

## Overseas Screening Requirements

**Active duty members are responsible for ensuring that they have met the following requirements before coming to see the Suitability Screening Coordinator.**

### **Requirements for Active Duty Members:**

1. PHA or Flight Physicals is current within the last 12 months.
2. Dental Class I or II. (Class III or IV are non-deployable).
3. No outstanding medical issues. (i.e. Surgical Procedures, Mental Health Treatment, Physical Therapy, etc.).
4. No outstanding Dental Issues (i.e. Major Dental Procedures, etc.).
5. **For females only.** Well Woman Exam is current within the last 12 months, with normal results. Females age 40 and above require a Mammogram current within the last 24 months.
6. **NAVMED 1300/1.**
  - a. Legibly fill in your personal information at the top of page 1 and 3.
  - b. **DO NOT** answer any of the medical questions on this Form. Medical and Dental Providers will complete their respective areas of the Form.
  - c. Page 3 will be completed by your Civilian or DOD Dentist. The Dentist should refer to block 8 for description of the four dental classifications.
7. **NAVMED 1300/2.** Suitability Screening Coordinator will complete this Form for each person being screened.
8. **DD Form 2807-1.**
  - a. Legibly complete blocks 1 – 9.
  - b. Answer blocks 10 – 28 as they apply to you. If you have any “YES” answers, a brief explanation is required in box 29 on page 2.
  - c. Ensure your name and full SSN is filled at the top of each page.
9. **NAVMED 1300/16.** This Form is for the sponsor only.
  - a. Legibly fill in your personal information at the top of each page.
  - b. Answer questions 1 – 16 on pages 1 and 2. For personnel E-4 and below, you must be counseled on questions 1 – 16 by a senior member in your chain of command.
  - c. If you have accompanied orders, list your dependents on page 3 in blocks 2 -6.
  - d. This Form will be validated by the MTF CO or designated representative (DFA of PAD).
  - e. Page 4 will be completed by your administration or career counseling department **after** your medical screening has been completed.

### **Requirements for Each Dependent:**

1. Immunizations required by host country must be up-to-date. Call NHCPR **Preventive Medicine clinic at (301) 757-2142.**
  - a. **Japan:** MMR, DPT, Poliovirus, Hepatitis B, Japanese encephalitis.
  - b. **Guam:** MMR, DPT, Poliovirus, Hepatitis A& B, Typhoid.

## Overseas Screening Requirements

- c. **Italy:** MMR, DPT, Poliovirus, Hepatitis B.
- d. **If your host country is not listed, please refer to CDC guidelines at <http://wwwnc.cdc.gov/travel/destinations/list.aspx>.**
2. No outstanding medical issues. (i.e. Surgical Procedures, Mental Health Treatment, Physical Therapy, etc.).
3. No outstanding Dental Issues (i.e. Major Dental Procedures, etc.).
4. **For females only.** Well Woman Exam is current within the last 12 months, with normal results. Females age 40 and above require a Mammogram current within the last 24 months.
5. Children must have Well Child Exam current within the last 12 months.
  - a. **If enrolled in EFMP, provide copy of enrollment documents.**
6. **NAVMED 1300/1.**
  - a. Legibly fill in your personal information at the top of page 1 and 3.
  - b. DO NOT answer any of the medical questions on this Form. Their Medical and Dental Providers will complete their respective areas of the Form.
  - c. Page 3 will be completed by your Civilian or DOD Dentist. The Dentist should refer to block 8 for description of the four dental classifications.
7. **NAVMED 1300/2.** Suitability Screening Coordinator will complete this Form for each person being screened.
8. **DD Form 2807-1.**
  - a. Legibly complete blocks 1 – 9.
  - b. Answer blocks 10 – 28 as they apply to you. If you have any “YES” answers, a brief explanation is required in box 29 on page 2.
  - c. Ensure name and full SSN is filled at the top of each page.
9. **DD Form 2792-1.**
  - a. Required for all dependent children from birth to 22<sup>nd</sup> birthday.
  - b. Follow instruction on Form to legibly complete this Form.

If you have any questions or difficulties completing any of the listed requirements, please do not hesitate to contact NHCPR SSC's office: **HM2 Davis, Ryan, (301)995-3891, Email: [usn.patuxent.navhlthclinpaxmd.list.nhcpr-efmp@mail.mil](mailto:usn.patuxent.navhlthclinpaxmd.list.nhcpr-efmp@mail.mil)**

## 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 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)? (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	<b>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.)</b>

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

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

**PART II**

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

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

8. Specify Dental Class: *(required for service members)* \_\_\_\_\_  
**Dental Classifications:** (Per DoDI 6025.19)  
**Normally considered worldwide deployable:**  
**Class 1** - Patients with a current dental examination, who do not require dental treatment or re-evaluation.  
**Class 2** - Patients with a current dental examination, who require non-urgent dental treatment or re-evaluation for oral conditions unlikely to result in a dental emergency within 12 months.  
  
**Normally not considered worldwide deployable:**  
**Class 3** - Patients who require urgent or emergent dental treatment for oral conditions with a high potential to cause a dental emergency in the next 12 months.  
**Class 4** - Patients who require a dental examination either because: (1) No type 1 (comprehensive) or type 2 (annual or periodic oral) dental examination was completed by a dental officer/privileged dentist within the past 12 months; (2) A patient's dental record does not exist or; (3) The dental record is not held by the responsible dental treatment facility or Medical Department activity.

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

Yes	No	ITEM
		1. Are any of the above shaded blocks checked? If yes, submit a suitability inquiry to the gaining MTF or medical department supporting the overseas/remote duty/operational location to determine local dental capabilities to provide required support. <i>(Attach Reply and answer question 2)</i> If no, proceed to question 3.
		2. Does the gaining MTF/operational platform have the capabilities to provide the current required dental support?
Yes	No	<b>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.)</b>

**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 _____

## 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
<b>A. FOR SERVICE MEMBERS:</b>					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.				
<b>SERVICE TREATMENT RECORD TO INCLUDE:</b>					
<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. Sickle 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>B. FOR FAMILY MEMBERS:</b>					
<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 <sup>nd</sup> Birthday OR High School Graduation)												
<b>FOR INFANTS AND TODDLERS (Birth to 36 Months) ELIGIBLE TO RECEIVE EARLY INTERVENTION SERVICES AS EVIDENCED BY AN INDIVIDUALIZED FAMILY SERVICE PLAN (IFSP):</b>												
<input type="checkbox"/> 2. Copy of the current IFSP and, if available, developmental assessments or evaluations.												
<b>FOR PRESCHOOL OR SCHOOL-AGE CHILDREN (Ages 3 to 22<sup>nd</sup> Birthday or High School Graduation) ELIGIBLE TO RECEIVE SPECIAL EDUCATION AND RELATED SERVICES AS EVIDENCED BY AN INDIVIDUALIZED EDUCATION PROGRAM (IEP):</b>												
<input type="checkbox"/> 3. Copy of the current IEP and, if available, developmental assessments or evaluations.												
<b>FOR EACH FAMILY MEMBER ENROLLED OR UNDERGOING ENROLLMENT IN THE EXCEPTIONAL FAMILY MEMBER PROGRAM (EFMP):</b>												
<input type="checkbox"/> 4. Copy of the DD Form 2792 and any EFMP correspondence.												
<b>D. FOR SSC USE ONLY</b>												
1. Date suitability screening conducted. Date: _____												
<b>E. SUITABILITY INQUIRY:</b>												
<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:												
<table style="width:100%; border:none;"> <tr> <td style="width:30%; vertical-align:top;"> <b>Medical Care:</b>  <input type="checkbox"/> Potential need identified  <input type="checkbox"/> N/A </td> <td style="width:30%; vertical-align:top;"> Date &amp; Time sent: _____  Sent by (Sending SSC): _____  Sent to (Gaining SSC): _____ </td> <td style="width:30%; vertical-align:top;"> Reply date &amp; time: _____  Reply from: _____  Contact #: _____  E-Mail: _____ </td> </tr> <tr> <td style="vertical-align:top;"> <b>Dental Services:</b>  <input type="checkbox"/> Potential need identified  <input type="checkbox"/> N/A </td> <td style="vertical-align:top;"> Date &amp; Time sent: _____  Sent by (Sending SSC): _____  Sent to (Gaining SSC): _____ </td> <td style="vertical-align:top;"> Reply date &amp; time: _____  Reply from: _____  Contact #: _____  E-Mail: _____ </td> </tr> <tr> <td style="vertical-align:top;"> <b>Special Education Services:</b>  <input type="checkbox"/> Potential need identified  <input type="checkbox"/> N/A </td> <td style="vertical-align:top;"> Date &amp; Time sent: _____  Sent by (Sending SSC): _____  Sent to (Gaining SSC): _____    Sent to (Gaining DoDEA): _____ </td> <td style="vertical-align:top;"> Reply date &amp; time: _____  Reply from: _____  Contact #: _____  E-Mail: _____  E-Mail: _____ </td> </tr> </table>				<b>Medical Care:</b> <input type="checkbox"/> Potential need identified <input type="checkbox"/> N/A	Date & Time sent: _____ Sent by (Sending SSC): _____ Sent to (Gaining SSC): _____	Reply date & time: _____ Reply from: _____ Contact #: _____ E-Mail: _____	<b>Dental Services:</b> <input type="checkbox"/> Potential need identified <input type="checkbox"/> N/A	Date & Time sent: _____ Sent by (Sending SSC): _____ Sent to (Gaining SSC): _____	Reply date & time: _____ Reply from: _____ Contact #: _____ E-Mail: _____	<b>Special Education Services:</b> <input type="checkbox"/> Potential need identified <input type="checkbox"/> N/A	Date & Time sent: _____ Sent by (Sending SSC): _____ Sent to (Gaining SSC): _____  Sent to (Gaining DoDEA): _____	Reply date & time: _____ Reply from: _____ Contact #: _____ E-Mail: _____ E-Mail: _____
<b>Medical Care:</b> <input type="checkbox"/> Potential need identified <input type="checkbox"/> N/A	Date & Time sent: _____ Sent by (Sending SSC): _____ Sent to (Gaining SSC): _____	Reply date & time: _____ Reply from: _____ Contact #: _____ E-Mail: _____										
<b>Dental Services:</b> <input type="checkbox"/> Potential need identified <input type="checkbox"/> N/A	Date & Time sent: _____ Sent by (Sending SSC): _____ Sent to (Gaining SSC): _____	Reply date & time: _____ Reply from: _____ Contact #: _____ E-Mail: _____										
<b>Special Education Services:</b> <input type="checkbox"/> Potential need identified <input type="checkbox"/> N/A	Date & Time sent: _____ Sent by (Sending SSC): _____ Sent to (Gaining SSC): _____  Sent to (Gaining DoDEA): _____	Reply date & time: _____ Reply from: _____ Contact #: _____ E-Mail: _____ E-Mail: _____										
Other information:												
F. SUITABILITY SCREENING COORDINATOR: Facility _____												
Printed Name: _____ E-mail: _____ Phone: _____	Signature _____	Date _____										

**REPORT OF MEDICAL HISTORY**

OMB No. 0704-0413  
OMB approval expires  
Oct 31, 2017

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

The public reporting burden for this collection of information is estimated to average 10 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing the burden, to the Department of Defense, Washington Headquarters Services, Executive Services Directorate, Directives Division, 4800 Mark Center Drive, Alexandria, VA 22304-3100 (0704-0413). 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, 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://dpclid.defense.gov/Privacy/SORNsIndex/BlanketRoutineUses.aspx> 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.

<b>1. LAST NAME, FIRST NAME, MIDDLE NAME (SUFFIX)</b>	<b>2. SOCIAL SECURITY NUMBER</b>	<b>3. TODAY'S DATE (YYYYMMDD)</b>
<b>4.a. HOME ADDRESS</b> ( <i>Street, Apartment No., City, State, and ZIP Code</i> )	<b>5. EXAMINING LOCATION AND ADDRESS</b> ( <i>Include ZIP Code</i> )	
<b>b. HOME TELEPHONE</b> ( <i>Include Area Code</i> )		

<b>X ALL APPLICABLE BOXES:</b>			<b>7.a. POSITION</b> ( <i>Title, Grade, Component</i> )
<b>6.a. SERVICE</b> <input type="checkbox"/> Army <input type="checkbox"/> Coast Guard <input type="checkbox"/> Navy <input type="checkbox"/> Marine Corps <input type="checkbox"/> Air Force	<b>6.b. COMPONENT</b> <input type="checkbox"/> Regular <input type="checkbox"/> Reserve <input type="checkbox"/> National Guard	<b>6.c. PURPOSE OF EXAMINATION</b> <input type="checkbox"/> Enlistment <input type="checkbox"/> Medical Board <input type="checkbox"/> Other ( <i>Specify</i> ) <input type="checkbox"/> Commission <input type="checkbox"/> Retirement <input type="checkbox"/> Retention <input type="checkbox"/> U.S. Service Academy <input type="checkbox"/> Separation <input type="checkbox"/> ROTC Scholarship Program	<b>b. USUAL OCCUPATION</b>
<b>8. CURRENT MEDICATIONS</b> ( <i>Prescription and Over-the-counter</i> )			<b>9. ALLERGIES</b> ( <i>Including insect bites/stings, foods, medicine or other substance</i> )

**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	12. (Continued)	YES	NO
<b>10.a. Tuberculosis</b>	<input type="radio"/>	<input type="radio"/>	<b>f. Foot trouble</b> ( <i>e.g., pain, corns, bunions, etc.</i> )	<input type="radio"/>	<input type="radio"/>
<b>b. Lived with someone who had tuberculosis</b>	<input type="radio"/>	<input type="radio"/>	<b>g. Impaired use of arms, legs, hands, or feet</b>	<input type="radio"/>	<input type="radio"/>
<b>c. Coughed up blood</b>	<input type="radio"/>	<input type="radio"/>	<b>h. Swollen or painful joint(s)</b>	<input type="radio"/>	<input type="radio"/>
<b>d. Asthma or any breathing problems related to exercise, weather, pollens, etc.</b>	<input type="radio"/>	<input type="radio"/>	<b>i. Knee trouble</b> ( <i>e.g., locking, giving out, pain or ligament injury, etc.</i> )	<input type="radio"/>	<input type="radio"/>
<b>e. Shortness of breath</b>	<input type="radio"/>	<input type="radio"/>	<b>j. Any knee or foot surgery including arthroscopy or the use of a scope to any bone or joint</b>	<input type="radio"/>	<input type="radio"/>
<b>f. Bronchitis</b>	<input type="radio"/>	<input type="radio"/>	<b>k. Any need to use corrective devices such as prosthetic devices, knee brace(s), back support(s), lifts or orthotics, etc.</b>	<input type="radio"/>	<input type="radio"/>
<b>g. Wheezing or problems with wheezing</b>	<input type="radio"/>	<input type="radio"/>	<b>l. Bone, joint, or other deformity</b>	<input type="radio"/>	<input type="radio"/>
<b>h. Been prescribed or used an inhaler</b>	<input type="radio"/>	<input type="radio"/>	<b>m. Plate(s), screw(s), rod(s) or pin(s) in any bone</b>	<input type="radio"/>	<input type="radio"/>
<b>i. A chronic cough or cough at night</b>	<input type="radio"/>	<input type="radio"/>	<b>n. Broken bone(s)</b> ( <i>cracked or fractured</i> )	<input type="radio"/>	<input type="radio"/>
<b>j. Sinusitis</b>	<input type="radio"/>	<input type="radio"/>	<b>13.a. Frequent indigestion or heartburn</b>	<input type="radio"/>	<input type="radio"/>
<b>k. Hay fever</b>	<input type="radio"/>	<input type="radio"/>	<b>b. Stomach, liver, intestinal trouble, or ulcer</b>	<input type="radio"/>	<input type="radio"/>
<b>l. Chronic or frequent colds</b>	<input type="radio"/>	<input type="radio"/>	<b>c. Gall bladder trouble or gallstones</b>	<input type="radio"/>	<input type="radio"/>
<b>11.a. Severe tooth or gum trouble</b>	<input type="radio"/>	<input type="radio"/>	<b>d. Jaundice or hepatitis</b> ( <i>liver disease</i> )	<input type="radio"/>	<input type="radio"/>
<b>b. Thyroid trouble or goiter</b>	<input type="radio"/>	<input type="radio"/>	<b>e. Rupture/hernia</b>	<input type="radio"/>	<input type="radio"/>
<b>c. Eye disorder or trouble</b>	<input type="radio"/>	<input type="radio"/>	<b>f. Rectal disease, hemorrhoids or blood from the rectum</b>	<input type="radio"/>	<input type="radio"/>
<b>d. Ear, nose, or throat trouble</b>	<input type="radio"/>	<input type="radio"/>	<b>g. Skin diseases</b> ( <i>e.g. acne, eczema, psoriasis, etc.</i> )	<input type="radio"/>	<input type="radio"/>
<b>e. Loss of vision in either eye</b>	<input type="radio"/>	<input type="radio"/>	<b>h. Frequent or painful urination</b>	<input type="radio"/>	<input type="radio"/>
<b>f. Worn contact lenses or glasses</b>	<input type="radio"/>	<input type="radio"/>	<b>i. High or low blood sugar</b>	<input type="radio"/>	<input type="radio"/>
<b>g. A hearing loss or wear a hearing aid</b>	<input type="radio"/>	<input type="radio"/>	<b>j. Kidney stone or blood in urine</b>	<input type="radio"/>	<input type="radio"/>
<b>h. Surgery to correct vision</b> ( <i>RK, PRK, LASIK, etc.</i> )	<input type="radio"/>	<input type="radio"/>	<b>k. Sugar or protein in urine</b>	<input type="radio"/>	<input type="radio"/>
<b>12.a. Painful shoulder, elbow or wrist</b> ( <i>e.g. pain, dislocation, etc.</i> )	<input type="radio"/>	<input type="radio"/>	<b>l. Sexually transmitted disease</b> ( <i>syphilis, gonorrhea, chlamydia, genital warts, herpes, etc.</i> )	<input type="radio"/>	<input type="radio"/>
<b>b. Arthritis, rheumatism, or bursitis</b>	<input type="radio"/>	<input type="radio"/>	<b>14.a. Adverse reaction to serum, food, insect stings or medicine</b>	<input type="radio"/>	<input type="radio"/>
<b>c. Recurrent back pain or any back problem</b>	<input type="radio"/>	<input type="radio"/>	<b>b. Recent unexplained gain or loss of weight</b>	<input type="radio"/>	<input type="radio"/>
<b>d. Numbness or tingling</b>	<input type="radio"/>	<input type="radio"/>	<b>c. Currently in good health</b> ( <i>if no, explain in Item 29 on Page 2.</i> )	<input type="radio"/>	<input type="radio"/>
<b>e. Loss of finger or toe</b>	<input type="radio"/>	<input type="radio"/>	<b>d. Tumor, growth, cyst, or cancer</b>	<input type="radio"/>	<input type="radio"/>

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

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

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.)

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)*

## SPECIAL EDUCATION/EARLY INTERVENTION SUMMARY

### PRIVACY ACT STATEMENT

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

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

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

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

### INSTRUCTIONS

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

#### DEMOGRAPHICS.

**Items 1 - 7.** Completed by sponsor or spouse.

**Item 1.** Request (X one):

- EFMP Registration/Enrollment Update - first enrollment application for the family member or to update a previous evaluation for the family member.
- Government Sponsored Travel.
- Change in EFMP Status.

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

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

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

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

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

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

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

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

### SPECIAL EDUCATION/EARLY INTERVENTION SUMMARY

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

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

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

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

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

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

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

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

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

**SPECIAL EDUCATION/EARLY INTERVENTION SUMMARY**

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

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

The public reporting burden for this collection of information is estimated to average 25 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing the burden, to the Department of Defense, Washington Headquarters Services, Executive Services Directorate, Directives Division, 4800 Mark Center Drive, Alexandria, VA 22350-3100 (0704-0411). Respondents should be aware that notwithstanding any other provision of law, no person shall be subject to any penalty for failing to comply with a collection of information if it does not display a currently valid OMB control number.  
**PLEASE DO NOT RETURN YOUR FORM TO THE ABOVE ORGANIZATION.**

**DEMOGRAPHICS**

**1. REQUEST** (X one)

<input type="checkbox"/> EFMP Registration/Enrollment Update	<input type="checkbox"/> Change in EFMP Status:	<input type="checkbox"/> Other (Explain)
<input type="checkbox"/> Government Sponsored Travel	<input type="checkbox"/> No longer requires IEP/IFSP services	
	<input type="checkbox"/> No longer qualifies as a dependent*	
	<input type="checkbox"/> Divorce/change in custody*	

(\*Provide documentation for change in status)

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

<b>a. CHILD/STUDENT NAME</b> (Last, First, Middle Initial)		<b>b. SPONSOR NAME</b> (Last, First, Middle Initial)		<b>c. CHILD/STUDENT CURRENT MAILING ADDRESS</b> (Street, Apartment Number, City, State, ZIP Code, APO/FPO)	
<b>d. FAMILY MEMBER PREFIX</b>	<b>e. CHILD/STUDENT DATE OF BIRTH</b> (YYYYMMDD)	<b>f. CHILD/STUDENT GENDER</b> (X one)			
		<input type="checkbox"/> MALE	<input type="checkbox"/> FEMALE		
<b>g. FAMILY HOME E-MAIL ADDRESS</b>			<b>h. HOME TELEPHONE NUMBER</b> (Include Area Code/Country Code)		

<b>3. a. SPONSOR RANK OR GRADE</b>	<b>b. INSTALLATION OF CURRENT ASSIGNMENT</b> (Include City, State, Country)
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<b>c. SPONSOR'S OFFICIAL E-MAIL ADDRESS</b>	<b>d. DUTY TELEPHONE NUMBER</b> (Include Area Code/Country Code)	<b>e. MOBILE NUMBER</b> (Include Area Code/Country Code)
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<b>f. STATUS</b> (X one)				<b>g. BRANCH OF SERVICE</b> (Military only)			
<input type="checkbox"/> Regular Active Service Member	<input type="checkbox"/> Active Reserve	<input type="checkbox"/> Active Guard	<input type="checkbox"/> Reserves	<input type="checkbox"/> Army	<input type="checkbox"/> Navy	<input type="checkbox"/> Air Force	<input type="checkbox"/> Marine Corps
	<input type="checkbox"/> National Guard	<input type="checkbox"/> Civilian			<input type="checkbox"/> Coast Guard		

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

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

<b>4.a. ARE BOTH SPOUSES ON ACTIVE DUTY?</b> (Military only) (X one. If Yes, answer b. - d. below)			
<input type="checkbox"/> YES	<input type="checkbox"/> NO	<b>b. ACTIVE DUTY SPOUSE'S NAME</b> (Last, First, Middle Initial)	<b>c. BRANCH OF SERVICE</b>
			<b>d. RANK/RATE</b>

**5. FOR CHILDREN FROM BIRTH TO AGE THREE ONLY:**  
 YES  NO is your child being evaluated for, or receiving, early intervention services on an Individualized Family Service Plan (IFSP)? (X one. If No, sign Item 7 and return to the requesting office. If Yes, have early intervention professional complete Page 3.)

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

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

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

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

**d.** Name/title home school program, if known: \_\_\_\_\_

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

<b>7. a. SIGNATURE</b>	<b>b. PRINTED NAME</b> (Last, First, Middle Initial)	<b>c. DATE</b> (YYYYMMDD)
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<b>8. ADMINISTRATIVE REVIEW</b> (Completed after review of entire form by local military MTF or office receiving form)			<b>f. STAMP</b>
<b>a. SPONSOR SSN</b>	<b>b. SPOUSE SSN</b> (If dual military)	<b>c. SSN USED IN DEERS</b> (If different from sponsor's)	
<b>d. MILITARY MTF OR OFFICE RECEIVING COMPLETED FORM</b>		<b>e. DATE</b> (YYYYMMDD)	

**SPECIAL EDUCATION/EARLY INTERVENTION SUMMARY**

**NOTE TO EDUCATIONAL AUTHORITY COMPLETING THIS FORM:**

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

**1. RELEASE OF INFORMATION** (To be completed by sponsor, spouse, legal guardian, or student who has reached the age of majority)

I hereby authorize the release of information on the DD Form 2792-1, and the attached reports to personnel of the Military Departments. This information will be used to evaluate and document my child/student's needs for educational services for the purpose of assignment coordination, EFMP registration or eligibility for other educationally related benefits.

<b>a. SIGNATURE</b>	<b>b. PRINTED NAME</b>	<b>c. RELATIONSHIP TO CHILD/STUDENT</b>	<b>d. DATE (YYYYMMDD)</b>
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**2. CHILD/STUDENT INFORMATION** (To be completed by sponsor, spouse, or legal guardian)

<b>a. NAME OF CHILD/STUDENT</b> (Last, First, Middle Initial)	<b>b. CURRENT GRADE LEVEL</b> (If school age)	<b>c. DATE OF BIRTH (YYYYMMDD)</b>	<b>d. GENDER (X one)</b> <input type="checkbox"/> FEMALE <input type="checkbox"/> MALE
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**3. EARLY INTERVENTION (EI) SERVICES - FOR CHILDREN UNDER 3 YEARS OF AGE** (To be completed by EI representative)

<b>YES</b>	<b>NO</b>	<b>a.</b> Is the child currently being evaluated for early intervention services? (If Yes, go directly to Item 8.)
		<b>b.</b> Does this child receive early intervention services under a current Individualized Family Service Plan (IFSP)? (If Yes, please attach current IFSP.) Date of next annual review (YYYYMMDD) _____
		<b>c.</b> Basis for eligibility: <input type="checkbox"/> Developmental Delay <input type="checkbox"/> Diagnosed physical or mental condition that has a high probability of resulting in a Developmental Delay
		<b>d.</b> Is there an identified disability? (If known, please specify):

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

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

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

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

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

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

<input type="checkbox"/> R01	Counseling					<input type="checkbox"/> R06	Special Transportation (Describe)
<input type="checkbox"/> R02	Occupational Therapy						
<input type="checkbox"/> R03	Physical Therapy						
<input type="checkbox"/> R04	Speech Therapy					<input type="checkbox"/> R07	Other (Describe):
<input type="checkbox"/> R05	Intensive Behavioral Intervention (Such as ABA)						

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

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

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

## REPORT OF SUITABILITY FOR OVERSEAS ASSIGNMENTS

Supporting Directive OPNAVINST 1300.14D

1. MEMBER'S NAME:		2. DATE:	3. NUMBER OF DEPENDENTS:
4. PRESENT SHIP/STATION:	5. UIC:	6. OVERSEAS LOCATION:	7. UIC:

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

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

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



1. MEMBER'S NAME:	2. DATE:
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**PART III: CMC/COB/SEA ENDORSEMENT**

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

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

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

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

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

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

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