

CONTACT INFORMATION

Please complete the below if you are picking up Exceptional Family Member Program (EFMP) information or packets. A Suitability Screening Coordinator will contact you to schedule an appointment. Please be sure to read the information carefully in your EFMP packet. Thank you for your cooperation and we look forward to completing your EFM process. PLEASE PRINT INFORMATION CLEARLY.

Date: _____

Rank and Name: _____

SSN: _____

Telephone Number: _____

Email: _____

Reason for Screening (Please circle): Initial Application
Update Application Humanitarian Reassignment
Other Medical Reason _____

Name and relationship of Family Members: _____

Name of Provider: _____

Location (Clinic) of Provider: _____

OFFICE USE ONLY

CLERK NAME (TAKING FORM): _____

TECHNICIAN'S NAME MAKING CONTACT: _____

RESPONSE FROM CONTACT: