NMRTU Point Loma Overseas/Remote Duty Screening Process For Family Members

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

REQUIRED DOCUMENTS LISTED BELOW:

PATIENT
DENTAL
NTC

1. **NAVMED 1300/2**

2. **DD Form 2807-1/Pages 1-3:** to be completed by all members with all yes answers explained in block 29.

3. **Exceptional Family Member Program (EFMP) Questionnaire.**
   If a family member is enrolled in the EFMP program, please the DD FORM 2792 and Category letter.

4. **DD Form 2792-1 School forms:** from birth to 19 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 program that assist with learning and child development required have page 3 filled out and signed by the associated organization.

5. **NAVMED 6224/8 Tuberculosis Exposure Risk Assessment questions 1 - 4b.**

6. **NAVMED 1300/1 Part 1**

7. **NAVMED 1300/1 Part II (page 3):** Must be taken to a civilian dentist to be signed (NOTE: If child does not have teeth -AND- is under the age of 24 months, a pediatrician may perform an oral dental screening).

8. **NAVMED 1300/16 Part I.**

9. **NAVMED 1300/16 Part II.**

10. **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. ***An example sheet can be provided upon request.***

11. **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 with HPV co-testing.

12. **IMMUNIZATIONS** – Copy of vaccine records (titers showing immunity are acceptable for some) The following immunizations are recommended by the Center of Disease Control for any travel outside of the continental U.S.:
    Adults: Hepatitis A & B (Or + Titers for Hepatitis A Virus Ab & Hepatitis B Virus Surface Ab), MMR, Varicella (or positive titers MMRV Ab IgG), Polio, and TDAP (no titers).
    Children: Age appropriate vaccines.
    While these may be recommendations, the lack of immunizations may affect your ability to PCS

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

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

OSS PROCESS

Upon receipt of your orders, go to NTC OSS website for guidance (https://sandiego.tricare.mil/Clinics/NBHC-NTC-San-Diego). Once all of your documents are completed report to NTC Point Loma for HM pre-screening process. If all supporting documents and IMR requirements are completed, a virtual appointment will be made for the member. If you prefer to send it through DoD SAFE please refer to the PowerPoint on the website for further guidance.

If you are approved for transfer you may pick up your paperwork in person Mon- Fri 0730-1200 and 1300-1500. If the medical provider has to send a message to the gaining command for further review, then you will contact our Message Traffic department at dha.san-diego.San-Diego-NMC.mbx.ntc-ssc@health.mil>

OVERSEAS/ SEA DUTY SCREENING CONTACT INFORMATION FOR AD MEMBERS

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): _____

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

Operational Screening		
Suitability Screening		

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.**

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.) _____

MEDICAL, DENTAL, AND EDUCATIONAL SUITABILITY SCREENING CHECKLIST AND WORKSHEET

Privacy Act Statement: OPNAVINST 1300.14D authorizes collection of this information. The following information and documents, as applicable, are required to conduct medical, dental, and educational screening to determine suitability for an overseas, remote duty, or operational assignment. Complete and current information is essential for completion of screening. Disclosure is voluntary, however, missing or incomplete 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.

The Suitability Screening Coordinator (SSC) at the military treatment facility (MTF) can assist in obtaining and completing the required information. The SSC will ensure required information and documents are complete and current before referral to a MTF provider for screening and a suitability recommendation. The SSC will place the completed original from in the individual's Service Treatment Record/Non-Service Treatment Record and retain a copy for audit. Medical, dental, and educational suitability screening is valid for 12 months from the date of completion if there were no significant changes in the medical, dental, or educational status of the service or family member. The service member must notify his or her commanding officer or officer in charge of any change in status (including pregnancy).
Complete one form for each Service and family member screened.

SERVICE MEMBER NAME	GRADE/ RATE	SSN

CURRENT UNIT	TELEPHONE NUMBER

NEXT DUTY STATION LOCATION & UNIT IDENTIFICATION CODE (UIC)	TYPE DUTY CLASSIFICATION CODE (Navy Enlisted Code Only)

FAMILY MEMBER NAME	FAMILY MEMBER PREFIX	Age

	ITEM	SSC Review YES	NO	N/A
A. FOR SERVICE MEMBERS:				
☐	1. Legible copy of orders or an Overseas Screening Notification. (For operational assignments, orders should indicate the platform to which assigned and a description of the duty assignment.)			
☐	2. Each family member name, family member prefix, social security number, address and telephone number, if other than the service member's.			
SERVICE TREATMENT RECORD TO INCLUDE:				
☐	3. 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 _____			
☐	4. Annual Periodic Health Assessment (PHA) current and documented? Date: _____			
☐	5. Current medical history (DD Form 2807-1)			
☐	6. Hearing (Audiogram)			
☐	7. Vision Examination			
☐	8. G-6P-D Test			
☐	9. PPD Test			
☐	10. Sickle Cell Trait Test			
☐	11. Negative HIV results current to 1 year of transfer Date Drawn: _____ Roster Number: _____			
☐	12. Blood Type: _____			
☐	13. DNA Testing completed and documented?			
☐	14. Required Immunizations (Assignment Specific)			
☐	15. Military Dental Records			
☐	16. Copies of civilian medical, dental, or mental health care records to include narrative summaries of any inpatient admissions in civilian facilities.			
☐	17. Mammogram current and documented. Date: _____			
☐	18. Pregnancy screen (verbal inquiry). (*Also, command will refer for pregnancy test 30 days prior to departure date.)*			
☐	Other:			
B. FOR FAMILY MEMBERS:				
☐	1. Non-Service Treatment Record (medical and dental) and include a completed DD Form 2807-1			
☐	2. Copies of civilian medical, dental, or mental health care records to include narrative summaries of any inpatient admissions in civilian facilities. Include a completed DD Form 2807-1			
☐	3. Recommended ACIP and required country specific immunizations (check current country specific immunization requirements issued by the Centers for Disease Control and Prevention (CDC) i.e. yellow fever)			

ITEM	SSC Review		
C. FOR DEPENDENT CHILDREN:	YES	NO	N/A
☐ 1. DD FORM 2792-1 (Required for ALL children birth to 22nd Birthday OR High School Graduation)			
FOR INFANTS AND TODDLERS (Birth to 36 Months) ELIGIBLE TO RECEIVE EARLY INTERVENTION SERVICES AS EVIDENCED BY AN INDIVIDUALIZED FAMILY SERVICE PLAN (IFSP):			
☐ 2. Copy of the current IFSP and, if available, developmental assessments or evaluations.			
FOR PRESCHOOL OR SCHOOL-AGE CHILDREN (Ages 3 to 22nd Birthday or High School Graduation) ELIGIBLE TO RECEIVE SPECIAL EDUCATION AND RELATED SERVICES AS EVIDENCED BY AN INDIVIDUALIZED EDUCATION PROGRAM (IEP):			
☐ 3. Copy of the current IEP and, if available, developmental assessments or evaluations.			
FOR EACH FAMILY MEMBER ENROLLED OR UNDERGOING ENROLLMENT IN THE EXCEPTIONAL FAMILY MEMBER PROGRAM (EFMP):			
☐ 4. Copy of the DD Form 2792 and any EFMP correspondence.			

D. FOR SSC USE ONLY

1. Date suitability screening conducted. Date: _____

E. SUITABILITY INQUIRY:

☐ 1. Are any of the shaded blocks checked on NAVMED Form 1300/1?
- ☐ YES (Suitability Inquiry required, proceed to question 2)
- ☐ NO (Line through question 2 and proceed to section F)

☐ 2. Suitability Inquiry:

Medical Care:
- ☐ Potential need identified
- ☐ N/A

Date & Time sent: _____ Reply date & time: _____
Sent by (Sending SSC): _____ Reply from: _____
Sent to (Gaining SSC): _____ Contact #: _____
E-Mail: _____

Dental Services:
- ☐ Potential need identified
- ☐ N/A

Date & Time sent: _____ Reply date & time: _____
Sent by (Sending SSC): _____ Reply from: _____
Sent to (Gaining SSC): _____ Contact #: _____
E-Mail: _____

Special Education Services:
- ☐ Potential need identified
- ☐ N/A

Date & Time sent: _____ Reply date & time: _____
Sent by (Sending SSC): _____ Reply from: _____
Sent to (Gaining SSC): _____ Contact #: _____
E-Mail: _____
Sent to (Gaining DoDEA): _____ E-Mail: _____

Other information:

F. SUITABILITY SCREENING COORDINATOR: Facility_____

Printed Name: _____ E-mail: _____ Phone: _____	Signature	Date

REPORT OF MEDICAL HISTORY

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

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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)*	5. EXAMINING LOCATION AND ADDRESS *(Include ZIP Code)*
b. HOME TELEPHONE *(Include Area Code)*	
c. EMAIL ADDRESS	

X ALL APPLICABLE BOXES:

6.a. SERVICE		b. COMPONENT	c. PURPOSE OF EXAMINATION	
☐ Army	☐ Coast Guard	☐ Regular	☐ Retention	☐ Other *(Specify)*
☐ Navy		☐ Reserve	☐ Separation	
☐ Marine Corps		☐ National Guard	☐ Medical Board	
☐ Air Force			☐ Retirement	

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)*

EXCEPTIONAL FAMILY MEMBER PROGRAM (EFMP) QUESTIONNAIRE

One questionnaire per family member

Please mark a Yes or No to each condition

Name _____

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

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

_____Are you 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?

_____Are you in a residential treatment facility?

_____Have you ever applied for a humanitarian reassignment for medical reasons?

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

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

_____Have you recently returned from overseas because medical or special educational services were not available?

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

_____Are you receiving medical care through a state medical program?

_____Are you receiving Social Security Supplemental Income (SSI) benefits?

_____Are you a geographic bachelor because of medical or educational needs?

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
(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: *(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	

EARLY INTERVENTION / SPECIAL EDUCATION SUMMARY

OMB No. 0704-0411
OMB APPROVAL EXPIRES 20230930

The public reporting burden for this collection of information, 0704-0411, is estimated to average 25 minutes per response, including 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-informationcollections@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**

PRIVACY ACT STATEMENT

AUTHORITY: 10 U.S.C. 136; 20 U.S.C. 927; DoDI 1315.19: DoDI 1342.12

PRINCIPAL PURPOSE(S): Information will be used by DoD personnel to evaluate and document the early intervention/special education needs of family members. This information will enable: (1) sponsors to enroll into the Exceptional Family Member Program (EFMP), (2) military assignment personnel to match the early intervention/special education needs of family members against the availability of early intervention/special education services through the Family Member Travel Screening (FMTS) process, (3) EFMP Family Support staff to offer information on community support services, and (4) civilian personnel offices to advise civilian employees about the availability of education services to meet the early intervention/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 applicable SORNs and routine uses that apply can be found at: Air Force: F036 AF PC C: Military Personnel Records System at: https://dpcld.defense.gov/Privacy/SORNsIndex/DOD-wide-SORN-Article-View/Article/569821/f036-af-pc-c/; F044 AF SG U: Special Needs and Educational and Developmental Intervention Services at: https://dpcld.defense.gov/Privacy/SORNsIndex/DOD-wide-SORN-Article-View/Article/569875/f044-af-sg-u/; Army: A0600-8-104b AHRC - Official Military Personnel Record at: https://dpcld.defense.gov/Privacy/SORNsIndex/DOD-wide-SORN-Article-View/Article/570054/a0600-8-104-ahrc/; A0608b CFSC, Personnel Affairs: Army Community Service Assistance Files at: https://dpcld.defense.gov/Privacy/SORNsIndex/DOD-wide-SORN-Article-View/Article/570084/a0608b-cfsc/"
DHA: EDHA 07: Military Health Information System at: http://dpcld.defense.gov/Privacy/SORNsIndex/DOD-wide-SORN-Article-View/Article/570672/edha-07/
OSD/JS: DMDC 02 DoD: Defense Enrollment Eligibility Reporting Systems (DEERS) at: https://dpcld.defense.gov/Privacy/SORNsIndex/DOD-wide-SORN-Article-View/Article/627618/dmdc-02-dod/
DPR 34 DoD: Defense Civilian Personnel Data System at: https://dpcld.defense.gov/Privacy/SORNsIndex/DOD-wide-SORN-Article-View/Article/570697/dpr-34-dod/
EDHA 16 DoD: Special Needs Program Management Information System (SNPMIS) Records at: https://dpcld.defense.gov/Privacy/SORNsIndex/DOD-wide-SORN-Article-View/Article/570679/edha-16-dod/
DoDEA 29: DoDEA Non-DoD Schools Program at: https://dpcld.defense.gov/Privacy/SORNsIndex/DOD-wide-SORN-Article-View/Article/570576/dodea-29/
DoDEA 26: Department of Defense Education Activity Educational Records at: https://dpcld.defense.gov/Privacy/SORNsIndex/DOD-wide-SORN-Article-View/Article/570573/dodea-26/
Navy and Marine Corps: "M01070-6: Marine Corps Official Military Personnel Files at: https://dpcld.defense.gov/Privacy/SORNsIndex/DOD-wide-SORN-Article-View/Article/570626/m01070-6/
M01754-6: Exceptional Family Member Program Records at: https://dpcld.defense.gov/Privacy/SORNsIndex/DOD-wide-SORN-Article-View/Article/570631/m01754-6/
N01070-3: Navy Military Personnel Records System at: https://dpcld.defense.gov/Privacy/SORNsIndex/DOD-wide-SORN-Article-View/Article/570310/n01070-3/
N01301-2: On-Line Distribution Information System (ODIS) at: https://dpcld.defense.gov/Privacy/SORNsIndex/DOD-wide-SORN-Article-View/Article/570320/n01301-2/

DISCLOSURE: Voluntary for civilian employees and applicants for civilian employment. 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 DoD Identification (DoD ID) number of the sponsor (and sponsor's spouse if dual military) allows the Military Healthcare System and Service personnel offices to work together to ensure any early intervention/special education needs of your dependent can be met at your next duty assignment. Dependent early intervention/special education needs are annotated in the official military personnel files which are retrieved by name and DoD ID number.

INSTRUCTIONS FOR COMPLETING DD FORM 2792-1, EARLY INTERVENTION / SPECIAL EDUCATION SUMMARY

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

DEMOGRAPHICS.

Items 1 - 7. To be completed by sponsor, spouse, legal guardian, or student who has reached the age of majority.

Item 1 Request (X one):

- Exceptional Family Member Program (EFMP) Enrollment or 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 Defense Enrollment Eligibility Reporting System (DEERS) under another sponsor. Self-Explanatory.

Items 4a. - d. Self-explanatory.

Item 5. Completed for children age birth to 3.

Items 6.a. - c. Completed for children ages 3 to 21 only. Children who are ages 3 to 5 should have the DD Form 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 Form 2792-1. NOTE: For 6.c., students that are home-schooled are eligible to receive some form of special education services in the public school setting. Therefore they may have a private school service plan. Include a copy of the service plan as applicable.

Items 7.a. - d. Signature of sponsor, spouse, legal guardian, or student who has reached the age of majority and completed the form. Self-explanatory.

Items 8.a. - f. Administrative Review. Completed by EFMP Office or Family Member Travel Screening (FMTS) Office responsible for enrollment or screening. NOTE: For 8.c., if child is entered into DEERS under a DoD ID number other than what is provided in 8.a. and 8.b., list the additional ID in 8.c.

EARLY INTERVENTION / SPECIAL EDUCATION 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 family member travel screening or EFMP enrollment.**

Items 9.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 10.a. - d. Child / Student Information. Completed by sponsor, spouse, or legal guardian. Self-explanatory.

Items 11.a. - e. Early Intervention Summary (EIS) Information. Completed by EIS or school personnel. Mark (X) Yes or No for each item. Include additional information as noted.

Items 12.a. - f. School Information. Completed by school personnel at the school the child attends. Mark (X) Yes or No for each item. Include additional information as noted.

Item 13. Completed by school personnel. Mark (X) eligibility category. Mark only one.

Item 14. Completed by school personnel. Mark (X) all related services provided and indicate total time services are provided.

Items 15.a - c. Completed by EIS and school personnel. Self-explanatory.

Items 16.a - j. Completed by EIS provider / school official information completing the form. Self-explanatory.

NOTE: If child is under 5 years of age, is not enrolled in school, a home school program, or engaged with an Early Intervention Services program, and does not have any identified needs, the parents or guardians can fill out and sign page 2 of the DD Form 2792-1 and return it to the requesting office. The completion of Page 3 is not required in this case.

EARLY INTERVENTION / SPECIAL EDUCATION SUMMARY

(Page 2, Items 1 - 7 to be completed by sponsor, parent, or legal guardian. Read Privacy Act Statement and Instructions before completing the form.)

DEMOGRAPHICS

1. REQUEST *(Select One)*

☐ EFMP Enrollment or Update

☐ Request for Government Sponsored Travel

☐ Request Change in EFMP Status:

☐ No longer requires IEP / IFSP

☐ No longer qualifies as a dependent

*(*Provide documentation to change status)*

☐ Divorce / change in custody*

☐ Family member deceased

2. CHILD / STUDENT INFORMATION *(To be completed by sponsor, spouse, legal guardian, or student who has reached the age of majority.)*

2a. CHILD / STUDENT NAME *(Last, First, Middle Initial)*	**2b. SPONSOR NAME** *(Last, First, Middle Initial)*	**2c. CHILD / STUDENT CURRENT MAILING ADDRESS** *(Street, Apartment Number, City, State, ZIP Code, APO / FPO)*
2d. FAMILY MEMBER PREFIX	**2e. CHILD / STUDENT DATE OF BIRTH** *(YYYYMMDD)*	**2f. CHILD / STUDENT GENDER** *(Select one)* ☐ Male ☐ Female
2g. FAMILY HOME E-MAIL ADDRESS	**2h. HOME TELEPHONE NUMBER** *(Include Country Code / Area Code)*	

3a. SPONSOR RANK OR GRADE	**3b. INSTALLATION OF SPONSOR'S CURRENT ASSIGNMENT** *(Include City, State, Country)*	
3c. SPONSOR'S OFFICIAL E-MAIL ADDRESS	**3d. DUTY TELEPHONE NUMBER** *(Include Country Code / Area Code)*	**3e. MOBILE NUMBER** *(Include Country Code / Area Code)*

3f. STATUS *(Select One)*

☐ Regular Active Service Member ☐ Active Reserve ☐ Active Guard

☐ Reserves ☐ National Guard ☐ Civilian

3g. BRANCH OF SERVICE *(Military Only)*

☐ Army ☐ Navy ☐ Air Force

☐ Marine Corps ☐ Coast Guard

3h. DOES CHILD RESIDE WITH SPONSOR? *(Select One. If No, Explain.)*

☐ Yes ☐ No _____

3i. IS THE CHILD / STUDENT ENROLLED IN DEERS UNDER A SPONSOR OTHER THAN THE ONE LISTED ABOVE? *(Select One. If Yes, provide name of sponsor)*

☐ Yes ☐ No _____

4a. ARE BOTH SPOUSES ON ACTIVE DUTY? *(Military Only. Select One. If Yes, Complete 4b.- 4d. below)* ☐ Yes ☐ No

4b. ACTIVE DUTY SPOUSE'S NAME *(Last, First, Middle Initial)*	**4c. BRANCH OF SERVICE**	**4d. RANK / RATE**

5. FOR CHILDREN FROM BIRTH TO AGE THREE ONLY:

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

6. EDUCATION SERVICES FOR DEPENDENTS 3 YEARS AND OLDER:

6a. Is your child being home-schooled full-time or part-time? *(Select one)* ☐ Yes, Part-Time ☐ Yes, Full-Time ☐ No *(If Yes, complete 6a(1) and 6a(2))*

6a(1). When did you start home-schooling? *(YYYYMMDD)* _____

6a(2). Name of home school program/title of courses: _____

6b. Is your child being evaluated for, or receiving, special education services on an IEP? If Yes, have the child's school (or primary care provider if school is not in session) complete page 3. ☐ Yes ☐ No

6c. List any special education-related services received in the last 3 years: *(include a copy of the service plan as applicable)* _____

7. 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 appropriate personnel of the Department of Defense. This information will be used to evaluate and document my child / student's needs for educational services for the purpose of assignment coordination, EFMP enrollment, or eligibility for other educationally related benefits.

7a. SIGNATURE	**7b. PRINTED NAME**	**7c. RELATIONSHIP TO CHILD / STUDENT**	**7d. DATE** *(YYYYMMDD)*

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

8a. SPONSOR DoD ID #	**8b. SPOUSE DoD ID #** *(If dual* military)	**8c. DoD ID # USED IN DEERS** *(If different from sponsor's)*	**8f. STAMP**

8d. MTF OR OFFICE RECEIVING COMPLETED FORM	**8e. DATE** *(YYYYMMDD)*	

EARLY INTERVENTION / SPECIAL EDUCATION 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.)*

9. 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 enrollment or eligibility for other educationally related benefits.

9a. PRINTED NAME	9b. SIGNATURE	9c. RELATIONSHIP TO CHILD / STUDENT	9d. DATE *(YYYYMMDD)*

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

10a. NAME OF CHILD / STUDENT *(Last, First, Middle Initial)*	10b. CURRENT GRADE LEVEL *(if school age)*	10c. DATE OF BIRTH *(YYYYMMDD)*	10d. GENDER *(Select one)*
			☐ Male ☐ Female

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

YES NO

☐ ☐ 11a. Is the child currently being evaluated for early intervention services?

☐ ☐ 11b. 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)* _____

☐ ☐ 11c. Has the child been found eligible but the family declined IFSP services?

11d. Basis for eligibility: ☐ Developmental Delay ☐ Diagnosed physical or mental condition that has a high probability of resulting in a Developmental Delay

11e. Is there an identified disability? *(If known, please specify)*

12. SCHOOL INFORMATION - FOR STUDENTS AGES 3 - 21 *(To be completed by school representative - answer all questions)*

YES NO

☐ ☐ 12a. Is this student currently being evaluated for special education services?

☐ ☐ 12b. Has the child been found eligible for special education services? *(If Yes, complete Item 13.)*

☐ ☐ 12c. 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 13 and proceed to Item 16)*

☐ ☐ 12d. Does this child / student receive special education services under a current Individualized Education Program (IEP)? Date of next annual review *(YYYYMMDD)* _____ *(If Yes, complete Items 13 and following and attach a copy of the current IEP.)*

☐ ☐ 12e. Were IEP services terminated by the IEP team due to ineligibility within the last 2 years? Date of IEP termination *(YYYYMMDD)* _____

☐ ☐ 12f. Was the IEP terminated at the request of the parents within the last year (parents withdrew student from special education)? *(If Yes, complete Items 13 and following).* Date of IEP termination *(YYYYMMDD)* _____

13. ELIGIBILITY CATEGORY FOR CHILDREN 3 TO 21 YEARS OF AGE *(Select only one)* ☐ N/A

- ☐ Autism Spectrum Disorder
- ☐ Deaf
- ☐ Blind
- ☐ Deaf / Blind
- ☐ Visually Impaired
- ☐ Traumatic Brain Injury
- ☐ Hearing Impaired
- ☐ Orthopedically Impaired
- ☐ Communication Impaired
  - ☐ Articulation
  - ☐ Dysfluency
  - ☐ Voice
  - ☐ Language / Phonology
- ☐ Developmental Delay
- ☐ Specific Learning Disability
- ☐ Emotionally Impaired
- ☐ Behavioral / Conduct Disorder
- ☐ Intellectual Disability
  - ☐ Mild
  - ☐ Moderate
  - ☐ Severe / Profound
- ☐ Other Health Impaired *(Specify)*

14. RELATED SERVICES ON IEP *(Select boxes next to related services and indicate total number of minutes or hours that services are provided.)* ☐ N/A

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

☐ Counseling			per	
☐ Occupational Therapy			per	
☐ Physical Therapy			per	
☐ Speech Therapy			per	
☐ Intensive Behavioral Intervention (such as ABA)			per	

☐ Special Transportation *(Describe)* _____

☐ Other *(Describe)* _____

15. BEHAVIOR / COMMUNICATION *(Select all that apply and specify in comments section)*

YES NO

☐ ☐ 15a. Child exhibits high risk or dangerous behavior

☐ ☐ 15b. Child is verbal *(If No, answer 15b(1)-15b(4) The student uses:)*

☐ ☐ 15b(1). Signing

☐ ☐ 15b(2). Picture Exchange Communication System (PECS)

☐ ☐ 15b(3). Communication Device

☐ ☐ 15b(4). Other

15c. COMMENTS

16. PROVIDER / SCHOOL INFORMATION

16a. NAME OF EARLY INTERVENTION PROGRAM OR SCHOOL	16b. SCHOOL DISTRICT	
16c. CITY, STATE, COUNTRY	**16d. TELEPHONE NUMBER** *(Include Country Code / Area code)*	**16e. FAX NUMBER** *(Include Country Code / Area Code)*
16f. E-MAIL ADDRESS	**16g. NAME OF INDIVIDUAL COMPLETING THIS SECTION**	
16h. SIGNATURE	**16i. TITLE**	**16j. DATE** *(YYYYMMDD)*

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 _____	Non-Navy Medical Facility/Civilian Dental 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 _____

REPORT OF SUITABILITY FOR OVERSEAS AND REMOTE DUTY ASSIGNMENTS
NAVPERS 1300/16 (Rev. 07-2024) Supporting Directive OPNAVINST 1300.14E

1. Member's Name (Last, First, MI)	2. Date	3. Number of Dependents

4. Current Ship/Station	5. Current UIC	6. Proposed Overseas/Remote Location	7. Proposed UIC

Part I: Command Review

The purpose of the command review is to determine, via a records review and personal interview, member's and their dependents suitability for duty/life in the proposed overseas/remote duty location per MILPERSMAN 1300-302. Any questions checked "YES" (with the exception of questions 10, 13-14 disqualifies the member for overseas/remote duty assignment. Complete PART I and obtain waiver(s) prior to starting PART II (NAVMED) 1300/1).

1. Has the member or his or her dependent(s) previously been reassigned, prior to normal tour completion, due to 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 personnel who REQUEST to separate/retire will be held to the DoD tour length.	☐ N/A	☐ Yes	☐ No
3.a (E-5 and above) Does the member, spouse, or family member(s) have serious problems of indebtedness, credit loss, or other financial problems which have not been reconciled with creditor(s) or interested parties?	☐ N/A	☐ Yes	☐ No
3.b (E-4 and below) Member must complete debt-to-income (DTI) ratio screening per OPNAVINST 1740.5D. Do not calculate the spouse's income unless guaranteed employment at the overseas location has been obtained. Is the DTI ratio 30% or greater?	☐ N/A	☐ Yes	☐ No
4. Has the member or his or her dependent(s) been convicted of any criminal offense (civilian or military) within the last 24 months or has/had any involvement in an ongoing criminal action?		☐ Yes	☐ No
5. Has the member or his or her dependent(s) been convicted of a sex offense? Information regarding whether a person is a sex offender may be found at Dru Sjodin National Sex Offender Public Web site (NSOPW) at www.nsopw.gov.		☐ Yes	☐ No
6. Does the member or his or her dependent(s) 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. A waiver of aftercare program does not quality the member; answer YES.		☐ Yes	☐ No
7. Is the member or his or her dependent(s) 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 FAP issues, 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, the gaining command and fleet and family support center (FFSC) must support the waiver request.		☐ Yes	☐ No
8. Was the member's spouse previously a member of the Military Services and was the characterization of separation "Other than Honorable"? Explain in the remarks section.	☐ N/A	☐ Yes	☐ No
9. 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
10. Are any of the member's dependents covered in a custody agreement? If "NO" or "N/A", go to question 12.	☐ N/A	☐ 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? (Navy policy does not require a separate agreement if not required by State law.)		☐ Yes	☐ No
11. Single parents/military couples with family members. Is there any reason why the Family Care Plan cannot be executed or is not per OPNAVINST 1740.4D?	☐ N/A	☐ Yes	☐ No
NOTE: While the unique situation of single parents with dependents is not disqualifying, this fact should be noted in the remarks.			
12. 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
13. Has the member and his or her adult dependents received "Level I" Anti-terrorism Force Protection (Level III for 0-5/0-6 Commanding Officer Awareness) training, prior to transfer, and has it been recorded on NAVPERS 1070/613?		☐ Yes	☐ No
14. Is the 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.	☐ N/A	☐ Yes	☐ No

REPORT OF SUITABILITY FOR OVERSEAS AND REMOTE DUTY ASSIGNMENTS
NAVPERS 1300/16 (Rev. 07-2024) Supporting Directive OPNAVINST 1300.14E

1. Member's Name (Last, First, MI)	2. Date	3. Number of Dependents

FOR PERSONNEL E-3 AND BELOW: *Ensure the member has been counseled and understand he or she cannot be assigned accompanied overseas duty. E-3 and below members will be assigned unaccompanied duty based on readiness needs. Acquiring family member(s) en route and bringing them without dependent entry approval/command sponsorship will most likely result in return to CONUS at his or her expense, and the Service member will complete the tour unaccompanied.*

15. I have been counseled on the above statement and understand. Member's Signature:

16. Remarks

I am aware that failure to divulge disqualifying information or amplifying information (medical/dental/personal) pertaining to the questions on this form may ultimately result in disciplinary action punishable under the UCMJ.

17. Member's Name and Rank/Rate:	18. Member's Signature:	19. Date:
20. Interviewer's Name, Rank/Rate and Title:	20. Interviewer's Signature:	22. Date:

Part II: Recommendation of Commanding Officer (or OIC) Medical Treatment Facility

Based on the information available as a result of screening, approved medical/dental waivers received and on the capabilities of the Navy Medicine Readiness and Training Command (NMRTC) in the area of assignment to which ordered, the following recommendation is forwarded.

a. Medical, dental, and educational screening was conducted per BUMEDINST 1300.2a.
b. Recommendation is based on a review of NAVMED 1300/1, Parts I & II. One form has been completed for each Service member and family member screened.
c. If a shaded block is checked on NAVMED 1300/1, coordination is required with the gaining NMRTC 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.
d. Family member screening is not required for an unaccompanied tour of 24 months or less (exception: screening is required for Diego Garcia and Souda Bay, Crete).
e. Do not forward sensitive medical or personal information with this form.

1. Service Member is suitable for this assignment. ☐ Yes ☐ No

Applicable family members and dependents suitability for this assignment.

2. Name: ☐ Yes ☐ No	3. Name: ☐ Yes ☐ No
4. Name: ☐ Yes ☐ No	5. Name: ☐ Yes ☐ No
6. Name: ☐ Yes ☐ No	7. 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. Names:

9. Name of CO/OIC or designee of cognizant medical facility.

10. Signature of CO/OIC or designee of cognizant medical facility.	11. Date:

REPORT OF SUITABILITY FOR OVERSEAS AND REMOTE DUTY ASSIGNMENTS
NAVPERS 1300/16 (Rev. 07-2024) Supporting Directive OPNAVINST 1300.14E

1. Member's Name (Last, First, MI)	2. Date	3. Number of Dependents

Part III: CMC/COB/SEA Endorsement

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

2. CMC/COB/SEA Name and Rank:	3. CMC/COB/SEA Signature:	4. Date:

Part IV: CO/OIC Endorsement

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

2. Remarks:
If the member is found unsuitable for this overseas/remote duty assignment and the CO/OIC still feels the member should be considered, submit a waiver (non-medical/ dental) request per MILPERSMAN - 1300-302

3. CO/OIC Name and Rank:	4. CO/OIC Signature:	5. Date: