our Message Traffic department. Contact information is listed on our website.

OVERSEAS/ SEA DUTY SCREENING CONTACT INFORMATION

Date: _____

Name (Last, First, Initial): _____

Rate / Rank: _____

Sponsor's SSN: _____

Work Extension: _____

Home/ Cell phone number: _____

Military email address: _____

Current Command (and UIC): _____

Detachment date from Current Command: _____

CPO/DIVO Contact: _____

Name of new command (and UIC): _____

Note: Only one copy of the first two pages is required per family. Each family member that needs to be screened will have their own packet.

Please check the box to indicate which type of screening you need:

Operational Screening	
Suitability Screening	

Our OSS department is only able to perform screenings for Navy and Marine Corps personnel.

Name of family members who require screening:

1). _____

2). _____

3). _____

4). _____

5). _____

6). _____

History of Limdu (If yes date and reason): _____

IF RECENTLY CLEARED FROM LIMDU YOU MUST PROVIDE SUPPORTING DOCUMENTS

NTC, BRANCH CLINIC OVERSEAS/ SUITABILITY SCREENING PROCESS (ACTIVE DUTY)

Upon receipt the Letter of Intent (LOI) or the hard copy orders. Please send all required documents through DOD SAFE <https://safe.apps.mil>

READINESS REQUIREMENTS: **Must be initialed by your Medical Department or PCM**

1. **Initials/Date:** _____ **PHA** – Within last 12 months.
2. **Initials/Date:** _____ **Physical Exam (if applicable)** – (Submarine, Flight, Radiation, Dive, MSG duty etc.)
3. **Initials/Date:** _____ **All Readiness Labs** – HIV (Within last 2 years), DNA, Blood type RH Factor, G6PD, and Sickle Cell Trait. (Most labs were completed in boot camp)
4. **Initials/Date:** _____ **Tests/Screenings** – Date of last PPD test/screening _____.
5. **Initials/Date:** _____ **Audiogram** – **DD 2215** Reference Audiogram, **DD 2216** (Annual if in hearing conservation program). Marines and all Navy operational platforms are required to get an annual audiogram.
6. **Initials/Date:** _____ **Immunizations** – All required military immunizations are up to date. *JEV if applicable, after appointment, upon determination of suitable for transfer.*
7. **Initials/Date:** _____ **Females** – PAP Smear (Per ACOG Guidelines), Mammogram (Ages 40 and above, completed in last 12 months)

REQUIRED FORMS

- **DD FORM 2807-1 PGS 1-3**
- **DD FORM 2807-1 PG 3 #30**
- **NAVMED 6224/8 – TB RISK ASSESSMENT FORM**
- **NAVPERS 1300/16**
- **NAVMED 1300/1 PART 1 SECTION A**
- **NAVMED 1300/1 PART 2**
– Must be taken to dental to be signed prior to DOD safe submission, dependents receive cosignature from sponsor's dental if care is not received from MTF.
- **NAVMED 1300/1 PART 1 SECTION B**
- **NAVPERS 1300/16 PART II**

Highlighted portions to be filled out by:

Patient

Primary Care Manager

NTC Screening Office

REPORT OF MEDICAL HISTORY

OMB No. 0704-0413
OMB approval expires
September, 30 2021

(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.mil. Respondents should be aware that notwithstanding any other provision of law, no person shall be subject to any penalty for failing to comply with a collection of information if it does not display a currently valid OMB control number. PLEASE DO NOT RETURN YOUR FORM TO THE ABOVE ORGANIZATION. RETURN COMPLETED FORM AS INDICATED ON PAGE 2.

PRIVACY ACT STATEMENT

AUTHORITY: 10 U.S.C. 136, Under Secretary Of Defense For Personnel And Readiness; DoD Directive 1145.2, United States Military Entrance Processing Command; DoD Instruction 6130.03, Medical Standards for Appointment, Enlistment, or Induction in the Military Services; and E.O. 9397 (SSN), as amended.

PRINCIPAL PURPOSE(S): The primary collection of this information is from individuals seeking to join the Armed Forces. The information collected on this form is used to assist DoD physicians in making determinations as to acceptability of applicants for military service and verifies disqualifying medical condition(s) noted on the prescreening form (DD 2807-2). An additional collection of information using this form occurs when a Medical Evaluation Board is convened to determine the medical fitness of a current member and if separation is warranted.

ROUTINE USE(S): The Routine Uses are listed in the applicable system of records notice found at: <http://dpclid.defense.gov/Privacy/SORNIndex/DOD-wide-SORN-Article-View/Article/570661/a0601-270-usmepcom-dod/>

DISCLOSURE: Voluntary; however, failure by an applicant to provide the information may result in delay or possible rejection of the individual's application to enter the Armed Forces. An applicant's SSN is used during the recruitment process to keep all records together and when requesting civilian medical records. For an Armed Forces member, failure to provide the information may result in the individual being placed in a non-deployable status. The SSN of an Armed Forces member is to ensure the collected information is filed in the proper individual's record.

WARNING: The information you have given constitutes an official statement. Federal law provides severe penalties (up to 5 years confinement or a \$10,000 fine or both), to anyone making a false statement.

1. LAST NAME, FIRST NAME, MIDDLE NAME (SUFFIX)	2.a. SOCIAL SECURITY NO.	b. DoD ID NO. (If applicable)	3. TODAY'S DATE (YYYYMMDD)
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4.a. HOME ADDRESS (Street, Apartment No., City, State, and ZIP Code)	5. EXAMINING LOCATION AND ADDRESS (Include ZIP Code) NMRTU Point Loma 2051 Cushing Rd, San Diego, CA 92106
b. HOME TELEPHONE (Include Area Code)	
c. EMAIL ADDRESS	

X ALL APPLICABLE BOXES:			7.a. POSITION (Title, Grade, Component)
6.a. SERVICE	b. COMPONENT	c. PURPOSE OF EXAMINATION	b. USUAL OCCUPATION
<input type="checkbox"/> Army <input type="checkbox"/> Coast Guard <input type="checkbox"/> Navy <input type="checkbox"/> Marine Corps <input type="checkbox"/> Air Force	<input type="checkbox"/> Regular <input type="checkbox"/> Reserve <input type="checkbox"/> National Guard	<input type="checkbox"/> Retention <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Separation <input type="checkbox"/> Medical Board <input type="checkbox"/> Retirement	

8. CURRENT MEDICATIONS (Prescription and Over-the-counter)	9. ALLERGIES (Including insect bites/stings, foods, medicine or other substance)
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Mark each item "YES" or "NO". Every item marked "YES" must be fully explained in Item 29 on Page 2.

HAVE YOU EVER HAD OR DO YOU NOW HAVE:	YES	NO
10.a. Tuberculosis	<input type="radio"/>	<input type="radio"/>
b. Lived with someone who had tuberculosis	<input type="radio"/>	<input type="radio"/>
c. Coughed up blood	<input type="radio"/>	<input type="radio"/>
d. Asthma or any breathing problems related to exercise, weather, pollens, etc.	<input type="radio"/>	<input type="radio"/>
e. Shortness of breath	<input type="radio"/>	<input type="radio"/>
f. Bronchitis	<input type="radio"/>	<input type="radio"/>
g. Wheezing or problems with wheezing	<input type="radio"/>	<input type="radio"/>
h. Been prescribed or used an inhaler	<input type="radio"/>	<input type="radio"/>
i. A chronic cough or cough at night	<input type="radio"/>	<input type="radio"/>
j. Sinusitis	<input type="radio"/>	<input type="radio"/>
k. Hay fever	<input type="radio"/>	<input type="radio"/>
l. Chronic or frequent colds	<input type="radio"/>	<input type="radio"/>
11.a. Severe tooth or gum trouble	<input type="radio"/>	<input type="radio"/>
b. Thyroid trouble or goiter	<input type="radio"/>	<input type="radio"/>
c. Eye disorder or trouble	<input type="radio"/>	<input type="radio"/>
d. Ear, nose, or throat trouble	<input type="radio"/>	<input type="radio"/>
e. Loss of vision in either eye	<input type="radio"/>	<input type="radio"/>
f. Worn contact lenses or glasses	<input type="radio"/>	<input type="radio"/>
g. A hearing loss or wear a hearing aid	<input type="radio"/>	<input type="radio"/>
h. Surgery to correct vision (RK, PRK, LASIK, etc.)	<input type="radio"/>	<input type="radio"/>
12.a. Painful shoulder, elbow or wrist (e.g. pain, dislocation, etc.)	<input type="radio"/>	<input type="radio"/>
b. Arthritis, rheumatism, or bursitis	<input type="radio"/>	<input type="radio"/>
c. Recurrent back pain or any back problem	<input type="radio"/>	<input type="radio"/>
d. Numbness or tingling	<input type="radio"/>	<input type="radio"/>
e. Loss of finger or toe	<input type="radio"/>	<input type="radio"/>

12. (Continued)	YES	NO
f. Foot trouble (e.g., pain, corns, bunions, etc.)	<input type="radio"/>	<input type="radio"/>
g. Impaired use of arms, legs, hands, or feet	<input type="radio"/>	<input type="radio"/>
h. Swollen or painful joint(s)	<input type="radio"/>	<input type="radio"/>
i. Knee trouble (e.g., locking, giving out, pain or ligament injury, etc.)	<input type="radio"/>	<input type="radio"/>
j. Any knee or foot surgery including arthroscopy or the use of a scope to any bone or joint	<input type="radio"/>	<input type="radio"/>
k. Any need to use corrective devices such as prosthetic devices, knee brace(s), back support(s), lifts or orthotics, etc.	<input type="radio"/>	<input type="radio"/>
l. Bone, joint, or other deformity	<input type="radio"/>	<input type="radio"/>
m. Plate(s), screw(s), rod(s) or pin(s) in any bone	<input type="radio"/>	<input type="radio"/>
n. Broken bone(s) (cracked or fractured)	<input type="radio"/>	<input type="radio"/>
13.a. Frequent indigestion or heartburn	<input type="radio"/>	<input type="radio"/>
b. Stomach, liver, intestinal trouble, or ulcer	<input type="radio"/>	<input type="radio"/>
c. Gall bladder trouble or gallstones	<input type="radio"/>	<input type="radio"/>
d. Jaundice or hepatitis (liver disease)	<input type="radio"/>	<input type="radio"/>
e. Rupture/hernia	<input type="radio"/>	<input type="radio"/>
f. Rectal disease, hemorrhoids or blood from the rectum	<input type="radio"/>	<input type="radio"/>
g. Skin diseases (e.g. acne, eczema, psoriasis, etc.)	<input type="radio"/>	<input type="radio"/>
h. Frequent or painful urination	<input type="radio"/>	<input type="radio"/>
i. High or low blood sugar	<input type="radio"/>	<input type="radio"/>
j. Kidney stone or blood in urine	<input type="radio"/>	<input type="radio"/>
k. Sugar or protein in urine	<input type="radio"/>	<input type="radio"/>
l. Sexually transmitted disease (syphilis, gonorrhea, chlamydia, genital warts, herpes, etc.)	<input type="radio"/>	<input type="radio"/>
14.a. Adverse reaction to serum, food, insect stings or medicine	<input type="radio"/>	<input type="radio"/>
b. Recent unexplained gain or loss of weight	<input type="radio"/>	<input type="radio"/>
c. Currently in good health (If no, explain in Item 29 on Page 2.)	<input type="radio"/>	<input type="radio"/>
d. Tumor, growth, cyst, or cancer	<input type="radio"/>	<input type="radio"/>

LAST NAME, FIRST NAME, MIDDLE NAME (SUFFIX)	SOCIAL SECURITY NUMBER	DoD ID NUMBER (if applicable)
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Mark each item "YES" or "NO". Every item marked "YES" must be fully explained in Item 29 below.

HAVE YOU EVER HAD OR DO YOU NOW HAVE:	YES	NO	YES	NO				
15. a. Dizziness or fainting spells	<input type="radio"/>	<input type="radio"/>	19. Have you been refused employment or been unable to hold a job or stay in school because of:	<input type="radio"/>				
b. Frequent or severe headache	<input type="radio"/>	<input type="radio"/>			a. Sensitivity to chemicals, dust, sunlight, etc.	<input type="radio"/>		
c. A head injury, memory loss or amnesia	<input type="radio"/>	<input type="radio"/>			b. Inability to perform certain motions	<input type="radio"/>		
d. Paralysis	<input type="radio"/>	<input type="radio"/>			c. Inability to stand, sit, kneel, lie down, etc.	<input type="radio"/>		
e. Seizures, convulsions, epilepsy or fits	<input type="radio"/>	<input type="radio"/>		d. Other medical reasons (If yes, give reasons.)	<input type="radio"/>			
f. Car, train, sea, or air sickness	<input type="radio"/>	<input type="radio"/>		20. Have you ever been treated in an Emergency Room? (If yes, for what?)	<input type="radio"/>			
g. A period of unconsciousness or concussion	<input type="radio"/>	<input type="radio"/>				21. Have you ever been a patient in any type of hospital? (If yes, specify when, where, why, and name of doctor and complete address of hospital.)	<input type="radio"/>	
h. Meningitis, encephalitis, or other neurological problems	<input type="radio"/>	<input type="radio"/>		22. Have you ever had, or have you been advised to have any operations or surgery? (If yes, describe and give age at which occurred.)	<input type="radio"/>			
16. a. Rheumatic fever	<input type="radio"/>	<input type="radio"/>	23. Have you ever had any illness or injury other than those already noted? (If yes, specify when, where, and give details.)					<input type="radio"/>
b. Prolonged bleeding (as after an injury or tooth extraction, etc.)	<input type="radio"/>	<input type="radio"/>		24. Have you consulted or been treated by clinics, physicians, healers, or other practitioners within the past 5 years for other than minor illnesses? (If yes, give complete address of doctor, hospital, clinic, and details.)	<input type="radio"/>			
c. Pain or pressure in the chest	<input type="radio"/>	<input type="radio"/>						
d. Palpitation, pounding heart or abnormal heartbeat	<input type="radio"/>	<input type="radio"/>		26. Have you ever been discharged from military service for any reason? (If yes, give date, reason, and type of discharge; whether honorable, other than honorable, for unfitness or unsuitability.)	<input type="radio"/>			
e. Heart trouble or murmur	<input type="radio"/>	<input type="radio"/>				27. Have you ever received, is there pending, or have you ever applied for pension or compensation for any disability or injury? (If yes, specify what kind, granted by whom, and what amount, when, why.)	<input type="radio"/>	
f. High or low blood pressure	<input type="radio"/>	<input type="radio"/>						
17. a. Nervous trouble of any sort (anxiety or panic attacks)	<input type="radio"/>	<input type="radio"/>		29. EXPLANATION OF "YES" ANSWER(S) (Describe answer(s), give date(s) of problem, name of doctor(s) and/or hospital(s), treatment given and current medical status.)				
b. Habitual stammering or stuttering	<input type="radio"/>	<input type="radio"/>						
c. Loss of memory or amnesia, or neurological symptoms	<input type="radio"/>	<input type="radio"/>						
d. Frequent trouble sleeping	<input type="radio"/>	<input type="radio"/>						
e. Received counseling of any type	<input type="radio"/>	<input type="radio"/>						
f. Depression or excessive worry	<input type="radio"/>	<input type="radio"/>						
g. Been evaluated or treated for a mental condition	<input type="radio"/>	<input type="radio"/>						
h. Attempted suicide	<input type="radio"/>	<input type="radio"/>						
i. Used illegal drugs or abused prescription drugs	<input type="radio"/>	<input type="radio"/>						
18. FEMALES ONLY. Have you ever had or do you now have:								
a. Treatment for a gynecological (female) disorder	<input type="radio"/>	<input type="radio"/>						
b. A change of menstrual pattern	<input type="radio"/>	<input type="radio"/>						
c. Any abnormal PAP smears	<input type="radio"/>	<input type="radio"/>						
d. First day of last menstrual period (YYYYMMDD)								
e. Date of last PAP smear (YYYYMMDD)								

NOTE: HAND TO THE DOCTOR OR NURSE, OR IF MAILED MARK ENVELOPE "TO BE OPENED BY MEDICAL PERSONNEL ONLY."

LAST NAME, FIRST NAME, MIDDLE NAME (SUFFIX)	SOCIAL SECURITY NUMBER	DoD ID NUMBER <i>(If applicable)</i>
30. EXAMINER'S SUMMARY AND ELABORATION OF ALL PERTINENT DATA <i>(Physician/practitioner shall comment on all positive answers in questions 10 - 29. Physician/practitioner may develop by interview any additional medical history deemed important, and record any significant findings here.)</i>		
a. COMMENTS		
b. TYPED OR PRINTED NAME OF EXAMINER <i>(Last, First, Middle Initial)</i>	c. SIGNATURE	d. DATE SIGNED <i>(YYYYMMDD)</i>

TUBERCULOSIS EXPOSURE RISK ASSESSMENT

FOR THE PATIENT *(Including those with previous positive tuberculin skin test)(Check the correct response)*

1. Since your last Tuberculosis Exposure Risk Assessment, were you exposed to anyone known to have or suspected of having active tuberculosis (i.e., individuals with persistent cough, weight loss, night sweats, and/or fever)? Yes No Don't Know

2. Since your last Tuberculosis Exposure Risk Assessment or Post-Deployment Health Assessment (DD Form 2796), did you have direct and prolonged contact with any individuals of the following groups: refugees or displaced persons; patients hospitalized with tuberculosis, prisoners, or homeless shelter populations? Yes No

3a. Check any countries where you have traveled or deployed to since your last Tuberculosis Exposure Risk Assessment.

<input type="checkbox"/> Bangladesh	<input type="checkbox"/> Ethiopia	<input type="checkbox"/> Pakistan	<input type="checkbox"/> UR Tanzania
<input type="checkbox"/> Brazil	<input type="checkbox"/> India	<input type="checkbox"/> Philippines	<input type="checkbox"/> Viet Nam
<input type="checkbox"/> Burma	<input type="checkbox"/> Indonesia	<input type="checkbox"/> Russian Federation	<input type="checkbox"/> Zimbabwe
<input type="checkbox"/> Cambodia	<input type="checkbox"/> Kenya	<input type="checkbox"/> South Africa	<input type="checkbox"/> None
<input type="checkbox"/> China	<input type="checkbox"/> Mozambique	<input type="checkbox"/> Thailand	
<input type="checkbox"/> DR Congo	<input type="checkbox"/> Nigeria	<input type="checkbox"/> Uganda	
<input type="checkbox"/> Other _____			

If any of these listed countries are selected, answer question 3c.

If "other" is checked, write in the name of the country or countries.

3b. Have you recently traveled to Afghanistan for any reason other than as part of a deployment requiring completion of a Post Deployment Health Assessment (PDHA)? Yes No If Yes, go to 3c. Otherwise, go to 4a.

3c. During this travel, did you have prolonged direct contact with the local population? Prolonged direct contact is generally understood as having been within six feet of a person with a bad continuous cough for at least 8 consecutive hours on a single day, or for a total of at least 15 hours per week of a multi-week stay. Yes No

4a. Have you recently had a chronic cough lasting more than 2 weeks? Yes No

4b. If you marked YES to chronic cough, did you have any of the following at the same time?
 Fever Cough up Blood Unexplained Weight Loss Night Sweats
 If any are checked, see the medical officer for evaluation.

FOR THE SCREENER

1. Questions 1 through 4 reviewed, all responses are negative, no further action is required. Yes No

2. There is at least one positive answer, patient to continue to medical officer for assessment. Yes No

FOR THE PROVIDER

(Expand on above answers to document decision making in determining risk)
(Note: Prior treated TST reactors require clinical evaluation to rule out active TB, not a repeat TST).

1. Provider Comments

2. Tuberculosis risk assessment, based on above responses
(If the answer to one or more of questions 1, 2, 3c, or 4b is a YES, test the patient.) Minimal Risk Increased Risk

3. Recommend Latent Tuberculosis Infection (LTBI) Testing Yes No

PROVIDER'S NAME	PROVIDER'S SIGNATURE	DATE
PATIENT'S IDENTIFICATION: <i>(For typed or written entries, give: Name - last, first, middle; SSN; Sex; Date of Birth; Rank/Grade.)</i>	HOSPITAL OR MEDICAL FACILITY	STATUS
	DEPARTMENT / SERVICE	RECORDS MAINTAINED AT
	SPONSOR'S NAME	SSN
	RELATIONSHIP TO SPONSOR	

MEDICAL, DENTAL AND EDUCATIONAL SUITABILITY SCREENING FOR SERVICE AND FAMILY MEMBERS

Privacy Act Statement

Authority: 5 U.S.C. 301, Departmental Regulations; and E. O. 9397 (SSN).

Purpose: To identify special, medical, dental or educational needs for the purpose of making a suitability recommendation for an overseas, remote duty, or operational assignment.

Routine uses: This form is completed by a medical treatment facility (MTF)/non-MTF dentist and physician, nurse practitioner, physician assistant, or independent duty corpsman (Service members only). An MTF Medical Screener must counter sign all screenings completed by non-Navy MTF Providers. The MTF Suitability Screening Coordinator (SSC) will place the completed original form in the individual's Service Treatment Record/Non-Service Treatment Record and retain a copy for audit.

Disclosure: Voluntary; however, failure to provide this information may delay the screening process, result in orders held in abeyance until completion of screening or affect the amount of leave in transit.

Refer to BUMEDINST 1300.2B for implementing guidance. **Complete one form for each Service and family member screened.**

SERVICE MEMBER NAME	GRADE / RATE	AGE	SSN
FAMILY MEMBER NAME	FAMILY MEMBER PREFIX	AGE	SSN
NEXT DUTY STATION LOCATION & UNIT IDENTIFICATION CODE (UIC):		TYPE DUTY CLASSIFICATION CODE: (Navy enlisted only)	

PART I

SECTION A. Medical Screening. Completed by the medical provider to identify special needs and determine if a Service or family member is suitable for an overseas, remote duty, or operational assignment. *Attach the completed Report of Medical History (DD 2807-1) to this form.*

Yes	No	N/A	ITEM
			1. All current health records (military and civilian) reviewed?
			2. All physical exams (to include special duty, aviation, submarine, radiation, asbestos, etc.) are current and filed in the Service Treatment Record? a. <i>Type of Physical</i> _____ b. <i>Completion date of physical</i> _____
			3. G-6P-D, PPD and Sickle Cell trait test and Blood Type completed & documented?
			4a. Immunizations are up-to-date and meet destination country requirements?
			4b. Has the individual elected to decline any ACIP recommended immunizations or country required Immunizations? If yes (circle): ACIP Country Specific Date Counseled: _____
			5. Reference audiogram documented on DD 2215?
			6. Latest audiogram (DD 2216) reviewed?
			7. HIV testing completed or drawn?
			8. DNA testing completed and documented?
			9. Are there pending consults or tests that have a bearing on assignment suitability?
			10. Any past limited duty or medical board(s)? (<i>document on DD 2807-1</i>)
			11. For Service members:
			a. Annual periodic health assessment current and documented?
			b. Pregnancy screening (verbal inquiry)? (<i>Also, Command will refer for pregnancy test 30 days prior to departure date</i>)
			c. If pregnant? (EDC: _____)
			12. For family members, U.S. Preventive Services Task Force screening test recommendations current and documented?
			13. If a Special Duty assignment, is there a condition, which by MANMED, chapter 15, section IV, is disqualifying?
			14. Are there any conditions requiring ongoing care in the following areas? (<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)
			f. Mental health or behavioral conditions (e.g., mood, personality disorder, ADD/ADHD, anxiety, psychosis, autism)
			g. Recurrent or frequent medications not on the standard formulary or require special attention (e.g., injections/infusions every 6-12 months, medication requiring Risk Evaluation and Mitigation Strategies per FD regulations, hormone replacement therapy, or medications requiring close monitoring of therapeutic blood level)? (<i>list on DD 2807-1</i>)
			h. Alcohol or substance abuse or dependence
			i. Developmental concerns (e.g., motor, cognitive, communication, social/emotional, or adaptive development)
			j. Specify other conditions or concerns:
			15. For Service/family members requiring medication.
			a. Does the patient's medication maintenance require a dose adjustment?
			b. Should medication use cease, could the underlying condition become life threatening, pose a risk for dangerous or disruptive behavior or result in a limited duty, MEDEVAC, or early return situation?
			c. Are there concerns about medication management capabilities at the gaining MTF/operational platform if the underlying condition is exacerbated?
			d. Has the service/family member registered with the mail order pharmacy program through TRICARE?

Yes	No	N/A	ITEM
			16. For service/family members with underlying medical conditions:
			a. Is there a requirement for special medical supplies, adaptive equipment, assistive technology devices, special accommodations, etc.?
			b. If exposed to a physically or emotionally demanding environment, could the underlying condition become life threatening, pose a risk for dangerous or disruptive behavior, or result in a limited duty or MEDEVAC situation?
			c. Are there any chronic medical or mental health conditions requiring routine or continuing access to care or access to specialized medical care? (document on DD 2807-1)
			d. Are there any potential environmental concerns or possible health effects at the gaining location? (if yes, communicate to family and document on appropriate SF 600)
			17. For infants and toddlers (birth to 36 months), is the child receiving or undergoing eligibility to receive early intervention services as evidenced by an Individualized Family Service Plan (IFSP)?
			18. For preschool and school age children, is the child receiving or undergoing eligibility to receive special education and/or related services as evidenced by an Individualized Education Program (IEP)?
			19. Explanation of "yes" responses in shaded boxes (include #): Are there any concerns about the gaining MTF/operational platform's capabilities to meet the individual's needs? Specify below: Navy MTF SSC Name, Signature, Stamp, and Date: _____

Non-Navy Medical Providers: STOP and proceed to SECTION C

SECTION B. Medical and Educational Screening Disposition. Completed by the screening Navy MTF medical provider to determine if a Service or family member is suitable for an overseas, remote duty, or operational assignment.

Yes	No	ITEM
		1. Are any of the above shaded blocks in Section A checked? If "yes", submit a suitability inquiry to the gaining MTF or medical department supporting the overseas/remote duty/operational location to determine local capabilities to provide required support. (Attach Reply and answer questions 1a and 1b.) If "no", proceed to question 2.
		a. Does the gaining location have the capabilities to provide the current required medical support?(Service MTFs/TRICARE, etc.)
		b. Does the gaining location have the capabilities to provide the required medical support (diagnostic and therapeutic) if the underlying condition is exacerbated? (To include all Service MTFs/operational platform, TRICARE, etc.)
		2. Is the shaded block of question 18 checked "yes"? If yes, Submit the DD 2792-1 and IEP to the gaining DoDEA Special Education Overseas Screening Coordinator and gaining MTF to determine local capabilities to provide required support. (Attach Reply with POC info and answer question 2a.) If no, proceed to question 3.
		a. Is the DoDEA Special Education Overseas Screening Coordinator recommending travel?
Yes	No	3. IS THE SERVICE/FAMILY MEMBER SUITABLE FOR THE OVERSEAS, REMOTE DUTY OR OPERATIONAL ASSIGNMENT? (Must be completed by an MTF medical screener. Answered after the inquiry is completed.)

SECTION C. Contact Information. Completed by the MTF/non-MTF civilian providers who completed PART I. The Navy MTF medical screener shall review and countersign all suitability screenings completed by non-Navy MTF civilian providers, denoting accountability for a complete and thorough suitability screening document review for each Service/family member.

Navy MTF Medical Screener (Signature) _____	Date _____	Non-Navy MTF/Civilian Medical Screener (Signature) _____	Date _____
Printed Name, Rank or Grade _____		Printed Name _____	
MTF or Duty Station _____		Address _____	
Telephone Number (include area/country code) _____		City, State, and Zip Code _____	
DSN Number _____		Telephone Number (include area/country code) _____	
Office Hours to contact _____		Office Hours to Contact _____	
E-mail Address _____		E-mail Address _____	

PART II

SERVICE / FAMILY MEMBER NAME	GRADE / RATE / FAMILY MEMBER PREFIX	SSN
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SECTION A. Dental Screening. Completed by a dental officer/privileged dentist prior to an overseas, remote duty, or operational assignment for the purpose of assessing and matching the dental needs of a service/family member to the support capabilities of the gaining medical treatment facility. **NOTE: If child does not have teeth -AND- is under the age of 24 months, a pediatrician may perform an oral dental screening.**

Yes	No	ITEM
		1. All current dental records (military and civilian) reviewed?
		2. All dental examinations are current? (If more than 180 days since last T-1 or T-2 dental exam, a dental officer/privileged dentist must, at a minimum, review the dental record and interval medical and dental history.)
		3. Is a reexamination required by a Navy MTF if examined or treated at a non-Navy facility?
		4. If service/family member is in Dental Class 3 or 4, can dental treatment or examination be completed before the transfer?
		5. Is there a requirement for follow-on care such as orthodontics, implants, specialty prosthetics, etc.?
		6. Are there any chronic dental conditions requiring routine or continuing access to care or access to specialized dental care?
		7. Are there any concerns about the gaining MTF/operational platform's capabilities to meet the individual's needs? <i>Specify below:</i>
Navy MTF SSC Name, Signature, Stamp, and Date: _____		

8. Specify Dental Class: *(required for service members)* _____
Dental Classifications: (Per DoDI 6025.19)
Normally considered worldwide deployable:
Class 1 - Patients with a current dental examination, who do not require dental treatment or re-evaluation.
Class 2 - Patients with a current dental examination, who require non-urgent dental treatment or re-evaluation for oral conditions unlikely to result in a dental emergency within 12 months.

Normally not considered worldwide deployable:
Class 3 - Patients who require urgent or emergent dental treatment for oral conditions with a high potential to cause a dental emergency in the next 12 months.
Class 4 - Patients who require a dental examination either because: (1) No type 1 (comprehensive) or type 2 (annual or periodic oral) dental examination was completed by a dental officer/privileged dentist within the past 12 months; (2) A patient's dental record does not exist or; (3) The dental record is not held by the responsible dental treatment facility or Medical Department activity.

SECTION B. Dental Screening Disposition. Completed by the screening MTF provider to determine if a service or family member is suitable for an overseas, remote duty, or operational assignment. **Non-Navy Medical Providers: STOP and proceed to SECTION C.**

Yes	No	ITEM
		1. Are any of the above shaded blocks checked? If yes, submit a suitability inquiry to the gaining MTF or medical department supporting the overseas/remote duty/operational location to determine local dental capabilities to provide required support. <i>(Attach Reply and answer question 2)</i> If no, proceed to question 3.
		2. Does the gaining MTF/operational platform have the capabilities to provide the current required dental support?
Yes	No	3. IS THE SERVICE/FAMILY MEMBER SUITABLE FOR THE OVERSEAS, REMOTE DUTY OR OPERATIONAL ASSIGNMENT? (Must be completed by an MTF dental screener. Answered after the inquiry is completed.)

SECTION C. Contact Information. Completed by the MTF/non-MTF civilian providers who completed PART II. The Navy MTF dental screener shall review and countersign all suitability screenings completed by non-Navy MTF civilian providers, denoting accountability for a complete and thorough suitability screening document review for each Service/family member.

Navy MTF Dental Screener (Signature) _____ Date _____ Printed Name, Rank or Grade _____ MTF or Duty Station _____ Telephone Number (include area/country code) _____ DSN Number _____ Office Hours to Contact _____ E-mail Address _____	Non-Navy Medical Facility/Civilian Dental Screener (Signature) _____ Date _____ Printed Name _____ Address _____ City, State, and Zip Code _____ Telephone Number (include area/country code) _____ Office Hours to Contact _____ E-mail Address _____
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REPORT OF SUITABILITY FOR OVERSEAS ASSIGNMENTS

Supporting Directive OPNAVINST 1300.14D

1. MEMBER'S NAME:	2. DATE:	3. NUMBER OF DEPENDENTS:
4. PRESENT SHIP/STATION:	5. UIC:	6. OVERSEAS LOCATION: N/A IF NOT OVERSEAS
7. UIC:		

PART I: COMMAND REVIEW - The purpose of the command review is to determine, via record review and personal interview, member and spouse/family member(s) suitability for overseas duty/life in the assigned overseas location. Refer to MILPERSMAN 1300-302 and 1300-304. Any questions checked "YES" (with the exception of questions 11, 15, and 16) disqualifies member for overseas assignment. Complete PART I and obtain waiver(s) prior to starting PART II (NAVMED 1300/1).

1. Has the member or any spouse/family member previously been reassigned, prior to normal tour completion, due to their unsuitability?	<input type="radio"/> Yes	<input type="radio"/> No
2. (For Enlisted Personnel) Has member obligated for the prescribed DoD tour? If "NO", member is unsuitable. NAVPERS 1070/613 entries for OBLISERV are prohibited. OBLISERV MUST BE COMPLETED WITHIN 30 DAYS OF RECEIPT OF ORDERS. For SRB issues, see the current NAVADMIN. For PFA see current NAVADMIN and OPNAV instruction. Officers and enlisted who REQUEST to separate/retire, will be held to the DoD tour length.	<input type="radio"/> Yes	<input type="radio"/> No
3. (E-5 and above) Does the member, spouse, or family member have serious problems of indebtedness, credit loss, or other financial problems which have not been reconciled with the creditor(s) or interested parties? (E-4 and below) Member must complete debt-to-income (DTI) ratio screening per OPNAVINST 1740.5B. Do not calculate the spouse's income unless guaranteed employment at the overseas location has been obtained. Is the DTI ratio 30% or greater.	<input type="radio"/> Yes	<input type="radio"/> No
4. Has the member ever been convicted of a sex offense? ** Has the member been convicted of any criminal offense (civilian or military) within the last 24 months or has/had any involvement in an ongoing criminal action? ** Information regarding whether a person is a sex offender may be found at Dru Sjodin National Sex Offender Public Website (NSOPW) at www.nsopw.gov .	<input type="radio"/> Yes	<input type="radio"/> No
5. Has the spouse or any family member ever been convicted of a sex offense? ** Has the spouse or any family member been convicted of any criminal offense (civilian or military) in the last 24 months or has/had any involvement in an ongoing criminal action? ** Information regarding whether a person is a sex offender may be found at Dru Sjodin National Sex Offender Public Website (NSOPW) at www.nsopw.gov .	<input type="radio"/> Yes	<input type="radio"/> No
6. Does the member have a record of any involvement with illegal drugs or alcohol within the past 24 months? Successful completion of an aftercare program will qualify the member and the question can be answered NO. Waiver of aftercare program does not qualify the member; answer YES.	<input type="radio"/> Yes	<input type="radio"/> No
7. Does the spouse/family member have a record of any involvement with illegal drugs or alcohol within the past 24 months?	<input type="radio"/> Yes	<input type="radio"/> No
8. Is the member or spouse/family member involved in an open Family Advocacy Program (FAP) case that is still under investigation or for which treatment was refused or is still ongoing? (If a local FAP representative is not available to provide a status of any FAP issues, then contact the Commander Navy Installation Command (CNIC), Lead of Case Management Section for FAP, at (901) 874-4361, DSN 882-4361, for this endorsement.) If the CO still wishes to request a waiver, then the gaining command and FFSC must support waiver request.	<input type="radio"/> Yes	<input type="radio"/> No
9. Was the member's spouse previously a member of the Armed Forces and the characterization of separation other than "Honorable"? Explain in the remarks section.	<input type="radio"/> Yes	<input type="radio"/> No
10. Has member failed two or more PFAs in a 3-year period? If yes, comply with OPNAVINST 6110.1H and most recent NAVADMIN, which govern Physical Readiness Program.	<input type="radio"/> Yes	<input type="radio"/> No
11. Are any of the member's dependents covered in a custody agreement? If "NO", go to question 12. a. Does agreement prevent removal of family members from continental United States (CONUS) without prior court approval or agreement between the interested parties? If "NO", go to question 12. b. Has member obtained prior court approval of requisite agreement from other interested party for removal of family members from CONUS, if required by state law? (Please note: Navy policy does not require a separate agreement if not required by state law.)	<input type="radio"/> Yes	<input type="radio"/> No

1. MEMBER'S NAME:		2. DATE:	
12. Single parents/military couples with family members. Is there any reason why the Family Care Plan cannot be executed or is not in accordance with OPNAVINST 1740.4D?		<input type="radio"/> Yes	<input type="radio"/> No
NOTE: While the unique situation of single parents with dependents is not disqualifying, this fact should be pointed out upon submission of suitability determination.			
13. If member is a first-termer and going to an overseas duty station, and has a pre-service moral waiver(s) for drug, alcohol, or criminal conviction, (identified in Section VI remarks of DD 1966 (3-07), Record of Military Processing), then mark block YES.		<input type="radio"/> Yes	<input type="radio"/> No
14. Does member have a history of unsatisfactory or below standard performance (any mark below 3.0) or any NJPs in the last 2 years?		<input type="radio"/> Yes	<input type="radio"/> No
15. Have member and adult dependents received "Level I" Antiterrorism Force Protection (Level III for 0-5/0-6 Commanding Officer Awareness Training), prior to transfer, and recorded on NAVPERS 1070/613?		<input type="radio"/> Yes	<input type="radio"/> No
16. Is dependent spouse a foreign national? If yes, see MILPERSMAN 1300-302 for "Non-US citizen dependents". Case by case coordination for dependents travel documents will be required.		<input type="radio"/> Yes	<input type="radio"/> No
FOR PERSONNEL E-3 AND BELOW: Ensure the members have been counseled that they cannot be assigned accompanied overseas duty. Members will be assigned unaccompanied based on readiness needs. Acquiring family member(s) en route and bringing them without dependent entry approval/command sponsorship will most probably result in return to CONUS at personal expense and servicemembers will complete tour unaccompanied.			
1. I have been counseled on the above: <input type="radio"/> Yes <input type="radio"/> No			
2. MEMBER'S SIGNATURE:		3. DATE:	
4. REMARKS:			
5. I, _____, am aware that the failure to divulge disqualifying information or amplifying information (medical, dental, personal) pertaining to the questions on this checklist may ultimately result in disciplinary action punishable under the UCMJ.			
6. MEMBER (NAME, RANK/RATE):		6. MEMBER (SIGNATURE)	7. DATE:
8. INTERVIEWER (NAME, RANK/RATE, COMMAND TITLE):		9. INTERVIEWER (SIGNATURE)::	10. DATE:

1. MEMBER'S NAME:	2. DATE:
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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.
3. If a shaded block is checked on NAVMED 1300/1, coordination is required with the gaining MTF/DTF supporting the overseas, remote duty, or operational location; or with the senior medical department representative of an operational platform. Coordination must indicate whether or not required medical, dental, or educational capabilities are available.
4. 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).
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.** Yes No

FAMILY MEMBERS SUITABILITY FOR THIS ASSIGNMENT.

2. NAME: <input type="radio"/> Yes <input type="radio"/> No	3. NAME: <input type="radio"/> Yes <input type="radio"/> No
4. NAME: <input type="radio"/> Yes <input type="radio"/> No	5. NAME: <input type="radio"/> Yes <input type="radio"/> No
6. NAME: <input type="radio"/> Yes <input type="radio"/> No	6. NAME: <input type="radio"/> Yes <input type="radio"/> No

The following family member(s) were referred for Exceptional Family Member Program (EFMP) enrollment (DO NOT DELAY SCREENING FOR EFM DETERMINATION):

8. NAME (s):

9. NAME OF CO/OIC OR DESIGNEE OF MEDICAL TREATMENT FACILITY:	10. DATE:	9. SIGNATURE OF CO/OIC OR DESIGNEE OF MEDICAL TREATMENT FACILITY:
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1. MEMBER'S NAME:	2. DATE:
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PART III: CMC/COB/SEA ENDORSEMENT

1. On the basis of all available information, I endorse / I do not endorse the member's orders for the overseas assignment.

2. CMC/COB/SEA (NAME AND RANK):	3. SIGNATURE OF CMC/COB/SEA:	4. DATE:
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PART IV: COMMANDING OFFICER'S ENDORSEMENT

1. On the basis of all available information, I endorse / I do not endorse the member's orders for the overseas assignment.

2. COMMANDING OFFICER (NAME AND RANK):	3. SIGNATURE OF COMMANDING OFFICER:	4. DATE:
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5. REMARKS:

If the Commanding Officer still feels member should be considered for overseas assignment, submit waiver (non-medical/dental) request per MILPERSMAN 1300-304.

PRIVACY STATEMENT: THE AUTHORITY TO REQUEST THIS INFORMATION IS CONTAINED IN 5 USC 301 DEPARTMENTAL REGULATIONS. THE INFORMATION WILL BE USED TO ASSIST OFFICIALS AND EMPLOYEES OF THE DEPARTMENT OF THE NAVY IN DETERMINING YOUR FUTURE DUTY ASSIGNMENT.

COMPLETION OF THE FORM IS MANDATORY EXCEPT FOR DUTY AND HOME PHONE NUMBERS, OR FAILURE TO PROVIDE REQUIRED INFORMATION MY RESULT IN DELAY IN RESPONSE TO OR DISAPPROVAL OF YOUR REQUEST.