REENLISTMENT PREREQUISISTES 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.

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
E6 / SSgt	MARINE, IM A	0123456789	3043	8014

6. DOR	7. AFADBD	8. PEBD	9. RECC	10. EAS	11. DCTB	12. MDSD	13. CRCR Cert Date	14. RCOMP	15. RUC	16. MCC
10/01/2014	20100307	20060327	20181001	20120601	20141003	20120326	201502	KF	88831	HAB

17. Type of Request	18. Length Requested	19. Career Designated *(AR Only)*	20. SOE Code
Reenlistment	(2,3,4) # OF YEARS	N/A	N/A

21. Organization (Unit / Section): LIST YOUR IMA DET/UNIT

22. Work Phone: (123) 456-7890

NOTE: Career Planner completes Blocks 23-33)

23. Conduct / Proficiency Marks

AVG CON in Enlistment ____ AVG PRO in Enlistment ____

(For ALL Cpls and below, to include Sgt's with less than 2 yrs TIG.)

24. Fitness Report Validation

FitRep Date Gap(s) ☐ Yes ☐ No

Date Verified : _____

25. Test Scores *(FTAP / LatMove Only)*

GT		MM		EL		CL	

26. Duty Station Options *(AR / LatMove Only)*

1st	2nd	3rd

27. LATMOVE Choices *(List only those MOS's SNM is qualified for.)*

1st	2nd	3rd

28. High School Graduate *(MSO Only)* ☐ Yes ☐ No

29. Previous Requests *(Within last 12 months.)* ☐ Yes ☐ No

30. Draw Case Codes 1) ____ / ____ 2) ____ / ____ 3) ____ / ____

31. UCMJ History *(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 : _____

32. Bonus Eligibility

Is SNM currently eligible for EAB/SSB? ☐ Yes ☐ No

(If yes, SOU must be completed.)

Is SNM currently eligible for KICKER? ☐ Yes ☐ No

(*If Yes, ensure SNM understands and completes kicker SOU*)

REB: _____ Bonus Amount : _____

Previous Bonus Payments

EAB/SSB: _____ Amount Paid : _____

EAB/SSB: _____ Amount Paid : _____

EAB/SSB: _____ Amount Paid : _____

33. Does SNM Require a Tattoo Waiver? *(SDA Only)* ☐ Yes ☐ No *(If yes, attach Color Photo and descriptions.)*

34. Does SNM Have Broken / Prior Service? ☐ Yes ☐ No *(If yes, attach Statement of Service (NAVMC 11501).)*

35. Active Duty Spouse Information

35a. Name	35b. Rank	35c. MOS	35d. Branch	35e. EAS	35f. MCC	35g. RTD
ACDU Spouse Name						

36. Remarks

(NOTE: Write out your retention request and length; and include any other retention related constraints or incentive requests.)

37. Member Certification. I certify that to the best of my knowledge all information provided above is accurate.

Marine's Signature : **MARINE HAND SIGN** Date : YYYYMMDD

Career Planner's Signature : _____ Date : _____

Reserve Reenlistment Extension Lateral Move (RRELM) Request

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

Rank	Name	EDIPI
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.)

Rank	Name	EDIPI

39. Command Recommendations

39a. SNCOIC ☐ Recommended ☐ Not Recommended

Comments :
(WITHIN YOUR CHAIN OF COMMAND, IF APPLICABLE)

TIER LEVEL: I II III IV (CIRCLE ONE)

Rank | Name | Signature | Date

39b. OIC ☐ Recommended ☐ Not Recommended

Comments :
(WITHIN YOUR CHAIN OF COMMAND, IF APPLICABLE)

TIER LEVEL: I II III IV (CIRCLE ONE)

Rank | Name | Signature | Date

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

Comments :
(WITHIN YOUR CHAIN OF COMMAND, IF APPLICABLE)

TIER LEVEL: I II III IV (CIRCLE ONE)

Rank | Name | Signature | Date

39d. STAFF SECTION OIC ☐ Recommended ☐ Not Recommended

Comments :
(WITHIN YOUR CHAIN OF COMMAND, IF APPLICABLE)

TIER LEVEL: I II III IV (CIRCLE ONE)

Rank | Name | Signature | Date

RETURN TO CAREER PLANNING OFFICE

Reserve Reenlistment Extension Lateral Move (RRELM) Request

Rank	Name	EDIPI

39e. SENIOR ENLISTED ADVISOR

Is SNM recommended for this request: ☐ Yes ☐ No

Comments :

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

TIER LEVEL: I II III IV (CIRCLE ONE)

Rank	Name	Signature	Date

39f. EXECUTIVE OFFICER

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)

TIER LEVEL: I II III IV (CIRCLE ONE)

Rank	Name	Signature	Date

Reserve Reenlistment Extension Lateral Move (RRELM) Request

Rank	Name	EDIPI
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.

Commander's Tier Evaluation:			
	☐ I	10%	
	☐ II	30%	
	☐ III	50%	
	☐ 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

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: YYYYMMDD

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

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

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://dpcld.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)
MARINE, IM AWESOME	123-45-6789	20150901

4.a. HOME ADDRESS (Street, Apartment No., City, State, and ZIP Code)	5. EXAMINING LOCATION AND ADDRESS (Include ZIP Code)
PHYSICAL OR MAILING ADDRESS	NAME OF MEICAL LOCATION/OFFICE ADDRESS WITH ZIP
b. HOME TELEPHONE (Include Area Code) (123) 456-7890	

X ALL APPLICABLE BOXES:

6.a. SERVICE	b. COMPONENT	c. PURPOSE OF EXAMINATION	7.a. POSITION (Title, Grade, Component)
[ ] Army [ ] Coast Guard	[ ] Regular	[ ] Enlistment [ ] Medical Board [ ] Other (Specify)	(RANK) / (GRADE) / IMA
[ ] Navy	[X] Reserve	[ ] Commission [ ] Retirement	b. USUAL OCCUPATION
[X] Marine Corps	[ ] National Guard	[X] Retention [ ] U.S. Service Academy	MOS / BILLET TITLE
[ ] Air Force		[ ] Separation [ ] ROTC Scholarship Program	

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	O	O
b. Lived with someone who had tuberculosis	O	O
c. Coughed up blood	O	O
d. Asthma or any breathing problems related to exercise, weather, pollens, etc.	O	O
e. Shortness of breath	O	O
f. Bronchitis	O	O
g. Wheezing or problems with wheezing	O	O
h. Been prescribed or used an inhaler	O	O
i. A chronic cough or cough at night	O	O
j. Sinusitis	O	O
k. Hay fever	O	O
l. Chronic or frequent colds	O	O
11.a. Severe tooth or gum trouble	O	O
b. Thyroid trouble or goiter	O	O
c. Eye disorder or trouble	O	O
d. Ear, nose, or throat trouble	O	O
e. Loss of vision in either eye	O	O
f. Worn contact lenses or glasses	O	O
g. A hearing loss or wear a hearing aid	O	O
h. Surgery to correct vision *(RK, PRK, LASIK, etc.)*	O	O
12.a. Painful shoulder, elbow or wrist *(e.g. pain, dislocation, etc.)*	O	O
b. Arthritis, rheumatism, or bursitis	O	O
c. Recurrent back pain or any back problem	O	O
d. Numbness or tingling	O	O
e. Loss of finger or toe	O	O

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

LAST NAME, FIRST NAME, MIDDLE NAME (SUFFIX)	SOCIAL SECURITY NUMBER
MARINE, IM AWESOME	123-45-6789

Mark each item "YES" or "NO". Every item marked "YES" must be fully explained in Item 29 below.

HAVE YOU EVER HAD OR DO YOU NOW HAVE:	YES	NO
15.a. Dizziness or fainting spells	○	○
b. Frequent or severe headache	○	○
c. A head injury, memory loss or amnesia	○	○
d. Paralysis	○	○
e. Seizures, convulsions, epilepsy or fits	○	○
f. Car, train, sea, or air sickness	○	○
g. A period of unconsciousness or concussion	○	○
h. Meningitis, encephalitis, or other neurological problems	○	○
16.a. Rheumatic fever	○	○
b. Prolonged bleeding *(as after an injury or tooth extraction, etc.)*	○	○
c. Pain or pressure in the chest	○	○
d. Palpitation, pounding heart or abnormal heartbeat	○	○
e. Heart trouble or murmur	○	○
f. High or low blood pressure	○	○
17.a. Nervous trouble of any sort *(anxiety or panic attacks)*	○	○
b. Habitual stammering or stuttering	○	○
c. Loss of memory or amnesia, or neurological symptoms	○	○
d. Frequent trouble sleeping	○	○
e. Received counseling of any type	○	○
f. Depression or excessive worry	○	○
g. Been evaluated or treated for a mental condition	○	○
h. Attempted suicide	○	○
i. Used illegal drugs or abused prescription drugs	○	○
18. FEMALES ONLY. Have you ever had or do you now have:		
a. Treatment for a gynecological (female) disorder	○	○
b. A change of menstrual pattern	○	○
c. Any abnormal PAP smears	○	○
d. First day of last menstrual period *(YYYYMMDD)*		
e. Date of last PAP smear *(YYYYMMDD)*		

	YES	NO
19. Have you been refused employment or been unable to hold a job or stay in school because of:		
a. Sensitivity to chemicals, dust, sunlight, etc.	○	○
b. Inability to perform certain motions	○	○
c. Inability to stand, sit, kneel, lie down, etc.	○	○
d. Other medical reasons *(If yes, give reasons.)*	○	○
20. Have you ever been treated in an Emergency Room? *(If yes, for what?)*	○	○
21. Have you ever been a patient in any type of hospital? *(If yes, specify when, where, why, and name of doctor and complete address of hospital.)*	○	○
22. Have you ever had, or have you been advised to have any operations or surgery? *(If yes, describe and give age at which occurred.)*	○	○
23. Have you ever had any illness or injury other than those already noted? (If yes, specify when, where, and give details.)	○	○
24. Have you consulted or been treated by clinics, physicians, healers, or other practitioners within the past 5 years for other than minor illnesses? *(If yes, give complete address of doctor, hospital, clinic, and details.)*	○	○
25. Have you ever been rejected for military service for any reason? *(If yes, give date and reason for rejection.)*	○	○
26. Have you ever been discharged from military service for any reason? *(If yes, give date, reason, and type of discharge; whether honorable, other than honorable, for unfitness or unsuitability.)*	○	○
27. Have you ever received, is there pending, or have you ever applied for pension or compensation for any disability or injury? *(If yes, specify what kind, granted by whom, and what amount, when, why.)*	○	○
28. Have you ever been denied life insurance?	○	○

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

(SNM EXPLAINS "YES" ANSWERS FROM ITEMS 10-28)

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
MARINE, IM AWESOME	123-45-6789

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

(NOTE FOR EXAMINER: ID APPLICABLE. STATEMENT OF "CLEARED FOR FULL DUTY" OR " NO LIMITATIONS" SHOULD BE WRITTEN AFTER OVERALL MO/PHYSICIAL/IDC COMMENTS)

b. TYPED OR PRINTED NAME OF EXAMINER *(Last, First, Middle Initial)*	c. SIGNATURE	d. DATE SIGNED *(YYYYMMDD)*
NAME OF MEDICAL OFFICER/PHYSICIAN/IDC		

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

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

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
MARINE, IM, A	123-45-6789	USMCR

4. UNIT OF ASSIGNMENT	5. UNIT ADDRESS
IMA DET/UNIT NAME	IMA DET/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.**

	(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 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?		YES		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)*
NAME OF DENTIST	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	11. DATE OF EXAMINATION *(YYYYMMDD)*
SIGNATURE OF DENTAL EXAMINER AND CIVILIAN STATE LICENSE NO.	

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.