**Naval Medicine Readiness and Training Detachment Bridgeport**
**DeWert Branch Clinic**
**Building 3005, State Route 108**
**Bridgeport, CA 93517**

**Clinic Hours: Monday to Friday (0800 – 1600)**
**Phone: (760) 932-1616**

# Overseas/Operational Suitability Screening

***Must have orders***

**Step 1:** Report to clinic to receive packet and medical readiness review to identify additional requirements per orders. Fill out highlighted portions indicated.

- **NAVMED 1300/2**
- **DD Form 2807-1 -** Explain all "Yes" answers in block 29 (expect 14c) with dates, given treatment and current medical status.
  - Ex: 12c. Low back pain (2011-2021). On and off pain, no medical care sought out, self-manageable. No limitations and able to complete PFT/CFT without medical waiver.
- **NAVMED 1300/1 -** Part II, Page 3 - Must have updated dental within a year..
- **NAVPERS 1300/16** – Page 2 of 3, complete Block 20-22 must be complete by **E-5 or above** interviewer.
- **NAVMED 6224/8 –** Tuberculosis Exposure Risk Assessment
- **Anti-terrorism Level 1 Certificate (within 1 year of detachment date)**
- **NSIPS Member Data Summary** – Navy personnel only.
- **Financial Planning Worksheet** – Navy personnel only, E-4 and below.
- **Copy of orders**

## Dependents Only (one packet per dependent):

- **NAVMED 1300/1** – Part II, Page 3 MUST be signed off by civilian dentist.
- **DD FORM 2807**-1
- **DD FORM 2792-1 - Special Education/Early Intervention Summary**
  - Required by family members with special educational/early intervention needs.

**Step 2:** Scheduled appointment. Appointment will only be scheduled if packet is completed.

**Step 3:** Following the medical provider's review, the packet is forwarded to the Naval Hospital's Patient Administration Department (PAD) for medical CO endorsement. Follow up in 7 business days after appointment for package status.

- Both service member and dependent packets will be routed together.
- Unresolved/ongoing medical conditions may result in medical inquiries to the gaining medical facility for suitability determination which may cause delay.

## Additional Information:

- **Females ONLY** require a pregnancy test 30 days prior to detachment date.

# MEDICAL, DENTAL, AND EDUCATIONAL SUITABILITY SCREENING CHECKLIST AND WORKSHEET

Privacy Act Statement: OPNAVINST 1300.14D authorizes collection of this information. The following information and documents, as applicable, are required to conduct medical, dental, and educational screening to determine suitability for an overseas, remote duty, or operational assignment. Complete and current information is essential for completion of screening. Disclosure is voluntary, however, missing or incomplete information may delay the screening process, result in orders held in abeyance until completion of screening, or affect the amount of leave in transit. Refer to BUMEDINST 1300.2B for implementing guidance.

The Suitability Screening Coordinator (SSC) at the military treatment facility (MTF) can assist in obtaining and completing the required information. The SSC will ensure required information and documents are complete and current before referral to a MTF provider for screening and a suitability recommendation. The SSC will place the completed original from in the individual's Service Treatment Record/Non-Service Treatment Record and retain a copy for audit. Medical, dental, and educational suitability screening is valid for 12 months from the date of completion if there were no significant changes in the medical, dental, or educational status of the service or family member. The service member must notify his or her commanding officer or officer in charge of any change in status (including pregnancy).
*Complete one form for each Service and family member screened.*

| SERVICE MEMBER NAME | GRADE/ RATE | SSN |
|---|---|---|
| | | |

| CURRENT UNIT | TELEPHONE NUMBER |
|---|---|
| | |
| NEXT DUTY STATION LOCATION & UNIT IDENTIFICATION CODE (UIC) | TYPE DUTY CLASSIFICATION CODE (Navy Enlisted Code Only) |
| | |

| FAMILY MEMBER NAME | FAMILY MEMBER PREFIX | Age |
|---|---|---|
| | | |

| | ITEM | SSC Review YES | NO | N/A |
|---|---|---|---|---|
| **A. FOR SERVICE MEMBERS:** | | | | |
| ☐ | 1. Legible copy of orders or an Overseas Screening Notification. (For operational assignments, orders should indicate the platform to which assigned and a description of the duty assignment.) | | | |
| ☐ | 2. Each family member name, family member prefix, social security number, address and telephone number, if other than the service member's. | | | |
| SERVICE TREATMENT RECORD TO INCLUDE: | | | | |
| ☐ | 3. All Physical Exams (to include special duty aviation, submarine, radiation, asbestos, etc.) are current and filed in the Service Treatment Record?<br>a. Type of Physical _____ b. Completion Date of Physical _____ | | | |
| ☐ | 4. Annual Periodic Health Assessment (PHA) current and documented? Date: _____ | | | |
| ☐ | 5. Current medical history (DD Form 2807-1) | | | |
| ☐ | 6. Hearing (Audiogram) | | | |
| ☐ | 7. Vision Examination | | | |
| ☐ | 8. G-6P-D Test | | | |
| ☐ | 9. PPD Test | | | |
| ☐ | 10. Sickle Cell Trait Test | | | |
| ☐ | 11. Negative HIV results current to 1 year of transfer<br>Date Drawn: _____ Roster Number: _____ | | | |
| ☐ | 12. Blood Type: _____ | | | |
| ☐ | 13. DNA Testing completed and documented? | | | |
| ☐ | 14. Required Immunizations (Assignment Specific) | | | |
| ☐ | 15. Military Dental Records | | | |
| ☐ | 16. Copies of civilian medical, dental, or mental health care records to include narrative summaries of any inpatient admissions in civilian facilities. | | | |
| ☐ | 17. Mammogram current and documented. Date: _____ | | | |
| ☐ | 18. Pregnancy screen (verbal inquiry). (*Also, command will refer for pregnancy test 30 days prior to departure date.)* | | | |
| ☐ | Other: | | | |
| **B. FOR FAMILY MEMBERS:** | | | | |
| ☐ | 1. Non-Service Treatment Record (medical and dental) and include a completed DD Form 2807-1 | | | |
| ☐ | 2. Copies of civilian medical, dental, or mental health care records to include narrative summaries of any inpatient admissions in civilian facilities. Include a completed DD Form 2807-1 | | | |
| ☐ | 3. Recommended ACIP and required country specific immunizations (check current country specific immunization requirements issued by the Centers for Disease Control and Prevention (CDC) i.e. yellow fever) | | | |

| ITEM | SSC Review | | |
|---|---|---|---|
| **C. FOR DEPENDENT CHILDREN:** | YES | NO | N/A |
| ☐ 1. DD FORM 2792-1 (Required for ALL children birth to 22nd Birthday OR High School Graduation) | | | |
| FOR INFANTS AND TODDLERS (Birth to 36 Months) ELIGIBLE TO RECEIVE EARLY INTERVENTION SERVICES AS EVIDENCED BY AN INDIVIDUALIZED FAMILY SERVICE PLAN (IFSP): | | | |
| ☐ 2. Copy of the current IFSP and, if available, developmental assessments or evaluations. | | | |
| FOR PRESCHOOL OR SCHOOL-AGE CHILDREN (Ages 3 to 22nd Birthday or High School Graduation) ELIGIBLE TO RECEIVE SPECIAL EDUCATION AND RELATED SERVICES AS EVIDENCED BY AN INDIVIDUALIZED EDUCATION PROGRAM (IEP): | | | |
| ☐ 3. Copy of the current IEP and, if available, developmental assessments or evaluations. | | | |
| FOR EACH FAMILY MEMBER ENROLLED OR UNDERGOING ENROLLMENT IN THE EXCEPTIONAL FAMILY MEMBER PROGRAM (EFMP): | | | |
| ☐ 4. Copy of the DD Form 2792 and any EFMP correspondence. | | | |

**D. FOR SSC USE ONLY**

1. Date suitability screening conducted. Date: _____

**E. SUITABILITY INQUIRY:**

☐ 1. Are any of the shaded blocks checked on NAVMED Form 1300/1?
- ☐ YES (Suitability Inquiry required, proceed to question 2)
- ☐ NO (Line through question 2 and proceed to section F)

☐ 2. Suitability Inquiry:

Medical Care:
- ☐ Potential need identified
- ☐ N/A

Date & Time sent: _____ Reply date & time: _____
Sent by (Sending SSC): _____ Reply from: _____
Sent to (Gaining SSC): _____ Contact #: _____
E-Mail: _____

Dental Services:
- ☐ Potential need identified
- ☐ N/A

Date & Time sent: _____ Reply date & time: _____
Sent by (Sending SSC): _____ Reply from: _____
Sent to (Gaining SSC): _____ Contact #: _____
E-Mail: _____

Special Education Services:
- ☐ Potential need identified
- ☐ N/A

Date & Time sent: _____ Reply date & time: _____
Sent by (Sending SSC): _____ Reply from: _____
Sent to (Gaining SSC): _____ Contact #: _____
E-Mail: _____
Sent to (Gaining DoDEA): _____ E-Mail: _____

Other information:

**F. SUITABILITY SCREENING COORDINATOR: Facility_____**

| | | |
|---|---|---|
| Printed Name: _____<br>E-mail: _____<br>Phone: _____ | Signature | Date |

# 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*
September, 30 2021



**PRIVACY ACT STATEMENT**

**AUTHORITY:** 10 U.S.C. 136, Under Secretary Of Defense For Personnel And Readiness; DoD Directive 1145.2, United States Military Entrance Processing Command; DoD Instruction 6130.03, Medical Standards for Appointment, Enlistment, or Induction in the Military Services; and E.O. 9397 (SSN), as amended.
**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.
**ROUTINE USE(S):** The Routine Uses are listed in the applicable system of records notice found at: http://dpcld.defense.gov/Privacy/SORNsIndex/DOD-wide-SORN-Article-View/Article/570661/a0601-270-usmepcom-dod/
**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.

| 1. LAST NAME, FIRST NAME, MIDDLE NAME (SUFFIX) | 2.a. SOCIAL SECURITY NO. | b. DoD ID NO. *(If applicable)* | 3. TODAY'S DATE *(YYYYMMDD)* |
|---|---|---|---|
| | | | |

**4.a. HOME ADDRESS** *(Street, Apartment No., City, State, and ZIP Code)*

NMRTD BRIDGEPORT
DEWERT BRANCH CLINIC
BUILDING 3005, STATE ROUTE 108
BRIDGEPORT, CA 93517

**b. HOME TELEPHONE** *(Include Area Code)*

**c. EMAIL ADDRESS**

**X ALL APPLICABLE BOXES:**

**6.a. SERVICE**

- ☐ Army
- ☐ Navy
- ☐ Marine Corps
- ☐ Air Force
- ☐ Coast Guard

**b. COMPONENT**

- ☐ Regular
- ☐ Reserve
- ☐ National Guard

**c. PURPOSE OF EXAMINATION**

- ☐ Retention
- ☐ Separation
- ☐ Medical Board
- ☐ Retirement
- ☐ Other *(Specify)*

**7.a. POSITION** *(Title, Grade, Component)*

**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: | YES | NO |
|---|---|---|
| **10.**a. Tuberculosis | ◯ | ◯ |
| b. Lived with someone who had tuberculosis | ◯ | ◯ |
| c. Coughed up blood | ◯ | ◯ |
| d. Asthma or any breathing problems related to exercise, weather, pollens, etc. | ◯ | ◯ |
| e. Shortness of breath | ◯ | ◯ |
| f. Bronchitis | ◯ | ◯ |
| g. Wheezing or problems with wheezing | ◯ | ◯ |
| h. Been prescribed or used an inhaler | ◯ | ◯ |
| i. A chronic cough or cough at night | ◯ | ◯ |
| j. Sinusitis | ◯ | ◯ |
| k. Hay fever | ◯ | ◯ |
| l. Chronic or frequent colds | ◯ | ◯ |
| **11.**a. Severe tooth or gum trouble | ◯ | ◯ |
| b. Thyroid trouble or goiter | ◯ | ◯ |
| c. Eye disorder or trouble | ◯ | ◯ |
| d. Ear, nose, or throat trouble | ◯ | ◯ |
| e. Loss of vision in either eye | ◯ | ◯ |
| f. Worn contact lenses or glasses | ◯ | ◯ |
| g. A hearing loss or wear a hearing aid | ◯ | ◯ |
| h. Surgery to correct vision *(RK, PRK, LASIK, etc.)* | ◯ | ◯ |
| **12.**a. Painful shoulder, elbow or wrist *(e.g. pain, dislocation, etc.)* | ◯ | ◯ |
| b. Arthritis, rheumatism, or bursitis | ◯ | ◯ |
| c. Recurrent back pain or any back problem | ◯ | ◯ |
| d. Numbness or tingling | ◯ | ◯ |
| e. Loss of finger or toe | ◯ | ◯ |

| 12. *(Continued)* | YES | NO |
|---|---|---|
| f. Foot trouble *(e.g., pain, corns, bunions, etc.)* | ◯ | ◯ |
| g. Impaired use of arms, legs, hands, or feet | ◯ | ◯ |
| h. Swollen or painful joint(s) | ◯ | ◯ |
| i. Knee trouble *(e.g., locking, giving out, pain or ligament injury, etc.)* | ◯ | ◯ |
| j. Any knee or foot surgery including arthroscopy or the use of a scope to any bone or joint | ◯ | ◯ |
| k. Any need to use corrective devices such as prosthetic devices, knee brace(s), back support(s), lifts or orthotics, etc. | ◯ | ◯ |
| l. Bone, joint, or other deformity | ◯ | ◯ |
| m. Plate(s), screw(s), rod(s) or pin(s) in any bone | ◯ | ◯ |
| n. Broken bone(s) *(cracked or fractured)* | ◯ | ◯ |
| **13.**a. Frequent indigestion or heartburn | ◯ | ◯ |
| b. Stomach, liver, intestinal trouble, or ulcer | ◯ | ◯ |
| c. Gall bladder trouble or gallstones | ◯ | ◯ |
| d. Jaundice or hepatitis *(liver disease)* | ◯ | ◯ |
| e. Rupture/hernia | ◯ | ◯ |
| f. Rectal disease, hemorrhoids or blood from the rectum | ◯ | ◯ |
| g. Skin diseases *(e.g. acne, eczema, psoriasis, etc.)* | ◯ | ◯ |
| h. Frequent or painful urination | ◯ | ◯ |
| i. High or low blood sugar | ◯ | ◯ |
| j. Kidney stone or blood in urine | ◯ | ◯ |
| k. Sugar or protein in urine | ◯ | ◯ |
| l. Sexually transmitted disease *(syphilis, gonorrhea, chlamydia, genital warts, herpes, etc.)* | ◯ | ◯ |
| **14.**a. Adverse reaction to serum, food, insect stings or medicine | ◯ | ◯ |
| b. Recent unexplained gain or loss of weight | ◯ | ◯ |
| c. Currently in good health *(If no, explain in Item 29 on Page 2.)* | ◯ | ◯ |
| d. Tumor, growth, cyst, or cancer | ◯ | ◯ |

| LAST NAME, FIRST NAME, MIDDLE NAME (SUFFIX) | SOCIAL SECURITY NUMBER | DoD ID NUMBER *(If applicable)* |
|---|---|---|
| | | |

**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 |
|---|---|---|
| **15.**a. Dizziness or fainting spells | ○ | ○ |
| b. Frequent or severe headache | ○ | ○ |
| c. A head injury, memory loss or amnesia | ○ | ○ |
| d. Paralysis | ○ | ○ |
| e. Seizures, convulsions, epilepsy or fits | ○ | ○ |
| f. Car, train, sea, or air sickness | ○ | ○ |
| g. A period of unconsciousness or concussion | ○ | ○ |
| h. Meningitis, encephalitis, or other neurological problems | ○ | ○ |
| **16.**a. Rheumatic fever | ○ | ○ |
| b. Prolonged bleeding *(as after an injury or tooth extraction, etc.)* | ○ | ○ |
| c. Pain or pressure in the chest | ○ | ○ |
| d. Palpitation, pounding heart or abnormal heartbeat | ○ | ○ |
| e. Heart trouble or murmur | ○ | ○ |
| f. High or low blood pressure | ○ | ○ |
| **17.**a. Nervous trouble of any sort *(anxiety or panic attacks)* | ○ | ○ |
| b. Habitual stammering or stuttering | ○ | ○ |
| c. Loss of memory or amnesia, or neurological symptoms | ○ | ○ |
| d. Frequent trouble sleeping | ○ | ○ |
| e. Received counseling of any type | ○ | ○ |
| f. Depression or excessive worry | ○ | ○ |
| g. Been evaluated or treated for a mental condition | ○ | ○ |
| h. Attempted suicide | ○ | ○ |
| i. Used illegal drugs or abused prescription drugs | ○ | ○ |
| **18. FEMALES ONLY.** Have you ever had or do you now have: | | |
| a. Treatment for a gynecological (female) disorder | ○ | ○ |
| b. A change of menstrual pattern | ○ | ○ |
| c. Any abnormal PAP smears | ○ | ○ |
| d. First day of last menstrual period *(YYYYMMDD)* | | |
| 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. | ○ | ○ |
| b. Inability to perform certain motions | ○ | ○ |
| c. Inability to stand, sit, kneel, lie down, etc. | ○ | ○ |
| d. Other medical reasons *(If yes, give reasons.)* | ○ | ○ |
| **20.** Have you ever been treated in an Emergency Room? *(If yes, for what?)* | ○ | ○ |
| **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.)* | ○ | ○ |
| **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.)* | ○ | ○ |
| **23.** Have you ever had any illness or injury other than those already noted? (If yes, specify when, where, and give details.) | ○ | ○ |
| **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.)* | ○ | ○ |
| **25.** Have you ever been rejected for military service for any reason? *(If yes, give date and reason for rejection.)* | ○ | ○ |
| **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.)* | ○ | ○ |
| **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.)* | ○ | ○ |
| **28.** Have you ever been denied life insurance? | ○ | ○ |

**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.)*

**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 | DoD ID NUMBER *(If applicable)* |
|---|---|---|
| | | |

**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**

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

# MEDICAL, DENTAL AND EDUCATIONAL SUITABILITY SCREENING FOR SERVICE AND FAMILY MEMBERS

**Privacy Act Statement**
**Authority**: 5 U.S.C. 301, Departmental Regulations; and E. O. 9397 (SSN).
**Purpose:** To identify special, medical, dental or educational needs for the purpose of making a suitability recommendation for an overseas, remote duty, or operational assignment.
**Routine uses:** This form is completed by a medical treatment facility (MTF)/non-MTF dentist and physician, nurse practitioner, physician assistant, or independent duty corpsman (Service members only). An MTF Medical Screener must counter sign all screenings completed by non-Navy MTF Providers. The MTF Suitability Screening Coordinator (SSC) will place the completed original form in the individual's Service Treatment Record/Non-Service Treatment Record and retain a copy for audit.
**Disclosure:** Voluntary; however, failure to provide this information may delay the screening process, result in orders held in abeyance until completion of screening or affect the amount of leave in transit.

Refer to BUMEDINST 1300.2B for implementing guidance. ***Complete one form for each Service and family member screened.***

| SERVICE MEMBER NAME | GRADE / RATE | AGE | SSN |
|---|---|---|---|
| | | | |

| FAMILY MEMBER NAME | FAMILY MEMBER PREFIX | AGE | SSN |
|---|---|---|---|
| | | | |

| NEXT DUTY STATION LOCATION & UNIT IDENTIFICATION CODE (UIC): | TYPE DUTY CLASSIFICATION CODE: (Navy enlisted only) |
|---|---|
| | |

## PART I

**SECTION A. Medical Screening**. Completed by the medical provider to identify special needs and determine if a Service or family member is suitable for an overseas, remote duty, or operational assignment. *Attach the completed Report of Medical History (DD 2807-1) to this form.*

| Yes | No | N/A | ITEM |
|---|---|---|---|
| | | | 1. All current health records (military and civilian) reviewed? |
| | | | 2. All physical exams (to include special duty, aviation, submarine, radiation, asbestos, etc.) are current and filed in the Service Treatment Record? *a. Type of Physical* _____ *b. Completion date of physical*_____ |
| | | | 3. G-6P-D, PPD and Sickle Cell trait test and Blood Type completed & documented? |
| | | | 4a. Immunizations are up-to-date and meet destination country requirements? |
| | | | 4b. Has the individual elected to decline any ACIP recommended immunizations or country required Immunizations? If yes (circle): ACIP Country Specific Date Counselled: _____ |
| | | | 5. Reference audiogram documented on DD 2215? |
| | | | 6. Latest audiogram (DD 2216) reviewed? |
| | | | 7. HIV testing completed or drawn? |
| | | | 8. DNA testing completed and documented? |
| | | | 9. Are there pending consults or tests that have a bearing on assignment suitability? |
| | | | 10. Any past limited duty or medical board(s)? *(document on DD 2807-1)* |
| | | | 11. For Service members: |
| | | | a. Annual periodic health assessment current and documented? |
| | | | b. Pregnancy screening (verbal inquiry)? *(Also, Command will refer for pregnancy test 30 days prior to departure date)* |
| | | | c. If pregnant? (EDC:_____ ) |
| | | | 12. For family members, U.S. Preventive Services Task Force screening test recommendations current and documented? |
| | | | 13. If a Special Duty assignment, is there a condition, which by MANMED, chapter 15, section IV, is disqualifying? |
| | | | 14. Are there any conditions requiring ongoing care in the following areas? *(document on DD 2807-1)* |
| | | | a. Orthopedic conditions (e.g., chronic back, knee, joint pain or weakness) |
| | | | b. Cardiovascular conditions (e.g., chest pain/angina, arrhythmia, valve disease, infarction) |
| | | | c. Gynecologic/Urologic conditions (e.g., chronic pelvic pain, abnormal PAP, breast mass) |
| | | | d. Neurologic conditions (e.g., seizure, pinched nerve, migraine, neuropathy) |
| | | | e. Respiratory conditions (e.g., asthma, RAD, chronic sinus, allergies) |
| | | | f. Mental health or behavioral conditions (e.g., mood, personality disorder, ADD/ADHD, anxiety, psychosis, autism) |
| | | | g. Recurrent or frequent medications not on the standard formulary or require special attention (e.g., injections/infusions every 6-12 months, medication requiring Risk Evaluation and Mitigation Strategies per FD regulations, hormone replacement therapy, or medications requiring close monitoring of therapeutic blood level)? *(list on DD 2807-1)* |
| | | | h. Alcohol or substance abuse or dependence |
| | | | i. Developmental concerns (e.g., motor, cognitive, communication, social/emotional, or adaptive development) |
| | | | j. Specify other conditions or concerns: |
| | | | 15. For Service/family members requiring medication. |
| | | | a. Does the patient's medication maintenance require a dose adjustment? |
| | | | b. Should medication use cease, could the underlying condition become life threatening, pose a risk for dangerous or disruptive behavior or result in a limited duty, MEDEVAC, or early return situation? |
| | | | c. Are there concerns about medication management capabilities at the gaining MTF/operational platform if the underlying condition is exacerbated? |
| | | | d. Has the service/family member registered with the mail order pharmacy program through TRICARE? |

| Yes | No | N/A | ITEM |
|---|---|---|---|
| | | | 16. For service/family members with underlying medical conditions: |
| | | | 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. Are there any chronic medical or mental health conditions requiring routine or continuing access to care or access to specialized medical care? *(document on DD 2807-1)* |
| | | | d. Are there any potential environmental concerns or possible health effects at the gaining location? *(if yes, communicate to family and document on appropriate SF 600)* |
| | | | 17. For infants and toddlers (birth to 36 months), is the child receiving or undergoing eligibility to receive early intervention services as evidenced by an Individualized Family Service Plan (IFSP)? |
| | | | 18. For preschool and school age children, is the child receiving or undergoing eligibility to receive special education and/or related services as evidenced by an Individualized Education Program (IEP)? |
| | | | 19. *Explanation of "yes" responses in shaded boxes (include #):*<br><br>Are there any concerns about the gaining MTF/operational platform's capabilities to meet the individual's needs? *Specify below:*<br><br>Navy MTF SSC Name, Signature, Stamp, and Date: _____ |

**Non-Navy Medical Providers: STOP and proceed to SECTION C**

**SECTION B. Medical and Educational Screening Disposition**. Completed by the screening Navy MTF medical provider to determine if a Service or family member is suitable for an overseas, remote duty, or operational assignment.

| Yes | No | ITEM |
|---|---|---|
| | | 1. Are any of the above shaded blocks in Section A checked?<br>If "yes", submit a suitability inquiry to the gaining MTF or medical department supporting the overseas/remote duty/operational location to determine local capabilities to provide required support. *(Attach Reply and answer questions 1a and 1b.)*<br>If "no", proceed to question 2. |
| | | a. Does the gaining location have the capabilities to provide the current required medical support?(Service MTFs/TRICARE, etc.) |
| | | b. Does the gaining location have the capabilities to provide the required medical support (diagnostic and therapeutic) if the underlying condition is exacerbated? (To include all Service MTFs/operational platform, TRICARE, etc.) |
| | | 2. Is the shaded block of question 18 checked "yes"?<br>If yes, Submit the DD 2792-1 and IEP to the gaining DoDEA Special Education Overseas Screening Coordinator and gaining MTF to determine local capabilities to provide required support. (Attach Reply with POC info and answer question 2a.) If no, proceed to question 3. |
| | | a. Is the DoDEA Special Education Overseas Screening Coordinator recommending travel? |

| Yes | No | 3. IS THE SERVICE/FAMILY MEMBER SUITABLE FOR THE OVERSEAS, REMOTE DUTY OR OPERATIONAL ASSIGNMENT? *(Must be completed by an MTF medical screener. Answered after the inquiry is completed.)* |
|---|---|---|
| | | |

**SECTION C. Contact Information**. Completed by the MTF/non-MTF civilian providers who completed PART I. The Navy MTF medical screener shall review and countersign all suitability screenings completed by non-Navy MTF civilian providers, denoting accountability for a complete and thorough suitability screening document review for each Service/family member.

| | |
|---|---|
| Navy MTF Medical Screener (Signature) Date | Non-Navy MTF/Civilian 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) |
| Office Hours to contact | Office Hours to Contact |
| E-mail Address | E-mail Address |

# PART II

| SERVICE / FAMILY MEMBER NAME | GRADE / RATE / FAMILY MEMBER PREFIX | SSN |
|---|---|---|
| | | |

**SECTION A. Dental Screening**. 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. **NOTE: If child does not have teeth -AND- is under the age of 24 months, a pediatrician may perform an oral dental screening.**

| Yes | No | ITEM |
|---|---|---|
| | | 1. All current dental records (military and civilian) reviewed? |
| | | 2. All dental examinations are current? (If more than 180 days since last T-1 or T-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. Are there any concerns about the gaining MTF/operational platform's capabilities to meet the individual's needs? *Specify below:* |

Navy MTF SSC Name, Signature, Stamp, and Date: _____

8. Specify Dental Class: *(required for service members)* _____

**Dental Classifications:** (Per DoDI 6025.19)

**Normally considered worldwide deployable:**

**Class 1** - Patients with a current dental examination, who do not require dental treatment or re-evaluation.

**Class 2** - 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.

**Normally not considered worldwide deployable:**

**Class 3** - 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.

**Class 4** - 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.

**SECTION B. Dental Screening Disposition**. Completed by the screening MTF provider to determine if a service or family member is suitable for an overseas, remote duty, or operational assignment. **Non-Navy Medical Providers: STOP and proceed to SECTION C.**

| Yes | No | ITEM |
|---|---|---|
| | | 1. Are any of the above shaded blocks checked?<br>If yes, submit a suitability inquiry to the gaining MTF or medical department supporting the overseas/remote duty/operational location to determine local dental capabilities to provide required support. *(Attach Reply and answer question 2)*<br>If no, proceed to question 3. |
| | | 2. Does the gaining MTF/operational platform have the capabilities to provide the current required dental support? |

| Yes | No | 3. IS THE SERVICE/FAMILY MEMBER SUITABLE FOR THE OVERSEAS, REMOTE DUTY OR OPERATIONAL ASSIGNMENT? *(Must be completed by an MTF dental screener. Answered after the inquiry is completed.)* |
|---|---|---|
| | | |

**SECTION C. Contact Information**. Completed by the MTF/non-MTF civilian providers who completed PART II. The Navy MTF dental screener shall review and countersign all suitability screenings completed by non-Navy MTF civilian providers, denoting accountability for a complete and thorough suitability screening document review for each Service/family member.

| | |
|---|---|
| Navy MTF Dental Screener (Signature) Date | Non-Navy Medical Facility/Civilian Dental 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) |
| Office Hours to Contact | Office Hours to Contact |
| E-mail Address | E-mail Address |

# REPORT OF SUITABILITY FOR OVERSEAS AND REMOTE DUTY ASSIGNMENTS

**NAVPERS 1300/16 (Rev. 07-2024)** Supporting Directive OPNAVINST 1300.14E

| 1. Member's Name (Last, First, MI) | 2. Date | 3. Number of Dependents |
|---|---|---|
| | | |

| 4. Current Ship/Station | 5. Current UIC | 6. Proposed Overseas/Remote Location | 7. Proposed UIC |
|---|---|---|---|
| | | | |

## Part I: Command Review

The purpose of the command review is to determine, via a records review and personal interview, member's and their dependents suitability for duty/life in the proposed overseas/remote duty location per MILPERSMAN 1300-302. Any questions checked "YES" (with the exception of questions 10, 13-14) disqualifies the member for overseas/remote duty assignment. Complete PART I and obtain waiver(s) prior to starting PART II (NAVMED) 1300/1).

| | | | |
|---|---|---|---|
| 1. Has the member or his or her dependent(s) previously been reassigned, prior to normal tour completion, due to unsuitability? | | ☐ Yes | ☐ 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 personnel who REQUEST to separate/retire will be held to the DoD tour length. | ☐ N/A | ☐ Yes | ☐ No |
| 3.a (E-5 and above) Does the member, spouse, or family member(s) have serious problems of indebtedness, credit loss, or other financial problems which have not been reconciled with creditor(s) or interested parties? | ☐ N/A | ☐ Yes | ☐ No |
| 3.b (E-4 and below) Member must complete debt-to-income (DTI) ratio screening per OPNAVINST 1740.5D. Do not calculate the spouse's income unless guaranteed employment at the overseas location has been obtained. Is the DTI ratio 30% or greater? | ☐ N/A | ☐ Yes | ☐ No |
| 4. Has the member or his or her dependent(s) been convicted of any criminal offense (civilian or military) within the last 24 months or has/had any involvement in an ongoing criminal action? | | ☐ Yes | ☐ No |
| 5. Has the member or his or her dependent(s) been convicted of a sex offense? Information regarding whether a person is a sex offender may be found at Dru Sjodin National Sex Offender Public Web site (NSOPW) at www.nsopw.gov. | | ☐ Yes | ☐ No |
| 6. Does the member or his or her dependent(s) 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. A waiver of aftercare program does not quality the member; answer YES. | | ☐ Yes | ☐ No |
| 7. Is the member or his or her dependent(s) 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 FAP issues, 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, the gaining command and fleet and family support center (FFSC) must support the waiver request. | | ☐ Yes | ☐ No |
| 8. Was the member's spouse previously a member of the Military Services and was the characterization of separation "Other than Honorable"? Explain in the remarks section. | ☐ N/A | ☐ Yes | ☐ No |
| 9. 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. | | ☐ Yes | ☐ No |
| 10. Are any of the member's dependents covered in a custody agreement? If "NO" or "N/A", go to question 12. | ☐ N/A | ☐ Yes | ☐ No |
| 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. | | ☐ Yes | ☐ No |
| 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? (Navy policy does not require a separate agreement if not required by State law.) | | ☐ Yes | ☐ No |
| 11. Single parents/military couples with family members. Is there any reason why the Family Care Plan cannot be executed or is not per OPNAVINST 1740.4D? | ☐ N/A | ☐ Yes | ☐ No |
| **NOTE: While the unique situation of single parents with dependents is not disqualifying, this fact should be noted in the remarks.** | | | |
| 12. Does member have a history of unsatisfactory or below standard performance (any mark below 3.0) or any NJPs in the last 2 years? | | ☐ Yes | ☐ No |
| 13. Has the member and his or her adult dependents received "Level I" Anti-terrorism Force Protection (Level III for 0-5/0-6 Commanding Officer Awareness) training, prior to transfer, and has it been recorded on NAVPERS 1070/613? | | ☐ Yes | ☐ No |
| 14. Is the 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. | ☐ N/A | ☐ Yes | ☐ No |

REPORT OF SUITABILITY FOR OVERSEAS AND REMOTE DUTY ASSIGNMENTS
**NAVPERS 1300/16 (Rev. 07-2024)** Supporting Directive OPNAVINST 1300.14E

| 1. Member's Name (Last, First, MI) | 2. Date | 3. Number of Dependents |
|---|---|---|
| | | |

***FOR PERSONNEL E-3 AND BELOW:*** *Ensure the member has been counseled and understand he or she cannot be assigned accompanied overseas duty. E-3 and below members will be assigned unaccompanied duty based on readiness needs. Acquiring family member(s) en route and bringing them without dependent entry approval/command sponsorship will most likely result in return to CONUS at his or her expense, and the Service member will complete the tour unaccompanied.*

15. I have been counseled on the above statement and understand. Member's Signature:

16. Remarks

I am aware that failure to divulge disqualifying information or amplifying information (medical/dental/personal) pertaining to the questions on this form may ultimately result in disciplinary action punishable under the UCMJ.

| 17. Member's Name and Rank/Rate: | 18. Member's Signature: | 19. Date: |
|---|---|---|
| | | |

| 20. Interviewer's Name, Rank/Rate and Title: | 20. Interviewer's Signature: | 22. Date: |
|---|---|---|
| | | |

Part II: Recommendation of Commanding Officer (or OIC) Medical Treatment Facility

Based on the information available as a result of screening, approved medical/dental waivers received and on the capabilities of the Navy Medicine Readiness and Training Command (NMRTC) in the area of assignment to which ordered, the following recommendation is forwarded.

a. Medical, dental, and educational screening was conducted per BUMEDINST 1300.2a.
b. Recommendation is based on a review of NAVMED 1300/1, Parts I & II. One form has been completed for each Service member and family member screened.
c. If a shaded block is checked on NAVMED 1300/1, coordination is required with the gaining NMRTC 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.
d. Family member screening is not required for an unaccompanied tour of 24 months or less (exception: screening is required for Diego Garcia and Souda Bay, Crete).
e. Do not forward sensitive medical or personal information with this form.

1. Service Member is suitable for this assignment. ☐ Yes ☐ No

*Applicable family members and dependents suitability for this assignment.*

| 2. Name: ☐ Yes ☐ No | 3. Name: ☐ Yes ☐ No |
|---|---|
| 4. Name: ☐ Yes ☐ No | 5. Name: ☐ Yes ☐ No |
| 6. Name: ☐ Yes ☐ No | 7. Name: ☐ Yes ☐ No |

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

8. Names:

9. Name of CO/OIC or designee of cognizant medical facility.

| 10. Signature of CO/OIC or designee of cognizant medical facility. | 11. Date: |
|---|---|
| | |

REPORT OF SUITABILITY FOR OVERSEAS AND REMOTE DUTY ASSIGNMENTS
**NAVPERS 1300/16 (Rev. 07-2024)** Supporting Directive OPNAVINST 1300.14E

| 1. Member's Name (Last, First, MI) | 2. Date | 3. Number of Dependents |
|---|---|---|
| | | |

**Part III: CMC/COB/SEA Endorsement**

1. On the basis of all available information, I ☐ endorse / ☐ do not endorse the member's orders for the overseas/remote duty assignment.

| 2. CMC/COB/SEA Name and Rank: | 3. CMC/COB/SEA Signature: | 4. Date: |
|---|---|---|
| | | |

**Part IV: CO/OIC Endorsement**

1. On the basis of all available information, I ☐ endorse / ☐ do not endorse the member's orders for the overseas/remote duty assignment.

2. Remarks:
*If the member is found unsuitable for this overseas/remote duty assignment and the CO/OIC still feels the member should be considered, submit a waiver (non-medical/ dental) request per MILPERSMAN - 1300-302*

| 3. CO/OIC Name and Rank: | 4. CO/OIC Signature: | 5. Date: |
|---|---|---|
| | | |

# TUBERCULOSIS EXPOSURE RISK ASSESSMENT

**FOR THE PATIENT** *(Including those with previous positive tuberculin skin test)(Check the correct response)*

1. Since your last Tuberculosis Exposure Risk Assessment, were you exposed to anyone known to have or suspected of having active tuberculosis (i.e., individuals with persistent cough, weight loss, night sweats, and/or fever)? ☐ Yes ☐ No ☐ Don't Know

2. Since your last Tuberculosis Exposure Risk Assessment or Post-Deployment Health Assessment (DD Form 2796), did you have direct and prolonged contact with any individuals of the following groups: refugees or displaced persons; patients hospitalized with tuberculosis , prisoners, or homeless shelter populations? ☐ Yes ☐ No

3a. Check any countries where you have traveled or deployed to since your last Tuberculosis Exposure Risk Assessment.

| | | | |
|---|---|---|---|
| ☐ Bangladesh | ☐ Ethiopia | ☐ Pakistan | ☐ UR Tanzania |
| ☐ Brazil | ☐ India | ☐ Philippines | ☐ Viet Nam |
| ☐ Burma | ☐ Indonesia | ☐ Russian Federation | ☐ Zimbabwe |
| ☐ Cambodia | ☐ Kenya | ☐ South Africa | ☐ None |
| ☐ China | ☐ Mozambique | ☐ Thailand | |
| ☐ DR Congo | ☐ Nigeria | ☐ Uganda | |

If any of these listed countries are selected, answer question 3c.

☐ Other _____ If "other" is checked, write in the name of the country or countries.

3b. Have you recently traveled to Afghanistan for any reason other than as part of a deployment requiring completion of a Post Deployment Health Assessment (PDHA)? ☐ Yes ☐ No If Yes, go to 3c. Otherwise, go to 4a.

3c. During this travel, did you have prolonged direct contact with the local population? Prolonged direct contact is generally understood as having been within six feet of a person with a bad continuous cough for at least 8 consecutive hours on a single day, or for a total of at least 15 hours per week of a multi-week stay. ☐ Yes ☐ No

4a. Have you recently had a chronic cough lasting more than 2 weeks? ☐ Yes ☐ No

4b. If you marked YES to chronic cough, did you have any of the following at the same time?

☐ Fever ☐ Cough up Blood ☐ Unexplained Weight Loss ☐ Night Sweats

If any are checked, see the medical officer for evaluation.

**FOR THE SCREENER**

1. Questions 1 through 4 reviewed, all responses are negative, no further action is required. ☐ Yes ☐ No

2. There is at least one positive answer, patient to continue to medical officer for assessment. ☐ Yes ☐ No

**FOR THE PROVIDER**

*(Expand on above answers to document decision making in determining risk)*

*(Note: Prior treated TST reactors require clinical evaluation to rule out active TB, not a repeat TST).*

1. Provider Comments

2. Tuberculosis risk assessment, based on above responses *(If the answer to one or more of questions 1, 2, 3c, or 4b is a YES, test the patient.)* ☐ Minimal Risk ☐ Increased Risk

3. Recommend Latent Tuberculosis Infection (LTBI) Testing ☐ Yes ☐ No

| | | |
|---|---|---|
| PROVIDER'S NAME | PROVIDER'S SIGNATURE | DATE |
| PATIENT'S IDENTIFICATION: *(For typed or written entries, give: Name - last, first, middle; SSN; Sex; Date of Birth; Rank/Grade.)* | HOSPITAL OR MEDICAL FACILITY | STATUS |
| | DEPARTMENT / SERVICE | RECORDS MAINTAINED AT |
| | SPONSOR'S NAME | SSN |
| | RELATIONSHIP TO SPONSOR | |

Name: _____

Rank/Grade: _____

DODID: _____

DOB: _____