PRINT THIS INFORMATION AND TAKE IT WITH YOU TO YOUR EXAM

Information for Aviation Commissioning Physicals

Updated 06 Nov 08

This physical should be done NO SOONER than 1 year prior to commissioning due to the lengthy processing time. Any delay in this process may result in a loss of commissioning date/orders or even loss of aviation service selection.

Please let the Medical Officer know of any changes that should to be applied to this information.

1. Get your medical and dental records from LT Cordova or wherever you have them stored.

2. Call Aviation Medical at NHB Beaufort (843) 228-7530 or Shaw AFB, SSgt. Larson or SSgt Denton (803) 895-6085/6193/91. When setting up your appointment **get the name and rank of who set it up for you**. Ensure they schedule all tests that you need to have done (specifically optometry and dental appointments). If you are going to Shaw, ensure you ID yourself as an initial Pilot or NFO (Navy) examinee.

3. Call NHB Beaufort or Shaw AFB again the day prior to your appointment to ensure that they are still expecting you. **Get the name and rank of who confirmed your appointment.**

Things to do prior to your exam and during the exam:

1. Fast for 12 hours prior to labs. **(DO NOT EAT OR DRINK ANYTHING EXCEPT WATER!!!!)**

2. Show up in khaki uniform. **DO NOT FORGET YOUR MEDICAL/DENTAL RECORDS AND MILIATRY ID**

3. Optometry – four refraction tests need to be complete in addition to the regular vision check. They are manifest refraction, cycloplegic refraction, red lens test, and slit lamp test – Also, ensure the folks at Shaw AFB know you need distant vision checked.

4. Make sure dental x-rays are put **in your dental record**.

5. **Be aware that you may need to return a second or third day for follow-up appointments to see the flight surgeon for a final "head to toe" exam and for him to sign you final paperwork.**

6. Females- Must have PAP done w/in the past year, bring results.

7. Day prior-Complete the following (forms can be found on the unit web site under medical forms):
   - DD Form 2807-1 (fill out on computer and print-it will not save)
   - DD From 2808 (fill out what you can on computer and print-it will not save)
   - CNET Form 6220/8 (print and complete)
   - Anthropometric Data Measurement Record OPNAV 3710/37A

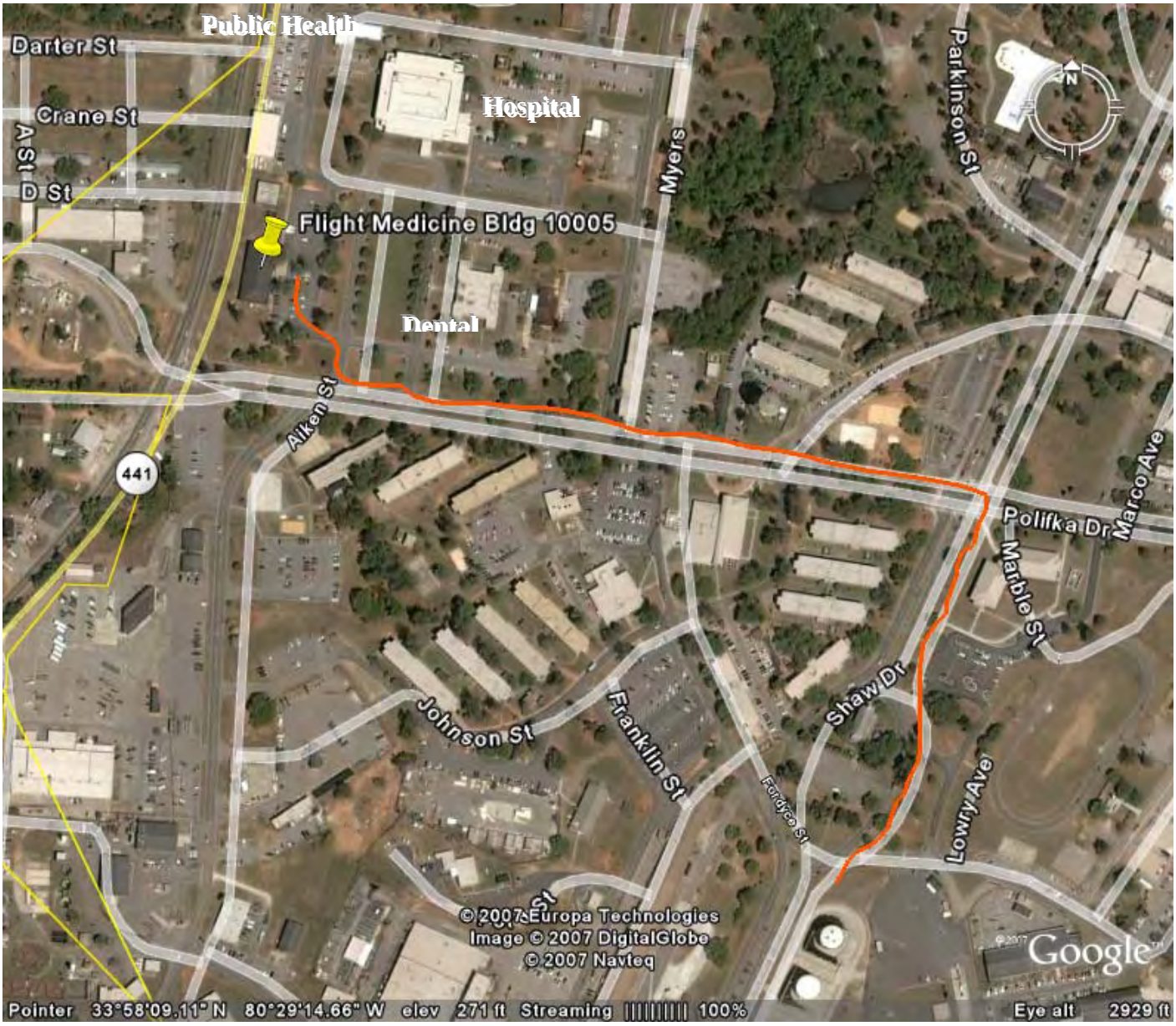
   SF 507-answer all questions. If you have had PRK, need ALL records pertaining to this surgery. Take all the above forms with you to your appointment.

8. END Result- Do not leave without the **copies** of the following or ensure they will be sent to the NROTC Medical Officer:
   - DD Form 2707-1 (signed by the Flight Surgeon)
   - DD FORM 2808 (signed by Flight Surgeon and Dental Officer)
   - SF Form 507
   - EKG trace and Chest X-ray
   - Anthropometric Data Measurement Record OPNAV 3710/37A
   - HIV Lab Results and any other Lab Results that are available
   - PAP results (if applicable)
   - Aeromedical Clearance Notice NAVMED 6410/2

Ensure the NROTC Medical Officer receives completed copies of all of the above-mentioned forms.

DIRECTIONS: Shaw AFB

1. Take US-378 E to Shaw AFB (approx 31 miles)
2. Turn right onto Shaw Dr.
3. Go through Main Gate and continue strait around the Chapel roundabout to light at Polifka Dr.
4. Turn Left onto Polifka Dr. continue straight until almost to end of the road.
5. Before gate, turn Right. Flight Medicine is Building 10005 on the left (brown building to the left of big open field). The hospital is the big white building. Public Health is the small building to the left and slightly behind the hospital. Dental is directly across Flight Medicine.



DIRECTIONS to NHB BEAUFORT
(You will need to go to both of the these locations)

Columbia to MCAS Beaufort
Take I-77 South
Merge I-26 East towards Charleston
Merge I-95 South towards Savannah
Exit 33 towards Beaufort (US-21 North)
Stay on US-21 North until you see MCAS Beaufort on your left (you will see airplanes at the corner)

MCAS Beaufort to NHB Beaufort
Keep driving past MCAS or take a left out of MCAS if you went in to the base (US-21 North)
RIGHT on Highway 280 (There will be RR tracks immediately after turning right)
Drive over the bridge past Parris Island
After the bridge look for a sign to take a RIGHT into NHB Beaufort
After going through the security gate, drive around the base to park in the visitor's parking lot
Aviation Medical Office is on the Third Floor at the other end of the building from which you entered (There are plenty of personnel there to ask for directions)
After you complete the physical:
-MCAS Beaufort waits for lab results, then will type it up and send it to USC Medical Officer
-You will put a cover letter on it (PT results, etc) and it gets sent to BUMED (work with Medical Officer to complete both of these)
-BUMED reviews and says if good for commissioning, then to sends it to NOMI (typically takes anywhere from 1 week to 1 month).
-NOMI reviews and says "yes, no, or need more info." This may take several months. Once it is at NOMI, you can be track it at the following web page: https://apps.nomi.med.navy.mil/NAMIEPE Click on the link Patient access to Waiver Disposition

NROTC
AVIATION PHYSICAL COVER SHEET

Applicant _____

Unit Name_____ Unit #_____

Date Submitted _____

Commissioning Date _____

Unit POC _____ phone_____

e-mail _____ fax_____

Please Select the appropriate boxes:

☐ Navy ☐ Pilot

☐ Marine Corps ☐ NFO

BUMED Recommendation

☐ Qualified Date _____

☐ Waiver Date _____

☐ Disqualify Date _____

NAMI Decision

☐ Qualified Date _____

☐ Waiver Granted Date _____

☐ Disqualified Date _____

REPORT OF MEDICAL EXAMINATION

1. DATE OF EXAMINATION (YYYYMMDD)	2. SOCIAL SECURITY NUMBER

PRIVACY ACT STATEMENT

AUTHORITY: 10 USC 504, 505, 507, 532, 978, 1201, 1202, and 4346; and E.O. 9397.
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.

3. LAST NAME - FIRST NAME - MIDDLE NAME (SUFFIX)	4. HOME ADDRESS *(Street, Apartment Number, City, State and ZIP Code)*	5. HOME TELEPHONE NUMBER *(Include Area Code)*

6. GRADE	7. DATE OF BIRTH (YYYYMMDD)	8. AGE	9. SEX	10.a. RACIAL CATEGORY *(X one or more)*	b. ETHNIC CATEGORY
			☐ Female ☐ Male	☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ White ☐ Native Hawaiian or Other Pacific Islander ☐ Decline to Respond	☐ Hispanic/Latino ☐ Not Hispanic/Latino ☐ Decline to Respond

11. TOTAL YEARS GOVERNMENT SERVICE a. MILITARY	b. CIVILIAN	12. AGENCY *(Non-Service Members Only)*	13. ORGANIZATION UNIT AND UIC/CODE
		DN	UNIVERSITY OF SOUTH CAROLINA NROTC UNIT UIC: N63313

14.a. RATING OR SPECIALTY *(Aviators Only)*	b. TOTAL FLYING TIME	c. LAST SIX MONTHS
SNA		

15.a. SERVICE	b. COMPONENT	c. PURPOSE OF EXAMINATION	16. NAME OF EXAMINING LOCATION, AND ADDRESS *(Include ZIP Code)*
☐ Army ☐ Coast Guard ☐ Navy ☐ Marine Corps ☐ Air Force	☒ Active Duty ☐ Reserve ☐ National Guard	☐ Enlistment ☐ Medical Board ☒ Other ☒ Commission ☐ Retirement SNA ☐ Retention ☐ U.S. Service Academy ☐ Separation ☐ ROTC Scholarship Program	20 ADOS/SGGM 431 MEDOWLARK ST SHAW AFB SC 29153

CLINICAL EVALUATION *(Check each item in appropriate column. Enter "NE" if not evaluated.)*

	Normal	Abnorm	NE
17. Head, face, neck, and scalp			
18. Nose			
19. Sinuses			
20. Mouth and throat			
21. Ears - General *(Int. and ext. canals/Auditory acuity under item 71)*			
22. Drums *(Perforation)*			
23. Eyes - General *(Visual acuity and refraction under items 61 - 63)*			
24. Ophthalmoscopic			
25. Pupils *(Equality and reaction)*			
26. Ocular motility *(Associated parallel movements, nystagmus)*			
27. Heart *(Thrust, size, rhythm, sounds)*			
28. Lungs and chest *(Include breasts)*			
29. Vascular system *(Varicosities, etc.)*			
30. Anus and rectum *(Hemorrhoids, Fistulae) (Prostate if indicated)*			
31. Abdomen and viscera *(Include hernia)*			
32. External genitalia *(Genitourinary)*			
33. Upper extremities			
34. Lower extremities *(Except feet)*			
35. Feet *(See Item 35 Continued)*			
36. Spine, other musculoskeletal			
37. Identifying body marks, scars, tattoos			
38. Skin, lymphatics			
39. Neurologic			
40. Psychiatric *(Specify any personality deviation)*			
41. Pelvic *(Females only)*			
42. Endocrine			

44. NOTES: *(Describe every abnormality in detail. Enter pertinent item number before each comment. Continue in item 73 and use additional sheets if necessary.)*

43. DENTAL DEFECTS AND DISEASE *(Please explain. Use dental form if completed by dentist. If dental examination not done by dental officer, explain in Item 44.)*

☐ Acceptable
☐ Not Acceptable Class _____

35. FEET *(Continued) (Circle category)*

Normal Arch — Mild — Asymptomatic
Pes Cavus — Moderate
Pes Planus — Severe — Symptomatic

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

LABORATORY FINDINGS

45. URINALYSIS	a. Albumin	46. URINE HCG	47. H/H	48. BLOOD TYPE
	b. Sugar	-		

TESTS	RESULTS	HIV SPECIMEN ID LABEL	DRUG TEST SPECIMEN ID LABEL
49. HIV	Date & result		-
50. DRUGS	-		
51. ALCOHOL	-		
52. OTHER			
a. PAP SMEAR	-		
b. Lipid	see #73		
c. Chest x-ray			

MEASUREMENTS AND OTHER FINDINGS

53. HEIGHT	54. WEIGHT	55. MIN WGT - MAX WGT	MAX BF %	56. TEMPERATURE	57. PULSE
	lbs.				

58. BLOOD PRESSURE			59. RED/GREEN *(Army Only)*	60. OTHER VISION TEST
a. 1ST	b. 2ND	c. 3RD	-	
SYS.	SYS. -	SYS. -		
DIAS.	DIAS. -	DIAS. -		

61. DISTANT VISION		62. REFRACTION BY AUTOREFRACTION OR MANIFEST			63. NEAR VISION			
Right 20/	Corr. to 20/	By	S.	CX	Right 20/	Corr. to 20/	by	-
Left 20/	Corr. to 20/	By	S.	CX	Left 20/	Corr. to 20/	by	-

64. HETEROPHORIA *(Specify distance)*

ES °	EX °	R.H.	L.H.	Prism div.	Prism Conv CT	NPR	PD
				-	-	-	-

65. ACCOMMODATION		66. COLOR VISION *(Test used and result)*		67. DEPTH PERCEPTION *(Test used and score)* AFVT	
Right -	Left -	PIP	Falant /14	Uncorrected	Corrected

68. FIELD OF VISION	69. NIGHT VISION *(Test used and score)*	70. INTRAOCULAR TENSION	
		O.D.	O.S.

71a. AUDIOMETER	Unit Serial Number						71b. Unit Serial Number							72a. READING ALOUD TEST
Date Calibrated *(YYYYMMDD)*							Date Calibrated *(YYYYMMDD)*							☐ SAT ☐ UNSAT
HZ	500	1000	2000	3000	4000	6000	HZ	500	1000	2000	3000	4000	6000	
Right							Right							72b. VALSALVA
Left							Left							☐ SAT ☐ UNSAT

73. NOTES *(Continued)* **AND SIGNIFICANT OR INTERVAL HISTORY** *(Use additional sheets if necessary.)*

Male labs
Chol:(120-199)
HDL:(>35-<200)
Trig:(40-160)
G6PD:,HGBS:,HGB:(14-18)
HCT:(41-51)
HIV:Negative
Drug UA:
BAT:<13(13-100)

Female labs
Chol:(120-199)
HDL:(>35-<200)
Trig:(40-160)
G6PD:,HGBS:,HGB:(12-16)
HCT:(37-47)
HIV:Negative
Drug UA:
BAT:<13(13-100)
HCG:

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

74.a. EXAMINEE/APPLICANT *(check one)*

☐ IS QUALIFIED FOR SERVICE

☐ IS NOT QUALIFIED FOR SERVICE

Student Naval Aviator

75. I have been advised of my disqualifying condition.

a. SIGNATURE OF EXAMINEE | **b. DATE** *(YYYYMMDD)*

b. PHYSICAL PROFILE

P	U	L	H	E	S	X	PROFILER INITIALS	DATE *(YYYYMMDD)*
1	1	1	1	1	1			

76. SIGNIFICANT OR DISQUALIFYING DEFECTS

ITEM NO.	MEDICAL CONDITION/DIAGNOSIS	ICD CODE	PROFILE SERIAL	RBJ DATE *(YYYYMMDD)*	QUALIFIED	DISQUALIFIED	EXAMINER INITIALS	WAIVER RECEIVED	
								SERVICE	DATE *(YYYYMMDD)*

77. SUMMARY OF DEFECTS AND DIAGNOSES *(List diagnoses with item numbers) (Use additional sheets if necessary.)*

78. RECOMMENDATIONS - FURTHER SPECIALIST EXAMINATIONS INDICATED *(Specify) (Use additional sheets if necessary.)*

PQ & AA DIF as SNA

79. MEPS WORKLOAD *(For MEPS use only)*

WKID	ST	DATE *(YYYYMMDD)*	INITIAL	WKID	ST	DATE *(YYYYMMDD)*	INITIAL

80. MEDICAL INSPECTION DATE	HT	WT	%BF	MAX WT	HCG	QUAL	DISQ	PHYSICIAN'S SIGNATURE

81.a. TYPED OR PRINTED NAME OF PHYSICIAN OR EXAMINER

ROBERT C. ALLEN, D.O.

b. SIGNATURE

82.a. TYPED OR PRINTED NAME OF PHYSICIAN OR EXAMINER

b. SIGNATURE

83.a. TYPED OR PRINTED NAME OF DENTIST OR PHYSICIAN *(Indicate which)*

Janice M. Allison, Lt Col, USAF, DC

b. SIGNATURE

84.a. TYPED OR PRINTED NAME OF REVIEWING OFFICER/APPROVING AUTHORITY

b. SIGNATURE

85. This examination has been administratively reviewed for completeness and accuracy.

a. SIGNATURE | **b. GRADE** | **c. DATE** *(YYYYMMDD)*

86. WAIVER GRANTED *(If yes, date and by whom)*

☐ **YES**

☐ **NO**

87. NUMBER OF ATTACHED SHEETS

REPORT OF MEDICAL HISTORY

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

Form Approved
OMB No. 0704-0413
Expires Aug 31, 2003

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 Department of Defense, Washington Headquarters Services, Directorate for Information Operations and Reports (0704-0413), 1215 Jefferson Davis Highway, Suite 1204, Arlington, VA 22202-4302. 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 ADDRESS. RETURN COMPLETED FORM AS INDICATED ON PAGE 2.

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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)*

b. HOME TELEPHONE *(Include Area Code)*

5. EXAMINING LOCATION AND ADDRESS *(Include ZIP Code)*

X ALL APPLICABLE BOXES:

6.a. SERVICE
- ☐ Army
- ☐ Navy
- ☐ Marine Corps
- ☐ Air Force
- ☐ Coast Guard

b. COMPONENT
- ☐ Active Duty
- ☐ Reserve
- ☐ National Guard

c. PURPOSE OF EXAMINATION
- ☐ Enlistment
- ☐ Commission
- ☐ Retention
- ☐ Separation
- ☐ Medical Board
- ☐ Retirement
- ☐ U.S. Service Academy
- ☐ ROTC Scholarship Program
- ☐ 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 orthodics, 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.)*	○	○
d. Tumor, growth, cyst, or cancer	○	○

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:	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 existing 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

30. EXAMINER'S SUMMARY AND ELABORATION OF ALL PERTINENT DATA *(Physician shall comment on all positive answers in questions 10 - 29. Physician 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)*

CAUTION: Concealment of medical history will be reported to higher authority and may result in
PERMANENT DISQUALIFICATION. ALL POSITIVE RESPONSES REQUIRE ELABORATION ON THE REVERSE BY A FLIGHT SURGEON

25. Have you ever been medically disqualified for any flight or other physical at any time? a. If you were disqualified, do you have a waiver?	YES ☐ NO ☐ YES ☐ NO ☐
26. Since your last physical or in the last 18 months, have you been sick, injured, consulted a physician, used medication (including over the counter), or been hospitalized for any reason?	YES ☐ NO ☐
27. Have you ever used or experimented with drugs (other than medications prescribed for you by a physician to treat a specific medical condition) to include: cocaine, crack, hashish, marijuana, PCP (angel dust), barbiturates (downers), amphetamines (speed, uppers), heroin, LSD, steroids or any other substance considered illegal or dangerous drugs by the U. S. Government?	YES ☐ NO ☐
28. Have you ever been evaluated for, or treated for any psychiatric problems, depression, stress, anxiety, nervous breakdown, schizophrenia, mania, psychosis, anorexia, bulimia, binge eating, self-induced vomiting, personality disorder or other mental illness, marital problems, or been told you had a learning disability?	YES ☐ NO ☐
29. Have you ever used alcohol to excess resulting in: legal problems to include areest for driving under the influence (DUI/DWI), absence from work or school, loss of job; impairment of health to include liver disease, ulcer, pancreatitis, blackouts (loss of memory), or marital problems?	YES ☐ NO ☐
30. Have you ever been diagnosed or had any level of treatment for alcohol abuse or dependence? a. What is your weekly consumption of alcohol?	YES ☐ NO ☐
31. Have you ever been told in the past that your uncorrected vision was worse than 20/20 in either eye?	YES ☐ NO ☐
32. Do you wear or have you ever worn contact lenses?	YES ☐ NO ☐
33. Have you ever had eye surgery or any operation or manipulation to correct poor vision such as radial kerotonomy (RK), Photorefractive Keratectomy (PRK, ALK or LASIK), Orthokeratology (Ortho-K) or eye rubbing to reshape the cornea (clear part)?	YES ☐ NO ☐
If you answered yes to PRK or LASIK, answer the following questions:	
a. When you read brightly illuminated road signs at night, do you have problems with hazy vision?	YES ☐ NO ☐
b. Do you have problems with glare or halos from oncoming headlights at night?	YES ☐ NO ☐
c. Do you have problems seeing because of double vision or ghost images?	YES ☐ NO ☐
d. Do you have problems seeing people or things at twilight?	YES ☐ NO ☐
e. Do you have concerns about your ability to perform aviation duty?	YES ☐ NO ☐
34. Have you ever fainted, had vertigo (spinning dizziness), seizures, convulsions, or sustained a head injury resulting in loss of consciousness, loss of memory, concussion, or skull fracture?	YES ☐ NO ☐
35. Have you ever had a migraine or other severe headache?	YES ☐ NO ☐

PATIENT IDENTIFICATION
Name: Last: First: M.I

SSN Command/School

36. Have you ever been diagnosed with asthma?	YES ☐ NO ☐
37. Do you have any history of generalized or severe reaction to stinging or biting insects or common foods?	YES ☐ NO ☐
38. Have you ever had hay fever, seasonal allergies, allergies to pollen, sinus problems, or used antihistamines, decongestants, nasal steroids, or allergy shots for relief of above symptoms?	YES ☐ NO ☐
39. Do you smoke or use any tobacco products? a. If so, what kind and how much?	YES ☐ NO ☐

PATIENT'S SIGNATURE _____
DATE:

Flight Surgeon Comments

Item Block	Comment	CD / NCD	Waiver Requested

FLIGHT SURGEON'S SIGNATURE _____STAMP

Name: Last First M.I _

SSN: _ Command/School:

ANTHROPOMETRIC DATA MEASUREMENT RECORD
OPNAV 3710/37A (07-05)

Name (Last, First, Middle Initial)			GRADE/RATE	SSN	Designator	Service

Age	Sex (circle) M / F	Date: DD MMM YYYY	Activity Conducting Evaluation	Training Program (Circle One) Pilot NFO Other_____

Command Currently Assigned to: _____

Complete this form only when the individual is determined to be "measurement required" IAW OPNAVINST 3710.37A.

1. Measurements shall are to be taken IAW OPNAVINST 3710.37A Enclosure 2
2. Measurements shall be taken at the maximum point of quiet respiration.
3. Measurements recorded to the nearest ¼ of an inch
4. Measurements shall be repeated at least once
5. If there is a variation larger than ½" or ½ # between repeated measurements, recheck body position and repeat measurements

ANTHROPOMETRIC DATA	**Measurements**
Weight (W) #1 _____ #2_____	_____POUNDS
Stature (Height (H)) #1 _____ #2 _____	_____INCHES
Sitting Height (SH) #1 _____ #2 _____	_____INCHES
Buttock-Knee Length (BKL) #1 _____ #2 _____	_____INCHES
Thumb Tip Reach (TTR) #1 _____ #2 _____	_____INCHES

Distribution:	Measurement Technician
Original: Health Record Copy 1: Retained in NATOPS Jacket Copy 2: Individual's Aviation Training Jacket	Print_____ Signature_____ Date _____

PRIVACY ACT STATEMENT: Authority: 10USC 5013, Secretary of the Navy and Executive Order 9397 (SSN)
Purpose: USN/USMC Anthropometry Data Measurement Record Routine Uses: To assess aircraft anthropometric compatibility. Information not disseminated outside DOD.
Disclosure: Voluntary, as part of aviation accession and retention assessment. Failure to supply requested data may eliminate individual from consideration for duty involving flying.

NROTC ANNUAL PHYSICAL CONDITION CERTIFICATE

Date: _____

RESET FORM

Instructions:

This certificate is to be completed annually by members of the NROTC Program as required by the Naval Administrative Manual (NAM). The intentional failure to disclose an illness or disease could be construed as an intent to defraud the Government and could result in the member's loss of disability benefits or be the basis for administrative action according to the NAM.

Type or clearly print member's name (last, first, middle initial); social security number; and unit to which assigned.

The member shall complete the appropriate responses, sign in ink, and date.

<table>
<tr><td colspan="3">1. Last Name, First Name, Middle Init.</td><td colspan="2">2. SSN</td><td>3. Rate/Rank</td></tr>
<tr><td>4. Designator/MOS/NEC</td><td>5. Sex</td><td>6. Age</td><td colspan="3">7. Date of Birth</td></tr>
<tr><td colspan="3">8. Known Allergies</td><td colspan="3">9. Unit or School and UIC</td></tr>
<tr><td colspan="6">10. Home Address Street City</td></tr>
<tr><td colspan="2">11. State Zip + 4 Code</td><td colspan="2">Home Phone Number</td><td colspan="2">Work Phone Number</td></tr>
<tr><td colspan="3">12. Location of Health Record</td><td colspan="3">13. Location of Dental Record</td></tr>
<tr><td colspan="3">14. Date of last Complete Physical Examination</td><td colspan="3">15. Purpose of Examination</td></tr>
<tr><td>16. Date of last Dental Exam</td><td>17. Type of Examination</td><td>18. Class</td><td>19. Date of last PAP and results</td><td colspan="2">20. Date of last Mammogram and results</td></tr>
<tr><td>21. Date of last HIV Blood Test</td><td>22. Body Fat %</td><td colspan="2">23. Height</td><td colspan="2">24. Weight</td></tr>
</table>

(Continue on Next Page)

NROTC ANNUAL PHYSICAL CONDITION CERTIFICATE

1. Have you had any injury, illness or disease within the past 12 months which required hospitalization or caused you to be absent from school, duty or civilian occupation for more than 3 consecutive days?
( ) NO ( ) YES If yes, explain: _____

_____

_____

2. Are you now, or have you been under a physician's care during the 12 past months?
( ) NO ( ) YES If yes, explain: _____

_____

_____

3. Have you taken prescription medications (other than birth control) in the past 12 months?
( ) NO ( ) YES If yes, what are they? _____

_____

_____

4. Do you have any physical defect(s), family or mental problems which might restrict your performance on active duty or prevent your mobilization?
( ) NO ( ) YES If yes, explain: _____

_____

_____

5. Additional comments: _____

_____

_____

Upon completion of indicated action, file completed certificate in member's Health Record and a copy in member's Dental Record.

I certify that the information contained in this form is true and complete to the best of my knowledge and belief.

MEMBER'S SIGNATURE: _____

PRT COORDINATOR: _____

COMMANDING OFFICER'S SIGNATURE: _____
(WHEN REQUIRED)

REVIEWING OFFICER'S COMMENTS: _____

_____

_____

_____

CNET 6220/8 (4-00)

CLEARANCE NOTICE (Aeromedical)

Date: _____

From: _____

To: _____

Name: _____

SSN: _____

Rank/Service: _____

HR Loc: _____

1. Recommend subject individual be found physically qualified and aeronautically adapted for duty involving flight as:

Class 1: ☐ SNA ☐ SGI ☐ SGII ☐ SGIII

Class 2: ☐ SNFO ☐ NFO ☐ ATC ☐ AC/SAR ☐ AC/FW ☐ Other _____ .

Waiver has been (recommended) (granted) for: _____ .

2. ☐ Corrective lens required in performance of flight duties.
   ☐ Corrective lens required and extra pair must be carried in performance of flight duties (DVA < 20/100). _____ .

3. ☐ Checkin/Annual Physical Examination.
   ☐ Following Aircraft Mishap/Incident.
   ☐ Return from sick/grounded list.
   ☐ Other (specify)

4. Date grounded _____ Reason _____ .
   Expiration date of clearance _____ .

Original to: ☐ CO
Copy to: ☐ Oper. Off.
☐ Trng. Off.

Signature: _____

☐ FS ☐ Other:
if other, received concurrence from:

_____ .
Name

_____ .
Unit

NAVMED 6150/2 _____ by _____ .
(Date) (Name)

NAVMED 6410/2 (Rev. 5-90) S/N 0105-LF-010-1700