



# Dependent Overseas Screening/Remote Duty “STEP-BY-STEP”



**Please utilize this document as a tool to complete your pre-requisites. This document is not required for your screening; however it could be very useful when used as a checklist to track your progress.**

**\*\*\*All family members are required to complete all prerequisites as listed below to receive an appointment to finalize their Overseas Medical Screening. Work with your Primary Care Provider to complete many of the below requirements.\*\*\***

- Do you have a copy of your Home Port Change Message/Letter of Intent? (Should be released sometime soon and will be given to your Active Duty Husband, Wife, or Partner). Ensure you have legible copies that NTC Suitability/Overseas Screening can keep on hand once you received it.
- Do you have the Suitability/Overseas Screening Packet? (**EACH** family member must have a packet to Include; **NAVMED 1300/1, NAVPERS 1300/16, and DD2807-1** (See Example below))

### Page 3 of NAVMED 1300/1 Dental Form

**\*\*\*\* ONLY FILL OUT NAVMED 1300/1 by dental & Only fill out your personal information on the top portion on Page 1, (DO NOT TOUCH PART 1), on Page 2, leave it entirely blank!**

**ALL DEPENDENTS require** a Dental signature and a Dental class assigned to them on NAVMED 1300/1 page 3 regardless of age. Those under age 1, may be screened by their Primary Care Provider, with documentation of “no teeth”, “no cleft lip” or “no cleft palate”.

PART II		
SERVICE / FAMILY MEMBER NAME	GRADE / RATE / FAMILY MEMBER PREFIX	SSN
<b>Dental Screening:</b> 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.		
Yes	No	N/A
ITEM		
		1. All current dental records (military and civilian) reviewed?
		2. All dental examinations are current? (If more than 180 days since last 1-1 or 1-2 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. Specify other concerns:
		8. Specify Dental Class: (required for service members)
<b>Dental Classifications:</b> (Per DoDI 6025.19) <b>Normally considered worldwide deployable:</b> <b>Class 1 -</b> Patients with a current dental examination, who do not require dental treatment or re-evaluation. <b>Class 2 -</b> 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. <b>Normally not considered worldwide deployable:</b> <b>Class 3 -</b> 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. <b>Class 4 -</b> 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.		
<b>IF ANY OF THE ABOVE SHADED BLOCKS ARE CHECKED, FORWARD A SUITABILITY INQUIRY TO THE GAINING MEDICAL TREATMENT FACILITY OR MEDICAL DEPARTMENT SUPPORTING THE OVERSEAS, REMOTE DUTY, OR OPERATIONAL LOCATION TO DETERMINE IF THE REQUIRED DENTAL SUPPORT IS AVAILABLE. (attach reply)</b>		
Yes	No	IS THE SERVICE/FAMILY MEMBER SUITABLE FOR THE OVERSEAS, REMOTE DUTY OR OPERATIONAL ASSIGNMENT? (completed by an MTF designated military dental screener only)
MTF Medical Screener (Signature) _____ Date _____		Civilian Medical Screener (Signature) _____ Date _____
Printed Name, Rank or Grade _____		Printed Name _____
DTF 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 _____

**Complete your Name and SSN  
(Completed by you)**

**Dental Class Assigned  
(Completed by Dental)**

**Dental Provider Signs (Completed by Dental)**

# DD 2807-1 (Medical History Form)

**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 Service Directorate (0704-013). 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)

6. SERVICE 7.a. POSITION (Title, Grade, Component)

6.a. SERVICE 6.b. COMPONENT 6.c. PURPOSE OF EXAMINATION 7.b. USUAL OCCUPATION

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.

HAVE YOU EVER HAD OR DO YOU NOW HAVE:

10.a. Tuberculosis YES NO  
b. Lived with someone who had tuberculosis YES NO  
c. Coughed up blood YES NO  
d. Suffered any breathing problems related to exercise, weather, pollen, etc. YES NO  
e. Shortness of breath YES NO  
f. Bronchitis YES NO  
g. Wheezing or problems with wheezing YES NO  
h. Been prescribed or used an inhaler YES NO  
i. A chronic cough or cough at night YES NO  
j. Sinusitis YES NO  
k. Hay fever YES NO  
l. Chronic or frequent colds YES NO

11.a. Severe tooth or gum trouble YES NO  
b. Thyroid trouble or goiter YES NO  
c. Eye disorder or trouble YES NO  
d. Ear, nose, or throat trouble YES NO  
e. Loss of vision in either eye YES NO  
f. Worn contact lenses or glasses YES NO  
g. A hearing loss or wear a hearing aid YES NO  
h. Surgery to correct vision (PRK, PRK, LASIK, etc.) YES NO

12.a. Painful shoulder, elbow or wrist (e.g. pain, dislocation, etc.) YES NO  
b. Arthritis, rheumatism, or bursitis YES NO  
c. Recurrent back pain or any back problem YES NO  
d. Numbness or tingling YES NO  
e. Loss of finger or toe YES NO

12. (Continued) YES NO  
f. Foot trouble (e.g. pain, corns, bunions, etc.) YES NO  
g. Impaired use of arms, legs, hands, or feet YES NO  
h. Swollen or painful joints YES NO  
i. Knee trouble (e.g. popping, giving out, pain or ligament injury, etc.) YES NO  
j. Any type of foot surgery including amputation or the use of a knee to any bone or foot YES NO  
k. Used any corrective devices such as prosthetic devices, brace(s), back supports, fit or orthotic, etc. YES NO  
l. Bone, joint, or other deformity YES NO  
m. Plate(s), screw(s), rod(s) or pin(s) in any bone YES NO  
n. Broken bone(s) (cracked or fractured) YES NO

13.a. Frequent indigestion or heartburn YES NO  
b. Stomach, liver, intestinal trouble, or ulcer YES NO  
c. Gall bladder trouble or gallstones YES NO  
d. Jaundice or hepatitis (liver disease) YES NO  
e. Rupture/thermia YES NO  
f. Rectal disease, hemorrhoids or blood from the rectum YES NO  
g. Skin diseases (e.g. acne, eczema, psoriasis, etc.) YES NO  
h. Frequent or painful urination YES NO  
i. High or low blood sugar YES NO  
j. Kidney stone or blood in urine YES NO  
k. Sugar or protein in urine YES NO  
l. Sexually transmitted disease (syphilis, gonorrhea, chlamydia, genital warts, herpes, etc.) YES NO

14.a. Adverse reaction to serum, food, insect stings or medicine YES NO  
b. Recent unexplained gain or loss of weight YES NO  
c. Currently in good health (If no, explain in item 29 on Page 2.) YES NO  
d. Tumor, growth, cyst, or cancer YES NO

DD FORM 2807-1, MAR 2007 DoD revision to SF 83 approved by OMB, August 3, 2000. PREVIOUS EDITIONS OBSOLETE. Page 1 of 3 Pages (do not professional)

**ALL DEPENDENTS INDIVIDUALLY**  
require to fill out blocks 1 – 29  
(Except Block 5, Screening Facility Name).

Also complete all blocks that require your name and social security on top of page 2 & 3. **(Completed by you)**

LAST NAME, FIRST NAME, MIDDLE NAME (SUFFIX) SOCIAL SECURITY NUMBER

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:

15.a. Dizziness or fainting spells YES NO  
b. Frequent or severe headache YES NO  
c. A head injury, memory loss or amnesia YES NO  
d. Paralysis YES NO  
e. Seizures, convulsions, epilepsy or fits YES NO  
f. Car, train, sea, or air sickness YES NO  
g. A period of unconsciousness or concussion YES NO  
h. Meningitis, encephalitis, or other neurological problems YES NO

16.a. Rheumatic fever YES NO  
b. Prolonged bleeding (as after an injury or tooth extraction, etc.) YES NO  
c. Pain or pressure in the chest YES NO  
d. Palpitation, pounding heart or abnormal heartbeat YES NO  
e. Heart trouble or murmur YES NO  
f. High or low blood pressure YES NO

17.a. Nervous trouble of any sort (anxiety or panic attacks) YES NO  
b. Habitual stammering or stuttering YES NO  
c. Loss of memory or amnesia, or neurological symptoms YES NO  
d. Frequent trouble sleeping YES NO  
e. Received counseling of any type YES NO  
f. Depression or excessive worry YES NO  
g. Been evaluated or treated for a mental condition YES NO  
h. Attempted suicide YES NO  
i. Used illegal drugs or abused prescription drugs YES NO

18. FEMALES ONLY. Have you ever had or do you now have:  
a. Treatment for a gynecological (female) disorder YES NO  
b. A change of menstrual pattern YES NO  
c. Any abnormal PAP smears YES NO  
d. First day of last menstrual period (YYYYMMDD) YES NO  
e. Date of last PAP smear (YYYYMMDD) YES NO

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. YES NO  
b. Inability to perform certain motions YES NO  
c. Inability to stand, sit, kneel, lie down, etc. YES NO  
d. Other medical reasons (If yes, give reasons.) YES NO

20. Have you ever been treated in an Emergency Room? (If yes, for what?) YES NO

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.) YES NO

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.) YES NO

23. Have you ever had any illness or injury other than those already noted? (If yes, specify when, where, and give details.) YES NO

24. Have you consulted or been treated by clinics, physicians, healers, or other practitioners within the past 5 years for other than minor diseases? (If yes, give complete address of doctor, hospital, clinic, and details.) YES NO

25. Have you ever been rejected for military service for any reason? (If yes, give date and reason for rejection.) YES NO

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 untimely or unsatisfactory.) YES NO

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.) YES NO

28. Have you ever been denied life insurance? YES NO

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.)

**EXPLAIN "YES" ANSWERS HERE  
IN DETAIL WITH DATES:**

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 (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

**\*\*\*LEAVE THIS BLOCK AND EVERYTHING BELOW THIS SHEET BLANK\*\*\***

b. TYPED OR PRINTED NAME OF EXAMINER (Last, First, Middle Initial) c. SIGNATURE d. DATE SIGNED (YYYYMMDD)

**NAVPERS 1300/16 (Over Sea Screening) "ONLY 1 FORM NEEDED PER FAMILY"**

1. MEMBER'S NAME:		2. DATE:	
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/ Souta 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. <input type="radio"/> Yes <input type="radio"/> 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 EFMP 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:

Fill in the Sponsor's Name (Active Duty Member) and **LEAVE DATE BLANK** on top of page

**Enter Each Family Members Name Per Block!** (Do **NOT** fill in the "Yes" or "No" Bubble.

**IMMUNIZATIONS**

- Do you have copies of your vaccine history that NTC Overseas Screening can keep on hand? Each family member must have copy!
- Do the immunizations include the following?
  - \_\_\_ Polio (Completed vaccine history or labs showing immunity)
  - \_\_\_ Varicella (Completed vaccine history or labs showing immunity)
  - \_\_\_ Hep-B/Hep-A (Completed vaccine history or labs showing immunity)
  - \_\_\_ MMR (Completed vaccine history or labs showing immunity)
  - \_\_\_ TDAP (Current within the last 10 years?)
  - \_\_\_ JEV for Japan only (Required upon finalization of Screening/Suitability determination)
  - \_\_\_ PPD (Tuberculosis Skin Test) **\*ALL MEMBERS 4 YEARS AND OLDER REQUIRE ONE WITHIN LAST 12 MONTHS\***
- If you have been a reactor to PPD, have you completed X-Rays or INH? Have proof and documentation to bring with you.

# PHYSICALS

Have your dependents completed a current Physical within the last 12 months?

\_\_\_ Well child physical (Full Head to Toe Physical)

\_\_\_ Male – (Full Head to Toe Physical)

\_\_\_ Woman- (Well Women Exam or Full Heads to Toe physical)

\*\*\*\* Is the individual family member's physical a complete head to toe physical, to include ears, nose, throat, lungs etc. and vital signs? Do you have legible copies that NTC Suitability/Overseas Screening can keep on hand?

For women, have you completed current PAP smear pathology report using American College of Gynecology Guidelines (**Under Age of 21- No PAP recommended, Ages 21-29 Normal PAP within 3 years, Ages 30-65 - Normal PAP AND negative HPV within 5 years or Normal PAP within 3 years**)?

If the pap was abnormal, in most cases a colposcopy must be done. In that case we also need the pathology report from the colposcopy. If you are unsure, bring in the latest PAP smear pathology report (A Copy of LAB RESULTS) for review.

For women 40 and over, do you have a current Mammogram within the last year? (Bring in proof of documentation)

For women who are that are pregnant and exceed 36 weeks of travel, they will need an OBGYN clearance to fly and MUST bring a copy to pre-screening. If they just had a baby, they must have a post partum physical that shows all is normal with no complications (this would count for dependent physical requirement)

# Special Education Summary / Exceptional Family Member Program (EFMP)

- Are your dependents enrolled in EFMP? If so, do you have legible copies of your EFMP paperwork that NTC Suitability/Overseas Screening can keep on hand (DD form 2792)?
  
- Do you have children that are between the ages of 3-21 years old? Have you completed a DD form 2792-1? Although your children may have been indicated as not needing IEP in the past, all school age children require a DD form 2792-1 completed. Do you have legible copies that NTC Suitability/Overseas Screening can keep on hand?

## Point of Contact:

Any questions, please contact NTC Suitability Screening office:

Front Desk Number: 619- 524-0562

Address: 2051 Cushing Road, San Diego CA, 92106-6000

Walk in prescreening hours of operation: 7:30 – 11:00 & 13:00 – 14:30 Monday – Friday

### WEBSITE INFORMATION:

<http://www.med.navy.mil/sites/nmcscd/Pages/Patients/SuitabilityScreeningCenter>

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**The intention of this check list is to ensure you and your family start the process as soon as possible and have a better understanding of the medical requirements that NTC Suitability Screening Office has in order to finalize the “Dependent’s Overseas Screening”. Our Screening Office is already about 2 weeks to 1 month booked out at the current moment but we are doing everything possible to accommodate. To avoid unnecessary delays, please start making appointments with your Primary Care Provider to complete the above requirements now. For any questions or concerns please call NTC Suitability Screening Office. If you are having any difficulty in reaching NTC Suitability Screening Office or have concerns, please let your Active Duty Spouse or Partner know.**

Sincerely,

**LCDR Jing, Ling**

**Division Officer**

**NTC Suitability Screening**

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