OKLAHOMA ARMY NATIONAL GUARD VACANCY ANNOUNCEMENT



OFFICER DIRECT APPOINTMENT ANNOUNCEMENT #: 25-01

Must be a current member of the Oklahoma Army National Guard

Position is Traditional (M-Day) Only

1 ostion is Traditional (14 Day) only												
POSITION: Basic Branch	Commissioned Officer	Minimum Rank/Grade to apply for Direct Appointment as 2LT/O1:	Maximum Rank/Grade to apply for Direct Appointment as 2LT/O1:									
,	based on the needs of the state and TAG approval)	SGT/E5	SGT/E5 or above									
MOS/AOC:	Unit/Location:	Opening Date:	Closing Date:									
Multiple	Branches/Positions throughout Oklahoma	1 October 2024	30 September 2025									

Commissioned officer entry level is 2LT/O1. Branch assignments are based upon the needs of the state and approved by The Adjutant General (TAG). Prior enlisted experience, civilian education, and Soldier professional goals will be considered. Soldiers requesting to appoint into aviation must have approval of the State Aviation Officer (SAO). All commissioned officer branches in the Oklahoma Army National Guard (OKARNG) are open to male and female Soldiers.

POSITION DESCRIPTION: Commissioned officers are first and foremost the leaders of Soldiers. They should be mentally and physically disciplined and well-versed in the tactics, techniques and procedures of their branch. Commissioned officers embody the warrior ethos and live the Army Values without exception. They place the welfare of their Soldiers ahead of their own and inspire others to achieve the same level of commitment and professionalism. Commissioned officer end state is: physically rugged, competent and confident officers who are adaptable, flexible, and prepared to train and lead Soldiers on any mission or terrain.

PREFERRED APPLICANTS WILL POSSESS THE FOLLOWING ATTRIBUTES: Applicants must have a firm understanding of Army Warrior Tasks and Troop Leading Procedures. Must display Military Professional Ethics and ethical decision-making at all times to include on/off duty, garrison and austere field conditions. Must be able to demonstrate personal skills in operations and communications, to include oral and written communication such as presentation briefs, providing feedback and effective listening; evaluate and develop junior leaders, and consistently prepare to transition with each level of military education agreeable with their next rank and position.

NOTICE: This packet is for the nomination of Direct Appointment, ONLY. Nominations do not guarantee a Soldier will be appointed as an Officer in the OKARNG. Upon nomination, selectee(s) must be approved by TAG, National Guard Bureau Personnel Policy Division (NGB-HRH) and the Federal Recognition Board (FRB).

MANDATORY REQUIREMENTS AT TIME OF APPLICATION:

- 1. Applicants should review Policy Memorandum (PM) 22-25 prior submission of application for direct appointment.
- 2. Must be current OKARNG Soldier in the rank of SGT or above.
- 3. Must have **served a minimum of 24 months** active (drill or mobilized) status in any federally recognized unit. Additionally, must have **served at least 12 months** in an active ARNG unit immediately preceding application for direct appointment.
- 4. Must be a United States Citizen.
- 5. Minimum age 22 years.
- 6. Maximum age 41 years 0 months as at the time of packet submission.
- 7. Must have **GT score of 110 or higher**.
- 8. Must have a Bachelor's Degree or higher.
- 9. Must have completed Basic Leader Course (or equivalent) or higher.
- 10. Must have at least five Non-Commissioned Officer Evaluation Reports (NCOERs) documenting leadership and above average accomplishments.
 - 11. Must possess a minimum FINAL SECRET security clearance prior to appointment.
 - 12. Must be able to pass a Commissioning Physical in accordance with DoDI 6130.03.
 - 13. Must have **PULHES of 1111111**; no permanent profiles/alternate Army Combat Fitness Test (ACFT) events.
 - 14. Must provide DTMS Individual Training Report (ITR) with **ACFT** results within 90 days of packet submission.
 - 15. Must be **in compliance with AR 600-9**; body fat percentage can be **no greater than 2% under maximum** allowable body fat percentage. Height/weight screening must be completed within 90 days of packet submission.
 - 16. Must have **NEVER** enrolled in OCS in the past.
 - 17. Must be able to complete the Basic Officer Leader Course (BOLC) within twelve months of appointment.
 - 18. No Civil Conviction or Moral Waivers are authorized for any item listed in **paragraph 12 of PM 22-25**. Any additional requests for waivers and/or exceptions to policy are considered on a case-by-case basis only.

SPECIAL INSTRUCTIONS:

- 1. Partial or incomplete applications will not be accepted.
- 2. Applications will be prescreened prior to a nomination board. Applicants not meeting the listed requirements will be notified by mail of packet disapproval. All others will be contacted to appear in person at a nomination board in Oklahoma City, OK; date and time to be determined.
- 3. Current AGR's may apply; however, if nominated and approved by TAG, NGB-HRH and the FRB, they **MUST** resign from the AGR program in order to accept their commission.
- 4. Current Technician Soldiers may apply; however, if nominated and approved by TAG, NGB-HRH and the FRB, J1/HRO approval is required prior to commissioning.
- 5. No promise of unit of assignment or regional location of assignment is made. If nominated and approved by TAG, NGB-HRH and the FRB, Soldiers will be assigned based on the needs of the Oklahoma Army National Guard.

EQUAL EMPLOYMENT OPPORTUNITY: All applicants will receive consideration without regard to race, color, national origin, creed, religion, marital status or other non-merit reasons not interfering with membership in the Army National Guard or performance of required duties.

HOW TO APPLY:

The forms and documents listed on the application checklist must be submitted in person or by certified mail to Officer Strength Manager. Applications must be received no later than close of business on the closing date of the announcement. Soldiers are highly encouraged to seek assistance from their S1 to review their packet prior to submission.

Oklahoma Army National Guard ATTN: NGOK-MPD-ROS 2550 N Air Depot Blvd MIDWEST CITY, OK 73141-1405

Officer Strength Management Office hours of operation: Monday – Friday, 0800-1600 hours and RTI drill weekends.

Officer Direct Appointment Announcement 25-01 _____ Rank: _____ Unit: _____ Name: Email Addresses (civilian & military): Phone number(s): **APPLICATION CHECKLIST** ☐ Application Checklist ☐ Enlisted Record Brief (certified copy; must list ASVAB Scores) ☐ Official College Transcripts from accredited college or university certifying completion of a baccalaureate degree or higher. ☐ Letters of Recommendation (LOR) from CO, BN and BDE Commanders. LORs must reference requested branch selection. ☐ DA Form 1059 for all levels of NCOES completed ☐ All Non-Commissioned Officer Evaluation Reports (Minimum of 5 years required. NCOERs must be profiled and uploaded to iPERMS – no E4 Special NCOERs / no draft copies) ☐ Security Clearance memorandum signed by Brigade Security Manager within 30 days of packet submission. Must be a minimum of final Secret security clearance within scope of 5 years. ☐ All DD Form 214s and NGB Form 22s (forms must list separation reason & RE Codes) ☐ NGB Form 23B (current within 90 days of packet submission) ☐ Current Individual Medical Readiness (IMR) printout from MEDPROS ☐ DTMS Individual Training Report - Army Combat Fitness Test (ACFT) ACFT must be within 90 days of packet submission. (More than one passing ACFT is highly encouraged) ☐ DTMS Individual Training Report - Army Physical Fitness Test (APFT) Must list last 3 APFTs ☐ DTMS Individual Training Report – Height/Weight Screening. Must be current within 90 days of packet submission. ☐ DA Form 5500/DA 5501 (if applicable) Must be current within 90 days of packet submission. ☐ OCS Enrollment and Attendance History Statement (see enclosure #1) □ DD Form 2807-2 (see enclosure #2) ☐ Civil Conviction Questionnaire (see enclosure #3)

NOTE: Please ensure that all required documents on the checklist are included with your application. Incomplete applications will not be considered.

OCS ENROLLMENT AND ATTENDANCE HISTORY

	I have nev	ver been enrolled or atte	nded OCS in the	e past.	
	I was prev	viously enrolled or attend	ed OCS.		
	a. Date(s) of	attendance: Start:	E	End:	
	b. I did not c explain the circumst		to the following ((check all that apply and	
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		Failure to pass Federal	Recognition Bo	pard	
		Honor Code violation			
		Law violation			
		Medical Injury/Illness			
		Involuntarily disenrolled	I		
		Did not desire to compl	ete program		
		Personal Reasons			
		Civilian employment			
		Other			
Remar	rks:				
	Printed Name	Rar	nk	Signature	

INSTRUCTIONS FOR COMPLETING DD FORM 2807-2, ACCESSIONS MEDICAL HISTORY REPORT

- 1. This form is to be completed by each individual who requires medical processing in accordance with Department of Defense Instruction (DODI) 6130.03, "Physical Standards for Appointment, Enlistment, or Induction" and DODI 1304.02, "Accession Processing Data Collection Forms." This form must be completed by the applicant with the assistance of the recruiter, parent(s), or guardian, as needed.
- 2. Replaces the existing medical prescreen form (DD Form 2807-2, MAR 2015) and the DoD Medical Examination Review Board Report of Medical History (DD Form 2492, MAR 2008). Additional questions have been added to improve its usefulness to the accessions medical pre-screening process. The questions are intended to provide the U.S. Military Entrance Processing Command (USMEPCOM) and Department of Defense Medical Examination Review Board (DoDMERB) with health history information necessary to identify conditions commonly related to medical causes for separation during basic and follow-on training (per P.L. 105-85, Div. A, Title V, S 532).
- 3. Use of medical history information facilitates efficient, timely, and accurate medical processing of individuals applying for Service in the United States Armed Forces or United States Coast Guard. Positive responses do not automatically result in disqualification but are necessary to prompt further explanation that will be used to determine medical qualification. Medical history information assists USMEPCOM/DoDMERB medical personnel in the medical prescreening of applicants. Accurate responses to all questions are critical and all positive responses must be fully explained. Applicant responses to questions may be verified using electronically obtained medical history by the USMEPCOM/DoDMERB. Medical history information will be used by the Department of Defense for continuity of care purposes if and when an applicant accesses into the Armed Forces or Coast Guard. Supporting medical information in the form of historical medical records may also be attached to the Service member's medical record. Medical history information collected by the USMEPCOM/DoDMERB during accession medical processing will serve as the foundation for a Service member's lifecycle electronic medical treatment record.
- 4. If processing at a MEPS: The completed DD Form 2807-2 along with all substantiating and supporting medical documents must be delivered to USMEPCOM for review prior to scheduling the applicant for medical examination. All documents must be submitted for review in accordance with standards below. After review, the Military Entrance Processing Station (MEPS) will notify the Recruiting Service of the applicant's status.
- 1 processing day prior for applicants with no positive medical history (all items marked "NO" with the exception of items 9 (glasses/contacts), 11 (defective color vision), and 20 (braces) which can be "YES").
- 2 processing days prior; for applicants with ANY positive medical history (other than those noted above) and 5 OR LESS single-sided pages of supporting medical documents.
- 3 processing days prior; for applicants with ANY positive medical history (other than those noted above) and MORE THAN 5 single-sided pages of supporting medical documents.

Secure electronic submission is preferable; if not feasible bring/mail to the nearest MEPS which can be found at http://www.mepcom.army.mil/battalions/index.html. All supporting medical documentation must be present with the DD Form 2807-2 to meet the above timeframes for review. After review by a USMEPCOM provider, appropriate processing notification will be made.

- 5. If processing at a MEPS: If an applicant has been seen by any Health Care Provider (HCP) and/or has been hospitalized for any reason, medical records/ documentation must be obtained and submitted along with a medical release to USMEPCOM. Provide all medical documents via secure electronic submission (if possible) to the nearest MEPS. If hand-carried or mailed, ensure they are sealed in an envelope marked: "CONFIDENTIAL: MEPS MEDICAL DEPARTMENT".
 - a. If the applicant was evaluated and/or treated on an outpatient basis, obtain a copy of actual treatment records of the private medical doctor/HCP including:
- (1) office or clinic assessment and progress notes, including the initial assessment documents, subsequent evaluation and treatment documents, and record of date when released from care to full, unrestricted activity;
 - (2) emergency room (ER) report(s);
 - (3) study reports (e.g., x-ray, magnetic resonance imaging (MRI), Computerized Tomography (CT));
 - (4) procedure reports (e.g., arthroscopy, electroencephalogram (EEG; brain wave test), echocardiogram (ultrasound of the heart));
 - (5) pathology reports (e.g., tissue specimens sent to lab for microscopic diagnosis, abnormal PAP smear cytology);
 - (6) specialty consultation records (e.g., neurologist, cardiologist, OB/GYN, gastroenterologist, orthopedic surgeon, pulmonologist, allergist).
- b. If the applicant was hospitalized, obtain a copy of the inpatient hospital record, to include (if any): ER report, admission history and physical, study reports, procedure reports, operative report (example: surgery to bone or joint), pathology report, specialty consultation reports, and discharge summary.
- c. If an applicant has been diagnosed or treated for any attention disorder (Attention Deficit Disorder (ADD), Attention Deficit Hyperactivity Disorder (ADHD), etc.), academic skills or perceptual defect, or had an Individualized Education Plan or 504 Plan, call/contact the MEPS medical department for additional instructions.
- d. Obtain any and all documents relating to any evaluation, treatment or consultation with a psychiatrist, psychologist-counselor, or therapist, on an inpatient or outpatient basis for any reason, including but not limited to counseling or treatment for adjustment or mood disorder, family or marriage problems, depression, treatment or rehabilitation for alcohol, drug, or substance abuse.
- 6. MEPS Chief Medical Officers (CMOs) or DoDMERB may locally modify the above instructions and instruct recruiters on what supporting medical documents they require to complete the DD Form 2807-2 medical prescreen review, if doing so enhances the efficiency of medical processing and is consistent with DODI 6130.03 and USMEPCOM/DoDMERB guidance.
- 7. If all attempts to obtain required substantiating and supporting medical documents fail, the recruiter must contact the appropriate medical department, "MEPS medical department for enlistment applicants" or DoDMERB for officer applicants, for guidance prior to submitting an incomplete medical prescreen packet.

ACCESSIONS MEDICAL HISTORY REPORT

OMB No. 0704-0413 OMB Approval Expires: September 30, 2021

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, at whs.mc-alex.esd.mbx.dd-dod-informationcollections@mail.mil. 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 ADDRESS.**

PRIVACY ACT STATEMENT AUTHORITY: 10 U.S.C. 504, Persons not qualified; 10 U.S.C. 505, Regular components: qualifications, term, grade; 10 U.S.C. 507, Extension of enlistment for members needing medical care or hospitalization; 10 U.S.C. 532, Qualifications for original appointment as a commissioned officer; 10 U.S.C. 978, Drug and alcohol abuse and dependency: testing of new entrants; 10 U.S.C. 1201, Regulars and members on active duty for more than 30 days: retirement; 10 U.S.C. 1202, Regulars and members on active duty for more than 30 days: temporary disability retired list; 10 U.S.C. 4346, Cadets: requirements for admission; DoD Directive 1145.2, United States Military Entrance Processing Command; and E.O. 9397 (SSN), as amended. PRINCIPAL PURPOSE(S): To obtain medical data for determination of medical fitness for enlistment, induction, appointment and retention for applicants and members of the Armed Forces. The information will also be used for medical boards and separation of Service members from the Armed Forces. ROUTINE USE(S): The Routine Uses are listed in the applicable system of records notice found at: http://dpcld.defense.gov/Privacy/SORNsIndex/DOD-wide-SORN-Article-View/Article/570661/a0601-270-usmepcom-dod/ 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. For an Armed Forces member, failure to provide the information may result in the individual being placed in a non-deployable status. WARNING: The information you have given constitutes an official statement. Federal law provides severe penalties (up to 5 years confinement or \$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 may be subject to prosecution under the Uniform Code of Military Justice or to administrative separation proceedings for discharge, and could receive a less than

under the Uniform Code of Milital	ry Justice or to adr	ninistrative separatioi	n proceedings	for discharge, and co	uid receive a i	ess than nonorable	discharge."			
SECTION I - APPLICANT										
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5. (X one)	6. HEIGHT	7. WEIGHT	8.a. SERV	ICE (X as applicat	ole)	8.b. COMPONEN	NT (X as ap	plicable)	9. DATE	=
a. SEX (at birth) b. GENDER		(lbs.)	Army	USMC	,	Regular	, ,,			YMMDD)
Male Male			Navy	USCG		Reserve				
Female Female			USAF	Other:		National Gua	rd			
10. PURPOSE OF EXAMINA	TION (X as app	licable)		11. POSITIO	N (If a curre	nt Federal Emplo	ovee) 12	. USUAL	OCCUI	PATION
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	C Scholarship	•								
	(Specify)									
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a. Name (Last, First, Middle	Initial)			b. Signature			c. Date	e Signed	(YYYYN	1MDD)
3. RECRUITING REPRESEN	ITATIVE: (If a r	epresentative was	used) I certi	fy all information	is complete	and true to the	best of my	knowled	dge.	
a. Name (Last, First, Middle	Initial)	b. Recru	uiter Identifica	ation Number	c. Signatur	е	d. Date	e Signed	(YYYYN	ЛМDD)
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CURRENTLY HAVE OR AN	Y HISTORY OF:		YES N	O CURRENTLY	HAVE OR	ANY HISTORY	OF:		YES	NO
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Double vision				4. Eye surgery	to improve vis	ion (RK, PRK, LAS	IK, etc.)			
2. Detached retina or surgery to	repair a detached i	retina		5. Night blindne	ess	<u> </u>	_			

Cataracts or surgery for cataracts

6. Glaucoma

SECTION III. MEDICAL HISTORY (Continued). Check each item "Yes" or "No." All "Yes" feath must be fully explained in Section IV. VES. NO. VES. Commonwell S. Advanced or "Astro we'v or any surpery to correct these Lary other spe condition, liquiry or surgery S. Advanced or "Astro we'v or any surpery to correct these Lary other spe condition, liquiry or surgery S. Advanced or "Astro we'v or any surpery to correct these S. Advanced or "Astro we'v or any surpery to correct these S. Advanced or "Astro we'v or any surpery to correct these S. Advanced or "Astro we'v or any surpery to correct these S. Advanced or "Astro we'v or any surpery to surpery the specific or any surpery to surpery the specific or any surpery to surpery the specific or any surpery or any state great preference and southern so you can be brindenes. S. Security by surrective disease (spythis, goronthes, chierangia, and southern so you can be brindenes. S. Security by surrective disease (spythis, goronthes, chierangia, and southern so you can be brindenes. S. Security by surrective disease (spythis, goronthes, chierangia, and southern so you can be brindenes. S. Security by surrective disease (spythis, goronthes, chierangia, and southern so you can be brindenes. S. Security by surrective disease (spythis, goronthes, chierangia, and southern so you can be brindenes. S. Security by surrective disease (spythis, goronthes, chierangia, and southern southe	LAST NAME - FIRST NAME - MIDDLE INITIAL (SUFFIX)							SOCIAL SECURITY NUMBER (Last 4)	DoD ID NUMBER (I	f ap _l	olica	ble)		
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S. First day of last menstrual period (VYYMMIDD) 1. Performand our drum or tubes in our drum(s) 1. Ear suppry, to include materiodectomy or repair of perforated ear drum 1. Loss of balance or vertigo 1. Loss of ba			П			_			imea, chiamyula,		Ш			
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15. Hearing loss or wear a hearing and gentile warts, herpies, etc.							59.	Sexually transmitted disease (syphilis, gonor	rrhea, chlamydia,		一		Г	$\overline{}$
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32. Palpitation, pounding heart or abnormal heartbeat 33. Heart surgery 34. Pain or pressure in the chest 35. An abnormal electrocardiogram (EKG) 36. Any other heart problems 37. Stomach, esophageal or intestinal ulcer 38. Difficulty swallowing 39. Frequent indigestion or heartburn 40. Gall bladder trouble or gallstones 41. Jaundice (except neonatal) or hepatitis (liver disease) 42. Rupture/hernia 43. Surgery to remove or repair a portion of the intestine or spleen (other than the appendix) 44. Chronic or recurrent intestinal problem of the small or large bowel such as Irritable Bowel Syndrome, Crohn's disease, User of the polity of the pol	HEART						76.	Painful hip, knee, ankle, foot or toes			Ц			
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46. Hemorrhoid surgery 92. Pulmonary embolism (blood clot in lung)	·	\vdash		_	Г	\neg		• •	sewhere)		\dashv	+	-	\dashv
92. Pulmonary embolism (blood clot in lung)		\vdash	H		+	\dashv	 	,	,		_	\dashv		
			H		+	\dashv	 92.	Pulmonary embolism (blood clot in lung)			Ш			\bot

LAST NAME - FIRST NAME - MIDDLE INITIAL (SUFFIX)	SOCIAL SECURITY NUMBER (Last 4) DoD ID NUMBER (If applicable)										
SECTION III - MEDICAL HISTORY (Continued). Check each	ch ite	m "	Yes"	' or "	No." A	II "Yes" items must be fully explain	ed in Section IV.				
CURRENTLY HAVE OR ANY HISTORY OF:		ES	_	NO		RENTLY HAVE OR ANY HISTORY		Y	'ES	N	-
SKIN AND CELLULAR					LEAF	RNING, PSYCHIATRIC. AND BEHAVIORA	L (Continued)				
93. Acne	П	$\overline{}$	Т	П		Been expelled or suspended from school	,		$\neg \neg$	П	\neg
94. Atopic dermatitis or eczema	┪	7		Ħ	_	Been kicked out or removed from your home	e		_		+
95. Psoriasis	┢			Ħ		Been arrested or other encounters with law			_	-	╅
96. Large or painful scars	╁	\dashv		H	_	Been evaluated or treated, either with media				<u>_</u> _	
97. Any other skin problems		+		Н		seling, for a mental condition, depression or				L	╛
BLOOD AND BLOOD FORMING TISSUES					140.	Nervous trouble of any sort (anxiety or pani	c attacks)		$\neg \neg$		1
98. Anemia (iron deficiency, sickle cell, thalassemia)	Г	$\overline{}$	Т			Anorexia, bulimia, or other eating disorder	,		_		┪
99. Blood clots requiring blood thinner medicine		+			142.	Habitual stammering or stuttering			_		┪
100. Absence or removal of the spleen	┢	_		H		Have you ever purposely cut or harmed you	ırself				┪
101. Prolonged bleeding (after an injury or tooth extraction)	┢	_		H		Have you ever attempted or considered suice			\dashv		╅
102. Any other blood or circulation problems	╁	_		H		Used illegal drugs or abused prescription dr					┪
SYSTEMIC					_	Have you been evaluated, treated, or hospit					
103. Adverse reaction to medication (describe reaction in Section IV)	Г	$\overline{}$	Т	П	٠ ا	substance abuse, addiction or dependence	(including illegal				
104. Adverse reaction to serum, insect bites, or stings	┢	_		H	'	drugs, prescription medications or other sub	ostances)				
105. Allergy to foods (milk, eggs, fish, meat, nuts, etc.)		_		Н		Have you been evaluated, treated, or hospi	talized for alcohol		!		٦ ١
106. Allergy to wool, latex, or other material	┝	+	+	H	-	abuse, dependence, or addiction					
107. Tuberculosis or lived with someone who had tuberculosis	┝	+		H		Post-Traumatic Stress Disorder or excessiv			'		٦ ١
	┝	_	-	\vdash		seling and/or medication following a trauma	·				
108. Positive test for tuberculosis (PPD or blood test)		_			_	Any other learning, psychiatric, or behaviora	al problems				
109. Malaria	-	4		H	_	ORS AND MALIGNANCIES					_
110. Disorder(s) of your immune system (including HIV)	┝	4		Н-		Tumor, growth, cyst, or cancer of any type				L	
111. Car, train, sea, or air sickness	L				_	ELLANEOUS					_
ENDOCRINE AND METABOLIC	_	_				Cold injury, frostbite or cold intolerance					
112. Thyroid trouble or goiter	!	4		Н	_	Heat injury, heat stroke or heat intolerance				L	
113. High or low blood sugar	Ļ	_		Щ	SUPI	PLEMENTAL QUESTIONS					
114. Diabetes or told that you should be tested for diabetes			_	Ш		Are you taking any medications, to include o					_
NEUROLOGIC	_	_				medications (OTCs), vitamin, herbal, or nuti (If "yes", list all in Section IV.)	ritional supplements			L	J
115. Cerebrovascular incident (stroke)		_		Ц.	-	Any recent unexplained gain or loss of weig	ıht		$\neg \vdash$	Г	\neg
116. Frequent or severe headaches, including migraines	<u> </u>	_		<u> </u>		Artificial or replacement body part (eye, bon					
117. Taking medication to prevent headaches						ioint, leg, arm, etc.)	ie, paiate, mp, knee,			L	
118. Lost time from work or school due to frequent or severe	Г				156.	Have you ever had any illness or injury othe	er than those				
headaches	-		-		- :	already noted? (If "yes", specify when, wher					
119. A skull fracture	┡	_	-	<u> </u>	-	Section IV.)					
120. A head injury, memory loss, or amnesia		_	-	Щ		Have you ever been treated in an Emergen	cy Room? (If "yes",		'		٦
121. A period of unconsciousness or concussion	!	4		Н-	_	explain in Section IV.)				_	
122. Loss of memory or amnesia, or neurological symptoms	Ļ	_		Щ		Have you ever been a patient in any type of being kept overnight)? (If "yes", specify whe	, , ,		_	lr	٦ ١
123. Paralysis	<u> </u>			<u> </u>		name of doctor and complete address of ho			_	┞	
124. Meningitis, encephalitis, or other neurological problems		_		Щ	159.	Have you ever had, or have you been advis	sed to have any				
125. Seizures, convulsions, epilepsy or fits				Щ	_	operations or surgery? (If "yes", describe ar	,				
126. Dizziness or fainting spells	Ļ			Щ		occurred in Section IV.)					
127. Any other neurologic problems						Have you ever been rejected for military Se				Г	٦ ١
SLEEP DISORDERS	_					reason? (If "yes", give date and reason in S	,				
128. Sleepwalking or narcolepsy						Have you ever been discharged from the many reason? (If "yes", give date, reason, and	•			_	_
129. Frequent trouble sleeping						whether honorable, other than honorable, fo				L	
130. Sleep apnea or severe snoring						unsuitability in Section IV.)					
LEARNING, PSYCHIATRIC. AND BEHAVIORAL						Have you ever been refused employment of				_	٦ ١
131. Evaluated or treated for Attention Deficit Disorder (ADD) or Attention Deficit Hyperactivity Disorder (ADHD)	[hold a job or stay in school because of any "yes", answer a - d below and give reasons	• , ,				
132. Taken (or taking) medication, drugs, or any substance to		_		$\overline{}$		a. Sensitivity to chemicals, dust, sunlight, et	tc.				
improve attention, behavior, or physical performance	L			Ш		b. Inability to perform certain motions				<u> </u>	
133. Diagnosed with a learning disorder, to include dyslexia						c. Inability to stand, sit, kneel, lie down, etc.					
134. Received counseling of any type					-	d. Other medical reasons				L	
135. Seen a psychiatrist, psychologist, social worker, counselor or other professional for any reason (inpatient or outpatient) including						Applied for and/or received disability evalua compensation for an injury or other medical provide details in Section IV.)					
counseling or treatment for school, adjustment, family, marriage, divorce, depression, anxiety, or treatment of alcohol, drug or substance abuse (Applicant or recruiter will request sealed medical supporting documents from health care providers marked "CONFIDENTIAL: MEPS MEDICAL DEPARTMENT" and submit directly to MEPS medical personnel.)						Have you ever been denied life insurance? on(s) in Section IV.)	(If "yes", provide				

LAST NAME - FIRST NAME - MIDDLE INITIAL (SUFFIX)	SOCIAL SECURITY NUMBER (Last 4)	DoD ID NUMBER (If applicable)
SECTION IV - APPLICANT COMMENTS. Explain all "Yes" answers to questions Begin with the item Number. Describe answer(s) fully: provide date(s) of prob Clinic(s) and/or Hospital(s) along with the City and State; explain what was dor status. Attach additional sheet(s) if necessary and sign and date each addition treatment records.	lem(s)/condition(s); provide names one (e.g., evaluation and/or treatment);	; and describe your current medical

LAST NAME - FIRST NAME - MIDDLE INITIAL (SUFFIX	()	SOCIAL SECURITY NUMBER	DoD ID NUMBER (If applicable)								
SECTION V - HEALTH CARE PROVIDER/INSUR Current/Previous Primary Care Physician(s)/Prainformation. Attach additional sheets if necess	actitioner(s) and/or Clinic(s) whe		urrent/Prev	ious Insurance Carrier(s)							
1. CURRENT PRIMARY CARE PHYSICIAN(S)/P	RACTITIONER(S) AND/OR CLINI	C(S)									
a. NAME(S)	b. ADDRESS (Include ZIP Code)		c. TELEPH	ONE (Include Area Code)							
2. PREVIOUS PRIMARY CARE PHYSICIAN(S)/P	PRACTITIONER(S) AND/OR CLINI	C(S)									
a. NAME(S)	b. ADDRESS (Include ZIP Code)		c. TELEPH	ONE (Include Area Code)							
3. CURRENT INSURANCE AND/OR PHARMACY BENEFIT MANAGER(S)											
a. NAME(S)	b. ADDRESS (Include ZIP Code)		c. TELEPH	ONE (Include Area Code)							
4. PREVIOUS INSURANCE AND/OR PHARMAC	Y BENEFIT MANAGER(S)										
a. NAME(S)	b. ADDRESS (Include ZIP Code)		c. TELEPH	ONE (Include Area Code)							
5. ADDITIONAL INSURANCE AND/OR PHARMA	CY BENEFIT MANAGER(S)										
a. NAME(S)	b. ADDRESS (Include ZIP Code)		c. TELEPH	ONE (Include Area Code)							

LAST NAME - FIRST NAME - MIDDLE INITIA	()		SOCIAL SECURI	TY NUMBER (Last 4)	DoD ID NUMBER (If applicable)					
SECTION VI - MEDICAL RECORDS	S RFI FA	SF				1				
Applicant (Patient) Name:	O RELEA		So	Social Security Number:						
Date of Birth: (MM/DD/YYYY)	Phone:		Ad	dress:						
I. I authorize the release of the following will delay medical qualification determina		on by ALL holders of my m	edical re	ecords/informatio	n (check all applicabl	e) Ch	noosing not to release all records			
All records		Abstract			Inpatient medica	al reco	ords			
Outpatient medical records	Laboratory/pathology	records		X-ray films/radio	logy	records				
Billing records		Pharmacy/prescription	n record	s	Psychotherapy/p	osych	iatric care records			
HIV, drug and/or alcohol use records	S	Other		•						
Please send my records listed above t	to:									
Name:			Ad	dress:						
Phone:			Fa	x:						
3. I authorize the release of the medical records that I marked above through an electronic health exchange if available. 4. I understand that if the person or agency that receives my information is not a health care provider or health plan covered by the HIPAA privacy regulations, the information described above may be redisclosed and is no longer protected by these regulations. 5. This authorization for medical records release will expire no later than 4 years from the date of signature or as directed by local laws. I understand written notification is necessary to cancel this authorization before such date and can be addressed to the department listed at item 2 of this form. I am aware that my cancellation will not be effective as to disclosures already made in reference to this authorization. 6. I understand that this disclosure may include information regarding drug abuse, alcoholism, or alcohol abuse, psychiatric or mental illness, Acquired Immunodeficiency Syndrome (AIDS) or infection with HIV regulated by Federal Statute (42 CFR Part 2).										
7. Applicant										
a. Signature						b. C	Pate Signed (YYYYMMDD)			
8. Parent or Guardian Signature is ma	ndatory fo	or minor applicant, signa	ture is	optional if applic	cant is of age					
a. NAME (Last, First, Middle Initial):			b. Sign	ature			c. Date Signed (YYYYMMDD)			

LAST NAME - FIRST NAME - MIDDLE INITIAL (SUFFIX)	SOCIAL SECURITY NUMBER (Last 4)	DoD ID NUMBER (If applicable)
SECTION VII - MEDICAL PROVIDER'S SUMMARY AND DESCRIPTION OF PERT Review and comment on all medical records, electronically provided medical history Defense Accessions Processing System. Medical providers may also develop any achere or by interview and document them on the DD Form 2808, "Report of Medical E	information, and other electronic data a dditional medical history deemed import	ant and record significant findings
COMMENTS:		

LAST NAME - FI	RST NAME -	MIDDLE	INITIAL (SU	IFFIX)				S	OCIAL SEC	CURIT	Y NUMBER	(Last 4)	DoD II	NUMBER	₹ (If app	licable)
SECTION VIII	- MEDICA	I PRO	VIDER'S	PRF	SCREE	N DFT	FRMINATI	ION B	ASED OF	ΝΔ	/ΔII ΔRI F	INFORM	/ΔΤΙΩ	N·		
1.a. DATE			AL PROCE											14.	- 4	PROVIDER
(YYYYMMDE		PRW	PH	RJ	METR	PNJ	ICD	c. IF NOT WITHIN STANDARDS: CD CONDITION PULHES SMWRA INPUT			4	INITIALS				
												+				
															-	
KEY: PA = Prod	essing Auth	norized;	PRW = Pro	cess	ing Requ	ested b	y SMWRA; F	PH = Pr	ocessing	Hold;	RJ = Retu	rn Justifie	d; MET	R = Medic	cal Eva	luation and/or
Treatment Reco L (Lower Extren													sical Ca	pacity), L	J (Uppe	er Extremities),
2. *FOR MEPS				. ,												
	a. PSN CO		PSN INCOM	1	c. NPS		d. *AE	е	. *RE		f. *ME	g. *O	E	h. DA		i. PROVIDER
ON EXAM:														(YYYYMI	ИDD)	INITIALS
3. AUTHORIZIN	IG MEDICA	L PROV	/IDER	,		•						•		_		
a. NAME (Last,	First, Middl	e Initial)					b. SIGNA	TURE						c. DATE	SIGNE	E D (YYYYMMDD
4. EXAMINING																ABBITIONAL
a. NAME (Last,	First, Middl	e Initial)				b	. SIGNATURE				c. DATE SIG	ined (YYY	YMMDD	SHEE	TS PRO	ADDITIONAL OVIDED
						\perp				\perp						
SECTION IX -	MEDICAL	. PROV	/IDER'S C	COMI	MENTS:											

LAST NAME - FIRST NAME - MIDDLE INITIAL (SUFFIX)	SOCIAL SECURITY NUMBER (Last 4)	DoD ID NUMBER (If applicable)
SECTION IX - MEDICAL PROVIDER'S COMMENTS (Continuation):		

CIVIL CONVICTION QUESTIONAIRE

Have you ever been arrested, charged, or adjudicated by a civil court for other than minor traffic violations (fine less than \$300)? (If yes, give date, place, charge, and sentence. Include any charges that were dismissed or expunged.)

Remarks:			
Printed Name	Rank	Signature	