REENLISTMENT PREREQUISISTES FOR RETENTION IN THE INDIVIDUAL READY RESERVE

This is a list of all the requirements necessary for reenlistment in the Individual Ready Reserve. 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 chain of command and then forwarded 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 IRR 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 Civilian Employment Information (CEI). Duration: Annually via MOL.
a. mol.usmc.mil

_______4. Certify your Career Retirement Credit Report (CRCR). Duration: Annually via MOL.
a. mol.usmc.mil

_______5. Height and Weight Verification Form. Annual Requirement.
a. Enclosed. Cannot be older than 90 Days

_______6. 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 Appropriate Duty Orders to be seen at a Military Treatment Facility (MTF). Civilian and VA providers are not allowed to perform HIV draw.

_______7. 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 Appropriate Duty Orders to be seen at a (MTF)

______8. If you are going to be seen by a MTF for any treatment please utilize the Medical Check In Sheet
a. Enclosed:

_______9. 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.

_______10. Sign the Medical Release Form.
a. Enclosed.

_______11. Provide 360 degree color photos in green on green PT gear i.e.: Front, Back, Left, and Right.
a. If you have tattoos showing in properly fitting PT that are not in compliance with MCBUL 1020 please take individual pictures of tattoos in question with a measuring device clearly showing length and width with a description of the tattoo

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 <u>sign in the LEGAL signature line</u>.

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 <u>sign in the SACO signature line</u>.

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
E5 / Sgt	I AM MARINE	123456789	0621	3531

6. DOR	7. AFADBD	8. PEBD	9. RECC	10. EAS	11. DCTB	12. MDSD	13. CRCR Cert Date	14. RCOMP	15. RUC	16. MCC
09/10/2015	N/A	20070909	20150909	N/A			201509	K7	88801	N/A

17. Type of Request	18. Length Requested	19. Career Designated *(AR Only)*	20. SOE Code
			BBCA

21. Organization (Unit / Section)	22. Work Phone
INDIVIDUAL READY RESERVE	+1 (123) 456-7899

23. Conduct / Proficiency Marks

AVG CON in Enlistment 4.5 AVG PRO in Enlistment 4.5

(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 : 08/25/2015

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

GT	100	MM	100	EL	100	CL	100

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) IT / TWICE PASS IRR 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
Non Judicial Punishment	97	10/19/2012

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

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
SPOUSES NAME	SGT	0111	USMC	20180601	1NJ	

36. Remarks

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

Marine's Signature : *I AM MARINE* Date : 8/25/2015

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
E5 / Sgt	I AM MARINE	123456789

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 :

This block has intentionally been crossed out and will be screen by MCIRSA medical staff with the members 2807 and or IMR

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 :

This block has intentionally been crossed out and will be screen by MCIRSA medical staff with the members 2813 and or IMR

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 :

This block has intentionally been crossed out and will be screen by MCIRSA staff based off of the members MOS

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 :

This block has intentionally been crossed out and will be screen by MCIRSA staff

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 :

I CERTIFY THAT I HAVE NO LEGAL ACTION PENDING WITH CIVILIAN AUTHORITIES AT THIS TIME.

The highlighted statement above must be written verbatim by the IRR Marine requesting retention

Rank: SGT Name: I AM MARINE

Legal (S-1) Signature: I AM MARINE Date: 8/25/2015

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 :

I CERTIFY THAT I HAVE NOT BEEN ASSIGNED TO ANY TREATMENT PROGRAM DURING MY CURRENT ENLISTMENT.

The highlighted statement above must be written verbatim by the IRR Marine requesting retention

Rank: SGT Name: I AM MARINE

SACO Signature: I AM MARINE Date: 8/25/2015

DEPARTMENT OF DEFENSE ACTIVE DUTY/RESERVE/GUARD/CIVILIAN FORCES DENTAL EXAMINATION	*OMB No. 0720-0022* *OMB approval expires* *Aug 31, 2016*

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

PLEASE DO NOT RETURN YOUR FORM TO THE ABOVE ORGANIZATION.

PRIVACY ACT STATEMENT

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

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

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

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

1. SERVICE MEMBER'S NAME *(Last, First, Middle Initial)*	2. SOCIAL SECURITY NUMBER	3. BRANCH OF SERVICE
MARINE I AM	123456789	USMC

4. UNIT OF ASSIGNMENT	5. UNIT ADDRESS
INDIVIDUAL READY RESERVE	2000 OPELOUSAS AVE NEW ORLEANS LA 70114

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

10. DENTIST'S SIGNATURE/STATE LICENSE NUMBER	11. DATE OF EXAMINATION *(YYYYMMDD)*
SIGNATURE AND LICENSE NUMBER REQUIRED	

REPORT OF MEDICAL HISTORY

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

OMB No. 0704-0413
OMB approval expires Oct 31, 2017

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

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

PRIVACY ACT STATEMENT

AUTHORITY: 10 U.S.C. 136, DoD Instruction 6130.03, and E.O. 9397, as amended (SSN).
PRINCIPAL PURPOSE(S): The primary collection of this information is from individuals seeking to join the Armed Forces. The information collected on this form is used to assist DoD physicians in making determinations as to acceptability of applicants for military service and verifies disqualifying medical condition(s) noted on the prescreening form (DD 2807-2). An additional collection of information using this form occurs when a Medical Evaluation Board is convened to determine the medical fitness of a current member and if separation is warranted. Completed forms are covered by recruiting, medical evaluation board, and official military personnel file SORNs maintained by each of the Services.
ROUTINE USE(S): The Blanket Routine Uses found at http://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 I AM	123456789	20151230

4.a. HOME ADDRESS *(Street, Apartment No., City, State, and ZIP Code)*
MOTO SEMPER YUT LN
DO OR DIE OORAH 1775

b. HOME TELEPHONE *(Include Area Code)*

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

X ALL APPLICABLE BOXES:

6.a. SERVICE	b. COMPONENT	c. PURPOSE OF EXAMINATION	
[ ] Army [ ] Coast Guard	[ ] Regular	[ ] Enlistment	[ ] Medical Board [ ] Other *(Specify)*
[ ] Navy	[X] Reserve	[ ] Commission	[ ] Retirement
[X] Marine Corps	[ ] National Guard	[X] Retention	[ ] U.S. Service Academy
[ ] Air Force		[ ] Separation	[ ] ROTC Scholarship Program

7.a. POSITION *(Title, Grade, Component)*

b. USUAL OCCUPATION

8. CURRENT MEDICATIONS *(Prescription and Over-the-counter)*

9. ALLERGIES *(Including insect bites/stings, foods, medicine or other substance)*

Mark each item "YES" or "NO". Every item marked "YES" must be fully explained in Item 29 on Page 2.

HAVE YOU EVER HAD OR DO YOU NOW HAVE:	YES	NO
10.a. Tuberculosis		X
b. Lived with someone who had tuberculosis		X
c. Coughed up blood		X
d. Asthma or any breathing problems related to exercise, weather, pollens, etc.		X
e. Shortness of breath		X
f. Bronchitis		X
g. Wheezing or problems with wheezing		X
h. Been prescribed or used an inhaler		X
i. A chronic cough or cough at night		X
j. Sinusitis		X
k. Hay fever		X
l. Chronic or frequent colds		X
11.a. Severe tooth or gum trouble		X
b. Thyroid trouble or goiter		X
c. Eye disorder or trouble		X
d. Ear, nose, or throat trouble		X
e. Loss of vision in either eye		X
f. Worn contact lenses or glasses		X
g. A hearing loss or wear a hearing aid		X
h. Surgery to correct vision *(RK, PRK, LASIK, etc.)*		X
12.a. Painful shoulder, elbow or wrist *(e.g. pain, dislocation, etc.)*		X
b. Arthritis, rheumatism, or bursitis		X
c. Recurrent back pain or any back problem		X
d. Numbness or tingling		X
e. Loss of finger or toe		X

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

LAST NAME, FIRST NAME, MIDDLE NAME (SUFFIX)	SOCIAL SECURITY NUMBER
MARINE I AM	123456789

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:

Item	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)* 1775		
e. Date of last PAP smear *(YYYYMMDD)* 1776		

Item	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
MARINE I AM	123456789

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)*
CIVILLIAN/MILITARY (MIL RECOMMENDED)		

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 CORPS INDIVIDUAL RESERVE SUPPORT ACTIVITY
MARINE FORCES RESERVE
2000 OPELOUSAS AVE
NEW ORLEANS, LA 70114

1040
CarPlan

From:	SGT	MARINE	AM	I	123456789/0111
	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 READY RESERVE RETENTION STATENENT OF UNDERSTANDING (SOU)

Ref: (a) TFRS Message R65198
(b) MARADMIN 436/11
(c) MCO Pl00R.l

1. Future retention in the Individual Ready Reserve (IRR) will be based on the following, as applicable:

a. I understand that at 30 days from my RECC, if my reenlistment package is not complete and submitted to Headquarters Marine Corps RCT, there is a possibility of being released from my Marine Corps Contract. IAM INT

b. Per Reference (a) I understand that at 15 days from my RECC, if I have not provided minimum requirements for extension of contract to the Marine Corps Individual Reserve Support Activity (MCIRSA) Career Planners, I will start to work with a Prior Service Recruiter for completion of an Off Contract Accession should I desire to be re-affiliated with the Marine Corps/Marine Corps Reserve. IAM INT

c. I understand that extensions are not in lieu of reenlistment and that I am not guaranteed to be retained due to the timeliness of my retention request.

d. Per reference (b)(c), I understand that if I have less than 20 satisfactory years, I must obtain 50 retirement points each anniversary year to attain a satisfactory year towards retirement. IAM INT

e. Based on subparagraph d, that in my Marine Online Account (MOL), my Career Retirement Credit Record (CRCR) indicates certification date of; 20160909 and reflects 10 satisfactory years and 4 unsatisfactory years. IAM INT

f. I understand that in order to be retained in the IRR I may not have more than 10 collective unsatisfactory years. IAM INT

g. I understand that I will not be favorably endorsed through the MCIRSA Career Planners if I have more than 4 consecutive unsatisfactory years. IAM INT

h. I understand that any deviation from the above criteria may require a waiver from CMC Headquarters Marine Corps. IAM INT

i. I understand that this document will be maintained by (MCIRSA) Career Planning section. IAM INT

2. On this date, 20160206, I, I AM MARINE understand, accept and agree to adhere to the criteria outlined above.

I AM MARINE
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 I AM 123456789/0111
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, I AM 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 +1(123)456-7899.

I Am Marine
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 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.