Student_____

USASC STUDENT INPROCESSING CHECKLIST

ERB

- ☐ At least 1 year remaining on current contract from grad date
- ☐ Secret security clearance
- ☐ GT score 100 or higher
- ☐ No flag

PHYSICAL

- ☐ Valid within a year
- ☐ Pass red green color vision test
- ☐ Statement saying SM is able to attend training

MENTAL EVAL

- ☐ Valid within a year
- ☐ Statement saying SM is able to attend training

ADDITIONAL DOCS

- ☐ APFT 70% each event (with in 30 days)
- ☐ Expert rifle Qual (with in 6 months)
- ☐ Commanders Recommendation letter
- ☐ 1610 Orders or 4187 bringing them to the course

Certifying OPS NCO _____

ENLISTED RECORD BRIEF

BRIEF DATE	NAME	RANK - DOR	PMOS	SSN	COMPONENT
20090105	[redacted]	SGT 20040901	11B	[redacted]	REGULAR

SECTION I – Assignment Information

OS/Deployment Combat Duty

Start-End Date	CT	MO	TS	TT
20060615-20070731	IZ	14	1	C
20021227-20040512	IZ	17	1	C
20011206-20020915	AF	9	1	C

#S - 3
#L - 0

	#	M
C	3	40
O	0	0
R	0	0

TOT: 40

Dwell Time	
Start	
Month - Days	0 Mo 0 Days

DEROS

DROS

Date Dependents Arrived OS

PMOS	11B	SQI	O
SMOS		PDSI/YRMO	/
Bonus MOS	11B	ASI	00

Bonus Enlist Elig Dt 20100101
Promotion Points/YRMO
Prev Promotion Points/YRMO
Prom Seq# | Prom Select Dt
Promotion MOS

ASVAB Test # / Dt ASVAB 10 / 20010201

GT	113	ELEC	117	FOOD	119	TECH	116
ADMIN	113	FA	121	COMMO	122		
CMBT	127	MECH	123	MAINT	121		

Delay Separation Reason
AEA / Dt L /

Flag Code	Flag Start Dt	Flag Expiration Dt
KA	20081117	
AA	20080205	

SECTION II – Security Data

PSI Status SECRET Fld Det PS Stat NONE
PSI Invest INIT
PSI Invest Compl 20010723

SECTION V – Foreign Language

Language	Read	Listen	Speak

DLAB

SECTION VI – Military Education

MEL/MES WARRIOR LDR/GRADUATED

Course	Year
FBCB2 LDR OPNET CERT	2005
TC-AIMS II FUNC USER	2005
WARRIOR LEADER CRS	2005
HAZMAT DRIVER INSTR	2005
SBCT TRANSITION CRS	2005
AIR ASSAULT	2003
COMBAT LIFE SAVERS CRS	2001
AIRBORNE	2001

BMQ
Correspondence CRS Total # Hrs

SECTION III – Service Data

BASD 20010222	PEBD 20010222	BESD 19000101
ETS 20100110	DIEMS 20010116	Reenl Elig/Prohib 10
# Days Lost	AGCM Dt 20070402	AGCM Elig Dt 20100402

	PVT	PV2	PFC	SPC - CPL
DOR			20010222	20030222
	SGT	SSG	SFC	MSG - 1SG
DOR	20040901			
DOR	SGM - CSM			

SECTION VII – CIVILIAN Education

Level Completed 4 YRS HS Yr 2001
DESG HIGH SCHOOL DIPLOMA
Institution Yr
Discipline
Institution Yr
Discipline
Number Of Semester Hours Completed 0

Technical Certification

Course Name	Dt Certified	Dt Expires

SECTION VIII – Awards and Decorations

ARCOM	4
AAM	1
VUA	1
AGCM	2
NDSM	1
ACM-CS	1
ICM-CS	1
GWOTEMA	1
GWTEM	1
GWTSM	1
ASR	1
OSR	3
CIB	1
PRCHTBAD	1
AIR ASLT	1

SECTION IV – Personal/Family Data

Date of Birth [redacted]	Birthplace [redacted]
Country of Citz US	Sex/Race MALE / CAUCAS
No of Dependent Adults/Children [redacted]	Religion CHR NO DENOM
Marital Status [redacted]	Spouse Birthplace/Citz /
PULHES 323213	Height/Weight /
EFMP Dt	#Cmd Sponsored 0
Physical Category C	APFT Dt P/F Score / /
Last Physical Exam 20080828	MMRB Results/Dt

Home of Record [redacted]
Mailing Address [redacted]
Mil Spouse SSN/MPC
Svc Comp / DoD
Emergency Data Verified Date 20081202

SECTION X - Remarks

HIV YRMO 200707
RGMT AFL 0187IN
Date Last Photo

Date of Loss
Date of Last PCS 20041124

SECTION IX – Assignment Information

Date of Last NCOER 20070630

ASGT	FROM	MO	UNIT NO	ORGANIZATION	STATION	LOC	COMD	DUTY TITLE	DMOS	ASI	LANG
PROJ											
Current						US	MC	INCOMING PERSONNEL	11B2O	00	YY
1st Prev						US	FC	SQUAD LEADER	11B3O	00	YY
2nd Prev						US	FC	VEHICLE STRYKER COMMANDE	11B3O	00	YY
3rd Prev						US	FC	CO MASTER STRYKER DRIVER	11B3O	00	YY
4th Prev						US	FC	BTN MASTER DRIVER	11B4O	00	YY
5th Prev						US	FC	BTN MASTER GUNNER	11B4O	00	YY
6th Prev						US	FC	SQUAD LEADER	11B3O	00	YY
7th Prev						US	FC	BATTALION SCOUT SQD LDR	11B3O	00	YY
8th Prev						US	FC	COMPANY SNIPER	11B3O	00	YY
9th Prev						US	FC	RIFLE SQUAD LEADER	11B3O	00	YY
10th Prev						US	FC	PLATOON SNIPER	11B2O	00	YY
11th Prev						US	FC	ANTIARMOR SPECIALIST	11B2O	00	YY
12th Prev						US	FC	RIFLE TEAM LEADER	11B2O	00	YY
13th Prev						US	FC	MACHINE GUNNER	11B2O	00	YY
14th Prev						US	FC	ASST MACHINE GUNNER	11B1O	00	YY
15th Prev						US	FC	RADIO TELEPHONE OPR	11B1O	00	YY
16th Prev						US	TC	SNIPER	11B1O	00	YY
17th Prev						US	TC	RIP SCHOOL	11B1O	00	YY
18th Prev						US	TC	AIRBORNE TRAINING	11B1O	00	YY
19th Prev						US	TC	RA TRAINEE	11B0O	00	YY
20th Prev											
21st Prev											
22nd Prev											
23rd Prev											
24th Prev											

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REPORT OF MEDICAL EXAMINATION

1. DATE OF EXAMINATION (YYYYMMDD)	2. SOCIAL SECURITY NUMBER
WITHIN 1 YEAR	

PRIVACY ACT STATEMENT

AUTHORITY: 10 USC 504, 505, 507, 532, 978, 1201, 1202, and 4346; and E.O. 9397.
PRINCIPAL PURPOSE(S): To obtain medical data for determination of medical fitness for enlistment, induction, appointment and retention for applicants and members of the Armed Forces. The information will also be used for medical boards and separation of Service members from the Armed Forces.
ROUTINE USE(S): None.
DISCLOSURE: Voluntary; however, failure by an applicant to provide the information may result in delay or possible rejection of the individual's application to enter the Armed Forces. For an Armed Forces member, failure to provide the information may result in the individual being placed in a non-deployable status.

3. LAST NAME - FIRST NAME - MIDDLE NAME (SUFFIX)	4. HOME ADDRESS *(Street, Apartment Number, City, State and ZIP Code)*	5. HOME TELEPHONE NUMBER *(Include Area Code)*

6. GRADE	7. DATE OF BIRTH *(YYYYMMDD)*	8. AGE	9. SEX	10.a. RACIAL CATEGORY *(X one or more)*	b. ETHNIC CATEGORY
			☐ Female ☐ Male	☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ White ☐ Native Hawaiian or Other Pacific Islander	☐ Hispanic/Latino ☐ Not Hispanic/Latino

11. TOTAL YEARS GOVERNMENT SERVICE a. MILITARY	b. CIVILIAN	12. AGENCY *(Non-Service Members Only)*	13. ORGANIZATION UNIT AND UIC/CODE

14.a. RATING OR SPECIALTY *(Aviators Only)*	b. TOTAL FLYING TIME	c. LAST SIX MONTHS

15.a. SERVICE	b. COMPONENT	c. PURPOSE OF EXAMINATION	16. NAME OF EXAMINING LOCATION, AND ADDRESS *(Include ZIP Code)*
☐ Army ☐ Coast Guard ☐ Navy ☐ Marine Corps ☐ Air Force	☐ Active Duty ☐ Reserve ☐ National Guard	☐ Enlistment ☐ Commission ☐ Retention ☐ Separation ☐ Medical Board ☐ Other ☐ Retirement ☐ U.S. Service Academy ☐ ROTC Scholarship Program	

CLINICAL EVALUATION *(Check each item in appropriate column. Enter "NE" if not evaluated.)*

	Normal	Abnorm	NE
17. Head, face, neck, and scalp			
18. Nose			
19. Sinuses			
20. Mouth and throat			
21. Ears - General *(Int. and ext. canals/Auditory acuity under item 71)*			
22. Drums *(Perforation)*			
23. Eyes - General *(Visual acuity and refraction under items 61 - 63)*			
24. Ophthalmoscopic			
25. Pupils *(Equality and reaction)*			
26. Ocular motility *(Associated parallel movements, nystagmus)*			
27. Heart *(Thrust, size, rhythm, sounds)*			
28. Lungs and chest *(Include breasts)*			
29. Vascular system *(Varicosities, etc.)*			
30. Anus and rectum *(Hemorrhoids, Fistulae) (Prostate if indicated)*			
31. Abdomen and viscera *(Include hernia)*			
32. External genitalia *(Genitourinary)*			
33. Upper extremities			
34. Lower extremities *(Except feet)*			
35. Feet *(See Item 35 Continued)*			
36. Spine, other musculoskeletal			
37. Identifying body marks, scars, tattoos			
38. Skin, lymphatics			
39. Neurologic			
40. Psychiatric *(Specify any personality deviation)*			
41. Pelvic *(Females only)*			
42. Endocrine			

44. NOTES: *(Describe every abnormality in detail. Enter pertinent item number before each comment. Continue in item 73 and use additional sheets if necessary.)*

43. DENTAL DEFECTS AND DISEASE *(Please explain. Use dental form if completed by dentist. If dental examination not done by dental officer, explain in Item 44.)*
☐ Acceptable
☐ Not Acceptable Class _____

35. FEET *(Continued) (Circle category)*
Normal Arch — Mild — Asymptomatic
Pes Cavus — Moderate
Pes Planus — Severe — Symptomatic

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LAST NAME - FIRST NAME - MIDDLE NAME (SUFFIX)	SOCIAL SECURITY NUMBER

LABORATORY FINDINGS

45. URINALYSIS	a. Albumin b. Sugar	46. URINE HCG	47. H/H	48. BLOOD TYPE

TESTS	RESULTS	HIV SPECIMEN ID LABEL	DRUG TEST SPECIMEN ID LABEL
49. HIV			
50. DRUGS			
51. ALCOHOL			
52. OTHER			
a. PAP SMEAR			
b.			
c.			

MEASUREMENTS AND OTHER FINDINGS

53. HEIGHT	54. WEIGHT lbs.	55. MIN WGT - MAX WGT MAX BF %	56. TEMPERATURE	57. PULSE

58. BLOOD PRESSURE			59. RED/GREEN *(Army Only)*	60. OTHER VISION TEST
a. 1ST	b. 2ND	c. 3RD	Make sure RED/GREEN is annotated here	
SYS.	SYS.	SYS.		
DIAS.	DIAS.	DIAS.		

61. DISTANCE VISION	62. REFRACTION BY AUTOREFRACTION OR MANIFEST	63. NEAR VISION
Right 20/ Corr. to 20/	By S. CX	Right 20/ Corr. to 20/ by
Left 20/ Corr. to 20/	By S. CX	Left 20/ Corr. to 20/ by

Make sure 20/20 is annotated here

64. HETEROPHORIA *(Specify distance)*

ES ° EX ° R.H. L.H. Prism div. Prism Conv CT NPR PD

65. ACCOMMODATION		66. COLOR VISION *(Test used and result)*	67. DEPTH PERCEPTION *(Test used and score)* AFVT	
Right	Left	PIP /14	Uncorrected	Corrected

68. FIELD OF VISION	69. NIGHT VISION *(Test used and score)*	70. INTRAOCULAR TENSION	
		O.D.	O.S.

71a. AUDIOMETER	Unit Serial Number						71b. Unit Serial Number							72a. READING ALOUD TEST
Date Calibrated *(YYYYMMDD)*							Date Calibrated *(YYYYMMDD)*							☐ SAT ☐ UNSAT
HZ	500	1000	2000	3000	4000	6000	HZ	500	1000	2000	3000	4000	6000	72b. VALSALVA
Right							Right							☐ SAT ☐ UNSAT
Left							Left							

73. NOTES *(Continued)* AND SIGNIFICANT OR INTERVAL HISTORY *(Use additional sheets if necessary.)*

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LAST NAME - FIRST NAME - MIDDLE NAME (SUFFIX)	SOCIAL SECURITY NUMBER

74.a. EXAMINEE/APPLICANT *(check one)*

[X] IS QUALIFIED FOR SERVICE

[ ] IS NOT QUALIFIED FOR SERVICE

Able to attend Sniper Training

75. I have been advised of my disqualifying condition.

a. SIGNATURE OF EXAMINEE	b. DATE *(YYYYMMDD)*

b. PHYSICAL PROFILE

P	U	L	H	E	S	X	PROFILER INITIALS	DATE *(YYYYMMDD)*

76. SIGNIFICANT OR DISQUALIFYING DEFECTS

ITEM NO.	MEDICAL CONDITION/DIAGNOSIS	ICD CODE	PROFILE SERIAL	RBJ DATE *(YYYYMMDD)*	QUALI-FIED	DIS-QUALI-FIED	EXAMINER INITIALS	WAIVER RECEIVED	
								SERVICE	DATE *(YYYYMMDD)*

77. SUMMARY OF DEFECTS AND DIAGNOSES *(List diagnoses with item numbers) (Use additional sheets if necessary.)*

78. RECOMMENDATIONS - FURTHER SPECIALIST EXAMINATIONS INDICATED *(Specify) (Use additional sheets if necessary.)*

79. MEPS WORKLOAD *(For MEPS use only)*

WKID	ST	DATE *(YYYYMMDD)*	INITIAL	WKID	ST	DATE *(YYYYMMDD)*	INITIAL

80. MEDICAL INSPECTION DATE	HT	WT	%BF	MAX WT	HCG	QUAL	DISQ	PHYSICIAN'S SIGNATURE

81.a. TYPED OR PRINTED NAME OF PHYSICIAN OR EXAMINER	b. SIGNATURE

82.a. TYPED OR PRINTED NAME OF PHYSICIAN OR EXAMINER	b. SIGNATURE

83.a. TYPED OR PRINTED NAME OF DENTIST OR PHYSICIAN *(Indicate which)*	b. SIGNATURE

84.a. TYPED OR PRINTED NAME OF REVIEWING OFFICER/APPROVING AUTHORITY	b. SIGNATURE

85. This examination has been administratively reviewed for completeness and accuracy.

a. SIGNATURE	b. GRADE	c. DATE *(YYYYMMDD)*

86. WAIVER GRANTED *(If yes, date and by whom)*

[ ] YES

[ ] NO

87. NUMBER OF ATTACHED SHEETS

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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 Aug 31, 2014

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, DoD Instruction 6130.03, and E.O. 9397, as amended (SSN).
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. Completed forms are covered by recruiting, medical evaluation board, and official military personnel file SORNs maintained by each of the Services.
ROUTINE USE(S): The Blanket Routine Uses found at http://privacy.defense.gov/blanket_uses.shtml apply to this collection.
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. If you are selected for enlistment, commission, or entrance into a commissioning program based on a false statement, you can be tried by military courts-martial or meet an administrative board for discharge and could receive a less than honorable discharge that would affect your future.

1. LAST NAME, FIRST NAME, MIDDLE NAME (SUFFIX)	2. SOCIAL SECURITY NUMBER	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)		

X ALL APPLICABLE BOXES:

6.a. SERVICE	b. COMPONENT	c. PURPOSE OF EXAMINATION		7.a. POSITION (Title, Grade, Component)
☐ Army ☐ Coast Guard	☐ Regular	☐ Enlistment	☐ Medical Board ☐ Other (Specify)	
☐ Navy	☐ Reserve	☐ Commission	☐ Retirement	b. USUAL OCCUPATION
☐ Marine Corps	☐ National Guard	☐ Retention	☐ U.S. Service Academy	
☐ Air Force		☐ Separation	☐ ROTC Scholarship Program	

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	○	○

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LAST NAME, FIRST NAME, MIDDLE NAME (SUFFIX)	SOCIAL SECURITY NUMBER

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."

DD FORM 2807-1, AUG 2011

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LAST NAME, FIRST NAME, MIDDLE NAME (SUFFIX)	SOCIAL SECURITY NUMBER

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)*

REPORT OF MENTAL STATUS EVALUATION

For use of this form see, AR 40-66; the proponent agency is OTSG.

SECTION I - REASON FOR EVALUATION

- ☐ Self-Referral
- ☐ Command-Directed Behavioral Health Evaluation
- ☐ Hospital Discharge
- ☐ Other: _____
- ☐ Advanced Training Application
- ☐ Clearance for Admin Sep under AR 635-200, Chapter _____
- ☐ MMRB/MEB

SECTION II - FITNESS FOR DUTY

FROM A BEHAVIORAL HEALTH STANDPOINT, THE ABOVE SERVICE MEMBER IS DEEMED:

- ☐ Fit for full duty, including deployment.
- ☐ Possibly non-deployable due to prescribed medications. Command surgeon waiver ☐ is ☐ is not recommended.
- ☐ Requires temporary duty limitations and will likely require behavioral health treatment to be restored to full duty.
- ☐ Unfit for duty due to a personality disorder or other mental condition that does not amount to a medical disability.
- ☐ Unfit for duty due to a serious mental condition that is not likely to resolve within 1 year.
- ☐ Further assessment is needed to determine fitness for duty.

SECTION III - PERTINENT FINDINGS ON MENTAL STATUS EXAMINATION

COGNITION: ☐ No obvious impairments ☐ Mildly impaired ☐ Moderately impaired ☐ Severely impaired

BEHAVIOR: ☐ Cooperative ☐ Uncooperative ☐ Manipulative ☐ Hostile ☐ Suspicious ☐ Bizarre

PERCEPTIONS: ☐ Normal ☐ Hallucinations ☐ Delusions ☐ Obsessions

IMPULSIVITY: ☐ Unlikely to be impulsive ☐ Occasionally impulsive ☐ Frequently impulsive

DANGEROUSNESS: ☐ None ☐ Suicidal Thoughts ☐ Homicidal Thoughts ☐ Suicidal Intent ☐ Homicidal Intent

OTHER: _____

SECTION IV - IMPRESSIONS

IN MY OPINION, THIS SERVICE MEMBER:

- ☐ Can understand and participate in administrative proceedings.
- ☐ Can appreciate the difference between right and wrong.
- ☐ Meets medical retention requirements (i.e., does not qualify for a Medical Evaluation Board).
- ☐ Requires further examination or testing to finalize diagnosis and recommendations.
- ☐ Other:

SECTION V - DIAGNOSES (ONLY THOSE REQUIRED FOR ADMINISTRATIVE PROCESSING)

AXIS I (psychiatric conditions):

AXIS II (personality & intelligence disorders):

AXIS III (medical conditions):

PATIENT INFORMATION

Patient Name: _____ *Rank/Grade:* _____ *Status:* _____

Prefix: _____ *DOB (YYYYMMDD):* _____ *Sponsor SSN:* _____ *MTF Code:* _____ *Date:* _____

PATIENT'S IDENTIFICATION *(For typed or written entries, give: Name - last, first, middle; grade; date; hospital or medical facility)*

SECTION VI - PROPOSED TREATMENTS

☐ None
☐ Follow-up appointments:

Clinic:	Phone No:	Location:	Date:	Time:

☐ Recommend command referral to: ☐ Unit Chaplain ☐ ASAP ☐ FAP ☐ JAG ☐ ACS ☐ OTHER _____

SECTION VII - RECOMMENDED PRECAUTIONS

(To be followed until no longer deemed necessary by a Behavior Heath Provider)

☐ None.
☐ Ensure the service member attends all follow-up appointments.
☐ Assigned duties should be relatively low-stress and ☐ should not invoke leadership responsibilities.
☐ Work hours should not exceed ____ per day and the service member should have __ day(s) off per week.
☐ Restrict access to or disarm all weapons and ammunition (including those that are privately owned).
☐ Prohibit the use of alcohol as alcohol is a CNS depressant and may impair inhibitions and judgment.

_____

☐ Inspect the service member's quarters and secure all hazardous items (e.g., pills, knives, razors, weapons, etc.).
☐ Move the service member into the barracks.
☐ Secure all medications and dispense no more than ____ days' worth at a time.
☐ Prohibit contact between the service member and _____ to prevent harm to self or other individual.
☐ Provide increased supervision (i.e., have someone check in with service member at least daily) or ...
☐ Assign someone to monitor the service member every ____ hours from first formation until lights out, and ensure he/she does not sleep in a room alone or ...
☐ Provide continuous 24/7 monitoring (e.g., to prevent self-injurious behavior, harm to others, substance use, etc.).
☐ Other:

SECTION VIII - ADDITIONAL COMMENTS

☐ A Temporary Profile with an "S" rating of _____ is hereby activated, to expire _____.
☐ The service member has been screened for Post Traumatic Stress Disorder and mild Traumatic Brain Injury. All positive screens require a comprehensive evaluation. Results of the screening are as follows:

- ☐ Post Traumatic Stress Disorder Screening: ☐ Score _____ ☐ Positive ☐ Negative
  - ☐ Service member was referred for: A comprehensive Post Traumatic Stress Disorder evaluation.
- ☐ Mild Traumatic Brain Injury Screening: ☐ Score _____ ☐ Positive ☐ Negative
  - ☐ Service member was referred for: A comprehensive mild Traumatic Brain Injury evaluation.

☐ The service member may participate in PT as allowed by physical profile, as exercise often improves mood.
☐ The service member meets psychiatric criteria for expeditious administrative separation IAW ☐ Chapter 5-13 or ... ☐ Chapter 5-17 of AR 635-200 (or equivalent regulation from his/her branch of Service).

(See Additional Comments on Page 3)

PATIENT INFORMATION

Patient Name: _____ *Rank/Grade:* _____ *Status:* _____

Prefix: _____ *DOB (YYYYMMDD):* _____ *Sponsor SSN:* _____ *MTF Code:* _____ *Date:* _____

PATIENT'S IDENTIFICATION *(For typed or written entries, give: Name - last, first, middle; grade; date; hospital or medical facility)*

SECTION VIII - ADDITIONAL COMMENTS *(Continued from previous page)*

☐ Service member does not have a severe mental disorder and is not considered mentally disordered. However, he/she has a long-standing disorder of character, behavior and adaptability (i.e., personality disorder).

☐ The Service-member has a condition that is likely to impair his/her judgment or reliability to protect classified information. (If checked, Commanders will ensure prompt notification to the Army Central Clearance Facility IAW AR 380-67 DA Personnel Security Program, by providing an incident report via the Joint Personnel Adjudication System (JPAS) or its successor.) (Provide detail in the remarks section on page 3.)

☐ It is the professional opinion of the undersigned that this service member will not respond to command efforts at rehabilitation (such as transfer, disciplinary action or reclassification), or to any behavioral health treatment methods currently available in the military.

☐ The service member manifests a long-standing, chronic pattern of difficulty adjusting (i.e., Adjustment Disorder) as characterized by: (Provide detail for the option you choose in the remarks section on Page 3.)

_____

☐ The service member shows no evidence of a disorder that would limit his/her potential to succeed in the military. He/she is cleared to participate in advanced military training.

☐ The service member has been screened for Post Traumatic Stress Disorder and Traumatic Brain Injury. These conditions are either not present or, if present, do not meet AR 40-501 criteria for a medical evaluation board. Command is advised to consider the influence of these conditions, if present, when determining final disposition.

☐ If the service member shows signs of further deterioration, command should call: *Name:* _____ *and Contact Information:* _____, during duty hours. After hours, they should escort the service member to the nearest Emergency Department.

☐ Service member has been screened for substance use disorders (i.e., alcohol and drugs).
Findings:

☐ Other:

REMARKS

BEHAVIORAL HEALTH PROVIDER SIGNATURE(S)

Behavioral Health Provider's Signature	Date	Behavioral Health Supervisory Co-Signature	Date

PATIENT INFORMATION

Patient Name: _____ *Rank/Grade:* _____ *Status:* _____

Prefix: _____ *DOB (YYYYMMDD):* _____ *Sponsor SSN:* _____ *MTF Code:* _____ *Date:* _____

PATIENT'S IDENTIFICATION *(For typed or written entries, give: Name - last, first, middle; grade; date; hospital or medical facility)*

Army Physical Fitness Test Scorecard

For use of this form, see FM 7-22; the proponent agency is TRADOC.

NAME (Last, First, MI)

GENDER
Male

UNIT
C 1/29 Sniper Course

	TEST ONE	TEST TWO	TEST THREE	TEST FOUR
DATE	20160107			
GRADE	E6			
AGE	35			
HEIGHT (IN INCHES)	72			
BODY COMPOSITION – WEIGHT: lbs	190 lbs	lbs	lbs	lbs
WEIGHT GO / NO-GO	☒ GO ☐ NO-GO	☐ GO ☐ NO-GO	☐ GO ☐ NO-GO	☐ GO ☐ NO-GO
BODY FAT: %	%	%	%	%
BODY FAT GO / NO-GO	☐ GO ☐ NO-GO	☐ GO ☐ NO-GO	☐ GO ☐ NO-GO	☐ GO ☐ NO-GO
PU RAW SCORE	75			
PU INITIALS	MH			
PU POINTS	100			
SU RAW SCORE	79			
SU INITIALS	MH			
SU POINTS	100			
2MR RAW SCORE	13:38			
2MR INITIALS	MH			
2MR POINTS	96			
ALTERNATE AEROBIC EVENT – EVENT				
TIME				
GO / NO-GO	☐ GO ☐ NO-GO	☐ GO ☐ NO-GO	☐ GO ☐ NO-GO	☐ GO ☐ NO-GO
TOTAL POINTS	296			
NCOIC/OIC SIGNATURE	[signature]			
COMMENTS	RECORD			

SPECIAL INSTRUCTION: USE INK

LEGEND: PU - PUSH UPS; SU - SIT UPS; 2MR - 2 MILE RUN; APFT - ARMY PHYSICAL FITNESS TEST

RECORD FIRE SCORECARD

For use of this form see FM 3-22.9; the proponent agency is TRADOC.

ID CODE	UNIT	DATE *(YYYYMMDD)*	EVALUATOR'S ID CODE
		20130507	

TABLE 1
PRONE SUPPORTED OR FOXHOLE SUPPORTED FIRING POSITION

RD	RANGE (m)	TIME (sec)	HIT	MISS	NO FIRE	RD	RANGE (m)	TIME (sec)	HIT	MISS	NO FIRE
1	50	3	☑	☐	☐	11	100	8	☑	☐	☐
2	200	6	☑	☐	☐	12	200		☑	☐	☐
3	100	4	☑	☐	☐	13	150	10	☑	☐	☐
4	150	5	☑	☐	☐	14	300		☐	☑	☐
5	300	8	☑	☐	☐	15	100	9	☑	☐	☐
6	250	7	☑	☐	☐	16	250		☑	☐	☐
7	50	3	☑	☐	☐	17	200	6	☑	☐	☐
8	200	6	☑	☐	☐	18	150	5	☑	☐	☐
9	150	5	☑	☐	☐	19	50	6	☑	☐	☐
10	250	7	☑	☐	☐	20	100		☑	☐	☐
TOTAL			10			TOTAL			9	1	

TABLE 2
PRONE UNSUPPORTED FIRING POSITION

RD	RANGE (m)	TIME (sec)	HIT	MISS	NO FIRE
1	200	6	☑	☐	☐
2	250	8	☑	☐	☐
3	150	6	☑	☐	☐
4	300	10	☐	☑	☐
5	200		☑	☐	☐
6	150	12	☑	☐	☐
7	200		☑	☐	☐
8	250	9	☐	☑	☐
9	150		☑	☐	☐
10	150	6	☑	☐	☐
TOTAL			8	2	

TABLE 3
KNEELING UNSUPPORTED FIRING POSITION

RD	RANGE (m)	TIME (sec)	HIT	MISS	NO FIRE
1	150	8	☑	☐	☐
2	50	4	☑	☐	☐
3	100	5	☑	☐	☐
4	150	6	☑	☐	☐
5	100	5	☑	☐	☐
6	50	4	☑	☐	☐
7	100	5	☑	☐	☐
8	150	6	☑	☐	☐
9	50	4	☑	☐	☐
10	100	5	☑	☐	☐
TOTAL			10		

SCORE

TABLE	HIT	MISS	NO FIRE
1	19	1	
2	8	2	
3	10		

FIRER'S QUALIFICATION SCORE 37

QUALIFICATION SCORE RATINGS *(Check One)*

- ☑ 36-40 -- EXPERT
- ☐ 23-29 -- MARKSMAN
- ☐ 30-35 -- SHARPSHOOTER
- ☐ 22 AND BELOW -- UNQUALIFIED

Qualified with IBA? ☐ YES ☑ NO

AIMING DEVICE USED *(Check One)*

- ☑ IRON SIGHT
- ☐ BACKUP IRON SIGHT
- ☐ M68, CCO
- ☐ ACOG
- ☐ AN/PAS-13 (DAY)
- ☐ AN/PAS-13 (NIGHT)
- ☐ AN/PAQ-4B/C
- ☐ AN/PEQ-2A/B

NIGHT FIRE EXERCISE

DATE *(YYYYMMDD)*	HIT	MISS	GO	NO GO
			☐	☐

CBRN FIRE EXERCISE

DATE *(YYYYMMDD)*	HIT	MISS	GO	NO GO
			☐	☐

REMARKS

SCORER'S INITIALS	DATE INITIALED *(YYYYMMDD)*
OFFICER'S INITIALS	DATE INITIALED *(YYYYMMDD)*

DEPARTMENT OF THE ARMY
C COMPANY, 1ST BATTALION 29TH INFANTRY REGIMENT
316TH CAVALRY BRIGADE
10431 WARE AVENUE, BUILDING 4966
FORT BENNING, GEORGIA 31905-4420

REPLY TO
ATTENTION OF

ATSH-INB-C

7 April 2016

MEMORANDUM FOR RECORD

SUBJECT: Commander's Recommendation to attend Sniper School

1. The below listed individual(s) have been tested and checked and are fully prepared to attend Sniper School.

Doe, John Q.	SGT	123-45-6789
Buck, Joe J.	SGT	987-65-4321

2. These soldier(s) have passed the following qualifications and trained on the following tasks prior to attending the Basic Sniper Course

-Passed the Army Physical Fitness Test with 70% in each event for their age group and able to pass HT/WT IAW the standards set in AR 600-9
-Quilfied expert with their assigned weapon within the last 6 months
-No prior record of Drug/Alcohol Abuse, Misconduct, or any other actions punishable under UCMJ.
-Has a GT score of 100 or above
-Has one (1) year retainabilty upon completeion of Sniper School training
-071-326-0512 (*) Estimate Range
-071-028-0060 (*) Detect Targets Based on Target Indicators
-071-028-0064 (*) Employ Movement as a Sniper (Stalking)

3. Myself or my duty appointed representative has inspected and confirmed the these soldier(s) meet the criteria to attend the course set forth by the United States Army Sniper School.

4. POC for this memorandumis the undersigned at 111-555-1234 or john.smith@us.army.mil.

JOHN R. SMITH
CPT, IN
Commanding

16

REQUEST AND AUTHORIZATION FOR TDY TRAVEL OF DOD PERSONNEL

(Reference: Joint Travel Regulations (JTR), Chapter 3)
(Read Privacy Act Statement on back before completing form.)

1. DATE OF REQUEST *(YYYYMMDD)*

REQUEST FOR OFFICIAL TRAVEL

2. NAME *(Last, First, Middle Initial)*	3. SOCIAL SECURITY NUMBER	4. POSITION TITLE AND GRADE/RATING

5. LOCATION OF PERMANENT DUTY STATION (PDS)	6. ORGANIZATIONAL ELEMENT	7. DUTY PHONE NUMBER *(Include Area Code)*

8. TYPE OF AUTHORIZATION	9. TDY PURPOSE *(See JTR, Appendix H)*	10a. APPROX. NO. OF TDY DAYS *(Including travel time)*	b. PROCEED DATE *(YYYYMMDD)*

11. ITINERARY ☐ VARIATION AUTHORIZED

12. TRANSPORTATION MODE

a. COMMERCIAL				b. GOVERNMENT			c. LOCAL TRANSPORTATION		
RAIL	AIR	BUS	SHIP	AIR	VEHICLE	SHIP	CAR RENTAL	TAXI	OTHER

☐ AS DETERMINED BY APPROPRIATE TRANSPORTATION OFFICER *(Overseas Travel only)*

PRIVATELY OWNED CONVEYANCE *(Check one)*
RATE PER MILE: _____
☐ ADVANTAGEOUS TO THE GOVERNMENT
☐ MILEAGE REIMBURSEMENT AND PER DIEM IS LIMITED TO CONSTRUCTED COST OF COMMON CARRIER TRANSPORTATION AND PER DIEM AS DETERMINED AND TRAVEL TIME AS LIMITED PER JTR

13. ☐ a. PER DIEM AUTHORIZED IN ACCORDANCE WITH JTR. ☐ b. OTHER RATE OF PER DIEM *(Specify)*

14. ESTIMATED COST				15. ADVANCE AUTHORIZED
a. PER DIEM	b. TRAVEL	c. OTHER	d. TOTAL	
$	$	$	$ 0.00	$

16. REMARKS *(Use this space for special requirements, leave, excess baggage, accommodations, registration fees, etc.)*

17. TRAVEL-REQUESTING OFFICIAL *(Title and signature)*	18. TRAVEL-APPROVING/DIRECTING OFFICIAL *(Title and signature)*

AUTHORIZATION

19. ACCOUNTING CITATION

20. AUTHORIZING/ORDER-ISSUING OFFICIAL *(Title and signature)*	21. DATE ISSUED *(YYYYMMDD)*
	22. TRAVEL AUTHORIZATION NUMBER