

READ THIS AND THE NOTES IN YOUR EPAR IN THEIR ENTIRETY BEFORE YOU SUBMIT ANYTHING. ENSURE YOU VIEW THE FILES TAB IN YOUR EPAR AS THAT IS WHERE ALL DOCUMENTATION IS ATTACHED AND WHERE YOU WILL NEED TO ATTACH ADDITIONAL DOCUMENTS TO BE PROCESSED. IF YOU MAKE ANY CHANGES TO THE EPAR...IE:ADD DOCUMENTS OR NOTES, ENSURE YOU CLICK THE **SUBMIT** BUTTON AT THE BOTTOM TO SEND BACK TO THIS UNIT FOR ACTION. **DO NOT CREATE MULTIPLE EPARS FOR THE SAME REASON AS THIS CREATES ADDITIONAL WORK AND SLOWS DOWN THE RETENTION PROCESS.**

This is in response to your EPAR request for USMCR retention. In order to submit a retention request to HQMC in the USMCR you will need to complete the items in the list provided in your EPAR. If any of these requirements have already been completed or are not relevant to your retention request, please disregard them or mark them as complete. Once these items have all been completed and the documents returned to the Career Planning Section, your request can be processed through the MFR/MCIRSA chain of command and then forwarded to HQMC-RCT. MOL will be your source of aid when completing these documents

Extensions are not in lieu of reenlistment, they are for specific situations that will prevent an individual from submitting for reenlistment. Communication is key for proper and timely processing of requests. If you are unable to fulfill an item on the checklist, notify the MCIRSA Career Planners immediately to alleviate late submission requests. Additionally, in the case of an extension request, you will need to submit the Reserve RELM routing form-NAVMC 11537A (ONLY 1st Page of NAVMC 11537A), your SRB Page 11's, and a Height and Weight Verification form (see prerequisite list in the attachments for guidance with these items).

PLEASE UTILIZE THE EPAR SYSTEM WHEN SUBMITTING ANY INFORMATION OR DOCUMENTS TO MCIRSA. All communications will be processed through the EPAR system; no member will email a MCIRSA Career Planner with retention documents. If there are any questions or concerns that are not answered in the example package or in this email, please add notes to your EPAR or call the number provided between the hours of 1300-1600 CST.

A MCIRSA Career Planner has screened your record and if any discrepancies or items that need to be completed have been found, are listed in the notes section of the EPAR. Please correct these problems ASAP to allow for timely processing of paperwork.

ALL CORRESPONDENCE AND DOCUMENTS MUST BE SUBMITTED VIA THE ORIGINAL EPAR THAT YOU HAVE CREATED TO BE PROCESSED IN A TIMELY MANNER.

MCIRSA CAREER PLANNERS
COMM: (504)-697-8490,8491,8492
MFR CUSTOMER SERVICE CENTER (800) 255-5082

REENLISTMENT PREREQUISITES FOR RETENTION OF AN IMA MARINE

This is a list of all the requirements necessary for reenlistment in the Marine Corps Reserves.

Please initial all items once they are completed or annotate they have already been completed or are not out of regulation. Once you complete these items, your request can be processed through the MCIRSA Career Planners and submitted to HQMC.

******* When possible please submit all forms in one single PDF in order for a more thorough and timely processing of your request.**

- _____1. **READ, INITIAL, and SIGN** the IMA Statement of Understanding when complete send this back through your EPAR acknowledging required allotted timelines. Your EPAR will be sent back for further completion of retention requirements.

- _____2. Complete a Reserve RELM routing sheet
 - a. Instructions are listed on Next Page.

- _____3. Certify your Career Retirement Credit Report (CRCR). Duration: Annually via MOL.
 - a. mol.usmc.mil

- _____4. Height and Weight Verification Form. Annual Requirement.
 - a. Enclosed. Cannot be older than 90 Days

- _____5. Medical Examination Form DD 2807-1. Duration: Annual Requirement.
 - a. Enclosed:
 - b. If you have and HIV test older than two years you may submit an additional EPAR with SUBJECT MEDICAL requesting Associate Duty Orders to be seen at a Military Treatment Facility (MTF). Civilian and VA providers are not allowed to perform HIV draw.

- _____6. Dental Examination Form DD 2813. Duration: Annual Requirement
 - a. Enclosed:
 - b. You may only be examined by a civilian provider two times before you must be seen by a (MTF).
 - c. You may submit an additional EPAR with SUBJECT MEDICAL requesting Associate Duty Orders to be seen at a (MTF)

- _____7. If you are going to be seen by a MTF for any treatment and you are not in a drilling status please utilize the Medical Check In Sheet
 - a. Enclosed:

- _____8. Verify you don't have any Fitness Report Date Gaps via Website below.
 - a. https://www.mmsb.usmc.mil/PesQuery/Date_Gap.aspx
 - b. If you have Date Gaps, follow the instructions below:
 1. Contact your prior Reporting Seniors to correct the issues.
 2. If that is not possible, contact MMSB at (703)784-5690.

- _____9. Sign the Medical Release Form.
 - a. Enclosed.

- _____10. Submit a 360-profile Color Photo in green USMC PT gear (front/rear/left/right pictures on a neutral background; this can be from smartphone/digital camera).
See Marine Corps Bulletin 1020 for current Tattoo Policy.

INSTRUCTIONS : RESERVE RELM (NAVMC 11537A, Version 1-2015)

Form valid for 90 days from earliest dated signature. Be prepared to recertify or re-complete this RELM if your request is unable to be submitted within this time period.

- 1. BLOCKS 1 - 37 (OMIT 19-20 & 23-33):** Complete using MOL (BIR) as your source of aid (some blocks may not apply). Leave block blank if unable to locate requested info. Write out your retention request in Block 36 (Remarks) and SIGN/DATE Block 37 (Marine Signature line); Career Planner will sign/date when completed form is submitted via EPAR.
- 2. BLOCKS 38A - 38B (Medical & Dental Certification):** If you complete PHA/Dental Examination through a military treatment facility (MTF), then have MTF personnel or an Independent Duty Corpsman (IDC) **CIRCLE EITHER SCREENED OR EXAMINED AND QUALIFIED**. These blocks and indicate your medical/dental status you **must have a class 1 or 2 dental status and be fit for full duty**. **DO NOT ALLOW CIVILIAN PROVIDER** to complete these blocks; if needed, you may request to have reviewed/certified by MCIRSA Medical Personnel by notifying MCIRSA Career Planner. Ensure any medical documentation is submitted to MCIRSA Medical, via EPAR, for appropriate processing and status update to your medical readiness record.
- 3. BLOCK 38C (Security Screening):** Have completed by unit Security Manager and, if applicable, provide a clearance Security Verification Letter (or JPAS Summary printout). If necessary, contact the MCIRSA Security Representative for assistance (via MCIRSA Career Planner).
- 4. BLOCK 38D (S-3 Training Certification):** Have completed by your Training section or Senior Enlisted Advisor/SNCOIC. A current class 1, 2, or 3 PFT/CFT must be present in MOL/MCTFS, this information will also be verified by the MCIRSA Career Planner office using the information in MCTFS or the inventory PFT/CFT rosters and/or Height-Weight form that you provide.
- 5. BLOCK 38E (Legal Certification):** Have your Senior Enlisted Advisor/SNCOIC, Op Sponsor, or OIC certify and state whether or not you are pending any civilian or military legal action. If legal action is pending, you must provide relative information/documentation and the current status regarding the situation.
- 6. BLOCK 38F (SACO Certification):** Have your Senior Enlisted Advisor/SNCOIC, Op Sponsor, or OIC certify and state whether or not you have been assigned to a substance abuse treatment program on your current contract. If you have or there is an issue with SACO pending, please provide relative information/documentation.
- 7. BLOCKS 39A-39G (Command Recommendations):** Provide to your chain of command for completion. Block 39g (CO Recommendation) must be signed by either the active duty Commanding Officer responsible for the IMA Detachment, the Operational Sponsor, or the MCIRSA Director (for RSP Marines ONLY). If Op Sponsor or Acting CO completes this block, the respective **AUTHORITY OR APPOINTMENT LETTER MUST BE PROVIDED**.

Reserve Reenlistment Extension Lateral Move (RRELM) Request

PRIVACY ACT STATEMENT

In accordance with the Privacy Act of 1974 (Public Law 93-579), this notice informs you of the purpose for collection of information on this form. Please read it before completing the form.

AUTHORITY: 10 U.S.C. 5013, Secretary of the Navy; 10 U.S.C. 5041, Headquarters, Marine Corps; and E.O. 9397 (SSN).

PRINCIPAL PURPOSE: Information collected by this form will be used to determine that personnel meet the reenlistment, extension, lateral move eligibility requirements and to obtain command recommendations. The information collected on this form will be filed within a Privacy Act Systems of Records collection governed by Privacy Act System of Records Notice M01040-1 which can be downloaded at :

<http://www.defenselink.mil/privacy/notices/usmc/M01040-1.shtml>.

RETENTION AND SAFEGUARDS: The collected information will be maintained in a database with restricted, limited access by personnel authorized to access this information. The database is protected by password, unique user IDs, and applicable layers of security access within applications. Records in this file system will only be retrieved by name and social security number. Disposition is pending (records are treated as permanent until the National Archives and Records Administration has approved the retention and disposition schedule).

ROUTINE USES: This form becomes part of Headquarters, U.S. Marine Corps permanent files within the Total Force Retention System (TFRS). All uses of this form are internal to the relevant service.

DISCLOSURE: Voluntary. However, failure to furnish personally identifiable information may negate the application.

Reserve Reenlistment Extension Lateral Move (RRELM) Request

1. Rank		2. Name (Last, First, MI)					3. EDIPI		4. MOS	5. BMOS		
6. DOR	7. AFADBD	8. PEBD	9. RECC	10. EAS	11. DCTB	12. MDSD	13. CRCR Cert Date	14. RCOMP	15. RUC	16. MCC		
17. Type of Request				18. Length Requested		19. Career Designated (AR Only)			20. SOE Code			
21. Organization (Unit / Section)								22. Work Phone				
23. Conduct / Proficiency Marks AVG <u>CON</u> in Enlistment ____ AVG <u>PRO</u> in Enlistment ____ <i>(For ALL Cpls and below, to include Sgt's with less than 2 yrs TIG.)</i>						24. Fitness Report Validation FitRep Date Gap(s) <input type="checkbox"/> Yes <input type="checkbox"/> No Date Verified : _____						
25. Test Scores <i>(FTAP / LatMove Only)</i>				26. Duty Station Options <i>(AR / LatMove Only)</i>			27. LATMOVE Choices <i>(List only those MOS's SNM is qualified for.)</i>					
GT		MM		EL		CL	1st	2nd	3rd	1st	2nd	3rd
28. High School Graduate (MSO Only) <input type="checkbox"/> Yes <input type="checkbox"/> No						29. Previous Requests (Within last 12 months.) <input type="checkbox"/> Yes <input type="checkbox"/> No						
30. Draw Case Codes		1) _____ / _____		2) _____ / _____		3) _____ / _____						
31. UCMJ History <i>(This section will include all Military and Civilian convictions on current contract or within the last 5 years)</i> Conviction Type : _____ Articles(s) : _____ Date : _____ Conviction Type : _____ Articles(s) : _____ Date : _____ Conviction Type : _____ Articles(s) : _____ Date : _____												
32. Bonus Eligibility Is SNM currently eligible for EAB/SSB? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>(If yes, SOU must be completed.)</i> Is SNM currently eligible for KICKER? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>(If Yes, ensure SNM understands and completes kicker SOU)</i> REB: _____ Bonus Amount : _____						<u>Previous Bonus Payments</u> EAB/SSB: _____ Amount Paid : _____ EAB/SSB: _____ Amount Paid : _____ EAB/SSB: _____ Amount Paid : _____						
33. Does SNM Require a Tattoo Waiver? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>(SDA Only)</i>						<i>(If yes, attach Color Photo and descriptions.)</i>						
34. Does SNM Have Broken / Prior Service? <input type="checkbox"/> Yes <input type="checkbox"/> No						<i>(If yes, attach Statement of Service (NAVMC 11501).)</i>						
35. Active Duty Spouse Information												
35a. Name		35b. Rank		35c. MOS		35d. Branch		35e. EAS		35f. MCC		35g. RTD
36. Remarks 												
37. Member Certification. I certify that to the best of my knowledge all information provided above is accurate. Marine's Signature : _____ Date : _____ Career Planner's Signature : _____ Date : _____												

Reserve Reenlistment Extension Lateral Move (RRELM) Request

(Please check the appropriate boxes and make brief comments justifying your recommendations.)

Rank	Name	EDIPI

39. Command Recommendations

39a. SNCOIC

Recommended

Not Recommended

Comments :

TIER LEVEL: I II III IV (CIRCLE ONE)

Rank	Name	Signature	Date
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39b. OIC

Recommended

Not Recommended

Comments :

TIER LEVEL: I II III IV (CIRCLE ONE)

Rank	Name	Signature	Date
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39c. SENIOR ENLISTED STAFF SECTION

Recommended

Not Recommended

Comments :

TIER LEVEL: I II III IV (CIRCLE ONE)

Rank	Name	Signature	Date
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39d. STAFF SECTION OIC

Recommended

Not Recommended

Comments :

TIER LEVEL: I II III IV (CIRCLE ONE)

Rank	Name	Signature	Date
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RETURN TO CAREER PLANNING OFFICE

FOR OFFICIAL USE ONLY
Privacy sensitive when filled in

Reserve Reenlistment Extension Lateral Move (RRELM) Request

Rank	Name	EDIPI
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39e. SENIOR ENLISTED ADVISOR

Is SNM recommended for this request: Yes No

Comments :

TIER LEVEL: I II III IV (CIRCLE ONE)

RankNameSignatureDate

39f. EXECUTIVE OFFICER

Is SNM recommended for this request: Yes No

Comments :

TIER LEVEL: I II III IV (CIRCLE ONE)

RankNameSignatureDate

Reserve Reenlistment Extension Lateral Move (RRELM) Request

Rank	Name	EDIPI

39g. Commanding Officer / Commander Recommendation

Must have Special Courts-Martial convening authority or be properly designated as "Acting", via an Assumption of Command or Appointment Letter.

Does SNM meet all reenlistment prerequisites : Yes No

Is SNM recommended for this request: Yes No

Tier I - Does superior work in all duties. Even extremely difficult or unusual assignments can be given with full confidence that they will be handled in a thoroughly competent manner. Demonstrates positive effect on others by example and persuasion. A Tier I Marine may not have any NJP, court martial, or civilian conviction on his current contract.

Tier II - Does excellent work in all regular duties, but needs assistance in dealing with extremely difficult or unusual assignments. Demonstrates reliability, good influence, sobriety, obedience, and industry. A Tier II Marine may have only one form of jeopardy on contract in the form of NJP or misdemeanor civilian conviction, but may have no courts martial.

Tier III - Can be depended upon to discharge regular duties thoroughly and competently but usually needs assistance in dealing with problems not of a routine nature. A Tier III Marine may have no more than two incidents of jeopardy in the form of NJP or misdemeanor civilian conviction, but have no courts martial conviction.

Tier IV - May or may not meet minimum standards. Any Marine with a courts martial conviction will be categorized as Tier IV.

Commander's Tier Evaluation:	<input type="checkbox"/> I	10%	
	<input type="checkbox"/> II	30%	
	<input type="checkbox"/> III	50%	
	<input type="checkbox"/> IV	10%	

Comments to HQMC (RA-RCT):

_____ Rank
_____ Name
_____ Signature
_____ Date

**DEPARTMENT OF DEFENSE
ACTIVE DUTY/RESERVE/GUARD/CIVILIAN FORCES DENTAL EXAMINATION**

OMB No. 0720-0022
OMB approval expires
Aug 31, 2016

The public reporting burden for this collection of information is estimated to average 3 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing the burden, to the Department of Defense, Washington Headquarters Services, Executive Services Directorate, Information Management Division, 4800 Mark Center Drive, Alexandria, VA 22350-3100 (0720-0022). Respondents should be aware that notwithstanding any other provision of law, no person shall be subject to any penalty for failing to comply with a collection of information if it does not display a currently valid OMB control number.

PLEASE DO NOT RETURN YOUR FORM TO THE ABOVE ORGANIZATION.

PRIVACY ACT STATEMENT

AUTHORITY: 10 U.S.C. 136; 10 U.S.C. 1074f; DoD Directives 1404.10, 5101.1, 5136.01, and 6490.02E; DoD Instruction 6025.19; and E.O. 9397 (SSN), as amended.

PRINCIPAL PURPOSE(S): To obtain information in order to record an assessment of an individual's dental health.

ROUTINE USE(S): Information collected may be used and disclosed generally as permitted under 45 CFR Parts 160 and 164, Health Insurance Portability and Accountability Act (HIPAA) Privacy and Security Rules, as implemented by DoD 6025.18-R, the DoD Health Information Privacy Regulation. Information may also be used and disclosed in accordance with 5 U.S.C. 552a(b) of the Privacy Act of 1974, as amended, which incorporates the DoD "Blanket Routine Uses" published at http://dpclo.defense.gov/privacy/SORNs/blanket_routine_uses.html. Information from this system may be shared with other Federal and State agencies and civilian health care providers, as necessary, to provide medical care and treatment and to guide possible referrals.

DISCLOSURE: Voluntary; however, failure to provide the information may result in delays in assessing your dental health needs for military service and/or for possible deployment outside the United States and its territories and possessions.

1. SERVICE MEMBER'S NAME (Last, First, Middle Initial)	2. SOCIAL SECURITY NUMBER	3. BRANCH OF SERVICE
4. UNIT OF ASSIGNMENT	5. UNIT ADDRESS	

6. EXAMINATION RESULTS
Dear Doctor,
The individual you are examining is an Active Duty/Guard/Reserve/Civilian member of the United States Armed Forces. This member needs your assessment of his/her dental health for worldwide duty. **Please mark (X) the block** that best describes the condition of the member, using as a suggested minimum a clinical examination with mirror and probe, and bitewing radiographs. **This form is meant to determine fitness for prolonged duty without ready access to dental care and is not intended to address the member's comprehensive dental needs.**

<input type="checkbox"/>	(1) Patient has good oral health and is not expected to require dental treatment or reevaluation for 12 months.
<input type="checkbox"/>	(2) Patient has some oral conditions, but you do not expect these conditions to result in dental emergencies within 12 months if not treated (i.e., requires prophylaxis, asymptomatic caries with minimal extension into dentin, edentulous areas not requiring immediate prosthetic treatment).
<input type="checkbox"/>	(3) Patient has oral conditions that you do expect to result in dental emergencies within 12 months if not treated. Examples of such conditions are: (X the applicable block or specify in the space provided)
<input type="checkbox"/>	(a) Infections: Acute oral infections, pulpal or periapical pathology, chronic oral infections, or other pathologic lesions and lesions requiring biopsy or awaiting biopsy report.
<input type="checkbox"/>	(b) Caries/Restorations: Dental caries or fractures with moderate or advanced extension into dentin; defective restorations or temporary restorations that patients cannot maintain for 12 months.
<input type="checkbox"/>	(c) Missing Teeth: Edentulous areas requiring immediate prosthodontic treatment for adequate mastication, communication, or acceptable esthetics.
<input type="checkbox"/>	(d) Periodontal Conditions: Acute gingivitis or pericoronitis, active moderate to advanced periodontitis, periodontal abscess, progressive mucogingival condition, moderate to heavy subgingival calculus, or periodontal manifestations of systemic disease or hormonal disturbances.
<input type="checkbox"/>	(e) Oral Surgery: Unerupted, partially erupted, or malposed teeth with historical, clinical, or radiographic signs or symptoms of pathosis that are recommended for removal.
<input type="checkbox"/>	(f) Other: Temporomandibular disorders or myofascial pain dysfunction requiring active treatment.

(4) If you selected Block (3) above, please indicate the condition(s) you identified in this patient if they appear above, or briefly describe the condition(s) below:

(5) Were X-rays consulted?	<input type="checkbox"/> YES	<input type="checkbox"/> NO	IF YES, DATE X-RAY WAS TAKEN (YYYYMMDD)
7. DENTIST'S NAME (Last, First, Middle Initial)	8. DENTIST'S ADDRESS (Street, City, State, 9-digit ZIP Code)		
9. DENTIST'S TELEPHONE NUMBER (Include Area Code)			
10. DENTIST'S SIGNATURE/STATE LICENSE NUMBER	11. DATE OF EXAMINATION (YYYYMMDD)		

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
Oct 31, 2017

The public reporting burden for this collection of information is estimated to average 10 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing the burden, to the Department of Defense, Washington Headquarters Services, Executive Services Directorate, Directives Division, 4800 Mark Center Drive, Alexandria, VA 22350-3100 (0704-0413). Respondents should be aware that notwithstanding any other provision of law, no person shall be subject to any penalty for failing to comply with a collection of information if it does not display a currently valid OMB control number.

PLEASE DO NOT RETURN YOUR FORM TO THE ABOVE ORGANIZATION. RETURN COMPLETED FORM AS INDICATED ON PAGE 2.

PRIVACY ACT STATEMENT

AUTHORITY: 10 U.S.C. 136, DoD Instruction 6130.03, and E.O. 9397, as amended (SSN).

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. Completed forms are covered by recruiting, medical evaluation board, and official military personnel file SORNs maintained by each of the Services.

ROUTINE USE(S): The Blanket Routine Uses found at <http://dpcl.d.defense.gov/Privacy/SORNsIndex/BlanketRoutineUses.aspx> apply to this collection.

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. If you are selected for enlistment, commission, or entrance into a commissioning program based on a false statement, you can be tried by military courts-martial or meet an administrative board for discharge and could receive a less than honorable discharge that would affect your future.

1. LAST NAME, FIRST NAME, MIDDLE NAME (SUFFIX)	2. SOCIAL SECURITY NUMBER	3. TODAY'S DATE (YYYYMMDD)
4.a. HOME ADDRESS (Street, Apartment No., City, State, and ZIP Code)	5. EXAMINING LOCATION AND ADDRESS (Include ZIP Code)	
b. HOME TELEPHONE (Include Area Code)		

X ALL APPLICABLE BOXES:

<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 33%; padding: 5px;">6.a. SERVICE</td> <td style="width: 33%; padding: 5px;">6.b. COMPONENT</td> <td style="width: 33%; padding: 5px;">6.c. PURPOSE OF EXAMINATION</td> </tr> <tr> <td style="padding: 5px;"> <input type="checkbox"/> Army <input type="checkbox"/> Coast Guard <input type="checkbox"/> Navy <input type="checkbox"/> Marine Corps <input type="checkbox"/> Air Force </td> <td style="padding: 5px;"> <input type="checkbox"/> Regular <input type="checkbox"/> Reserve <input type="checkbox"/> National Guard </td> <td style="padding: 5px;"> <input type="checkbox"/> Enlistment <input type="checkbox"/> Commission <input type="checkbox"/> Retention <input type="checkbox"/> Separation <input type="checkbox"/> Medical Board <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Retirement <input type="checkbox"/> U.S. Service Academy <input type="checkbox"/> ROTC Scholarship Program </td> </tr> </table>	6.a. SERVICE	6.b. COMPONENT	6.c. PURPOSE OF EXAMINATION	<input type="checkbox"/> Army <input type="checkbox"/> Coast Guard <input type="checkbox"/> Navy <input type="checkbox"/> Marine Corps <input type="checkbox"/> Air Force	<input type="checkbox"/> Regular <input type="checkbox"/> Reserve <input type="checkbox"/> National Guard	<input type="checkbox"/> Enlistment <input type="checkbox"/> Commission <input type="checkbox"/> Retention <input type="checkbox"/> Separation <input type="checkbox"/> Medical Board <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Retirement <input type="checkbox"/> U.S. Service Academy <input type="checkbox"/> ROTC Scholarship Program	7.a. POSITION (Title, Grade, Component) b. USUAL OCCUPATION
6.a. SERVICE	6.b. COMPONENT	6.c. PURPOSE OF EXAMINATION					
<input type="checkbox"/> Army <input type="checkbox"/> Coast Guard <input type="checkbox"/> Navy <input type="checkbox"/> Marine Corps <input type="checkbox"/> Air Force	<input type="checkbox"/> Regular <input type="checkbox"/> Reserve <input type="checkbox"/> National Guard	<input type="checkbox"/> Enlistment <input type="checkbox"/> Commission <input type="checkbox"/> Retention <input type="checkbox"/> Separation <input type="checkbox"/> Medical Board <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Retirement <input type="checkbox"/> U.S. Service Academy <input type="checkbox"/> ROTC Scholarship Program					

8. CURRENT MEDICATIONS (Prescription and Over-the-counter)	9. ALLERGIES (Including insect bites/stings, foods, medicine or other substance)
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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	12. (Continued)	YES	NO
10.a. Tuberculosis	<input type="radio"/>	<input type="radio"/>	f. Foot trouble (e.g., pain, corns, bunions, etc.)	<input type="radio"/>	<input type="radio"/>
b. Lived with someone who had tuberculosis	<input type="radio"/>	<input type="radio"/>	g. Impaired use of arms, legs, hands, or feet	<input type="radio"/>	<input type="radio"/>
c. Coughed up blood	<input type="radio"/>	<input type="radio"/>	h. Swollen or painful joint(s)	<input type="radio"/>	<input type="radio"/>
d. Asthma or any breathing problems related to exercise, weather, pollens, etc.	<input type="radio"/>	<input type="radio"/>	i. Knee trouble (e.g., locking, giving out, pain or ligament injury, etc.)	<input type="radio"/>	<input type="radio"/>
e. Shortness of breath	<input type="radio"/>	<input type="radio"/>	j. Any knee or foot surgery including arthroscopy or the use of a scope to any bone or joint	<input type="radio"/>	<input type="radio"/>
f. Bronchitis	<input type="radio"/>	<input type="radio"/>	k. Any need to use corrective devices such as prosthetic devices, knee brace(s), back support(s), lifts or orthotics, etc.	<input type="radio"/>	<input type="radio"/>
g. Wheezing or problems with wheezing	<input type="radio"/>	<input type="radio"/>	l. Bone, joint, or other deformity	<input type="radio"/>	<input type="radio"/>
h. Been prescribed or used an inhaler	<input type="radio"/>	<input type="radio"/>	m. Plate(s), screw(s), rod(s) or pin(s) in any bone	<input type="radio"/>	<input type="radio"/>
i. A chronic cough or cough at night	<input type="radio"/>	<input type="radio"/>	n. Broken bone(s) (cracked or fractured)	<input type="radio"/>	<input type="radio"/>
j. Sinusitis	<input type="radio"/>	<input type="radio"/>	13.a. Frequent indigestion or heartburn	<input type="radio"/>	<input type="radio"/>
k. Hay fever	<input type="radio"/>	<input type="radio"/>	b. Stomach, liver, intestinal trouble, or ulcer	<input type="radio"/>	<input type="radio"/>
l. Chronic or frequent colds	<input type="radio"/>	<input type="radio"/>	c. Gall bladder trouble or gallstones	<input type="radio"/>	<input type="radio"/>
11.a. Severe tooth or gum trouble	<input type="radio"/>	<input type="radio"/>	d. Jaundice or hepatitis (liver disease)	<input type="radio"/>	<input type="radio"/>
b. Thyroid trouble or goiter	<input type="radio"/>	<input type="radio"/>	e. Rupture/hernia	<input type="radio"/>	<input type="radio"/>
c. Eye disorder or trouble	<input type="radio"/>	<input type="radio"/>	f. Rectal disease, hemorrhoids or blood from the rectum	<input type="radio"/>	<input type="radio"/>
d. Ear, nose, or throat trouble	<input type="radio"/>	<input type="radio"/>	g. Skin diseases (e.g. acne, eczema, psoriasis, etc.)	<input type="radio"/>	<input type="radio"/>
e. Loss of vision in either eye	<input type="radio"/>	<input type="radio"/>	h. Frequent or painful urination	<input type="radio"/>	<input type="radio"/>
f. Worn contact lenses or glasses	<input type="radio"/>	<input type="radio"/>	i. High or low blood sugar	<input type="radio"/>	<input type="radio"/>
g. A hearing loss or wear a hearing aid	<input type="radio"/>	<input type="radio"/>	j. Kidney stone or blood in urine	<input type="radio"/>	<input type="radio"/>
h. Surgery to correct vision (RK, PRK, LASIK, etc.)	<input type="radio"/>	<input type="radio"/>	k. Sugar or protein in urine	<input type="radio"/>	<input type="radio"/>
12.a. Painful shoulder, elbow or wrist (e.g. pain, dislocation, etc.)	<input type="radio"/>	<input type="radio"/>	l. Sexually transmitted disease (syphilis, gonorrhea, chlamydia, genital warts, herpes, etc.)	<input type="radio"/>	<input type="radio"/>
b. Arthritis, rheumatism, or bursitis	<input type="radio"/>	<input type="radio"/>	14.a. Adverse reaction to serum, food, insect stings or medicine	<input type="radio"/>	<input type="radio"/>
c. Recurrent back pain or any back problem	<input type="radio"/>	<input type="radio"/>	b. Recent unexplained gain or loss of weight	<input type="radio"/>	<input type="radio"/>
d. Numbness or tingling	<input type="radio"/>	<input type="radio"/>	c. Currently in good health (If no, explain in Item 29 on Page 2.)	<input type="radio"/>	<input type="radio"/>
e. Loss of finger or toe	<input type="radio"/>	<input type="radio"/>	d. Tumor, growth, cyst, or cancer	<input type="radio"/>	<input type="radio"/>

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

YES NO

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

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

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

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

- 19. Have you been refused employment or been unable to hold a job or stay in school because of:
 - a. Sensitivity to chemicals, dust, sunlight, etc. YES NO
 - b. Inability to perform certain motions YES NO
 - c. Inability to stand, sit, kneel, lie down, etc. YES NO
 - d. Other medical reasons (If yes, give reasons.) YES NO

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

21. Have you ever been a patient in any type of hospital? (If yes, specify when, where, why, and name of doctor and complete address of hospital.) YES NO

22. Have you ever had, or have you been advised to have any operations or surgery? (If yes, describe and give age at which occurred.) YES NO

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

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

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

26. Have you ever been discharged from military service for any reason? (If yes, give date, reason, and type of discharge; whether honorable, other than honorable, for unfitness or unsuitability.) YES NO

27. Have you ever received, is there pending, or have you ever applied for pension or compensation for any disability or injury? (If yes, specify what kind, granted by whom, and what amount, when, why.) YES NO

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

29. EXPLANATION OF "YES" ANSWER(S) (Describe answer(s), give date(s) of problem, name of doctor(s) and/or hospital(s), treatment given and current medical status.)

NOTE: HAND TO THE DOCTOR OR NURSE, OR IF MAILED MARK ENVELOPE "TO BE OPENED BY MEDICAL PERSONNEL ONLY."

LAST NAME, FIRST NAME, MIDDLE NAME (SUFFIX)

SOCIAL SECURITY NUMBER

30. EXAMINER'S SUMMARY AND ELABORATION OF ALL PERTINENT DATA *(Physician/practitioner shall comment on all positive answers in questions 10 - 29. Physician/practitioner may develop by interview any additional medical history deemed important, and record any significant findings here.)*

a. COMMENTS

b. TYPED OR PRINTED NAME OF EXAMINER *(Last, First, Middle Initial)*

c. SIGNATURE

d. DATE SIGNED
(YYYYMMDD)



UNITED STATES MARINE CORPS

FORCE HEADQUARTERS GROUP
2000 OPELOUSAS AVE NEW
ORLEANS LA 70146-5400

IN REPLY REFER TO:
1040
CarPlan

Subj: HEIGHT AND WEIGHT VERIFICATION FOR IMA AND IRR RETENTION

Ref: (a) MCO 6110.13 W CH 2
(b) MCO 1040R.35

Date: _____

Rank/Name: _____ EDIPI: _____

Marine's Age: _____ years old Date of Birth: _____ (yyymmdd)

Height: _____ inches

Weight: _____ lbs

Max Wt: _____ lbs (only those exceeding height/weight standards will undergo a body fat assessment)

Body Fat: _____ %

MALES:		Abdomen	Neck			Abdomen	Neck
1				1			
2				2			
3				3			

- | | Male Age | Percent |
|---|----------|---------|
| 1. Abdomen (round down to the ½") _____ Inches | 17-25 | 18% |
| 2. Neck (round up to the nearest ½") _____ Inches | 26-35 | 19% |
| 3. Subtract (-) NECK from ABDOMEN and RECORD _____ Inches | 36-45 | 20% |
| 4. PERCENT FAT ESTIMATION for MALE HEIGHT is _____ % | 46+ | 21% |

FEMALES:		Abdomen	Hips	Neck			Abdomen	Hips	Neck
1					1				
2					2				
3					3				

- | | Female Age | Percent |
|--|------------|---------|
| 1. Abdomen (round down to the ½") _____ Inches | 17-25 | 26% |
| 2. Hips (round down to the nearest ½") _____ Inches | 26-35 | 27% |
| 3. Neck (round up to the nearest ½") _____ Inches | 36-45 | 28% |
| 4. Add WAIST (+) HIP then Subtract (-) NECK _____ Inches | 46+ | 29% |
| 5. PERCENT FAT ESTIMATION for FEMALE HEIGHT is _____ % | | |

Verifier: _____
Rank
Last Name
First Name
MI
(Signature)

Verifier: _____
Rank
Last Name
First Name
MI
(Signature)

Signature of Marine

CO/XO/SGTMAJ CERTIFIER



UNITED STATES MARINE CORPS

FORCE HEADQUARTERS GROUP
2000 OPELOUSAS AVE NEW
ORLEANS LA 70146-5400

IN REPLY REFER TO:
1040
CarPlan

From: _____
RANK LAST NAME, FIRST NAME, MI EDIPI/MOS

To: Commandant of the Marine Corps (CMC)-Retention Continuation Transition
 (RCT), 3280 Russell Rd, Quantico, VA 22134-5103

Via: Marine Corps Individual Reserve Support Activity, Career Planner

Subj: AUTHORIZATION TO USE PHA/PHYSICAL/MEDICAL DOCUMENTATION IN CONJUNCTION
 WITH MY RETENTION REQUEST

1. In connection with my request and intent to reenlist/extend, I,
 _____, authorize HQMC and all its necessary
 entities including Marine Corps Individual Reserve Support Activity, authority
 to review and submit aforementioned documents in consideration of such
 request.

2. I may be reached at _____.

Signature of Marine

MARINE CORPS INDIVIDUAL RESERVES SUPPORT ACTIVITY MEDICAL CHECK IN SHEET

This check in sheet is required to receive associate duty orders to complete requirements for your medical and dental readiness. This check in sheet must be completed and turned back in to MCIRSA medical before your orders are completed.

Marines rank _____

Marines name _____

Marines EDIPI (on military ID card) _____

Military treatment facility name _____

Appointment time _____ Date _____

Physical health assessment (PHA) completion (date) _____

HIV draw completion date _____

Dental examination completion date _____

Dental class (1,2,3,4) _____

Notes: Completed DD form 2807 and DD 2813 must be submitted with this check in sheet via EPAR using the subject "Medical" to ensure your medical readiness is received and ran correctly.