NTC, BRANCH CLINIC OVERSEAS/REMOTE DUTY SCREENING PROCESS FAMILY MEMBERS

OSS PROCESS

Upon review of your documents, you will be contacted to schedule an appointment to be pre-screened. During this virtual appointment the corpsman will ensure that you have all of the correct documentation and requirements completed. If your documents are incomplete and/or missing requirements, you will be informed of what is incomplete and rescheduled to be pre-screened again. Once all of your documents are completed, then the corpsman will book an appointment for you to be screened by our medical provider. (This appointment will also be over the phone.) If you are suitable for transfer you may pick up your paperwork in person or have it sent 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: ___________________

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.

NTC, BRANCH CLINIC OVERSEAS/REMOTE DUTY SCREENING PROCESS FAMILY MEMBERS

Name of family members who require screening:

1). ____

2). ____

3). ____

4). ____

5). ____

6). ____

Family members part of the Exceptional Family Member Program (EFMP):

1). ____

2.) ____

3.) ____

4.) ____

5.) ____

6.) ____

NTC, BRANCH CLINIC OVERSEAS/REMOTE DUTY SCREENING PROCESS FAMILY MEMBERS

Upon receipt the Letter of Intent (LOI) or the hard copy orders, the medical pre-requisites below need to be completed as soon as possible. Please send all required documents & prerequisites through DOD SAFE or drop them off at our office.

EVERY MEMBER OF THE FAMILY MUST HAVE THE MANDATORY FORMS COMPLETED:

1. NAVMED 1300/1 PART 1 & PART 1 BACK
2. NAVMED 1300/1 PART II (PAGE 3) – Must be taken to civilian dentist to be signed off (Infants ages 6 months or younger or those without teeth can have their primary care provider evaluate and fill out the form accordingly.
3. DD FORM 2807-1 / PGS 1-3: TO BE COMPLETED BY MEMBER W/ ALL YES'S EXPLAINED IN BLOCK 29
4. DD FORM 2792-1 / School Forms – From birth to 18 years old, page 2 needs to be filled out, and signed by the parent/guardian. Children that have recently, or are currently attending daycare, school, or any other programs that assist with learning and child development need to have page 3 filled out and signed by the associated organization.
5. Exceptional Family Member Program (EFMP) Questionnaire
6. NAVMED 6224/8 TB RISK ASSESSMENT FORM
7. NAVMED 1300/16 (PGS 1-4) PREREQUISITES FOR EACH DEPENDENT

1. PHYSICAL EXAM – A full physical within the last 12 months is required by your primary care provider. We cannot accept a "Summary Copy", nor can we accept a "Patient Memo Copy" as this will not contain the necessary information to perform your screening. A full **Review of Systems is required**. A review of systems would display an examination of each body system. For example: Systemic, Head, Musculoskeletal, Cardiovascular, Pulmonary, Gastrointestinal etc.

2. PAP SMEAR – For females over the age of 21, a pap smear with the results is required. If you no longer require pap smears due to medical issues, please provide documentation. For women ages 21-30 a pap smear is required every 3 years. If the pap smear was collected after the age of 30, it is required every 5 years.

3. IMMUNIZATIONS – COPY OF VACCINE RECORDS (TITERS SHOWING IMMUNITY acceptable for some)

The following immunizations are recommended by the Center for Disease Control for any travel outside of the continental US

ADULTS: HEPATITIS A & B (Or + Titers for Hepatitis A Virus Ab & Hepatitis B Virus Surface Ab), MMR & VARICELLA (Or + Titers MMRV Ab IgG), POLIO, & TDAP (No Titers).

CHILDREN: AGE APPROPRIATE VACCINES

While these may be recommendations, the lack of immunizations may affect your ability to PCS.

4. DENTAL – As stated above, all dependents must have their 1300/1 part completed a dental provider. More information provided in block 3 of the mandatory forms above.

If a family member is enrolled in the EFMP program, please bring that paper work.

FAILURE TO COMPLETE THE FOLLOWING PREREQUISITES WILL RESULT IN DELAYS IN SCHEDULING AN APPOINTMENT.

ONLY COMPLETE HIGHLIGHTED PORTIONS OF THE FORMS BELOW TO INCLUDE 2792-1 (SCHOOL FORMS) AND NAME & DATE ON THE 1300/16 PGS.

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. 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?
			14. Are there any conditions requiring ongoing care in the following areas? *(document on DD 2807-1)*
			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)? *(list on DD 2807-1)*
			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

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? *Specify below:* 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. *(Attach Reply and answer question 2)* 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

REPORT OF MEDICAL HISTORY

(This information is for official and medically confidential use only and will not be released to unauthorized persons.)

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

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://dpcld.defense.gov/Privacy/SORNsIndex/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)*

4.a. **HOME ADDRESS** *(Street, Apartment No., City, State, and ZIP Code)*

b. **HOME TELEPHONE** *(Include Area Code)*

c. **EMAIL ADDRESS**

5. **EXAMINING LOCATION AND ADDRESS** *(Include ZIP Code)*

X ALL APPLICABLE BOXES:

6.a. **SERVICE**
- Army
- Navy
- Marine Corps
- Air Force
- Coast Guard

b. **COMPONENT**
- Regular
- Reserve
- National Guard

c. **PURPOSE OF EXAMINATION**
- Retention
- Separation
- Medical Board
- Retirement
- Other *(Specify)*

7.a. **POSITION** *(Title, Grade, Component)*

b. **USUAL OCCUPATION**

8. **CURRENT MEDICATIONS** *(Prescription and Over-the-counter)*

9. **ALLERGIES** *(Including insect bites/stings, foods, medicine or other substance)*

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	◯	◯
b. Lived with someone who had tuberculosis	◯	◯
c. Coughed up blood	◯	◯
d. Asthma or any breathing problems related to exercise, weather, pollens, etc.	◯	◯
e. Shortness of breath	◯	◯
f. Bronchitis	◯	◯
g. Wheezing or problems with wheezing	◯	◯
h. Been prescribed or used an inhaler	◯	◯
i. A chronic cough or cough at night	◯	◯
j. Sinusitis	◯	◯
k. Hay fever	◯	◯
l. Chronic or frequent colds	◯	◯
11.a. Severe tooth or gum trouble	◯	◯
b. Thyroid trouble or goiter	◯	◯
c. Eye disorder or trouble	◯	◯
d. Ear, nose, or throat trouble	◯	◯
e. Loss of vision in either eye	◯	◯
f. Worn contact lenses or glasses	◯	◯
g. A hearing loss or wear a hearing aid	◯	◯
h. Surgery to correct vision *(RK, PRK, LASIK, etc.)*	◯	◯
12.a. Painful shoulder, elbow or wrist *(e.g. pain, dislocation, etc.)*	◯	◯
b. Arthritis, rheumatism, or bursitis	◯	◯
c. Recurrent back pain or any back problem	◯	◯
d. Numbness or tingling	◯	◯
e. Loss of finger or toe	◯	◯

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

LAST NAME, FIRST NAME, MIDDLE NAME (SUFFIX)	SOCIAL SECURITY NUMBER	DoD ID NUMBER *(If applicable)*

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
15. a. Dizziness or fainting spells	◯	◯
b. Frequent or severe headache	◯	◯
c. A head injury, memory loss or amnesia	◯	◯
d. Paralysis	◯	◯
e. Seizures, convulsions, epilepsy or fits	◯	◯
f. Car, train, sea, or air sickness	◯	◯
g. A period of unconsciousness or concussion	◯	◯
h. Meningitis, encephalitis, or other neurological problems	◯	◯
16. a. Rheumatic fever	◯	◯
b. Prolonged bleeding *(as after an injury or tooth extraction, etc.)*	◯	◯
c. Pain or pressure in the chest	◯	◯
d. Palpitation, pounding heart or abnormal heartbeat	◯	◯
e. Heart trouble or murmur	◯	◯
f. High or low blood pressure	◯	◯
17. a. Nervous trouble of any sort *(anxiety or panic attacks)*	◯	◯
b. Habitual stammering or stuttering	◯	◯
c. Loss of memory or amnesia, or neurological symptoms	◯	◯
d. Frequent trouble sleeping	◯	◯
e. Received counseling of any type	◯	◯
f. Depression or excessive worry	◯	◯
g. Been evaluated or treated for a mental condition	◯	◯
h. Attempted suicide	◯	◯
i. Used illegal drugs or abused prescription drugs	◯	◯
18. FEMALES ONLY. Have you ever had or do you now have:		
a. Treatment for a gynecological (female) disorder	◯	◯
b. A change of menstrual pattern	◯	◯
c. Any abnormal PAP smears	◯	◯
d. First day of last menstrual period *(YYYYMMDD)*		
e. Date of last PAP smear *(YYYYMMDD)*		

	YES	NO
19. Have you been refused employment or been unable to hold a job or stay in school because of:		
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 *(If yes, give reasons.)*	◯	◯
20. Have you ever been treated in an Emergency Room? *(If yes, for what?)*	◯	◯
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.)*	◯	◯
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.)*	◯	◯
23. Have you ever had any illness or injury other than those already noted? (If yes, specify when, where, and give details.)	◯	◯
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.)*	◯	◯
25. Have you ever been rejected for military service for any reason? *(If yes, give date and reason for rejection.)*	◯	◯
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.)*	◯	◯
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.)*	◯	◯
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 status.)*

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 *(If applicable)*

30. EXAMINER'S SUMMARY AND ELABORATION OF ALL PERTINENT DATA *(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.)*

a. COMMENTS

b. TYPED OR PRINTED NAME OF EXAMINER *(Last, First, Middle Initial)*	c. SIGNATURE	d. DATE SIGNED *(YYYYMMDD)*

SPECIAL EDUCATION/EARLY INTERVENTION SUMMARY

PRIVACY ACT STATEMENT

AUTHORITY: 10 U.S.C. 136; 20 U.S.C. 927; DoDI 1315.19: DoDI 1342.12; and E.O. 9397 (as amended).

PRINCIPAL PURPOSE(S): Information will be used by DoD personnel to evaluate and document the special education needs of family members. This information will enable: (1) Military assignment personnel to match the special education needs of family members against the availability of educational services, and (2) Civilian personnel officers to advise civilian employees about the availability of education services to meet the special education needs of their family members. The personally identifiable information collected on this form is covered by a number of system of records notices pertaining to Official Military Personnel Files, Exceptional Family Member or Special Needs files, Civilian Personnel Files, and DoD Education Activity files. The SORNs may be found at http://dpclo.defense.gov/Privacy/SORNsIndex/DODComponentNotices.aspx.

ROUTINE USE(S): DoD Blanket Routine Uses 1, 4, 6, 8, 9, 12, and 15 found at http://dpclo.defense.gov/Privacy/SORNSIndex/BlanketRoutineUses.aspx may apply.

DISCLOSURE: Voluntary for civilian employees and applicants for civilian employment; however, the information must be provided if you intend to enroll your child with special education needs in a school funded by the Department of Defense or a school in which DoD is responsible for paying the tuition for a space-required family member. Mandatory for military personnel. Failure or refusal to provide the information or providing false information may result in administrative sanctions or punishment under either Article 92 (dereliction of duty) or Article 107 (false official statement), Uniform Code of Military Justice. The Social Security Number of the sponsor (and sponsor's spouse if dual military) allows the DoD Education Activity and Service personnel offices to work together to ensure any special education needs of your dependent can be met at your next duty assignment. Dependent special education needs are annotated in the official military personnel files which are retrieved by name and Social Security Number.

INSTRUCTIONS

The DD Form 2792-1 is completed to identify a family member with special educational/early intervention needs.

DEMOGRAPHICS.

Items 1 - 7. Completed by sponsor or spouse.

Item 1. Request (X one):
- EFMP Registration/Enrollment Update - first enrollment application for the family member or to update a previous evaluation for the family member.
- Government Sponsored Travel.
- Change in EFMP Status.

Items 2.a. - h. Child/Student Information. Self-explanatory.

Items 3.a. - h. Sponsor Information. Self-explanatory.

Item 3.i. Child/student enrolled in DEERS under another sponsor. Self-explanatory.

Items 4.a. - d. Self-explanatory.

Item 5. Completed for children age birth to 3 who have or require an IFSP.

Item 6.a. - e. Completed for children ages 3 to 21 only who have or require an IEP. Children who have IEPs and are ages 3 to 5 should have the DD 2792-1 completed at the school the child would normally attend for kindergarten. High School graduates, students who have passed the G.E.D. and college students are not required to complete the DD 2792-1.

Items 7.a. - c. Signature of sponsor or spouse who completed the form. Self-explanatory.

Items 8.a. - f. Administrative Review. Completed by EFMP responsible for screening or enrollment in the MTF.

SPECIAL EDUCATION/EARLY INTERVENTION SUMMARY

DD Form 2792-1 is completed by the parents and school or early intervention staff. **Only this form should be provided to school or early intervention staff. Do not include medical information forms that may be used for EFMP screening or enrollment.**

Items 1.a. - d. Sponsor Information. Signature of sponsor, spouse, legal guardian, or student who has reached the age of majority is REQUIRED to authorize the school to release information.

Items 2.a. - d. Child/Student Information. Completed by sponsor, spouse, or legal guardian. Self-explanatory.

Items 3.a. - d. EIS Information. Completed by EIS or school personnel. Mark (X) Yes or No for each item. Include additional information as noted.

Items 4.a. - f. School Information. Completed by school personnel at the public school the child attends or would attend. Mark (X) Yes or No for each item. Include additional information as noted.

Item 5. Completed by school personnel. Mark (X) eligibility category. Mark only one. (Codes are for Army coding only.)

Item 6. Completed by school personnel. Mark (X) all related services provided and indicate total time services are provided.

Item 7. Completed by EIS and school personnel. Self-explanatory.

Item 8. Completed by EIS provider/school official information completing form. Self-explanatory.

SPECIAL EDUCATION/EARLY INTERVENTION SUMMARY

(Page 1, Items 1 - 7 to be completed by sponsor, parent or legal guardian.)
(Read Privacy Act Statement and Instructions before completing this form.)

OMB No. 0704-0411
OMB approval expires
Jul 31, 2017

The public reporting burden for this collection of information is estimated to average 25 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 (0704-0411). 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.

DEMOGRAPHICS

1. REQUEST *(X one)*

- ☐ EFMP Registration/Enrollment Update
- ☐ Government Sponsored Travel
- ☐ Change in EFMP Status:
  - ☐ No longer requires IEP/IFSP services
  - ☐ No longer qualifies as a dependent*
  - ☐ Divorce/change in custody*
- ☐ Other *(Explain)*

*(*Provide documentation for change in status)*

2. CHILD/STUDENT INFORMATION *(To be completed by sponsor, spouse or legal guardian)*

a. CHILD/STUDENT NAME *(Last, First, Middle Initial)*

b. SPONSOR NAME *(Last, First, Middle Initial)*

c. CHILD/STUDENT CURRENT MAILING ADDRESS *(Street, Apartment Number, City, State, ZIP Code, APO/FPO)*

d. FAMILY MEMBER PREFIX

e. CHILD/STUDENT DATE OF BIRTH *(YYYYMMDD)*

f. CHILD/STUDENT GENDER *(X one)*
☐ **MALE** ☐ **FEMALE**

g. FAMILY HOME E-MAIL ADDRESS

h. HOME TELEPHONE NUMBER *(Include Area Code/Country Code)*

3. a. SPONSOR RANK OR GRADE

b. INSTALLATION OF CURRENT ASSIGNMENT *(Include City, State, Country)*

c. SPONSOR'S OFFICIAL E-MAIL ADDRESS

d. DUTY TELEPHONE NUMBER *(Include Area Code/Country Code)*

e. MOBILE NUMBER *(Include Area Code/Country Code)*

f. STATUS *(X one)*

- ☐ Regular Active Service Member
- ☐ Active Reserve
- ☐ Active Guard
- ☐ Reserves
- ☐ National Guard
- ☐ Civilian

g. BRANCH OF SERVICE *(Military only)*

- ☐ Army
- ☐ Navy
- ☐ Air Force
- ☐ Marine Corps
- ☐ Coast Guard

h. DOES CHILD RESIDE WITH SPONSOR? *(X one. If No, explain.)*
☐ **YES** ☐ **NO**

i. IS THE CHILD/STUDENT ENROLLED IN DEERS UNDER A SPONSOR OTHER THAN THE ONE LISTED ABOVE? *(X one. If Yes, provide name of sponsor:)*
☐ **YES** ☐ **NO**

4.a. ARE BOTH SPOUSES ON ACTIVE DUTY? *(Military only) (X one. If Yes, answer b. - d. below)*
☐ **YES** ☐ **NO**

b. ACTIVE DUTY SPOUSE'S NAME *(Last, First, Middle Initial)*

c. BRANCH OF SERVICE

d. RANK/RATE

5. FOR CHILDREN FROM BIRTH TO AGE THREE ONLY:

☐ **YES** ☐ **NO** Is your child being evaluated for, or receiving, early intervention services on an Individualized Family Service Plan (IFSP)? *(X one. If No, sign Item 7 and return to the requesting office. If Yes, have early intervention professional complete Page 3.)*

6. FOR STUDENTS AGES 3 - 21 WHO ARE ELIGIBLE FOR ELEMENTARY AND SECONDARY EDUCATION *(Includes preschool-aged children)***:**

☐ **YES** ☐ **NO** a. Is your child being home-schooled? *(X one. If No, sign Item 7 and take Page 3 to your child's school. If Yes, complete the following and sign Item 7.)*

b. Is your child being home-schooled part-time or full-time? *(X one)* ☐ Part-time ☐ Full-time

c. When did you start home-schooling? *(YYYYMMDD)* ____________

d. Name/title home school program, if known: ____________

e. List any special education-related services received in the last 3 years:

7. a. SIGNATURE

b. PRINTED NAME *(Last, First, Middle Initial)*

c. DATE *(YYYYMMDD)*

8. ADMINISTRATIVE REVIEW *(Completed after review of entire form by local military MTF or office receiving form)*

a. SPONSOR SSN

b. SPOUSE SSN *(If dual military)*

c. SSN USED IN DEERS *(If different from sponsor's)*

d. MILITARY MTF OR OFFICE RECEIVING COMPLETED FORM

e. DATE *(YYYYMMDD)*

f. STAMP

SPECIAL EDUCATION/EARLY INTERVENTION SUMMARY

NOTE TO EDUCATIONAL AUTHORITY COMPLETING THIS FORM:
It is important to the military and to the family that the service member be assigned to a location that can meet the child's educational needs. Your support in completing this form is appreciated. *(If applicable, attach a copy of the child's most recent active Individualized Family Service Plan (IFSP) or Individualized Education Program (IEP) to this page.)*

1. RELEASE OF INFORMATION *(To be completed by sponsor, spouse, legal guardian, or student who has reached the age of majority)*
I hereby authorize the release of information on the DD Form 2792-1, and the attached reports to personnel of the Military Departments. This information will be used to evaluate and document my child/student's needs for educational services for the purpose of assignment coordination, EFMP registration or eligibility for other educationally related benefits.

a. SIGNATURE	b. PRINTED NAME	c. RELATIONSHIP TO CHILD/ STUDENT	d. DATE *(YYYYMMDD)*

2. CHILD/STUDENT INFORMATION *(To be completed by sponsor, spouse, or legal guardian)*

a. NAME OF CHILD/STUDENT *(Last, First, Middle Initial)*	b. CURRENT GRADE LEVEL *(If school age)*	c. DATE OF BIRTH *(YYYYMMDD)*	d. GENDER *(X one)*
			☐ FEMALE ☐ MALE

3. EARLY INTERVENTION (EI) SERVICES - FOR CHILDREN UNDER 3 YEARS OF AGE *(To be completed by EI representative)*

YES	NO	
		a. Is the child currently being evaluated for early intervention services? *(If Yes, go directly to Item 8.)*
		b. Does this child receive early intervention services under a current Individualized Family Service Plan (IFSP)? *(If Yes, please attach current IFSP.)* Date of next annual review *(YYYYMMDD)* ____________

c. Basis for eligibility: ☐ Developmental Delay ☐ Diagnosed physical or mental condition that has a high probability of resulting in a Developmental Delay

d. Is there an identified disability? *(If known, please specify)*:

4. SCHOOL INFORMATION - FOR STUDENTS AGES 3 - 21 *(To be completed by school representative)*

YES	NO	
		a. Has this child ever been evaluated for, or been offered, special education services by your school? *(If No, skip to Item 8.)*
		b. Is this student currently being evaluated for special education services? If Yes, what disability category? ____________ *(Skip to Item 8)*
		c. If your school determined the student eligible for special education services within the past 3 years, did the parent decline special education services? *(If Yes, complete eligibility information in Item 5 and proceed to Item 8.)*
		d. Does this child/student receive special education services under a current Individualized Education Program (IEP)? *(If Yes, please attach a copy of the current IEP, and complete Items 5 and following.)* Date of next annual review *(YYYYMMDD)* ____________
		e. Were IEP services terminated by the IEP team within the last 2 years? *(If Yes, skip to Item 8.)* Date of IEP termination *(YYYYMMDD)* ____________
		f. Was the IEP terminated at the request of the parents within the last year *(parents withdrew student from special education)*? *(If Yes, complete Items 5 and following.)*

5. ELIGIBILITY CATEGORY FOR CHILDREN 3 TO 21 YEARS OF AGE *(X only one)*

	Code	Category		Code	Category		Code	Category
	N07	Autism Spectrum Disorder:		N09	Communication Impaired:		N16	Behavioral/Conduct Disorder
	N01	Deaf			Articulation		N04	Intellectual Disability *(Mental Retardation)*:
	N02	Blind			Dysfluency			Mild
	N13	Deaf/Blind			Voice			Moderate
	N11	Visually Impaired			Language/Phonology			Severe/Profound
	N05	Traumatic Brain Injury		N15	Developmental Delay		N08	Other Health Impaired *(Specify)*
	N03	Hearing Impaired		N12	Specific Learning Disability			
	N06	Orthopedically Impaired		N10	Emotionally Impaired			

6. RELATED SERVICES ON IEP *(X boxes next to related services and indicate total number of minutes or hours that services are provided.)*

SERVICE: M = Minutes, H = Hours per W = Week, M = Month *(Example:)* 20 M per W

	Code	Service				
	R01	Counseling			per	
	R02	Occupational Therapy			per	
	R03	Physical Therapy			per	
	R04	Speech Therapy			per	
	R05	Intensive Behavioral Intervention *(Such as ABA)*			per	

☐ R06 Special Transportation *(Describe)*

☐ R07 Other *(Describe)*:

7. BEHAVIOR/COMMUNICATION *(X all that apply and explain in comments section.)*

YES	NO	
		a. Child exhibits high risk or dangerous behavior.
		b. Child is verbal *(If No, answer c.-f. The student uses:)*
		c. Signing *(Specify language or system)*
		d. Picture Exchange Communication System (PECS)
		e. Communication Device *(Specify)*
		f. Other *(Specify)*

g. COMMENTS

8. PROVIDER/SCHOOL INFORMATION

a. NAME OF EARLY INTERVENTION PROGRAM OR SCHOOL	b. SCHOOL DISTRICT

c. CITY, STATE, COUNTRY	d. TELEPHONE NUMBER *(Include Area Code/ Country Code)*	e. FAX NUMBER *(Include Area Code/ Country Code)*

f. E-MAIL ADDRESS	g. NAME OF INDIVIDUAL COMPLETING THIS SECTION

h. SIGNATURE	i. TITLE	j. DATE SIGNED *(YYYYMMDD)*

EXCEPTIONAL FAMILY MEMBER PROGRAM (EFMP) QUESTIONNAIRE

Please mark a Yes or No to each condition and return to front desk.

Name______________________________

_____ Do you have a family member with a chronic medical or mental health condition or educational needs requiring access to care or services?

_____Do you have a child who has an Individualized Education Program (IEP), Individual Family Service Plan, or section 504 plan?

_____Do you have a dependent parent, spouse, or child receiving treatment for cancer, lupus, heart disease, high/low cholesterol, hypertension, chronic migraines, chronic lower back pain, hyper/hypothyroidism, leukemia, diabetes, mental/emotional needs, asthma, or other long-term illness?

_____Do you sponsor a family member in a residential treatment facility?

_____Have you ever applied for a humanitarian reassignment for medical reasons of your immediate family member?

_____Have you recently considered a hardship discharge because of ongoing family medical or educational needs?

_____Have you recently submitted a NAVPERS 1306/7 requesting special assignment because of medical or educational needs?

_____Has your family recently returned from overseas because medical or special educational services were not available.

_____Have you recently had to take an unaccompanied tour because a family member failed overseas/remote duty station area screening?

_____Do you have a child receiving medical care through a state medical program?

_____Do you have a family member receiving Social Security Supplemental Income (SSI) benefits?

_____Are you a geographic bachelor because of a family member's extended medical or educational needs?

Front Desk Staff Only

_____EFMP Survey complete and included in screening paperwork

If family member answers yes to any question, please direct them to the EFMP Coordinator to initiate the EFMP screening process.

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.

☐ Bangladesh	☐ Ethiopia	☐ Pakistan	☐ UR Tanzania
☐ Brazil	☐ India	☐ Philippines	☐ Viet Nam
☐ Burma	☐ Indonesia	☐ Russian Federation	☐ Zimbabwe
☐ Cambodia	☐ Kenya	☐ South Africa	☐ None
☐ China	☐ Mozambique	☐ Thailand	
☐ DR Congo	☐ Nigeria	☐ Uganda	

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

☐ Other ______________________

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 ☐ Minimal Risk ☐ Increased Risk
   (If the answer to one or more of questions 1, 2, 3c, or 4b is a YES, test the patient.)
3. Recommend Latent Tuberculosis Infection (LTBI) Testing ☐ Yes ☐ No

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

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:	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).

Question		
1. Has the member or any spouse/family member previously been reassigned, prior to normal tour completion, due to their unsuitability?	Yes	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.	Yes	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?	Yes	No
(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.	Yes	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.	Yes	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.	Yes	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 quality the member; answer YES.	Yes	No
7. Does the spouse/family member have a record of any involvement with illegal drugs or alcohol within the past 24 months?	Yes	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.	Yes	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.	Yes	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.	Yes	No
11. Are any of the member's dependents covered in a custody agreement? If "NO", go to question 12.	Yes	No
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.	Yes	No
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.)	Yes	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?	◯ Yes	◯ 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.	◯ Yes	◯ 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?	◯ Yes	◯ 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?	◯ Yes	◯ 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.	◯ Yes	◯ 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: ◯ Yes ◯ 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:

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:	◯ Yes	◯ No	3. NAME:	◯ Yes	◯ No
4. NAME:	◯ Yes	◯ No	5. NAME:	◯ Yes	◯ No
6. NAME:	◯ Yes	◯ No	6. NAME:	◯ Yes	◯ 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:

1. MEMBER'S NAME:	2. DATE:

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:

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:

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.

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