

Sea Duty Screening Requirements

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

Requirements:

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.

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>

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.

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

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

OMB No. 0704-0413
OMB approval expires
Mar 31, 2010

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, Executive Services Directorate (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 USC 504, 505, 507, 532, 978, 1201, 1202, and 4346; and E.O. 9397 (SSAN).

PRINCIPAL PURPOSE(S): To obtain medical data for determination of medical fitness for enlistment, induction, appointment and retention for applicants and members of the Armed Forces. The information will also be used for medical boards and separation of Service members from the Armed Forces.

ROUTINE USE(S): None.

DISCLOSURE: Voluntary; however, failure by an applicant to provide the information may result in delay or possible rejection of the individual's application to enter the Armed Forces. For an Armed Forces member, failure to provide the information may result in the individual being placed in a non-deployable status.

WARNING: The information you have given constitutes an official statement. Federal law provides severe penalties (up to 5 years confinement or a \$10,000 fine or both), to anyone making a false statement. If you are selected for enlistment, commission, or entrance into a commissioning program based on a false statement, you can be tried by military courts-martial or meet an administrative board for discharge and could receive a less than honorable discharge that would affect your future.

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

X ALL APPLICABLE BOXES:			7.a. POSITION (Title, Grade, Component)					
<table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:20%; padding: 5px;">6.a. SERVICE</td> <td style="width:20%; padding: 5px;">6.b. COMPONENT</td> <td style="width:60%; padding: 5px;">6.c. PURPOSE OF EXAMINATION</td> </tr> <tr> <td style="padding: 5px;"> <input type="checkbox"/> Army <input type="checkbox"/> Coast Guard <input type="checkbox"/> Navy <input type="checkbox"/> Marine Corps <input type="checkbox"/> Air Force </td> <td style="padding: 5px;"> <input type="checkbox"/> Active Duty <input type="checkbox"/> Reserve <input type="checkbox"/> National Guard </td> <td style="padding: 5px;"> <input type="checkbox"/> Enlistment <input type="checkbox"/> Medical Board <input checked="" type="checkbox"/> Other (Specify) <input type="checkbox"/> Commission <input type="checkbox"/> Retirement sea screen. <input type="checkbox"/> Retention <input type="checkbox"/> Separation <input type="checkbox"/> U.S. Service Academy <input type="checkbox"/> ROTC Scholarship Program </td> </tr> </table>	6.a. SERVICE	6.b. COMPONENT	6.c. PURPOSE OF EXAMINATION	<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"/> Active Duty <input type="checkbox"/> Reserve <input type="checkbox"/> National Guard	<input type="checkbox"/> Enlistment <input type="checkbox"/> Medical Board <input checked="" type="checkbox"/> Other (Specify) <input type="checkbox"/> Commission <input type="checkbox"/> Retirement sea screen. <input type="checkbox"/> Retention <input type="checkbox"/> Separation <input type="checkbox"/> U.S. Service Academy <input type="checkbox"/> ROTC Scholarship Program	7.b. USUAL OCCUPATION	
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8. CURRENT MEDICATIONS (Prescription and Over-the-counter)		9. ALLERGIES (Including insect bites/stings, foods, medicine or other substance)						

Mark each item "YES" or "NO". Every item marked "YES" must be fully explained in Item 29 on Page 2.

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b. Stomach, liver, intestinal trouble, or ulcer	<input type="radio"/>	<input type="radio"/>																																																																																																																																																											
c. Gall bladder trouble or gallstones	<input type="radio"/>	<input type="radio"/>																																																																																																																																																											
d. Jaundice or hepatitis (liver disease)	<input type="radio"/>	<input type="radio"/>																																																																																																																																																											
e. Rupture/hernia	<input type="radio"/>	<input type="radio"/>																																																																																																																																																											
f. Rectal disease, hemorrhoids or blood from the rectum	<input type="radio"/>	<input type="radio"/>																																																																																																																																																											
g. Skin diseases (e.g. acne, eczema, psoriasis, etc.)	<input type="radio"/>	<input type="radio"/>																																																																																																																																																											
h. Frequent or painful urination	<input type="radio"/>	<input type="radio"/>																																																																																																																																																											
i. High or low blood sugar	<input type="radio"/>	<input type="radio"/>																																																																																																																																																											
j. Kidney stone or blood in urine	<input type="radio"/>	<input type="radio"/>																																																																																																																																																											
k. Sugar or protein in urine	<input type="radio"/>	<input type="radio"/>																																																																																																																																																											
l. Sexually transmitted disease (syphilis, gonorrhea, chlamydia, genital warts, herpes, etc.)	<input type="radio"/>	<input type="radio"/>																																																																																																																																																											
14.a. Adverse reaction to serum, food, insect stings or medicine	<input type="radio"/>	<input type="radio"/>																																																																																																																																																											
b. Recent unexplained gain or loss of weight	<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"/>																																																																																																																																																											
d. Tumor, growth, cyst, or cancer	<input type="radio"/>	<input type="radio"/>																																																																																																																																																											

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

LAST NAME, FIRST NAME, MIDDLE NAME (SUFFIX)	SOCIAL SECURITY NUMBER	
30. EXAMINER'S SUMMARY AND ELABORATION OF ALL PERTINENT DATA <i>(Physician/practitioner shall comment on all positive answers in questions 10 - 29. Physician/practitioner may develop by interview any additional medical history deemed important, and record any significant findings here.)</i>		
a. COMMENTS		
b. TYPED OR PRINTED NAME OF EXAMINER <i>(Last, First, Middle Initial)</i>	c. SIGNATURE	d. DATE SIGNED <i>(YYYYMMDD)</i>

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>																		
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DEPARTMENT OF THE NAVY

NAVAL HOSPITAL
3475 N SARATOGA STREET
OAK HARBOR, WASHINGTON 98278-8800

From: Transfers Section, Personnel Support Activity Detachment,
Whidbey Island WA.

Subj: SCREENING FOR ASSIGNMENT TO SEA DUTY.

Ref: (a) NAVPERS 15909E Chapter 24

(b) BUMED Washington DC 210129z DEC94

(c) MANMED Art 15-30

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

Rank/Rate Name : _____

Present Command: _____

FIRST ENDORSEMENT

From: Commanding Officer, Naval Hospital Oak Harbor

To: Transfers Section, 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 **DENTAL** suitable/unsuitable for duty with _____

(UNIT/COMMAND/SQUADRON)

Signature of MEDICAL DOCTOR/IDC

Signature of DENTIST

DATE _____

DATE _____