

Overseas Screening Requirements

Active duty members are responsible for ensuring that they have met the following requirements before coming in to their appointments.

Requirements for active duty members:

1. Current PHA or flight physical. (within the last 12 months)
2. Dental class one or two. (classes three and four are non-deployable)
3. No outstanding medical issues. i.e.(surgical procedures, mental health treatment, physical therapy)
4. No outstanding dental issues. i.e.(major dental procedures)
5. For females Pap smear needs to be current within one year, with normal results. Females age 40+ a mammogram is required within the last 24 months.
6. A completed DD2807-1.
7. A NAVMED 1300/1.
8. A NAVPERS 1300/16.

Requirements for dependants:

1. For females (18 years and older) a Pap smear needs to be current within two years of transferring date and results need to be normal. Females 40 years and older require a current mammogram.
2. Immunizations required by the host country must be up to date. Immunizations clinic phone number is (360) 257- 9591.
3. No outstanding medical issues. i.e.(surgical procedures, mental health treatment, physical therapy)
4. No outstanding dental issues. i.e.(major dental procedures)
5. Dental clearance on (NAVMED 1300/1 page 3) needs to be completed by their dentist.
6. Children must have a current well child exam (within 12 months).
7. A completed DD2807-1.
8. A NAVMED 1300/1.

If you have any questions or difficulties completing any of the listed requirements please do not hesitate to contact the NHOH Suitability office. If you are unable to complete these requirements before your appointment you may reschedule through TRICARE 1-800-404-4506 or contact the NHOH Suitability office.

Phone (360) 257 – 9830.

Email:ssc-nh-oakharbor@med.navy.mil

Website: <http://www.med.navy.mil/sites/nhoh/Services/Pages/SSC.aspx>

IMMUNIZATIONS

Japan:

MMR

DPT

Poliovirus

Hepatitis B

Japanese encephalitis

Guam:

MMR

DPT

Poliovirus

Hepatitis A & B

Typhoid

Italy:

MMR

DPT

Poliovirus

Hepatitis B

If your host country is not listed here please refer to the CDC's guidelines.

CDC website: <http://wwwnc.cdc.gov/travel/destinations/list.aspx>

Instructions for Completing Forms

Complete these forms prior to your appointment.

DD2807-1:

1. Complete blocks 1 – 9. Please write legibly.
2. For blocks 10 – 28 answer the medical questions as they apply to you. If you have any “YES” answers a brief explanation is required in box 29 on page 2.
3. Ensure that your name and full SSN is filled in at the top of each page.

NAVMED 1300/1:

1. Fill in your personal information at the top of page one and three.
2. Do not answer any of the medical questions on this form. They are to be completed by medical and dental personnel.
3. Page three is to be completed by a civilian or DOD dentist. The dentist should refer to box 8 for descriptions of the four dental classifications.

Memorandum:

1. This form is for the sponsor only.
2. Fill in your name, rank, and your present command.

NAVPERS 1300/16:

1. This form is for the sponsor only.
2. Fill in your personal information at the top of each page.
3. Answer questions 1-16 on pages one and two. Note(For personnel E-4 and below you must be counseled on questions 1-16 by a senior member in your chain of command)
4. If you have accompanied orders list your dependants on page three in boxes 2-6.
5. Page four will be filled out by your admin department **after** your medical screening has been completed.

If you have any questions or concerns, please refer to our website or contact the NHOH suitability office.

Website: <http://www.med.navy.mil/sites/nhoh/Services/Pages/SSC.aspx>

Phone: (360) 257 9830

Email: ssc-nh-oakharbor@med.navy.mil

REPORT OF MEDICAL HISTORY

OMB No. 0704-0413
OMB approval expires
Aug 31, 2014

(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, Information Management Division, 1155 Defense Pentagon, Washington, DC 20301-1155 (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://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)	NAVAL HOSPITAL OAK HARBOR 3475 N SARATOGA STREET OAK HARBOR, WA 98278-8800	

X ALL APPLICABLE BOXES:			7.a. POSITION (Title, Grade, Component)
6.a. SERVICE	b. COMPONENT	c. PURPOSE OF EXAMINATION	b. USUAL OCCUPATION
<input type="checkbox"/> Army <input type="checkbox"/> Coast Guard <input type="checkbox"/> Navy <input type="checkbox"/> Marine Corps <input type="checkbox"/> Air Force	<input type="checkbox"/> Regular <input type="checkbox"/> Reserve <input type="checkbox"/> National Guard	<input type="checkbox"/> Enlistment <input type="checkbox"/> Medical Board <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Commission <input type="checkbox"/> Retention <input type="checkbox"/> Separation <input type="checkbox"/> Retirement <input type="checkbox"/> U.S. Service Academy <input type="checkbox"/> ROTC Scholarship Program	

8. CURRENT MEDICATIONS (Prescription and Over-the-counter)	9. ALLERGIES (Including insect bites/stings, foods, medicine or other substance)
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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
10.a. Tuberculosis	<input type="radio"/>	<input type="radio"/>	f. Foot trouble (e.g., pain, corns, bunions, etc.)	<input type="radio"/>	<input type="radio"/>
b. Lived with someone who had tuberculosis	<input type="radio"/>	<input type="radio"/>	g. Impaired use of arms, legs, hands, or feet	<input type="radio"/>	<input type="radio"/>
c. Coughed up blood	<input type="radio"/>	<input type="radio"/>	h. Swollen or painful joint(s)	<input type="radio"/>	<input type="radio"/>
d. Asthma or any breathing problems related to exercise, weather, pollens, etc.	<input type="radio"/>	<input type="radio"/>	i. Knee trouble (e.g., locking, giving out, pain or ligament injury, etc.)	<input type="radio"/>	<input type="radio"/>
e. Shortness of breath	<input type="radio"/>	<input type="radio"/>	j. Any knee or foot surgery including arthroscopy or the use of a scope to any bone or joint	<input type="radio"/>	<input type="radio"/>
f. Bronchitis	<input type="radio"/>	<input type="radio"/>	k. Any need to use corrective devices such as prosthetic devices, knee brace(s), back support(s), lifts or orthotics, etc.	<input type="radio"/>	<input type="radio"/>
g. Wheezing or problems with wheezing	<input type="radio"/>	<input type="radio"/>	l. Bone, joint, or other deformity	<input type="radio"/>	<input type="radio"/>
h. Been prescribed or used an inhaler	<input type="radio"/>	<input type="radio"/>	m. Plate(s), screw(s), rod(s) or pin(s) in any bone	<input type="radio"/>	<input type="radio"/>
i. A chronic cough or cough at night	<input type="radio"/>	<input type="radio"/>	n. Broken bone(s) (cracked or fractured)	<input type="radio"/>	<input type="radio"/>
j. Sinusitis	<input type="radio"/>	<input type="radio"/>	13.a. Frequent indigestion or heartburn	<input type="radio"/>	<input type="radio"/>
k. Hay fever	<input type="radio"/>	<input type="radio"/>	b. Stomach, liver, intestinal trouble, or ulcer	<input type="radio"/>	<input type="radio"/>
l. Chronic or frequent colds	<input type="radio"/>	<input type="radio"/>	c. Gall bladder trouble or gallstones	<input type="radio"/>	<input type="radio"/>
11.a. Severe tooth or gum trouble	<input type="radio"/>	<input type="radio"/>	d. Jaundice or hepatitis (liver disease)	<input type="radio"/>	<input type="radio"/>
b. Thyroid trouble or goiter	<input type="radio"/>	<input type="radio"/>	e. Rupture/hernia	<input type="radio"/>	<input type="radio"/>
c. Eye disorder or trouble	<input type="radio"/>	<input type="radio"/>	f. Rectal disease, hemorrhoids or blood from the rectum	<input type="radio"/>	<input type="radio"/>
d. Ear, nose, or throat trouble	<input type="radio"/>	<input type="radio"/>	g. Skin diseases (e.g. acne, eczema, psoriasis, etc.)	<input type="radio"/>	<input type="radio"/>
e. Loss of vision in either eye	<input type="radio"/>	<input type="radio"/>	h. Frequent or painful urination	<input type="radio"/>	<input type="radio"/>
f. Worn contact lenses or glasses	<input type="radio"/>	<input type="radio"/>	i. High or low blood sugar	<input type="radio"/>	<input type="radio"/>
g. A hearing loss or wear a hearing aid	<input type="radio"/>	<input type="radio"/>	j. Kidney stone or blood in urine	<input type="radio"/>	<input type="radio"/>
h. Surgery to correct vision (RK, PRK, LASIK, etc.)	<input type="radio"/>	<input type="radio"/>	k. Sugar or protein in urine	<input type="radio"/>	<input type="radio"/>
12.a. Painful shoulder, elbow or wrist (e.g. pain, dislocation, etc.)	<input type="radio"/>	<input type="radio"/>	l. Sexually transmitted disease (syphilis, gonorrhea, chlamydia, genital warts, herpes, etc.)	<input type="radio"/>	<input type="radio"/>
b. Arthritis, rheumatism, or bursitis	<input type="radio"/>	<input type="radio"/>	14.a. Adverse reaction to serum, food, insect stings or medicine	<input type="radio"/>	<input type="radio"/>
c. Recurrent back pain or any back problem	<input type="radio"/>	<input type="radio"/>	b. Recent unexplained gain or loss of weight	<input type="radio"/>	<input type="radio"/>
d. Numbness or tingling	<input type="radio"/>	<input type="radio"/>	c. Currently in good health (If no, explain in Item 29 on Page 2.)	<input type="radio"/>	<input type="radio"/>
e. Loss of finger or toe	<input type="radio"/>	<input type="radio"/>	d. Tumor, growth, cyst, or cancer	<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:	a. Sensitivity to chemicals, dust, sunlight, etc.	<input type="radio"/>	<input type="radio"/>
b. Frequent or severe headache	<input type="radio"/>	<input type="radio"/>		b. Inability to perform certain motions	<input type="radio"/>	<input type="radio"/>
c. A head injury, memory loss or amnesia	<input type="radio"/>	<input type="radio"/>		c. Inability to stand, sit, kneel, lie down, etc.	<input type="radio"/>	<input type="radio"/>
d. Paralysis	<input type="radio"/>	<input type="radio"/>		d. Other medical reasons (If yes, give reasons.)	<input type="radio"/>	<input type="radio"/>
e. Seizures, convulsions, epilepsy or fits	<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"/>
f. Car, train, sea, or air sickness	<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"/>	<input type="radio"/>
g. A period of unconsciousness or concussion	<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"/>
h. Meningitis, encephalitis, or other neurological problems	<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"/>
16.a. Rheumatic fever	<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"/>	
b. Prolonged bleeding (as after an injury or tooth extraction, etc.)	<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"/>
c. Pain or pressure in the chest	<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"/>	
d. Palpitation, pounding heart or abnormal heartbeat	<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"/>
e. Heart trouble or murmur	<input type="radio"/>	<input type="radio"/>	28. Have you ever been denied life insurance?	<input type="radio"/>	<input type="radio"/>	
f. High or low blood pressure	<input type="radio"/>	<input type="radio"/>			<input type="radio"/>	<input type="radio"/>
17.a. Nervous trouble of any sort (anxiety or panic attacks)	<input type="radio"/>	<input type="radio"/>	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.)			
b. Habitual stammering or stuttering	<input type="radio"/>	<input type="radio"/>				
c. Loss of memory or amnesia, or neurological symptoms	<input type="radio"/>	<input type="radio"/>				
d. Frequent trouble sleeping	<input type="radio"/>	<input type="radio"/>				
e. Received counseling of any type	<input type="radio"/>	<input type="radio"/>				
f. Depression or excessive worry	<input type="radio"/>	<input type="radio"/>				
g. Been evaluated or treated for a mental condition	<input type="radio"/>	<input type="radio"/>				
h. Attempted suicide	<input type="radio"/>	<input type="radio"/>				
i. Used illegal drugs or abused prescription drugs	<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)						

NOTE: HAND TO THE DOCTOR OR NURSE, OR IF MAILED MARK ENVELOPE "TO BE OPENED BY MEDICAL PERSONNEL ONLY."

Yes	No	N/A	ITEM
			17. For service/family members with underlying medical conditions: <i>(if not applicable, check block and skip to #18)</i>
			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. Can the gaining MTF/operational platform provide the current required medical support?
			d. Can the gaining MTF/operational platform provide required medical support (diagnostic and therapeutic) if the underlying condition is exacerbated?
			e. Are there any chronic medical or mental health conditions requiring routine or continuing access to care or access to specialized medical care? <i>(document on DD 2807-1)</i>
			f. If required, were potential environmental concerns and possible health effects communicated to each service and family member? <i>(document on appropriate SF 600)</i>
			18. For infants and toddlers (birth through 2 years, inclusive) with a disability, is the child receiving or eligible to receive early intervention services as evidenced by an Individualized Family Service Plan (IFSP)?
			19. For preschool and school children (ages 3 through 21, inclusive) with a disability, is the child receiving or eligible to receive special education and related services as evidenced by an Individualized Education Program (IEP) and DD 2792, Addendum B?
			20. Specify other concerns:

IF ANY OF THE ABOVE SHADED BLOCKS ARE CHECKED, QUERY THE GAINING MEDICAL TREATMENT FACILITY OR MEDICAL DEPARTMENT SUPPORTING THE OVERSEAS, REMOTE DUTY OR OPERATIONAL LOCATION CONCERNING LOCAL CAPABILITIES TO PROVIDE REQUIRED SUPPORT. *(Attach Reply)*

Yes	No	IS THE SERVICE/FAMILY MEMBER SUITABLE FOR THE OVERSEAS, REMOTE DUTY OR OPERATIONAL ASSIGNMENT? <i>(completed by an MTF medical screener only)</i>														
		<table border="0" style="width: 100%;"> <tr> <td style="width: 50%; border-bottom: 1px solid black;">MTF Medical Screener (Signature)</td> <td style="width: 50%; border-bottom: 1px solid black;">Date</td> </tr> <tr> <td style="border-bottom: 1px solid black;">Printed Name, Rank or Grade</td> <td style="border-bottom: 1px solid black;">Printed Name</td> </tr> <tr> <td style="border-bottom: 1px solid black;">MTF or Duty Station</td> <td style="border-bottom: 1px solid black;">Address</td> </tr> <tr> <td style="border-bottom: 1px solid black;">Telephone Number (include area/country code)</td> <td style="border-bottom: 1px solid black;">City, State, and ZIP Code</td> </tr> <tr> <td style="border-bottom: 1px solid black;">DSN Number</td> <td style="border-bottom: 1px solid black;">Telephone Number (include area/country code)</td> </tr> <tr> <td style="border-bottom: 1px solid black;">Telefax Number (include area/country code)</td> <td style="border-bottom: 1px solid black;">Telefax Number (include area/country code)</td> </tr> <tr> <td style="border-bottom: 1px solid black;">E-mail Address</td> <td style="border-bottom: 1px solid black;">E-mail Address</td> </tr> </table>	MTF 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)	Telefax Number (include area/country code)	Telefax Number (include area/country code)	E-mail Address	E-mail Address
MTF 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)															
Telefax Number (include area/country code)	Telefax Number (include area/country code)															
E-mail Address	E-mail Address															

MEMORANDUM ENDORSEMENT

From: Transfer Section, Personnel Support Activity Detachment, Whidbey Island WA
To: Naval Hospital Oak Harbor WA,

Subj: SCREENING FOR ASSIGNMENT TO OPERATIONAL DUTY

Ref: (a) MILPERSMAN
(b) BUMED Washington DC 210129Z DEC94
(c) MANMED Art 15-30

1. Per references (a) through (c), medical and dental screenings are required to be completed and documented prior to transfer to sea duty.

Rank/Name:

Present Command:

FIRST ENDORSEMENT

From: Commanding Officer, Naval Hospital Oak Harbor
To: Officer in Charge, Personnel Support Activity Detachment Whidbey Island

1. Per references (a) through (c) member has been screened and is considered to be Medically suitable/unsuitable and Dentally suitable/unsuitable for duty with deployable units.

Signature of MEDICAL DOCTOR/IDC

Signature of DENTIST

DATE: _____

DATE: _____

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 www.nsopw.gov .	<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 www.nsopw.gov .	<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"/> No

Reset Form

Print Form

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
NOTE: While the unique situation of single parents with dependents is not disqualifying, this fact should be pointed out upon submission of suitability determination.			
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
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.			
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 II: RECOMMENDATION OF COMMANDING OFFICER (OR OIC) OF MEDICAL TREATMENT FACILITY.

Based on the information available as a result of screening, approved medical/dental waivers received, and on the capabilities of the Medical/Dental Treatment Facility (MTF/DTF) in the area of assignment to which ordered, the following recommendation is forwarded.

1. Medical, dental, and educational screening was conducted per BUMEDINST 1300.2A.
2. Recommendation is based on a review of NAVMED 1300/1, Parts I and II. One form has been completed for each service and family member screened.
3. If a shaded block is checked on NAVMED 1300/1, coordination is required with the gaining MTF/DTF supporting the overseas, remote duty, or operational location; or with the senior medical department representative of an operational platform. Coordination must indicate whether or not required medical, dental, or educational capabilities are available.
4. Family member screening is not required if an unaccompanied tour of 24 months or less (exception: screening is required for Diego Garcia/ Souda Bay, Crete).
5. Do not forward sensitive medical or personal information with this form.

The following recommendation(s) are made based on a review of each NAVMED 1300/1, Parts I and II, and if required, the response from the gaining MTF/DTF or senior medical department representative of the gaining command:

1. SERVICEMEMBER IS SUITABLE FOR THIS ASSIGNMENT. Yes No

FAMILY MEMBERS SUITABILITY FOR THIS ASSIGNMENT.

2. NAME: <input type="radio"/> Yes <input type="radio"/> No	3. NAME: <input type="radio"/> Yes <input type="radio"/> No
4. NAME: <input type="radio"/> Yes <input type="radio"/> No	5. NAME: <input type="radio"/> Yes <input type="radio"/> No
6. NAME: <input type="radio"/> Yes <input type="radio"/> No	6. NAME: <input type="radio"/> Yes <input type="radio"/> No

The following family member(s) were referred for Exceptional Family Member Program (EFMP) enrollment (DO NOT DELAY SCREENING FOR EFM DETERMINATION):

8. NAME (s):

9. NAME OF CO/OIC OR DESIGNEE OF MEDICAL TREATMENT FACILITY:	10. DATE:	9. SIGNATURE OF CO/OIC OR DESIGNEE OF MEDICAL TREATMENT FACILITY:
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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.