

## 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](http://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](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 (RREL) Request

<b>1. Rank</b> E6 / SSgt		<b>2. Name</b> (Last, First, MI) MARINE, IM A				<b>3. EDIPI</b> 0123456789		<b>4. MOS</b> 3043		<b>5. BMOS</b> 8014	
<b>6. DOR</b> 10/01/2014	<b>7. AFADBD</b> 20100307	<b>8. PEBD</b> 20060327	<b>9. RECC</b> 20181001	<b>10. EAS</b> 20120601	<b>11. DCTB</b> 20141003	<b>12. MDSD</b> 20120326	<b>13. CRCR Cert Date</b> 201502	<b>14. RCOMP</b> KF	<b>15. RUC</b> 88831	<b>16. MCC</b> HAB	
<b>17. Type of Request</b> Reenlistment					<b>18. Length Requested</b> (2,3,4) # OF YEARS		<b>19. Career Designated (AR Only)</b> N/A			<b>20. SOE Code</b> N/A	
<b>21. Organization</b> (Unit / Section) <b>LIST YOUR IMA DET/UNIT</b>								<b>22. Work Phone</b> (123) 456-7890			
<b>23. Conduct / Proficiency Marks</b> AVG CON in Enlistment _____ AVG PRO in Enlistment _____ (For ALL Cpls and below, to include Sgt's with less than 2 yrs TIG.)						<b>24. Fitness Report Validation</b> FitRep Date Gap(s) <input type="checkbox"/> Yes <input type="checkbox"/> No Date Verified : _____					
<b>25. Test Scores</b> (FTAP / LatMove Only)				<b>26. Duty Station Options</b> (AR / LatMove Only)			<b>27. LATMOVE Choices</b> (List only those MOS's SNM is qualified for.)				
GT		MM		EL		CL		1st	2nd	3rd	
<b>28. High School Graduate (MSO Only)</b> <input type="checkbox"/> Yes <input type="checkbox"/> No							<b>29. Previous Requests (Within last 12 months.)</b> <input type="checkbox"/> Yes <input type="checkbox"/> No				
<b>30. Draw Case Codes</b>		1) _____ / _____		2) _____ / _____		3) _____ / _____					
<b>31. UCMJ History</b> (This section will include all Military and Civilian convictions on current contract or within the last 5 years)											
Conviction Type : _____				Articles(s) : _____				Date : _____			
Conviction Type : _____				Articles(s) : _____				Date : _____			
Conviction Type : _____				Articles(s) : _____				Date : _____			
<b>32. Bonus Eligibility</b>						<b>Previous Bonus Payments</b>					
Is SNM currently eligible for EAB/SSB? <input type="checkbox"/> Yes <input type="checkbox"/> No (If yes, SOU must be completed.)						EAB/SSB: _____ Amount Paid : _____					
Is SNM currently eligible for KICKER? <input type="checkbox"/> Yes <input type="checkbox"/> No (If Yes, ensure SNM understands and completes kicker SOU)						EAB/SSB: _____ Amount Paid : _____					
REB: _____ Bonus Amount : _____						EAB/SSB: _____ Amount Paid : _____					
<b>33. Does SNM Require a Tattoo Waiver?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No (SDA Only)						(If yes, attach Color Photo and descriptions.)					
<b>34. Does SNM Have Broken / Prior Service?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No						(If yes, attach Statement of Service (NAVMC 11501).)					
<b>35. Active Duty Spouse Information</b>											
<b>35a. Name</b>		<b>35b. Rank</b>		<b>35c. MOS</b>		<b>35d. Branch</b>		<b>35e. EAS</b>		<b>35f. MCC</b>	
ACDU Spouse Name											
<b>36. Remarks</b>  (NOTE: Write out your retention request and length; and include any other retention related constraints or incentive requests.)											
<b>37. Member Certification.</b> I certify that to the best of my knowledge all information provided above is accurate.											
<b>Marine's Signature :</b> _____ <b>MARINE HAND SIGN</b>						<b>Date :</b> _____ YYYYMMDD					
<b>Career Planner's Signature :</b> _____						<b>Date :</b> _____					

# Reserve Reenlistment Extension Lateral Move (RREL) Request

(All signatures on this form must be within 90 days of submission)

<b>Rank</b>	<b>Name</b>	<b>EDIPI</b>
E6 / SSgt	MARINE, IM A	0123456789

**38. Command Screening**

**38a. Medical Certification**

SNM has been **SCREENED / EXAMINED** and found **QUALIFIED / UNQUALIFIED** for retention.

SNM's Duty Status is : ☐ Full Duty ☐ Light Duty  
☐ Limited Duty ☐ No Duty

*(Medical MUST be recertified if SNM fails to reenlist within 90 days.)*

If unqualified give reason :

**(NOTE: ENSURE THAT APPROPRIATE STATUS IS CIRCLED ABOVE - "SCREENED OR EXAMINED"; "QUALIFIED OR UNQUALIFIED")**

Rank
Name

Medical Officer / IDC / Medical Rep Signature
Date

**38b. Dental Certification**

SNM has been **SCREENED / EXAMINED** and found **QUALIFIED / UNQUALIFIED** for retention.

SNM's Dental Class : \_\_\_\_\_

If unqualified give reason :

**(NOTE: ENSURE THAT APPROPRIATE STATUS IS CIRCLED ABOVE - "SCREENED OR EXAMINED"; "QUALIFIED OR UNQUALIFIED")**

Rank
Name

Dental Officer / IDC / Medical Rep Signature
Date

**38c. Security Screening (S-2)**

Does SNM have a security clearance? ☐ Yes ☐ No

*(If so, provide letter from the Security Manager / SSO stating what level and the date it was adjudicated)*

Comments :

**(NOTE: SEE YOUR SECURITY MANAGER IF APPLICABLE; OTHERWISE NOTIFY CAREER PLANNER)**

Rank
Name

Security (S-2) Signature
Date

**38d. Training Certification (S-3)**

PFT Date : \_\_\_\_\_ Score : \_\_\_\_\_ Class : \_\_\_\_\_

CFT Date : \_\_\_\_\_ Score : \_\_\_\_\_ Class : \_\_\_\_\_

Ht : \_\_\_\_\_ Wt : \_\_\_\_\_ Max : \_\_\_\_\_ BF% : \_\_\_\_\_

BCP Program : ☐ Yes ☐ No Date Assigned \_\_\_\_\_

Comments :

**(NOTE: IF PFT/CFT NOT CURRENT IN BTR/MCTFS, THEN ATTACH PFT/CFT INVENTORY ROSTERS)**

Rank
Name

Training (S-3) Signature
Date

**Note:** If SNM exceeds ht/wt standards must be signed off by SgtMaj or CO.

**NOT REQUIRED: DISREGARD THIS NOTE WRT SGTMAJ/CO SIGNATURE**

SgtMaj/CO Name, Rank, Signature and Date

**38e. Legal Certification**

Legal action may include actions taken by civilian authorities.

Is SNM pending any legal action at this time? ☐ Yes ☐ No

*(If yes, documents must be provided.)*

Comments :

**(NOTE: SNM CANNOT SELF-CERTIFY. TO BE COMPLETED BY OP SPONSOR, OIC, OR SEA)**

Rank
Name

Legal (S-1) Signature
Date

**38f. SACO Certification**

Has SNM been assigned to any treatment program during the current contract? ☐ Yes ☐ No

*(If yes, certificate of completion must be provided.)*

Comments :

**(NOTE: SNM CANNOT SELF-CERTIFY. TO BE COMPLETED BY OP SPONSOR, OIC, OR SEA)**

Rank
Name

SACO Signature
Date

## Reserve Reenlistment Extension Lateral Move (RRELM) Request

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

<b>Rank</b>	<b>Name</b>	<b>EDIPI</b>	
E6 / SSgt	MARINE, IM A	0123456789	

**39. Command Recommendations**

**39a. SNCOIC** ☐ Recommended ☐ Not Recommended

Comments :

(WITHIN YOUR CHAIN OF COMMAND, IF APPLICABLE)

\_\_\_\_\_  
Rank Name Signature Date

**39b. OIC** ☐ Recommended ☐ Not Recommended

Comments :

(WITHIN YOUR CHAIN OF COMMAND, IF APPLICABLE)

\_\_\_\_\_  
Rank Name Signature Date

**39c. SENIOR ENLISTED STAFF SECTION** ☐ Recommended ☐ Not Recommended

Comments :

(WITHIN YOUR CHAIN OF COMMAND, IF APPLICABLE)

\_\_\_\_\_  
Rank Name Signature Date

**39d. STAFF SECTION OIC** ☐ Recommended ☐ Not Recommended

Comments :

(WITHIN YOUR CHAIN OF COMMAND, IF APPLICABLE)

\_\_\_\_\_  
Rank Name Signature Date

**\*RETURN TO CAREER PLANNING OFFICE\***

**NAVMC 11537A** (Rev. 1-2015) (EF)  
PREVIOUS EDITIONS ARE OBSOLETE

FOR OFFICIAL USE ONLY  
Privacy sensitive when filled in

## Reserve Reenlistment Extension Lateral Move (RRELM) Request

<b>Rank</b> E6 / SSgt	<b>Name</b> MARINE, IM A	<b>EDIPI</b> 0123456789
--------------------------	-----------------------------	----------------------------

**39e. SENIOR ENLISTED ADVISOR**

Is SNM recommended for this request: ☐ Yes ☐ No

Comments :

(WITHIN YOUR CHAIN OF COMMAND, IF APPLICABLE; STRONGLY RECOMMENDED)

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Rank

Name

Signature

Date

**39f. OP SPONSOR/RSP OIC**

Is SNM recommended for this request: ☐ Yes ☐ No

Comments :

(WITHIN YOUR CHAIN OF COMMAND, IF APPLICABLE; RECOMMENDED IF OP SPONSOR DOES NOT COMPLETE BLOCK 39G; OR MANDATORY FOR RSP COMMANDER)

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Rank

Name

Signature

Date

## Reserve Reenlistment Extension Lateral Move (RRELM) Request

<b>Rank</b>	<b>Name</b>	<b>EDIPI</b>
E6 / SSgt	MARINE, IM A	0123456789

### 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 **{\*FOR CAREER PLANNER ACTION\***





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.

<b>Commander's Tier Evaluation:</b>	<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):

(NOTE: To be completed by your IMA Det/Unit Commanding Officer or Op Sponsor (must provide Op Sponsor Appointment/Authority Letter to SNM or MCIRSA Career Planners). The MCIRSA Director may also complete this recommendation (default Tier II); however in this case, the SNCOIC/SEA, OIC, or Op Sponsor recommendation blocks are mandatory. RSP Commanders cannot complete this block.)

Rank

Name

Signature

Date



<b>REPORT OF MEDICAL HISTORY</b> (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 Aug 31, 2014
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, Information Management Division, 1155 Defense Pentagon, Washington, DC 20301-1155 (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.		
<b>PLEASE DO NOT RETURN YOUR FORM TO THE ABOVE ORGANIZATION. RETURN COMPLETED FORM AS INDICATED ON PAGE 2.</b>		
<b>PRIVACY ACT STATEMENT</b>		
<b>AUTHORITY:</b> 10 U.S.C. 136, DoD Instruction 6130.03, and E.O. 9397, as amended (SSN). <b>PRINCIPAL PURPOSE(S):</b> 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. <b>ROUTINE USE(S):</b> The Blanket Routine Uses found at <a href="http://privacy.defense.gov/blanket_uses.shtml">http://privacy.defense.gov/blanket_uses.shtml</a> apply to this collection. <b>DISCLOSURE:</b> 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.		
<b>WARNING:</b> 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.		
<b>1. LAST NAME, FIRST NAME, MIDDLE NAME (SUFFIX)</b> MARINE, IM AWESOME	<b>2. SOCIAL SECURITY NUMBER</b> 123-45-6789	<b>3. TODAY'S DATE (YYYYMMDD)</b> 20150901
<b>4.a. HOME ADDRESS (Street, Apartment No., City, State, and ZIP Code)</b> PHYSICAL OR MAILING ADDRESS	<b>6. EXAMINING LOCATION AND ADDRESS (Include ZIP Code)</b> NAME OF MEDICAL LOCATION/OFFICE ADDRESS W/ZIP	
<b>b. HOME TELEPHONE (include Area Code)</b> (123) 456-7890		
<b>X ALL APPLICABLE BOXES:</b>		<b>7.a. POSITION (Title, Grade, Component)</b> (RANK) / (GRADE) / IMA
<b>8.a. SERVICE</b> <input type="checkbox"/> Army <input type="checkbox"/> Coast Guard <input type="checkbox"/> Navy <input checked="" type="checkbox"/> Marine Corps <input type="checkbox"/> Air Force	<b>b. COMPONENT</b> <input type="checkbox"/> Regular <input checked="" type="checkbox"/> Reserve <input type="checkbox"/> National Guard	<b>c. PURPOSE OF EXAMINATION</b> <input type="checkbox"/> Enlistment <input type="checkbox"/> Medical Board <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Commission <input type="checkbox"/> Retirement <input checked="" type="checkbox"/> Retention <input type="checkbox"/> U.S. Service Academy <input type="checkbox"/> Separation <input type="checkbox"/> ROTC Scholarship Program
<b>8. CURRENT MEDICATIONS (Prescription and Over-the-counter)</b> (self-explanatory)		<b>9. ALLERGIES (Including insect bites/stings, foods, medicine or other substance)</b> (self-explanatory)
<b>Mark each item "YES" or "NO". Every item marked "YES" must be fully explained in Item 29 on Page 2.</b>		
<b>HAVE YOU EVER HAD OR DO YOU NOW HAVE:</b> YES    NO		<b>12. (Continued)</b> YES    NO
<b>10.a. Tuberculosis</b> <input type="radio"/> YES <input type="radio"/> NO		<b>f. Foot trouble (e.g., pain, corns, bunions, etc.)</b> <input type="radio"/> YES <input type="radio"/> NO
<b>b. Lived with someone who had tuberculosis</b> <input type="radio"/> YES <input type="radio"/> NO		<b>g. Impaired use of arms, legs, hands, or feet</b> <input type="radio"/> YES <input type="radio"/> NO
<b>c. Coughed up blood</b> <input type="radio"/> YES <input type="radio"/> NO		<b>h. Swollen or painful joint(s)</b> <input type="radio"/> YES <input type="radio"/> NO
<b>d. Asthma or any breathing problems related to exercise, weather, pollens, etc.</b> <input type="radio"/> YES <input type="radio"/> NO		<b>i. Knee trouble (e.g., locking, giving out, pain or ligament injury, etc.)</b> <input type="radio"/> YES <input type="radio"/> NO
<b>e. Shortness of breath</b> <input type="radio"/> YES <input type="radio"/> NO		<b>j. Any knee or foot surgery including arthroscopy or the use of a scope to any bone or joint</b> <input type="radio"/> YES <input type="radio"/> NO
<b>f. Bronchitis</b> <input type="radio"/> YES <input type="radio"/> NO		<b>k. Any need to use corrective devices such as prosthetic devices, knee brace(s), back support(s), lifts or orthotics, etc.</b> <input type="radio"/> YES <input type="radio"/> NO
<b>g. Wheezing or problems with wheezing</b> <input type="radio"/> YES <input type="radio"/> NO		<b>l. Bone, joint, or other deformity</b> <input type="radio"/> YES <input type="radio"/> NO
<b>h. Been prescribed or used an inhaler</b> <input type="radio"/> YES <input type="radio"/> NO		<b>m. Plate(s), screw(s), rod(s) or pin(s) in any bone</b> <input type="radio"/> YES <input type="radio"/> NO
<b>i. A chronic cough or cough at night</b> <input type="radio"/> YES <input type="radio"/> NO		<b>n. Broken bone(s) (cracked or fractured)</b> <input type="radio"/> YES <input type="radio"/> NO
<b>j. Sinusitis</b> <input type="radio"/> YES <input type="radio"/> NO		<b>13.a. Frequent indigestion or heartburn</b> <input type="radio"/> YES <input type="radio"/> NO
<b>k. Hay fever</b> <input type="radio"/> YES <input type="radio"/> NO		<b>b. Stomach, liver, intestinal trouble, or ulcer</b> <input type="radio"/> YES <input type="radio"/> NO
<b>l. Chronic or frequent colds</b> <input type="radio"/> YES <input type="radio"/> NO		<b>c. Gall bladder trouble or gallstones</b> <input type="radio"/> YES <input type="radio"/> NO
<b>11.a. Severe tooth or gum trouble</b> <input type="radio"/> YES <input type="radio"/> NO		<b>d. Jaundice or hepatitis (liver disease)</b> <input type="radio"/> YES <input type="radio"/> NO
<b>b. Thyroid trouble or goiter</b> <input type="radio"/> YES <input type="radio"/> NO		<b>e. Rupture/hernia</b> <input type="radio"/> YES <input type="radio"/> NO
<b>c. Eye disorder or trouble</b> <input type="radio"/> YES <input type="radio"/> NO		<b>f. Rectal disease, hemorrhoids or blood from the rectum</b> <input type="radio"/> YES <input type="radio"/> NO
<b>d. Ear, nose, or throat trouble</b> <input type="radio"/> YES <input type="radio"/> NO		<b>g. Skin diseases (e.g. acne, eczema, psoriasis, etc.)</b> <input type="radio"/> YES <input type="radio"/> NO
<b>e. Loss of vision in either eye</b> <input type="radio"/> YES <input type="radio"/> NO		<b>h. Frequent or painful urination</b> <input type="radio"/> YES <input type="radio"/> NO
<b>f. Worn contact lenses or glasses</b> <input type="radio"/> YES <input type="radio"/> NO		<b>i. High or low blood sugar</b> <input type="radio"/> YES <input type="radio"/> NO
<b>g. A hearing loss or wear a hearing aid</b> <input type="radio"/> YES <input type="radio"/> NO		<b>j. Kidney stone or blood in urine</b> <input type="radio"/> YES <input type="radio"/> NO
<b>h. Surgery to correct vision (RK, PRK, LASIK, etc.)</b> <input type="radio"/> YES <input type="radio"/> NO		<b>k. Sugar or protein in urine</b> <input type="radio"/> YES <input type="radio"/> NO
<b>12.a. Painful shoulder, elbow or wrist (e.g. pain, dislocation, etc.)</b> <input type="radio"/> YES <input type="radio"/> NO		<b>l. Sexually transmitted disease (syphilis, gonorrhea, chlamydia, genital warts, herpes, etc.)</b> <input type="radio"/> YES <input type="radio"/> NO
<b>b. Arthritis, rheumatism, or bursitis</b> <input type="radio"/> YES <input type="radio"/> NO		<b>14.a. Adverse reaction to serum, food, insect stings or medicine</b> <input type="radio"/> YES <input type="radio"/> NO
<b>c. Recurrent back pain or any back problem</b> <input type="radio"/> YES <input type="radio"/> NO		<b>b. Recent unexplained gain or loss of weight</b> <input type="radio"/> YES <input type="radio"/> NO
<b>d. Numbness or tingling</b> <input type="radio"/> YES <input type="radio"/> NO		<b>c. Currently in good health (If no, explain in Item 29 on Page 2.)</b> <input type="radio"/> YES <input type="radio"/> NO
<b>e. Loss of finger or toe</b> <input type="radio"/> YES <input type="radio"/> NO		<b>d. Tumor, growth, cyst, or cancer</b> <input type="radio"/> YES <input type="radio"/> NO

LAST NAME, FIRST NAME, MIDDLE NAME (SUFFIX) <b>MARINE, IM AWESOME</b>		SOCIAL SECURITY NUMBER <b>123-45-6789</b>	
<b>Mark each item "YES" or "NO". Every item marked "YES" must be fully explained in Item 28 below.</b>			
<b>HAVE YOU EVER HAD OR DO YOU NOW HAVE:</b>		<b>YES</b>	<b>NO</b>
15.a. Dizziness or fainting spells	<input type="radio"/>	<input type="radio"/>	18. 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. <input type="radio"/> <input type="radio"/> b. Inability to perform certain motions <input type="radio"/> <input type="radio"/> c. Inability to stand, sit, kneel, lie down, etc. <input type="radio"/> <input type="radio"/> d. Other medical reasons (If yes, give reasons.) <input type="radio"/> <input type="radio"/> 20. Have you ever been treated in an Emergency Room? (If yes, for what?) <input type="radio"/> <input type="radio"/> 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.) <input type="radio"/> <input type="radio"/> 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.) <input type="radio"/> <input type="radio"/> 23. Have you ever had any illness or injury other than those already noted? (If yes, specify when, where, and give details.) <input type="radio"/> <input type="radio"/> 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.) <input type="radio"/> <input type="radio"/> 26. Have you ever been rejected for military service for any reason? (If yes, give date and reason for rejection.) <input type="radio"/> <input type="radio"/> 28. 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.) <input type="radio"/> <input type="radio"/> 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.) <input type="radio"/> <input type="radio"/> 28. Have you ever been denied life insurance? <input type="radio"/> <input type="radio"/>
b. Frequent or severe headache	<input type="radio"/>	<input type="radio"/>	
c. A head injury, memory loss or amnesia	<input type="radio"/>	<input type="radio"/>	
d. Paralysis	<input type="radio"/>	<input type="radio"/>	
e. Seizures, convulsions, epilepsy or fits	<input type="radio"/>	<input type="radio"/>	
f. Car, train, sea, or air sickness	<input type="radio"/>	<input type="radio"/>	
g. A period of unconsciousness or concussion	<input type="radio"/>	<input type="radio"/>	
h. Meningitis, encephalitis, or other neurological problems	<input type="radio"/>	<input type="radio"/>	
18.a. Rheumatic fever	<input type="radio"/>	<input type="radio"/>	28. 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.) (SNM EXPLAINS "YES" ANSWERS FROM ITEMS 10-28)
b. Prolonged bleeding (as after an injury or tooth extraction, etc.)	<input type="radio"/>	<input type="radio"/>	
c. Pain or pressure in the chest	<input type="radio"/>	<input type="radio"/>	
d. Palpitation, pounding heart or abnormal heartbeat	<input type="radio"/>	<input type="radio"/>	
e. Heart trouble or murmur	<input type="radio"/>	<input type="radio"/>	
f. High or low blood pressure	<input type="radio"/>	<input type="radio"/>	
17.a. Nervous trouble of any sort (anxiety or panic attacks)	<input type="radio"/>	<input type="radio"/>	
b. Habitual stammering or stuttering	<input type="radio"/>	<input type="radio"/>	
c. Loss of memory or amnesia, or neurological symptoms	<input type="radio"/>	<input type="radio"/>	
d. Frequent trouble sleeping	<input type="radio"/>	<input type="radio"/>	
e. Received counseling of any type	<input type="radio"/>	<input type="radio"/>	
f. Depression or excessive worry	<input type="radio"/>	<input type="radio"/>	
g. Been evaluated or treated for a mental condition	<input type="radio"/>	<input type="radio"/>	
h. Attempted suicide	<input type="radio"/>	<input type="radio"/>	
i. Used illegal drugs or abused prescription drugs	<input type="radio"/>	<input type="radio"/>	
18. FEMALES ONLY. Have you ever had or do you now have:			
a. Treatment for a gynecological (female) disorder	<input type="radio"/>	<input type="radio"/>	
b. A change of menstrual pattern	<input type="radio"/>	<input type="radio"/>	
c. Any abnormal PAP smears	<input type="radio"/>	<input type="radio"/>	
d. First day of last menstrual period (YYYYMMDD)			
e. Date of last PAP smear (YYYYMMDD)			

**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) <b>MARINE, IM AWESOME</b>		SOCIAL SECURITY NUMBER <b>123-45-6789</b>
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.)		
<b>a. COMMENTS</b> (Note for EXAMINER: if applicable, statement of "cleared for full duty" or "no limitations" should be written after overall MO/Physician/IDC comments.)		
<b>b. TYPED OR PRINTED NAME OF EXAMINER (Last, First, Middle Initial)</b> NAME OF MEDICAL OFFICER/PHYSICIAN/IDC		<b>c. SIGNATURE</b> SIGNATURE OF EXAMINER
		<b>d. DATE SIGNED</b> (YYYYMMDD)



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

OMB No. 0720-0022  
OMB approval expires  
Jul 31, 2009

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, Executive Service Directorate (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:** Public Law 105-85, Sec. 765; DoD Directive 6490.2; E.O. 9397.

**ROUTINE USE(S):** None.

**PRINCIPAL PURPOSE(S):** An assessment by a dentist of the state of your dental health for the next 12 months is needed to determine your fitness for prolonged duty without ready access to dental care.

**DISCLOSURE:** Voluntary; however, failure to provide the information may result in delays in assessing your dental health needs for military service.

**1. SERVICE MEMBER'S NAME (Last, First, Middle Initial)**

MARINE, IM A

**2. SOCIAL SECURITY NUMBER**

123-45-6789

**3. BRANCH OF SERVICE**

USMCR

**4. UNIT OF ASSIGNMENT**

IMA DET/UNIT NAME

**5. UNIT ADDRESS**

IMA DET/UNIT ADDRESS

**6. EXAMINATION RESULTS**

Dear Doctor,

The individual you are examining is an Active Duty/Guard/Reserve 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.**

(1) Patient has good oral health and is not expected to require dental treatment or reevaluation for 12 months.

(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).

(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)

- (a) **Infections:** Acute oral infections, pulpal or periapical pathology, chronic oral infections, or other pathologic lesions and lesions requiring biopsy or awaiting biopsy report.
- (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.
- (c) **Missing Teeth:** Edentulous areas requiring immediate prosthodontic treatment for adequate mastication, communication, or acceptable esthetics.
- (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.
- (e) **Oral Surgery:** Unerupted, partially erupted, or malposed teeth with historical, clinical, or radiographic signs or symptoms of pathosis that are recommended for removal.
- (f) **Other:** Temporomandibular disorders or myofascial pain dysfunction requiring active treatment.

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

(5) Were X-rays consulted?

YES

NO

IF YES, DATE X-RAY WAS TAKEN (YYYYMMDD)

**7. DENTIST'S NAME (Last, First, Middle Initial)**

NAME OF DENTIST

**8. DENTIST'S ADDRESS (Street, City, State, 9-digit ZIP Code)**

ADDRESS AND/OR STAMP OF DENTAL OFFICE

**9. DENTIST'S TELEPHONE NUMBER (Include Area Code)**

(123) 456-7890

**10. DENTIST'S SIGNATURE/STATE LICENSE NUMBER**

SIGNATURE OF DENTAL EXAMINER AND CIVILIAN STATE LICENSE NO.

**11. DATE OF EXAMINATION (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: \_\_\_\_\_ SGT MARINE, IM A EDIPI: 0123456789

Marine's Age: 24 years old Date of Birth: 19910101 (yyyymmdd)

Height: 70 inches

Weight: 192 lbs

Max Wt: 191 lbs (only those exceeding height/weight standards will undergo a body fat assessment)

\*Body Fat: 17 %

## MALES:

	Abdomen	Neck		Abdomen	Neck
1	33.5	15	1	33.5	16
2	34	15.5	2	34.5	15
3	34.5	16	3	34	15.5

1. Abdomen (round down to the ½") 34 Inches
2. Neck (round up to the nearest ½") 15.5 Inches
3. Subtract (-) NECK from ABDOMEN and RECORD 18.5 Inches
4. PERCENT FAT ESTIMATION for MALE HEIGHT is 17 %

Male Age	Percent
17-25	18%
26-35	19%
36-45	20%
46+	21%

## FEMALES:

	Abdomen	Hips	Neck		Abdomen	Hips	Neck
1				1			
2				2			
3				3			

1. Abdomen (round down to the ½") \_\_\_\_\_ Inches
2. Hips (round down to the nearest ½") \_\_\_\_\_ Inches
3. Neck (round up to the nearest ½") \_\_\_\_\_ Inches
4. Add WAIST (+) HIP then Subtract (-) NECK \_\_\_\_\_ Inches
5. PERCENT FAT ESTIMATION for FEMALE HEIGHT is \_\_\_\_\_ %

Female Age	Percent
17-25	26%
26-35	27%
36-45	28%
46+	29%

Verifier: SGT WALKER WATER WATER WALKER  
Rank Last Name First Name MI (Signature)

Verifier: SSGT HARDER TRAIN (Only if body fat assessment necessary)  
Rank Last Name First Name MI (Signature)

I Am Marine  
Signature of Marine

(Only if body fat assessment necessary)  
CO/XO/SGTMAJ CERTIFIER



UNITED STATES MARINE CORPS

MARINE FORCES RESERVE  
2000 OPELOUSAS AVE  
NEW ORLEANS, LA 70146

IN REPLY REFER TO:  
1040  
CarPlan

From: SGT MARINE, IM A 0123456789  
RANK LAST NAME, FIRST NAME, MI EDIPI/MOS

To: Career Planner, Marine Corps Individual Reserve Support Activity, Force Headquarters Group, Marine Forces Reserve

Subj: INDIVIDUAL MOBILIZATION AUGMENTEE RETENTION STATEMENT OF UNDERSTANDING (SOU)

Ref: (a) MARADMIN 436/11  
(b) MCO P1001R.1\_  
(c) DOD Directive 1235.13 para 4.18

1. Future retention in the Individual Mobilization Augmentee (IMA) will be based on the following, as applicable:

a. Per reference (a)(b), I understand that if I am not retirement eligible (have not attained 20 satisfactory years), I must maintain 50 retirement points each anniversary year to attain a satisfactory year towards retirement. \_\_\_\_ INT

b. Per reference (c), I understand that once I have reached 20 satisfactory years (considered retirement eligible), I must maintain satisfactory years each anniversary year thereafter, to maintain retention eligibility. If I do not maintain satisfactory years, I may be asked to retire. \_\_\_\_ INT

c. I understand that based on the date outlined in paragraph 2, that in my Marine Online Account, my Career Retirement Credit Record (CRCR) indicates certification date of \_\_\_\_ YYYYMM \_\_\_\_; I understand Marine Corps Total Force System reflects (this same information as in Marine Online) 6 unsatisfactory years and 1 satisfactory years. \_\_\_\_ INT

d. I understand that in order to be retained in the IMA I may not have more than 10 collective unsatisfactory years. \_\_\_\_ INT

e. I understand that I will not be favorably endorsed for retention if I have more than 2 consecutive unsatisfactory years. \_\_\_\_ INT

f. I understand that any deviation from the above criteria may require a waiver from CMC, Headquarters Marine Corps. \_\_\_\_ INT

g. I understand that at 45 days from my RECC, if my reenlistment package is not complete, I can be dropped to the IRR. \_\_\_\_ INT

h. I understand that at 30 days from my RECC, if my reenlistment package has not been submitted to Headquarters Marine Corps I may need to contact a local Prior Service Recruiter for further affiliation in the IMA.

2. On this date, \_\_\_\_ YYYYMMDD \_\_\_\_, I, \_\_\_\_ IM A MARINE \_\_\_\_, understand, accept, and agree to adhere to the criteria outlined above.

\_\_\_\_\_  
Marine Signature



# UNITED STATES MARINE CORPS

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

IN REPLY REFER TO:  
1040  
CarPlan

From: SGT MARINE, IM A 0123456789 / 0111  
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, **IM A MARINE**, 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 (123) 456-7890.

SIGNATURE

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 \_\_\_\_\_ Sgt \_\_\_\_\_

Marines name \_\_\_\_\_ I Am Marine \_\_\_\_\_

Marines EDIPI (on military ID card) \_\_\_\_\_ 123456789 \_\_\_\_\_

Military treatment facility name \_\_\_\_\_ Washington Naval Yard \_\_\_\_\_

Appointment time \_\_\_\_\_ 1500 \_\_\_\_\_ Date \_\_\_\_\_ January 1 2025 \_\_\_\_\_

Physical health assessment (PHA) completion (date) \_\_\_\_\_ January 1 2025 \_\_\_\_\_

HIV draw completion date \_\_\_\_\_ January 1 2025 \_\_\_\_\_

Dental examination completion date \_\_\_\_\_ January 1 2025 \_\_\_\_\_

Dental class (1,2,3,4) \_\_\_\_\_ 1 \_\_\_\_\_

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.