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 Navy Medicine Readiness & Training Unit China Lake 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.

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 #):* 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: _____

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? 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.)* 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"? 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? 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)* 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

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: _____

EARLY INTERVENTION / SPECIAL EDUCATION SUMMARY

OMB No. 0704-0411
OMB approval expires 12/31/2026

PRIVACY ACT STATEMENT

AUTHORITY: 10 U.S.C. 136; 20 U.S.C. 927; DoDI 1315.19: DoDI 1342.12

PRINCIPAL PURPOSE(S): Information will be used by DoD personnel to evaluate and document the early intervention/special education needs of family members. This information will enable: (1) sponsors to enroll into the Exceptional Family Member Program (EFMP), (2) military assignment personnel to match the early intervention/special education needs of family members against the availability of early intervention/special education services through the Family Member Travel Screening (FMTS) process, (3) EFMP Family Support staff to offer information on community support services, and (4) civilian personnel offices to advise civilian employees about the availability of education services to meet the early intervention/special education needs of their family members. The personally identifiable information collected on this form is covered by a number of system of records notices pertaining to Official Military Personnel Files, Exceptional Family Member or Special Needs files, Civilian Personnel Files, and DoD Education Activity files.

The applicable SORNs and routine uses that apply can be found at: Air Force: F036 AF PC C: Military Personnel Records System at: https://dpcld.defense.gov/Privacy/SORNsIndex/DOD-wide-SORN-Article-View/Article/569821/f036-af-pc-c/; F044 AF SG U: Special Needs and Educational and Developmental Intervention Services at: https://dpcld.defense.gov/Privacy/SORNsIndex/DOD-wide-SORN-Article-View/Article/569875/f044-af-sg-u/; Army: A0600-8-104b AHRC - Official Military Personnel Record at: https://dpcld.defense.gov/Privacy/SORNsIndex/DOD-wide-SORN-Article-View/Article/570054/a0600-8-104-ahrc/; A0608b CFSC, Personnel Affairs: Army Community Service Assistance Files at: https://dpcld.defense.gov/Privacy/SORNsIndex/DOD-wide-SORN-Article-View/Article/570084/a0608b-cfsc/"
DHA: EDHA 07: Military Health Information System at: http://dpcld.defense.gov/Privacy/SORNsIndex/DOD-wide-SORN-Article-View/Article/570672/edha-07/
OSD/JS: DMDC 02 DoD: Defense Enrollment Eligibility Reporting Systems (DEERS) at: https://dpcld.defense.gov/Privacy/SORNsIndex/DOD-wide-SORN-Article-View/Article/627618/dmdc-02-dod/
DPR 34 DoD: Defense Civilian Personnel Data System at: https://dpcld.defense.gov/Privacy/SORNsIndex/DOD-wide-SORN-Article-View/Article/570697/dpr-34-dod/
EDHA 16 DoD: Special Needs Program Management Information System (SNPMIS) Records at: https://dpcld.defense.gov/Privacy/SORNsIndex/DOD-wide-SORN-Article-View/Article/570679/edha-16-dod/
DoDEA 29: DoDEA Non-DoD Schools Program at: https://dpcld.defense.gov/Privacy/SORNsIndex/DOD-wide-SORN-Article-View/Article/570576/dodea-29/
DoDEA 26: Department of Defense Education Activity Educational Records at: https://dpcld.defense.gov/Privacy/SORNsIndex/DOD-wide-SORN-Article-View/Article/570573/dodea-26/
Navy and Marine Corps: "M01070-6: Marine Corps Official Military Personnel Files at: https://dpcld.defense.gov/Privacy/SORNsIndex/DOD-wide-SORN-Article-View/Article/570626/m01070-6/
M01754-6: Exceptional Family Member Program Records at: https://dpcld.defense.gov/Privacy/SORNsIndex/DOD-wide-SORN-Article-View/Article/570631/m01754-6/
N01070-3: Navy Military Personnel Records System at: https://dpcld.defense.gov/Privacy/SORNsIndex/DOD-wide-SORN-Article-View/Article/570310/n01070-3/
N01301-2: On-Line Distribution Information System (ODIS) at: https://dpcld.defense.gov/Privacy/SORNsIndex/DOD-wide-SORN-Article-View/Article/570320/n01301-2/

DISCLOSURE: Voluntary for civilian employees and applicants for civilian employment. Mandatory for military personnel: failure or refusal to provide the information or providing false information may result in administrative sanctions or punishment under either Article 92 (dereliction of duty) or Article 107 (false official statement), Uniform Code of Military Justice. The DoD Identification (DoD ID) number of the sponsor (and sponsor's spouse if dual military) allows the Military Healthcare System and Service personnel offices to work together to ensure any early intervention/special education needs of your dependent can be met at your next duty assignment. Dependent early intervention/special education needs are annotated in the official military personnel files which are retrieved by name and DoD ID number.

INSTRUCTIONS FOR COMPLETING DD FORM 2792-1, EARLY INTERVENTION / SPECIAL EDUCATION SUMMARY

The DD Form 2792-1 is completed to identify a family member with early intervention / special education needs.

DEMOGRAPHICS.

Items 1 - 7. To be completed by sponsor, spouse, legal guardian, or student who has reached the age of majority.

Item 1 Request (X one):

- Exceptional Family Member Program (EFMP) Enrollment or Update - first enrollment application for the family member or to update a previous evaluation for the family member.
- Government Sponsored Travel.
- Change in EFMP Status.

Items 2.a. - h. Child / Student Information. Self-explanatory.

Items 3.a. - h. Sponsor Information. Self-explanatory.

Item 3.i. Child / student enrolled in Defense Enrollment Eligibility Reporting System (DEERS) under another sponsor. Self-Explanatory.

Items 4a. - d. Self-explanatory.

Item 5. Completed for children age birth to 3.

Items 6.a. - c. Completed for children ages 3 to 21 only. Children who are ages 3 to 5 should have the DD Form 2792-1 completed at the school the child would normally attend for kindergarten. High school graduates, students who have passed the G.E.D., and college students are not required to complete the DD Form 2792-1. NOTE: For 6.c., students that are home-schooled are eligible to receive some form of special education services in the public school setting. Therefore they may have a private school service plan. Include a copy of the service plan as applicable.

Items 7.a. - d. Signature of sponsor, spouse, legal guardian, or student who has reached the age of majority and completed the form. Self-explanatory.

Items 8.a. - f. Administrative Review. Completed by EFMP Office or Family Member Travel Screening (FMTS) Office responsible for enrollment or screening. NOTE: For 8.c., if child is entered into DEERS under a DoD ID number other than what is provided in 8.a. and 8.b., list the additional ID in 8.c.

EARLY INTERVENTION / SPECIAL EDUCATION SUMMARY.

DD Form 2792-1 is completed by the parents and school or early intervention staff. **Only this form should be provided to school or early intervention staff. Do not include medical information forms that may be used for family member travel screening or EFMP enrollment.**

Items 9.a. - d. Sponsor Information. Signature of sponsor, spouse, legal guardian, or student who has reached the age of majority is REQUIRED to authorize the school to release information.

Items 10.a. - d. Child / Student Information. Completed by sponsor, spouse, or legal guardian. Self-explanatory.

Items 11.a. - e. Early Intervention Summary (EIS) Information. Completed by EIS or school personnel. Mark (X) Yes or No for each item. Include additional information as noted.

Items 12.a. - f. School Information. Completed by school personnel at the school the child attends. Mark (X) Yes or No for each item. Include additional information as noted.

Item 13. Completed by school personnel. Mark (X) eligibility category. Mark only one.

Item 14. Completed by school personnel. Mark (X) all related services provided and indicate total time services are provided.

Items 15.a - c. Completed by EIS and school personnel. Self-explanatory.

Items 16.a - j. Completed by EIS provider / school official information completing the form. Self-explanatory.

NOTE: If child is under 5 years of age, is not enrolled in school, a home school program, or engaged with an Early Intervention Services program, and does not have any identified needs, the parents or guardians can fill out and sign page 2 of the DD Form 2792-1 and return it to the requesting office. The completion of Page 3 is not required in this case.

EARLY INTERVENTION / SPECIAL EDUCATION SUMMARY

(Page 2, Items 1 - 7 to be completed by sponsor, parent, or legal guardian. Read Privacy Act Statement and Instructions before completing the form.)

DEMOGRAPHICS

1. REQUEST *(Select One)*

☐ EFMP Enrollment or Update

☐ Request for Government Sponsored Travel

☐ Request Change in EFMP Status:

☐ No longer requires IEP / IFSP

☐ No longer qualifies as a dependent

*(*Provide documentation to change status)*

☐ Divorce / change in custody*

☐ Family member deceased

2. CHILD / STUDENT INFORMATION *(To be completed by sponsor, spouse, legal guardian, or student who has reached the age of majority.)*

2a. CHILD / STUDENT NAME *(Last, First, Middle Initial)*	**2b. SPONSOR NAME** *(Last, First, Middle Initial)*	**2c. CHILD / STUDENT CURRENT MAILING ADDRESS** *(Street, Apartment Number, City,State, ZIP Code, APO / FPO)*
2d. FAMILY MEMBER PREFIX	**2e. CHILD / STUDENT DATE OF BIRTH** *(YYYYMMDD)*	**2f. CHILD / STUDENT SEX** *(Select one)* ☐ Male ☐ Female
2g. FAMILY HOME E-MAIL ADDRESS	**2h. HOME TELEPHONE NUMBER** *(Include Country Code / Area Code)*	

3a. SPONSOR RANK OR GRADE	**3b. INSTALLATION OF SPONSOR'S CURRENT ASSIGNMENT** *(Include City, State, Country)*	
3c. SPONSOR'S OFFICIAL E-MAIL ADDRESS	**3d. DUTY TELEPHONE NUMBER** *(Include Country Code / Area Code)*	**3e. MOBILE NUMBER** *(Include Country Code / Area Code)*

3f. STATUS *(Select One)*

☐ Regular Active Service Member ☐ Active Reserve ☐ Active Guard

☐ Reserves ☐ National Guard ☐ Civilian

3g. BRANCH OF SERVICE *(Military Only)*

☐ Army ☐ Navy ☐ Air Force

☐ Marine Corps ☐ Coast Guard

3h. DOES CHILD RESIDE WITH SPONSOR? *(Select One. If No, Explain.)*

☐ Yes ☐ No _____

3i. IS THE CHILD / STUDENT ENROLLED IN DEERS UNDER A SPONSOR OTHER THAN THE ONE LISTED ABOVE? *(Select One. If Yes, provide name of sponsor)*

☐ Yes ☐ No _____

4a. ARE BOTH SPOUSES ON ACTIVE DUTY? *(Military Only. Select One. If Yes, Complete 4b.- 4d. below)* ☐ Yes ☐ No

4b. ACTIVE DUTY SPOUSE'S NAME *(Last, First, Middle Initial)*	**4c. BRANCH OF SERVICE**	**4d. RANK / RATE**

5. FOR CHILDREN FROM BIRTH TO AGE THREE ONLY:

☐ Yes ☐ No Is your child being evaluated for, or eligible for early intervention services on an Individualized Family Service Plan (IFSP)? *(Select one. If No, sign Item 7 and return to the requesting office. If Yes, have early intervention professional complete page 3.)*

6. EDUCATION SERVICES FOR DEPENDENTS 3 YEARS AND OLDER:

6a. Is your child being home-schooled full-time or part-time? *(Select one)* ☐ Yes, Part-Time ☐ Yes, Full-Time ☐ No *(If Yes, complete 6a(1) and 6a(2))*

6a(1). When did you start home-schooling? *(YYYYMMDD)* _____

6a(2). Name of home school program/title of courses: _____

6b. Is your child being evaluated for, or receiving, special education services on an IEP?
If Yes, have the child's school (or primary care provider if school is not in session) complete page 3. ☐ Yes ☐ No

6c. List any special education-related services received in the last 3 years: *(include a copy of the service plan as applicable)* _____

7. RELEASE OF INFORMATION *(To be completed by sponsor, spouse, legal guardian, or student who has reached the age of majority)* I hereby authorize the release of information on the DD Form 2792-1, and the attached reports to appropriate personnel of the Department of Defense. This information will be used to evaluate and document my child / student's needs for educational services for the purpose of assignment coordination, EFMP enrollment, or eligibility for other educationally related benefits.

7a. SIGNATURE	**7b. PRINTED NAME**	**7c. RELATIONSHIP TO CHILD / STUDENT**	**7d. DATE** *(YYYYMMDD)*

8. ADMINISTRATIVE REVIEW *(Completed after review of entire form by local MTF or office receiving form.)*

8a. SPONSOR DoD ID #	**8b. SPOUSE DoD ID #** *(If dual* military)	**8c. DoD ID # USED IN DEERS** *(If different from sponsor's)*	**8f. STAMP**

8d. MTF OR OFFICE RECEIVING COMPLETED FORM	**8e. DATE** *(YYYYMMDD)*

EARLY INTERVENTION / SPECIAL EDUCATION SUMMARY

NOTE TO EDUCATIONAL AUTHORITY COMPLETING THIS FORM: It is important to the military and to the family that the service member be assigned to a location that can meet the child's educational needs. Your support in completing this form is appreciated. *(If applicable, attach a copy of the child's most recent active Individualized Family Service Plan (IFSP) or Individualized Education Program (IEP) to this page.)*

9. RELEASE OF INFORMATION (To be completed by sponsor, spouse, legal guardian, or student who has reached the age of majority) I hereby authorize the release of information on the DD Form 2792-1, and the attached reports to personnel of the Military Departments. This information will be used to evaluate and document my child / student's needs for educational services for the purpose of assignment coordination, EFMP enrollment or eligibility for other educationally related benefits.

9a. PRINTED NAME	9b. SIGNATURE	9c. RELATIONSHIP TO CHILD / STUDENT	9d. DATE *(YYYYMMDD)*

10. CHILD / STUDENT INFORMATION *(To be completed by sponsor, spouse, or legal guardian)*

10a. NAME OF CHILD / STUDENT *(Last, First, Middle Initial)*	10b. CURRENT GRADE LEVEL *(if school age)*	10c. DATE OF BIRTH *(YYYYMMDD)*	10d. SEX *(Select one)*
			☐ Male ☐ Female

11. EARLY INTERVENTION SERVICES (EIS) - FOR CHILDREN UNDER 3 YEARS OF AGE *(To be completed by EIS representative)*

YES NO

☐ ☐ 11a. Is the child currently being evaluated for early intervention services?

☐ ☐ 11b. Does this child receive early intervention services under a current Individualized Family Service Plan (IFSP)? *(If Yes, please attach current IFSP)*. Date of next annual review *(YYYYMMDD)* _____

☐ ☐ 11c. Has the child been found eligible but the family declined IFSP services?

11d. Basis for eligibility: ☐ Developmental Delay ☐ Diagnosed physical or mental condition that has a high probability of resulting in a Developmental Delay

11e. Is there an identified disability? *(If known, please specify)*

12. SCHOOL INFORMATION - FOR STUDENTS AGES 3 - 21 *(To be completed by school representative - answer all questions)*

YES NO

☐ ☐ 12a. Is this student currently being evaluated for special education services?

☐ ☐ 12b. Has the child been found eligible for special education services? *(If Yes, complete Item 13.)*

☐ ☐ 12c. If your school determined the student eligible for special education services within the past 3 years, did the parent decline special education services? *(If Yes, complete eligibility information in Item 13 and proceed to Item 16)*

☐ ☐ 12d. Does this child / student receive special education services under a current Individualized Education Program (IEP)? Date of next annual review *(YYYYMMDD)* _____ *(If Yes, complete Items 13 and following and attach a copy of the current IEP.)*

☐ ☐ 12e. Were IEP services terminated by the IEP team due to ineligibility within the last 2 years? Date of IEP termination *(YYYYMMDD)* _____

☐ ☐ 12f. Was the IEP terminated at the request of the parents within the last year (parents withdrew student from special education)? *(If Yes, complete Items 13 and following).* Date of IEP termination *(YYYYMMDD)* _____

13. ELIGIBILITY CATEGORY FOR CHILDREN 3 TO 21 YEARS OF AGE *(Select only one)* ☐ N/A

- ☐ Autism Spectrum Disorder
- ☐ Deaf
- ☐ Blind
- ☐ Deaf / Blind
- ☐ Visually Impaired
- ☐ Traumatic Brain Injury
- ☐ Hearing Impaired
- ☐ Orthopedically Impaired
- ☐ Communication Impaired
  - ☐ Articulation
  - ☐ Dysfluency
  - ☐ Voice
  - ☐ Language / Phonology
- ☐ Developmental Delay
- ☐ Specific Learning Disability
- ☐ Emotionally Impaired
- ☐ Behavioral / Conduct Disorder
- ☐ Intellectual Disability
  - ☐ Mild
  - ☐ Moderate
  - ☐ Severe / Profound
- ☐ Other Health Impaired *(Specify)*

14. RELATED SERVICES ON IEP *(Select boxes next to related services and indicate total number of minutes or hours that services are provided.)* ☐ N/A

SERVICE: M = Minutes, H = Hours per W = Week, M = Month (Example: 20 M per W)

☐ Counseling			per		☐ Special Transportation *(Describe)*
☐ Occupational Therapy			per		
☐ Physical Therapy			per		☐ Other *(Describe)*
☐ Speech Therapy			per		
☐ Intensive Behavioral Intervention (such as ABA)			per		

15. BEHAVIOR / COMMUNICATION *(Select all that apply and specify in comments section)*

YES NO

☐ ☐ 15a. Child exhibits high risk or dangerous behavior

☐ ☐ 15b. Child is verbal *(If No, answer 15b(1)-15b(4) The student uses:)*

- ☐ ☐ 15b(1). Signing
- ☐ ☐ 15b(2). Picture Exchange Communication System (PECS)
- ☐ ☐ 15b(3). Communication Device
- ☐ ☐ 15b(4). Other

15c. COMMENTS

16. PROVIDER / SCHOOL INFORMATION

16a. NAME OF EARLY INTERVENTION PROGRAM OR SCHOOL	16b. SCHOOL DISTRICT	
16c. CITY, STATE, COUNTRY	**16d. TELEPHONE NUMBER** *(Include Country Code / Area code)*	**16e. FAX NUMBER** *(Include Country Code / Area Code)*
16f. E-MAIL ADDRESS	**16g. NAME OF INDIVIDUAL COMPLETING THIS SECTION**	
16h. SIGNATURE	**16i. TITLE**	**16j. DATE** *(YYYYMMDD)*