

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 MEMBER

Date: _____

Name (Last, First, Initial): _____

Rate / Rank: _____

Sponsor's SSN: _____

Work Extension: _____

Home/ Cell phone number: _____

Military email address: _____

Current Command (and UIC): _____

Detachment date from Current Command: _____

CPO/DIVO Contact: _____

Name of new command (and UIC): _____

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

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

Operational Screening	<input type="checkbox"/>
Suitability Screening	<input type="checkbox"/>

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

Name of family members who require screening:

1). _____

2). _____

3). _____

4). _____

5). _____

6). _____

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

IF RECENTLY CLEARED FROM LIMDU YOU MUST PROVIDE SUPPORTING DOCUMENTS

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

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

REQUIRED FORMS

- **DD FORM 2807-1 PG 1-3**
- **NAVMED 6224/8 – TB RISK ASSESSMENT FORM**
- **NAVPERS 1300/16**
- **NAVMED 1300/1 PART 1**
- **NAVMED 1300/1 PART 2**
 - Must be taken to dental to be signed prior to submission. Dependents receive signature from Civilian Dental Facility.
- **NAVPERS 1300/16 PART II**

Highlighted portions to be filled out by:

Patient

Dental Facility

NTC Screening Office

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
A. FOR SERVICE MEMBERS:					
					YES NO N/A
<input type="checkbox"/>	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.)				
<input type="checkbox"/>	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:					
<input type="checkbox"/>	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 _____				
<input type="checkbox"/>	4. Annual Periodic Health Assessment (PHA) current and documented? Date: _____				
<input type="checkbox"/>	5. Current medical history (DD Form 2807-1)				
<input type="checkbox"/>	6. Hearing (Audiogram)				
<input type="checkbox"/>	7. Vision Examination				
<input type="checkbox"/>	8. G-6P-D Test				
<input type="checkbox"/>	9. PPD Test				
<input type="checkbox"/>	10. Sickie Cell Trait Test				
<input type="checkbox"/>	11. Negative HIV results current to 1 year of transfer Date Drawn: _____ Roster Number: _____				
<input type="checkbox"/>	12. Blood Type: _____				
<input type="checkbox"/>	13. DNA Testing completed and documented?				
<input type="checkbox"/>	14. Required Immunizations (Assignment Specific)				
<input type="checkbox"/>	15. Military Dental Records				
<input type="checkbox"/>	16. Copies of civilian medical, dental, or mental health care records to include narrative summaries of any inpatient admissions in civilian facilities.				
<input type="checkbox"/>	17. Mammogram current and documented. Date: _____				
<input type="checkbox"/>	18. Pregnancy screen (verbal inquiry). (Also, command will refer for pregnancy test 30 days prior to departure date.)				
<input type="checkbox"/>	Other:				
B. FOR FAMILY MEMBERS:					
<input type="checkbox"/>	1. Non-Service Treatment Record (medical and dental) and include a completed DD Form 2807-1				
<input type="checkbox"/>	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				
<input type="checkbox"/>	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
<input type="checkbox"/>	1. DD FORM 2792-1 (Required for ALL children birth to 22 nd 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):				
<input type="checkbox"/>	2. Copy of the current IFSP and, if available, developmental assessments or evaluations.			
FOR PRESCHOOL OR SCHOOL-AGE CHILDREN (Ages 3 to 22 nd Birthday or High School Graduation) ELIGIBLE TO RECEIVE SPECIAL EDUCATION AND RELATED SERVICES AS EVIDENCED BY AN INDIVIDUALIZED EDUCATION PROGRAM (IEP):				
<input type="checkbox"/>	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):				
<input type="checkbox"/>	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:				
<input type="checkbox"/>	1. Are any of the shaded blocks checked on NAVMED Form 1300/1? <input type="checkbox"/> YES (Suitability Inquiry required, proceed to question 2) <input type="checkbox"/> NO (Line through question 2 and proceed to section F)			
<input type="checkbox"/>	2. Suitability Inquiry: <div style="display: flex; justify-content: space-between;"> <div style="width: 30%;"> Medical Care: <input type="checkbox"/> Potential need identified <input type="checkbox"/> N/A </div> <div style="width: 30%;"> Date & Time sent: _____ Sent by (Sending SSC): _____ Sent to (Gaining SSC): _____ </div> <div style="width: 30%;"> Reply date & time: _____ Reply from: _____ Contact #: _____ E-Mail: _____ </div> </div> <div style="display: flex; justify-content: space-between;"> <div style="width: 30%;"> Dental Services: <input type="checkbox"/> Potential need identified <input type="checkbox"/> N/A </div> <div style="width: 30%;"> Date & Time sent: _____ Sent by (Sending SSC): _____ Sent to (Gaining SSC): _____ </div> <div style="width: 30%;"> Reply date & time: _____ Reply from: _____ Contact #: _____ E-Mail: _____ </div> </div> <div style="display: flex; justify-content: space-between;"> <div style="width: 30%;"> Special Education Services: <input type="checkbox"/> Potential need identified <input type="checkbox"/> N/A </div> <div style="width: 30%;"> Date & Time sent: _____ Sent by (Sending SSC): _____ Sent to (Gaining SSC): _____ Sent to (Gaining DoDEA): _____ </div> <div style="width: 30%;"> Reply date & time: _____ Reply from: _____ Contact #: _____ E-Mail: _____ E-Mail: _____ </div> </div>			
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.)				OMB No. 0704-0413 OMB approval expires September, 30 2021	
<p>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.</p>					
<p style="text-align: center;">PRIVACY ACT STATEMENT</p> <p>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.</p> <p>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.</p> <p>ROUTINE USE(S): The Routine Uses are listed in the applicable system of records notice found at: http://dpcl.d.defense.gov/Privacy/SORNSIndex/DOD-wide-SORN-Article-View/Article/570661/a0601-270-usmepcom-dod/</p> <p>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.</p>					
<p>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.</p>					
1. LAST NAME, FIRST NAME, MIDDLE NAME (SUFFIX)		2.a. SOCIAL SECURITY NO.		b. DoD ID NO. (If applicable)	
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)		NMRTU Point Loma 2051 Cushing Rd, San Diego, CA 92106			
c. EMAIL ADDRESS					
X ALL APPLICABLE BOXES:				7.a. POSITION (Title, Grade, Component)	
6.a. SERVICE <input type="checkbox"/> Army <input type="checkbox"/> Coast Guard <input type="checkbox"/> Navy <input type="checkbox"/> Marine Corps <input type="checkbox"/> Air Force		b. COMPONENT <input type="checkbox"/> Regular <input type="checkbox"/> Reserve <input type="checkbox"/> National Guard		c. PURPOSE OF EXAMINATION <input type="checkbox"/> Retention <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Separation <input type="checkbox"/> Medical Board <input type="checkbox"/> Retirement	
8. CURRENT MEDICATIONS (Prescription and Over-the-counter)		9. ALLERGIES (Including insect bites/stings, foods, medicine or other substance)			
<p>Mark each item "YES" or "NO". Every item marked "YES" must be fully explained in Item 29 on Page 2.</p>					
HAVE YOU EVER HAD OR DO YOU NOW HAVE:				12. (Continued)	
10.a. Tuberculosis YES NO <input type="radio"/> <input type="radio"/>				f. Foot trouble (e.g., pain, corns, bunions, etc.) YES NO <input type="radio"/> <input type="radio"/>	
b. Lived with someone who had tuberculosis YES NO <input type="radio"/> <input type="radio"/>				g. Impaired use of arms, legs, hands, or feet YES NO <input type="radio"/> <input type="radio"/>	
c. Coughed up blood YES NO <input type="radio"/> <input type="radio"/>				h. Swollen or painful joint(s) YES NO <input type="radio"/> <input type="radio"/>	
d. Asthma or any breathing problems related to exercise, weather, pollens, etc. YES NO <input type="radio"/> <input type="radio"/>				i. Knee trouble (e.g., locking, giving out, pain or ligament injury, etc.) YES NO <input type="radio"/> <input type="radio"/>	
e. Shortness of breath YES NO <input type="radio"/> <input type="radio"/>				j. Any knee or foot surgery including arthroscopy or the use of a scope to any bone or joint YES NO <input type="radio"/> <input type="radio"/>	
f. Bronchitis YES NO <input type="radio"/> <input type="radio"/>				k. Any need to use corrective devices such as prosthetic devices, knee brace(s), back support(s), lifts or orthotics, etc. YES NO <input type="radio"/> <input type="radio"/>	
g. Wheezing or problems with wheezing YES NO <input type="radio"/> <input type="radio"/>				l. Bone, joint, or other deformity YES NO <input type="radio"/> <input type="radio"/>	
h. Been prescribed or used an inhaler YES NO <input type="radio"/> <input type="radio"/>				m. Plate(s), screw(s), rod(s) or pin(s) in any bone YES NO <input type="radio"/> <input type="radio"/>	
i. A chronic cough or cough at night YES NO <input type="radio"/> <input type="radio"/>				n. Broken bone(s) (cracked or fractured) YES NO <input type="radio"/> <input type="radio"/>	
j. Sinusitis YES NO <input type="radio"/> <input type="radio"/>				13.a. Frequent indigestion or heartburn YES NO <input type="radio"/> <input type="radio"/>	
k. Hay fever YES NO <input type="radio"/> <input type="radio"/>				b. Stomach, liver, intestinal trouble, or ulcer YES NO <input type="radio"/> <input type="radio"/>	
l. Chronic or frequent colds YES NO <input type="radio"/> <input type="radio"/>				c. Gall bladder trouble or gallstones YES NO <input type="radio"/> <input type="radio"/>	
11.a. Severe tooth or gum trouble YES NO <input type="radio"/> <input type="radio"/>				d. Jaundice or hepatitis (liver disease) YES NO <input type="radio"/> <input type="radio"/>	
b. Thyroid trouble or goiter YES NO <input type="radio"/> <input type="radio"/>				e. Rupture/hernia YES NO <input type="radio"/> <input type="radio"/>	
c. Eye disorder or trouble YES NO <input type="radio"/> <input type="radio"/>				f. Rectal disease, hemorrhoids or blood from the rectum YES NO <input type="radio"/> <input type="radio"/>	
d. Ear, nose, or throat trouble YES NO <input type="radio"/> <input type="radio"/>				g. Skin diseases (e.g. acne, eczema, psoriasis, etc.) YES NO <input type="radio"/> <input type="radio"/>	
e. Loss of vision in either eye YES NO <input type="radio"/> <input type="radio"/>				h. Frequent or painful urination YES NO <input type="radio"/> <input type="radio"/>	
f. Worn contact lenses or glasses YES NO <input type="radio"/> <input type="radio"/>				i. High or low blood sugar YES NO <input type="radio"/> <input type="radio"/>	
g. A hearing loss or wear a hearing aid YES NO <input type="radio"/> <input type="radio"/>				j. Kidney stone or blood in urine YES NO <input type="radio"/> <input type="radio"/>	
h. Surgery to correct vision (RK, PRK, LASIK, etc.) YES NO <input type="radio"/> <input type="radio"/>				k. Sugar or protein in urine YES NO <input type="radio"/> <input type="radio"/>	
12.a. Painful shoulder, elbow or wrist (e.g. pain, dislocation, etc.) YES NO <input type="radio"/> <input type="radio"/>				l. Sexually transmitted disease (syphilis, gonorrhea, chlamydia, genital warts, herpes, etc.) YES NO <input type="radio"/> <input type="radio"/>	
b. Arthritis, rheumatism, or bursitis YES NO <input type="radio"/> <input type="radio"/>				14.a. Adverse reaction to serum, food, insect stings or medicine YES NO <input type="radio"/> <input type="radio"/>	
c. Recurrent back pain or any back problem YES NO <input type="radio"/> <input type="radio"/>				b. Recent unexplained gain or loss of weight YES NO <input type="radio"/> <input type="radio"/>	
d. Numbness or tingling YES NO <input type="radio"/> <input type="radio"/>				c. Currently in good health (If no, explain in Item 29 on Page 2.) YES NO <input type="radio"/> <input type="radio"/>	
e. Loss of finger or toe YES NO <input type="radio"/> <input type="radio"/>				d. Tumor, growth, cyst, or cancer YES NO <input type="radio"/> <input type="radio"/>	

LAST NAME, FIRST NAME, MIDDLE NAME (SUFFIX)	SOCIAL SECURITY NUMBER	DoD ID NUMBER <i>(If applicable)</i>
Mark each item "YES" or "NO". Every item marked "YES" must be fully explained in Item 29 below.		
HAVE YOU EVER HAD OR DO YOU NOW HAVE:	YES NO	YES NO
15. a. Dizziness or fainting spells <input type="radio"/> YES <input type="radio"/> NO b. Frequent or severe headache <input type="radio"/> YES <input type="radio"/> NO c. A head injury, memory loss or amnesia <input type="radio"/> YES <input type="radio"/> NO d. Paralysis <input type="radio"/> YES <input type="radio"/> NO e. Seizures, convulsions, epilepsy or fits <input type="radio"/> YES <input type="radio"/> NO f. Car, train, sea, or air sickness <input type="radio"/> YES <input type="radio"/> NO g. A period of unconsciousness or concussion <input type="radio"/> YES <input type="radio"/> NO h. Meningitis, encephalitis, or other neurological problems <input type="radio"/> YES <input type="radio"/> NO	19. Have you been refused employment or been unable to hold a job or stay in school because of: <div style="margin-left: 20px;"> a. Sensitivity to chemicals, dust, sunlight, etc. <input type="radio"/> YES <input type="radio"/> NO b. Inability to perform certain motions <input type="radio"/> YES <input type="radio"/> NO c. Inability to stand, sit, kneel, lie down, etc. <input type="radio"/> YES <input type="radio"/> NO d. Other medical reasons <i>(If yes, give reasons.)</i> <input type="radio"/> YES <input type="radio"/> NO </div>	
16. a. Rheumatic fever <input type="radio"/> YES <input type="radio"/> NO b. Prolonged bleeding <i>(as after an injury or tooth extraction, etc.)</i> <input type="radio"/> YES <input type="radio"/> NO c. Pain or pressure in the chest <input type="radio"/> YES <input type="radio"/> NO d. Palpitation, pounding heart or abnormal heartbeat <input type="radio"/> YES <input type="radio"/> NO e. Heart trouble or murmur <input type="radio"/> YES <input type="radio"/> NO f. High or low blood pressure <input type="radio"/> YES <input type="radio"/> NO	20. Have you ever been treated in an Emergency Room? <i>(If yes, for what?)</i> <input type="radio"/> YES <input type="radio"/> NO 21. Have you ever been a patient in any type of hospital? <i>(If yes, specify when, where, why, and name of doctor and complete address of hospital.)</i> <input type="radio"/> YES <input type="radio"/> NO	
17. a. Nervous trouble of any sort <i>(anxiety or panic attacks)</i> <input type="radio"/> YES <input type="radio"/> NO b. Habitual stammering or stuttering <input type="radio"/> YES <input type="radio"/> NO c. Loss of memory or amnesia, or neurological symptoms <input type="radio"/> YES <input type="radio"/> NO d. Frequent trouble sleeping <input type="radio"/> YES <input type="radio"/> NO e. Received counseling of any type <input type="radio"/> YES <input type="radio"/> NO f. Depression or excessive worry <input type="radio"/> YES <input type="radio"/> NO g. Been evaluated or treated for a mental condition <input type="radio"/> YES <input type="radio"/> NO h. Attempted suicide <input type="radio"/> YES <input type="radio"/> NO i. Used illegal drugs or abused prescription drugs <input type="radio"/> YES <input type="radio"/> NO	22. Have you ever had, or have you been advised to have any operations or surgery? <i>(If yes, describe and give age at which occurred.)</i> <input type="radio"/> YES <input type="radio"/> NO 23. Have you ever had any illness or injury other than those already noted? <i>(If yes, specify when, where, and give details.)</i> <input type="radio"/> YES <input type="radio"/> NO	
18. FEMALES ONLY. Have you ever had or do you now have: <div style="margin-left: 20px;"> a. Treatment for a gynecological (female) disorder <input type="radio"/> YES <input type="radio"/> NO b. A change of menstrual pattern <input type="radio"/> YES <input type="radio"/> NO c. Any abnormal PAP smears <input type="radio"/> YES <input type="radio"/> NO d. First day of last menstrual period (YYYYMMDD) <input type="radio"/> YES <input type="radio"/> NO e. Date of last PAP smear (YYYYMMDD) <input type="radio"/> YES <input type="radio"/> NO </div>	24. Have you consulted or been treated by clinics, physicians, healers, or other practitioners within the past 5 years for other than minor illnesses? <i>(If yes, give complete address of doctor, hospital, clinic, and details.)</i> <input type="radio"/> YES <input type="radio"/> NO 25. Have you ever been rejected for military service for any reason? <i>(If yes, give date and reason for rejection.)</i> <input type="radio"/> YES <input type="radio"/> NO	
26. Have you ever been discharged from military service for any reason? <i>(If yes, give date, reason, and type of discharge; whether honorable, other than honorable, for unfitness or unsuitability.)</i> <input type="radio"/> YES <input type="radio"/> NO	27. Have you ever received, is there pending, or have you ever applied for pension or compensation for any disability or injury? <i>(If yes, specify what kind, granted by whom, and what amount, when, why.)</i> <input type="radio"/> YES <input type="radio"/> NO	
28. Have you ever been denied life insurance? <input type="radio"/> YES <input type="radio"/> NO		
29. EXPLANATION OF "YES" ANSWER(S) <i>(Describe answer(s), give date(s) of problem, name of doctor(s) and/or hospital(s), treatment given and current medical status.)</i>		

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 <i>(Physician/practitioner shall comment on all positive answers in questions 10 - 29. Physician/practitioner may develop by interview any additional medical history deemed important, and record any significant findings here.)</i>		
a. COMMENTS		
b. TYPED OR PRINTED NAME OF EXAMINER <i>(Last, First, Middle Initial)</i>	c. SIGNATURE	d. DATE SIGNED <i>(YYYYMMDD)</i>

TUBERCULOSIS EXPOSURE RISK ASSESSMENT

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

1.	Since your last Tuberculosis Exposure Risk Assessment, were you exposed to anyone known to have or suspected of having active tuberculosis (i.e., individuals with persistent cough, weight loss, night sweats, and/or fever)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> 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?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
3a.	Check any countries where you have traveled or deployed to since your last Tuberculosis Exposure Risk Assessment.			
	<input type="checkbox"/> Bangladesh	<input type="checkbox"/> Ethiopia	<input type="checkbox"/> Pakistan	<input type="checkbox"/> UR Tanzania
	<input type="checkbox"/> Brazil	<input type="checkbox"/> India	<input type="checkbox"/> Philippines	<input type="checkbox"/> Viet Nam
	<input type="checkbox"/> Burma	<input type="checkbox"/> Indonesia	<input type="checkbox"/> Russian Federation	<input type="checkbox"/> Zimbabwe
	<input type="checkbox"/> Cambodia	<input type="checkbox"/> Kenya	<input type="checkbox"/> South Africa	<input type="checkbox"/> None
	<input type="checkbox"/> China	<input type="checkbox"/> Mozambique	<input type="checkbox"/> Thailand	
	<input type="checkbox"/> DR Congo	<input type="checkbox"/> Nigeria	<input type="checkbox"/> Uganda	
	<input type="checkbox"/> Other _____			If any of these listed countries are selected, answer question 3c. If "other" is checked, write in the name of the country or countries.
3b.	Have you recently traveled to Afghanistan for any reason other than as part of a deployment requiring completion of a Post Deployment Health Assessment (PDHA)?	<input type="checkbox"/> Yes	<input type="checkbox"/> 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.	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
4a.	Have you recently had a chronic cough lasting more than 2 weeks?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
4b.	If you marked YES to chronic cough, did you have any of the following at the same time?			
	<input type="checkbox"/> Fever	<input type="checkbox"/> Cough up Blood	<input type="checkbox"/> Unexplained Weight Loss	<input type="checkbox"/> 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.	<input type="checkbox"/> Yes	<input type="checkbox"/> No
2.	There is at least one positive answer, patient to continue to medical officer for assessment.	<input type="checkbox"/> Yes	<input type="checkbox"/> 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 <i>(If the answer to one or more of questions 1, 2, 3c, or 4b is a YES, test the patient.)</i>	<input type="checkbox"/> Minimal Risk	<input type="checkbox"/> Increased Risk
3.	Recommend Latent Tuberculosis Infection (LTBI) Testing	<input type="checkbox"/> Yes	<input type="checkbox"/> No

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

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

Privacy Act Statement

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

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

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

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

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

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

PART I

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

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

Yes	No	N/A	ITEM
			16. For service/family members with underlying medical conditions:
			a. Is there a requirement for special medical supplies, adaptive equipment, assistive technology devices, special accommodations, etc.?
			b. If exposed to a physically or emotionally demanding environment, could the underlying condition become life threatening, pose a risk for dangerous or disruptive behavior, or result in a limited duty or MEDEVAC situation?
			c. Are there any chronic medical or mental health conditions requiring routine or continuing access to care or access to specialized medical care? (document on DD 2807-1)
			d. Are there any potential environmental concerns or possible health effects at the gaining location? (if yes, communicate to family and document on appropriate SF 600)
			17. For infants and toddlers (birth to 36 months), is the child receiving or undergoing eligibility to receive early intervention services as evidenced by an Individualized Family Service Plan (IFSP)?
			18. For preschool and school age children, is the child receiving or undergoing eligibility to receive special education and/or related services as evidenced by an Individualized Education Program (IEP)?
			19. Explanation of "yes" responses in shaded boxes (include #):
			Are there any concerns about the gaining MTF/operational platform's capabilities to meet the individual's needs? Specify below:
			Navy MTF SSC Name, Signature, Stamp, and Date: _____
Non-Navy Medical Providers: STOP and proceed to SECTION C			
SECTION B. Medical and Educational Screening Disposition. Completed by the screening Navy MTF medical provider to determine if a Service or family member is suitable for an overseas, remote duty, or operational assignment.			
Yes	No		ITEM
			1. Are any of the above shaded blocks in Section A checked? If "yes", submit a suitability inquiry to the gaining MTF or medical department supporting the overseas/remote duty/operational location to determine local capabilities to provide required support. (Attach Reply and answer questions 1a and 1b.) If "no", proceed to question 2.
			a. Does the gaining location have the capabilities to provide the current required medical support?(Service MTFs/TRICARE, etc.)
			b. Does the gaining location have the capabilities to provide the required medical support (diagnostic and therapeutic) if the underlying condition is exacerbated? (To include all Service MTFs/operational platform, TRICARE, etc.)
			2. Is the shaded block of question 18 checked "yes"? If yes, Submit the DD 2792-1 and IEP to the gaining DoDEA Special Education Overseas Screening Coordinator and gaining MTF to determine local capabilities to provide required support. (Attach Reply with POC info and answer question 2a.) If no, proceed to question 3.
			a. Is the DoDEA Special Education Overseas Screening Coordinator recommending travel?
Yes	No		3. IS THE SERVICE/FAMILY MEMBER SUITABLE FOR THE OVERSEAS, REMOTE DUTY OR OPERATIONAL ASSIGNMENT? (Must be completed by an MTF medical screener. Answered after the inquiry is completed.)
SECTION C. Contact Information. Completed by the MTF/non-MTF civilian providers who completed PART I. The Navy MTF medical screener shall review and countersign all suitability screenings completed by non-Navy MTF civilian providers, denoting accountability for a complete and thorough suitability screening document review for each Service/family member.			
Navy MTF Medical Screener (Signature) _____ Date _____ 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 MTF/Civilian Medical Screener (Signature) _____ Date _____ Printed Name _____ Address _____ City, State, and Zip Code _____ Telephone Number (include area/country code) _____ Office Hours to Contact _____ 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? <i>Specify below:</i>
Navy MTF SSC Name, Signature, Stamp, and Date: _____		
8. Specify Dental Class: <i>(required for service members)</i> _____ Dental Classifications: (Per DoDI 6025.19) Normally considered worldwide deployable: Class 1 - Patients with a current dental examination, who do not require dental treatment or re-evaluation. Class 2 - Patients with a current dental examination, who require non-urgent dental treatment or re-evaluation for oral conditions unlikely to result in a dental emergency within 12 months. Normally not considered worldwide deployable: Class 3 - Patients who require urgent or emergent dental treatment for oral conditions with a high potential to cause a dental emergency in the next 12 months. Class 4 - Patients who require a dental examination either because: (1) No type 1 (comprehensive) or type 2 (annual or periodic oral) dental examination was completed by a dental officer/privileged dentist within the past 12 months; (2) A patient's dental record does not exist or; (3) The dental record is not held by the responsible dental treatment facility or Medical Department activity.		
SECTION B. Dental Screening Disposition. Completed by the screening MTF provider to determine if a service or family member is suitable for an overseas, remote duty, or operational assignment. Non-Navy Medical Providers: STOP and proceed to SECTION C.		
Yes	No	ITEM
		1. Are any of the above shaded blocks checked? If yes, submit a suitability inquiry to the gaining MTF or medical department supporting the overseas/remote duty/operational location to determine local dental capabilities to provide required support. <i>(Attach Reply and answer question 2)</i> If no, proceed to question 3.
		2. Does the gaining MTF/operational platform have the capabilities to provide the current required dental support?
Yes	No	3. IS THE SERVICE/FAMILY MEMBER SUITABLE FOR THE OVERSEAS, REMOTE DUTY OR OPERATIONAL ASSIGNMENT? <i>(Must be completed by an MTF dental screener. Answered after the inquiry is completed.)</i>
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.		
<div style="border-bottom: 1px solid black; margin-bottom: 5px;">Navy MTF Dental Screener (Signature) _____</div> <div style="border-bottom: 1px solid black; margin-bottom: 5px;">Date _____</div> <div style="border-bottom: 1px solid black; margin-bottom: 5px;">Printed Name, Rank or Grade _____</div> <div style="border-bottom: 1px solid black; margin-bottom: 5px;">MTF or Duty Station _____</div> <div style="border-bottom: 1px solid black; margin-bottom: 5px;">Telephone Number (include area/country code) _____</div> <div style="border-bottom: 1px solid black; margin-bottom: 5px;">DSN Number _____</div> <div style="border-bottom: 1px solid black; margin-bottom: 5px;">Office Hours to Contact _____</div> <div style="border-bottom: 1px solid black; margin-bottom: 5px;">E-mail Address _____</div>		<div style="border-bottom: 1px solid black; margin-bottom: 5px;">Non-Navy Medical Facility/Civilian Dental Screener (Signature) _____</div> <div style="border-bottom: 1px solid black; margin-bottom: 5px;">Date _____</div> <div style="border-bottom: 1px solid black; margin-bottom: 5px;">Printed Name _____</div> <div style="border-bottom: 1px solid black; margin-bottom: 5px;">Address _____</div> <div style="border-bottom: 1px solid black; margin-bottom: 5px;">City, State, and Zip Code _____</div> <div style="border-bottom: 1px solid black; margin-bottom: 5px;">Telephone Number (include area/country code) _____</div> <div style="border-bottom: 1px solid black; margin-bottom: 5px;">Office Hours to Contact _____</div> <div style="border-bottom: 1px solid black; margin-bottom: 5px;">E-mail Address _____</div>

ADMINISTRATIVE REMARKS

NAVPERS 1070/613 (REV. 08-2012) PREVIOUS EDITIONS ARE OBSOLETE

SUPPORTING DIRECTIVE MILPERSMAN 1070-320

SHIP OR STATION:

SUBJECT:

☐ PERMANENT☐ TEMPORARY

SUITABILITY SCREENING

AUTHORITY (IF PERMANENT)

MIPERSMAN 1300-800

_____: 1. SUITABILITY SCREENING FOR BUPERS ORDERS _____ COMPLETED
TODAY'S DATE

2. ULTIMATE DUTY STATION: _____

3. UIC: _____

MEMBER IS FOUND:

SUITABLE

UNSUITABLE

SIGNATURE OF OFFICIAL
BY DIRECTION

TODAY'S DATE

I, _____, ACKNOWLEDGE THAT HAVE BEEN FOUND

FOR ORDERS LISTED ABOVE

SIGNATURE OF MEMBER

ENTERED AND VERIFIED IN ELECTRONIC SERVICE RECORD:

VERIFYING OFFICIAL RANK OR GRADE/TITLE:

DATE:

SIGNATURE OF VERIFYING OFFICIAL:

NAME (LAST, FIRST, MIDDLE):

SOCIAL SECURITY NUMBER:

BRANCH AND CLASS:

FOR OFFICIAL USE ONLY
PRIVACY SENSITIVE

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 (NAVMD) 1300/1).

1. Has the member or his or her dependent(s) previously been reassigned, prior to normal tour completion, due to unsuitability?	<input type="checkbox"/> Yes	<input type="checkbox"/> 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.	<input type="checkbox"/> N/A	<input type="checkbox"/> Yes <input type="checkbox"/> 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?	<input type="checkbox"/> N/A	<input type="checkbox"/> Yes <input type="checkbox"/> 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?	<input type="checkbox"/> N/A	<input type="checkbox"/> Yes <input type="checkbox"/> 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?	<input type="checkbox"/> Yes	<input type="checkbox"/> 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 .	<input type="checkbox"/> Yes	<input type="checkbox"/> 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 qualify the member; answer YES.	<input type="checkbox"/> Yes	<input type="checkbox"/> 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.	<input type="checkbox"/> Yes	<input type="checkbox"/> 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.	<input type="checkbox"/> N/A	<input type="checkbox"/> Yes <input type="checkbox"/> 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.	<input type="checkbox"/> Yes	<input type="checkbox"/> No
10. Are any of the member's dependents covered in a custody agreement? If "NO" or "N/A", go to question 12.	<input type="checkbox"/> N/A	<input type="checkbox"/> Yes <input type="checkbox"/> 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.	<input type="checkbox"/> Yes	<input type="checkbox"/> 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.)	<input type="checkbox"/> Yes	<input type="checkbox"/> 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?	<input type="checkbox"/> N/A	<input type="checkbox"/> Yes <input type="checkbox"/> 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?	<input type="checkbox"/> Yes	<input type="checkbox"/> 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?	<input type="checkbox"/> Yes	<input type="checkbox"/> 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.	<input type="checkbox"/> N/A	<input type="checkbox"/> Yes <input type="checkbox"/> 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
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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: