

ShipShape Referral Form

CFL Directions: Type in the information, print it out, have member bring their own referral to first class.

From: _____ Activity Head
_____ Activity Name
_____ Activity Address

To: Director, Health Promotion Department, Naval Hospital or Branch Clinic,
_____ Medical Treatment Facility Name

Subject: REFERRAL OF SNM FOR PARTICIPATION IN SHIPSHAPE WEIGHT MANAGEMENT PROGRAM ICO

_____ Candidate's Name and Rank

USN _____ SSN USNR

Ref: (a) BUMED Memorandum of Understanding dtd 5 Sep 00
(b) OPNAVINST 6110.1G

1. This command requests approval for this SNM to participate in the ShipShape Weight Management Program as directed by reference (a) & (b). The following information is submitted for your records. The member's measurements were taken on _____ **[Insert date here]**.

- a. HT: _____ **[Insert here]**
- b. WT: _____ **[Insert here]**
- c. Body Fat%: _____ **[Insert here]**
- d. Is SNM currently enrolled in Command Fitness Enhancement Program (FEP)?
 ___ Yes ___ No
- e. Is SNM currently on LIMDU? ___ Yes ___ No
- f. Brief synopsis of reason for referral for SNM to participate in ShipShape Program:

_____ **[Insert reason for referral here]**

2. Request quota ICO _____ **[Insert name & rank of SNM here]**

for: (check one box)

- next available class
- next available class convening between _____ **[Beginning date]** & _____ **[End date]** due to our operational commitments.

Command understands enrollment of SNM in ShipShape Program will require a commitment of SNM's attendance at eight (8) consecutive weekly sessions with follow up provided by our CFL.

3. CFL or other Command Point of Contact (POC) is _____ **[Name and rank]** who can be reached at:

_____ **[Insert commercial area code and phone number]**

or _____ **[Insert DSN phone number];**

FAX _____ **[Insert COMM fax number];**

E-mail _____ **[Insert email address]**

_____ **[Insert name and rank of signer]**