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

Below are instructions on how to complete the RRELM route sheet (NAVMC 11537A):

1. **Blocks 1 - 18:** Personnel Information. This information can be obtained via MOL: BIR and BTR

2. **Blocks 19 & 20**: Not applicable.

3. **Block 21:** Write "Marine Corps Individual Reserve Support Activity".

4. **Block 22:** Write in a GOOD contact phone number where you can be reached at regular business hours

5. **Blocks 23 – 33:** Not Applicable.

6. **Block 34:** This will be verified by the Career Planner.

7. **Block 35(a-g):** Fill out only if you have an Active Duty Spouse.

8. **Block 37:** Sign and date on line stating "Marines Signature". Your Career Planner will Sign on the next line.

9. **Blocks 38a - 38b: (Medical & Dental):** This block has intentionally been crossed out and will be screen by MCIRSA medical staff with the members 2807-1 2813 and or IMR
2807-1 and 2813 (see below).

   a. You should also have a Physical Health Assessment Form DD 2807 completed within 1 year of this form which is reflective in 3270, if not, complete one (Instructions on first page).

   b. You should also have a Dental Examination Form DD 2813 completed within 1 year of this form, if not, complete one (Instructions on first page).

10. **Block 38c (Security Screening):** This block has intentionally been crossed out and will be screen by MCIRSA staff based off of the members MOS

11. **Block 38d (S-3 Training): This block has intentionally been crossed out and will be screen by MCIRSA staff**

12. **Block 38e (Legal Certification):** The following statement will be written in by you: "I certify that I have no legal action pending with civilian authorities at this time." You will then fill in your information and sign in the LEGAL signature line.

13. **Block 38f (Saco Certification):** The following statement will be written in by you: "I certify that I have not been assigned to any treatment program during my current enlistment contract." You will then fill in your information and sign in the SACO signature line.

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 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 : _____ Article(s) : _____ Date : _____

Conviction Type : _____ Article(s) : _____ Date : _____

Conviction Type : _____ Article(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

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

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

Rank	Name	EDIPI

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 :

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 :

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 :

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 :

Rank _____ Name _____

Training (S-3) Signature _____ Date _____

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

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 :

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 :

Rank _____ Name _____

SACO Signature _____ Date _____

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

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.**

	(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)*
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

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)*
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:

6.a. SERVICE	b. COMPONENT	c. PURPOSE OF EXAMINATION		7.a. POSITION *(Title, Grade, Component)*
☐ Army ☐ Coast Guard	☐ Regular	☐ Enlistment	☐ Medical Board ☐ Other *(Specify)*	
☐ Navy	☐ Reserve	☐ Commission	☐ Retirement	b. USUAL OCCUPATION
☐ Marine Corps	☐ National Guard	☐ Retention	☐ U.S. Service Academy	
☐ 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	○	○
b. Lived with someone who had tuberculosis	○	○
c. Coughed up blood	○	○
d. Asthma or any breathing problems related to exercise, weather, pollens, etc.	○	○
e. Shortness of breath	○	○
f. Bronchitis	○	○
g. Wheezing or problems with wheezing	○	○
h. Been prescribed or used an inhaler	○	○
i. A chronic cough or cough at night	○	○
j. Sinusitis	○	○
k. Hay fever	○	○
l. Chronic or frequent colds	○	○
11.a. Severe tooth or gum trouble	○	○
b. Thyroid trouble or goiter	○	○
c. Eye disorder or trouble	○	○
d. Ear, nose, or throat trouble	○	○
e. Loss of vision in either eye	○	○
f. Worn contact lenses or glasses	○	○
g. A hearing loss or wear a hearing aid	○	○
h. Surgery to correct vision *(RK, PRK, LASIK, etc.)*	○	○
12.a. Painful shoulder, elbow or wrist *(e.g. pain, dislocation, etc.)*	○	○
b. Arthritis, rheumatism, or bursitis	○	○
c. Recurrent back pain or any back problem	○	○
d. Numbness or tingling	○	○
e. Loss of finger or toe	○	○

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

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

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

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

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

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

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

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

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:_____(yyyymmdd)

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		

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

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:_____
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 appropriate 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.