



OKLAHOMA ARMY NATIONAL GUARD VACANCY ANNOUNCEMENT

OKLAHOMA
ARMY NATIONAL GUARD

OFFICER DIRECT APPOINTMENT ANNOUNCEMENT #: 25-08

Must be a current member of the Oklahoma Army National Guard

****Position is Traditional (M-Day) Only****

POSITION:	Minimum Rank/Grade to apply for Direct Appointment as 2LT/O1:	Maximum Rank/Grade to apply for Direct Appointment as 2LT/O1:	
Basic Branch Commissioned Officer (Branch determination 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	15 August 2025	30 September 2026

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) 25-18** 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 111111**; no permanent profiles/alternate Army Fitness Test (AFT) events.
14. Must provide DTMS Individual Training Report (ITR) with **AFT** 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 25-18**. 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 25-08

Name: _____ Rank: _____ Unit: _____

Email Addresses (civilian & military): _____

Phone number(s): _____

APPLICATION CHECKLIST

- Application Checklist
- IPPS- A Soldier Talent Profile
- GT Score Results (Provide either REDD Report; DD 1966 pg 1; or Education Verification memo from the State Education Officer)
- 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, DD 214-1s, and NGB Form 22s (forms must list separation reason & RE Codes)
- NGB Form 23A or IPPSA Retirement Points Statement (current within 90 days of packet submission)
- Current Individual Medical Readiness (IMR) printout from MEDPROS (Green in all areas)
- DTMS Individual Training Report (ITR) - Army Fitness Test (AFT). Must be current within 90 days of packet submission.
- 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 never been enrolled or attended OCS in the past.

I was previously enrolled or attended OCS.

a. Date(s) of attendance: Start: _____ End: _____

b. I did not complete the course due to the following (check all that apply and explain the circumstances for release).:

Cadre Request

Failure to pass Federal Recognition Board

Honor Code violation

Law violation

Medical Injury/Illness

Involuntarily disenrolled

Did not desire to complete program

Personal Reasons

Civilian employment

Other

Remarks:

Printed Name

Rank

Signature

ACCESSIONS MEDICAL HISTORY REPORT

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.mmc-alex.esd.mbx.dd-dodinformationcollections@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. 136, Under Secretary of Defense for Personnel and Readiness; 10 U.S.C. Subtitle A, General Military Law, Part II, Personnel (Chapter 31, Enlistments and Chapter 33, Original Appointments of Regular Officers in Grades Above Warrant Officer Grades); 10 U.S.C. 3013, Secretary of the Army; 10 U.S.C. 5013, Secretary of the Navy; 10 U.S.C. 8013, Secretary of the Air Force; DoD Directive (DoDD) 1145.02E, United States Military Entrance Processing Command (USMEPCOM); DoD Instruction (DoDI) 1304.02, Accession Processing Data Collection Forms; DoDI 1304.12E, DoD Military Personnel Accession Testing Programs; DoDI 1304.26, Qualification Standards for Enlistment, Appointment and Induction; DoDI 1332.18, Disability Evaluation System; DoDI 6130.03, Medical Standards for Appointment, Enlistment, or Induction in the Military Services; DoD Manual 1145.02, Military Entrance Processing Station (MEPS); USMEPCOM Regulation 680-3, Entrance Processing and Reporting System Management; and E.O. 9397 (SSN), as amended.

PURPOSE: To obtain medical data for determination of medical fitness for enlistment, induction, appointment, and retention for applicants and members of the Armed Forces. This form may also be used by Medical Evaluation Boards to determine the medical fitness of a current member and if separation is warranted.

ROUTINE USE(S): Disclosure of records are generally permitted under 5 U.S.C. 522a(b)(3) of the Privacy Act of 1974, as amended. Pursuant to 5 U.S.C. 522a(b)(3), records may be disclosed as a routine use to Federal, State and local health departments for compliance with public health communicable disease reporting laws in accordance with 42 U.S.C. 264. A complete list of routine uses may be found in the applicable System of Records Notice, United States Military Entrance Processing Command (USMEPCOM) Integrated Resource System (USMIRS), A0601-270 at: <https://www.federalregister.gov/documents/2021/04/21/2021-08286/privacy-act-of-1974-system-of-records>.

DISCLOSURE: Voluntary; however, failure to provide the requested information may result in an inability to process your application for enlistment or appointment in the Armed Forces. For current Armed Forces members, failure to provide the requested information may result in being placed in non-deployable status.

Additional system of records notices:

Physical/Medical Evaluation Records

Army: <https://dpcid.defense.gov/Privacy/SORNsIndex/DOD-wide-SORN-Article-View/Article/569965/a040-3b-dasg/>Navy: <https://dpcid.defense.gov/Privacy/SORNsIndex/DOD-wide-SORN-Article-View/Article/570339/nm01850-2/>Air Force: <https://dpcid.defense.gov/Privacy/SORNsIndex/DOD-wide-SORN-Article-View/Article/569861/>

SECTION I – APPLICANT INFORMATION

1. LAST NAME – FIRST NAME – MIDDLE INITIAL (Suffix)	2. AGE	3. DATE OF BIRTH (YYYYMMDD)	4.a. SOCIAL SECURITY NUMBER	4.b. DoD ID NUMBER (If applicable)
5. SEX (X one)	6.a. SERVICE PROCESSING FOR (X as applicable)			6.b. COMPONENT (X as applicable)
<input type="checkbox"/> Male	<input type="checkbox"/> Army	<input type="checkbox"/> Navy	<input type="checkbox"/> Marine Corps	<input type="checkbox"/> Air Force
<input type="checkbox"/> Female	<input type="checkbox"/> Coast Guard	<input type="checkbox"/> USPHS	<input type="checkbox"/> Space Force	<input type="checkbox"/> NOAA
		<input type="checkbox"/> Other: _____		
7. PURPOSE OF EXAMINATION (X as applicable)		8. POSITION (If current Federal Employee) (Job Title, Grade, Component)		
<input type="checkbox"/> Enlistment <input type="checkbox"/> U.S. Service Academy				
<input type="checkbox"/> Commission <input type="checkbox"/> ROTC Scholarship <input type="checkbox"/> Other: _____				

SECTION II - APPLICANT (OR PARENT/GUARDIAN) AUTHORIZATION STATEMENT

- I Have read and understand the warning and penalties that are associated with providing a false statement.
- I Agree that all protected health information and personally identifiable information (PHI/PII) or data disclosed by myself or others on my behalf with my consent during the accession process is no longer protected by federal Health Insurance Portability and Accountability Act (HIPAA) Privacy Rules and may be further disseminated as needed.
- I Authorize release of medical records and information relating to grades, performance, individual education plans, and disciplinary proceedings. Under the Family Educational Rights and Privacy Act (FERPA), United States Military Entrance Processing Command (USMEPCOM)/Department of Defense Medical Examination Review Board (DoDMERB) is authorized to receive all of my education/disciplinary records for evaluation of my suitability for Military Service.
- I Understand that a medical examination is part of the accession evaluation, may require several visits to the Military Entrance Processing Station (MEPS), or DoDMERB contracted medical center. I may have blood work and/or other medical tests, procedures such as cerumen removal, and/or specialty consultations performed as part of my processing.
- I Understand that the results of the examination, tests, and consults are not performed as part of an individual healthcare treatment plan, but will be reviewed and considered as part of my accession application file.
- I Understand that the MEPS/DoDMERB medical staff are not my healthcare providers. If I do not receive notice of an abnormal result of a test or a consultation, I am not to assume that the result is normal. Furthermore, if any test or consultation results are abnormal, then I am responsible for obtaining those results from the MEPS/DoDMERB contracted medical center to discuss medical results, it is my responsibility to take quick action to return to the MEPS/DoDMERB contracted medical center.
- I Understand that neither USMEPCOM nor DoDMERB are financially responsible for costs associated with any necessary follow-up evaluations and/or treatment based on my screening evaluation.
- I Understand that any concerns that I have about my health and healthcare are my responsibility to address with my personal healthcare provider(s).
- I Understand that I must provide required documentation regarding my health history which, upon my accession, will become part of my Service member lifecycle medical treatment record.
- I Authorize a MEPS/DoDMERB contracted medical center to perform my accession medical evaluation.
- I Understand that I have the right to refuse to sign this authorization, however I also understand that failure to do so will prevent my further processing.
- I Understand that this authorization will expire four years from the date of the signature below, or sooner if written request is received by the USMEPCOM/DoDMERB Privacy Office. I have the right to revoke this authorization in writing, except to the extent that the DoD has acted in reliance on this information.

1. APPLICANT AUTHORIZATION AND CERTIFICATION

I Certify that the information on this form is true and complete to the best of my knowledge and belief, and no person has advised me to conceal or falsify any information about my medical and mental/behavioral health history.

a. SIGNATURE	b. DATE SIGNED (YYYYMMDD)
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2. PARENT OR GUARDIAN AUTHORIZATION (Signature is mandatory if applicant is a minor)

a. NAME (Last, First, Middle Initial)	b. SIGNATURE	c. DATE SIGNED (YYYYMMDD)
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3. RECRUITING REPRESENTATIVE CERTIFICATION: (If applicable) I certify that all applicant information above is complete and true to the best of my knowledge.

a. NAME (Last, First, Middle Initial)	b. RECRUITER IDENTIFICATION NUMBER	c. SIGNATURE	d. DATE SIGNED (YYYYMMDD)
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CUI (when filled in)

LAST NAME – FIRST NAME – MIDDLE INITIAL (Suffix)	SOCIAL SECURITY NUMBER			DoD ID NUMBER (If applicable)			
SECTION III - MEDICAL HISTORY							
1. Medications: any prescription or over the counter medication(s) taken regularly or as needed (list each and explain in SECTION IV)			2. Allergies: reaction to food(s), insect bites/stings, medication(s) or other substances (list each and explain in SECTION IV)				
Read each of the following questions and answer by checking "YES" or "NO". Every question must be answered. Every "YES" answer must be explained in SECTION IV. Explain each item to the best of your ability. Your medical records may be requested to clarify your medical history.							
HAVE YOU EVER HAD OR DO YOU NOW HAVE:		YES	NO	HAVE YOU EVER HAD OR DO YOU NOW HAVE:		YES	NO
EYES/VISION:							
3. Double vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
4. Detached retina or surgery to repair a detached retina	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
5. Keratoconus, glaucoma, cataracts or surgery for cataracts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
6. Vision correction procedure such as Lasik, PRK, or lens implant	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
7. Night blindness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
8. Any other eye condition, injury, or surgery/procedure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
EAR/SHEARING:							
9. Cholesteatoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
10. Ear drum perforation or tubes inserted into the ear drum(s) in the past 12 months	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
11. Any other ear surgery or procedure including mastoidectomy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
12. Loss of balance or vertigo	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
13. Hearing loss or use of hearing aid(s)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
NOSE, SINUSES, MOUTH, AND LARYNX:							
14. Ear, nose, or throat conditions such as vocal cord dysfunction	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
15. Recurrent nose bleeds, chronic sinus infections, or sinus surgery	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
16. Absence of, or disturbance of sense of smell	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
17. Any surgery of the face, throat, or jaw	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
DENTAL: (If you wear braces/aligners, then you must submit a letter from your orthodontist stating that active orthodontic treatment will be completed before beginning active duty)							
18. Braces or aligners	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
19. Any tooth or gum problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
LUNGS, CHEST WALL, PLEURA, AND MEDIASTINUM:							
20. Asthma, asthmatic bronchitis, wheezing, shortness of breath, or other breathing problems worsened by exercise, weather, pollens, etc.	<input type="checkbox"/>	<input type="checkbox"/>					
21. Prescription for an inhaler, steroids, or any other medication for breathing problem	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
22. Pneumonia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
23. Chronic cough or frequent coughing at night	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
24. Collapsed lung or other lung condition(s)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
25. History of chest, chest wall, or breast surgery	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
HEART:							
26. Heart murmur or valve problem(s)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
27. Palpitations, skipped/abnormal heartbeats, or pounding heart	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
28. Chest pain/pressure or an abnormal electrocardiogram (EKG)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
29. Heart surgery	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
30. Any other heart condition	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
ABDOMEN AND GASTROINTESTINAL SYSTEM:							
31. Problems of the stomach, esophagus, or intestine such as ulcer(s)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
32. Frequent indigestion/heartburn, difficulty swallowing, or eosinophilic esophagitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
33. Gallbladder disease or gallstones	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
34. Hepatitis or jaundice (except neonatal jaundice)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
35. Hernia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
36. Any abdominal surgery/endoscopy such as appendectomy, bowel resection, hernia repair, or colonoscopy	<input type="checkbox"/>	<input type="checkbox"/>					
37. Weight loss surgery such as gastric bypass or lap banding	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
38. Chronic or recurrent intestinal disease such as irritable bowel syndrome, inflammatory bowel disease, or celiac disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
39. Anorectal disease, blood from the rectum, or hemorrhoids	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
FEMALES ONLY:							
40. First day of the last menstrual period (YYYYMMDD)							
41. A change in menstrual pattern (other than pregnancy)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
42. Pregnancy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
43. Any abnormal PAP test	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
44. Endometriosis, uterine fibroid, or ovarian cyst	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
45. Any other gynecological disorder that required evaluation, treatment, or surgery	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
MALES ONLY:							
46. Undescended/absent testicle(s), or testicular implant	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
47. Any scrotal mass, swelling, or pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
48. Prostate problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
URINARY SYSTEM:							
49. Absence of, or a congenital abnormality of a kidney such as horseshoe kidney	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
50. Blood or protein in urine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
51. Painful or difficult urination	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
52. Kidney stone	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
53. Kidney or urinary tract disease, surgery, or infection	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
54. Bedwetting or treatment for bedwetting in the past 12 months	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
SPINE AND SACROILIAC JOINTS:							
55. Back or neck pain, or herniated disc	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
56. Abnormal curvature of any part of the spine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
57. Vertebral fracture or stress injury of the spine such as spondylolysis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
58. Back or neck surgery	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
UPPER EXTREMITIES:							
59. Any pain, swelling, weakness, numbness, or stiffness of the shoulder, elbow, wrist, hand, or fingers	<input type="checkbox"/>	<input type="checkbox"/>					
UPPER EXTREMITIES: (Continued)							
60. Dislocated shoulder, elbow, or wrist	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
LOWER EXTREMITIES:							
61. Foot conditions such as plantar fasciitis, heel spur, or painful bunions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
62. Knee injury resulting in ligament/cartilage tear, instability, or locking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
63. Any pain, swelling, weakness, numbness, or stiffness of the hip, knee, ankle, foot, or toes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
64. Dislocated hip, knee, ankle, or foot	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
MISCELLANEOUS CONDITIONS OF THE EXTREMITIES:							
65. Bone, muscle, or joint deformity, injury, or persistent pain/swelling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
66. Impaired use of arms, hands, fingers, legs, feet, or toes (any reason)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
67. Joint swelling/inflammation such as arthritis, gout, or bursitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
68. Compartment syndrome, shin splints, or stress reaction/fracture	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
69. Any surgery of the bone or joint such as placing a screw, plate, rod, pin, prosthetic/graft or arthroscopy	<input type="checkbox"/>	<input type="checkbox"/>					
70. Any use of prescribed corrective/prosthetic devices such as a brace, back support, heel lift, or orthotic inserts	<input type="checkbox"/>	<input type="checkbox"/>					
VASCULAR:							
71. Abnormal (high or low) blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
72. Pale, blue, or numb fingers or toes with exposure to cold such as Raynaud's phenomenon/disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
73. Kawasaki disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
SKIN:							
74. Acne that required prescription medication(s)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
75. Skin rash such as atopic dermatitis, eczema, or psoriasis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
76. Any other skin condition such as recurrent hives, abscesses (hidradenitis), pilonidal cyst, or cancer (melanoma)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
BLOOD AND BLOOD FORMING SYSTEM:							
77. Anemia such as iron deficiency, sickle cell, or thalassemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
78. Blood clot(s), a clotting disorder, or history of taking a blood thinner	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
79. Absence or removal of the spleen	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
80. Prolonged bleeding such as after an injury or dental procedure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
81. Any other blood or circulation condition	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
SYSTEMIC:							
82. Severe allergic reaction to any substance requiring emergency care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
83. Tested positive for tuberculosis (skin or blood test), or lived with someone who had it	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
84. Immune system condition such as rheumatoid arthritis, lupus, multiple sclerosis, or AIDS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
85. Sexually transmitted disease such as herpes, syphilis, gonorrhea, chlamydia, or HIV	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
86. Rhabdomyolysis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
ENDOCRINE AND METABOLIC:							
87. Thyroid conditions such as goiter or hypo/hyperthyroidism	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
88. Diabetes or hypoglycemia (low blood sugar)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
89. Any other endocrine (hormone) condition such as growth hormone deficiency, adrenal insufficiency, or hypo/hyperparathyroidism	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
NEUROLOGIC:							
90. Stroke, aneurysm, or bleeding in or around the brain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
91. Frequent or severe headaches such as migraines, cluster, or tension	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
92. A head injury, concussion, or skull fracture	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
93. Infection of the brain or spinal cord such as abscess, meningitis, or encephalitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
94. Seizures, epilepsy, or convulsions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
95. Syncope or fainting spells	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
96. Any other neurologic condition such as paralysis, myasthenia gravis, Tourette's, or memory loss	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
SLEEP:							
97. Sleep apnea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
98. Sleepwalking, narcolepsy, or difficulty with sleep such as falling/staying asleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
LEARNING, PSYCHIATRIC, AND BEHAVIORAL:							
99. Attention Deficit or Hyperactivity disorder (ADD/ADHD), dyslexia, autism spectrum, or other learning disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
100. A behavioral/mental health condition such as anxiety/panic attacks, depression, adjustment disorder, PTSD, personality disorder, addiction, or drug/substance abuse including alcohol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
101. Evaluation or treatment either with medication or counseling for any behavioral/mental health condition	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
102. Eating disorder such as anorexia or bulimia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
103. Self-inflicted injury such as cutting or burning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
104. Suicidal thoughts, gesture, or attempt	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
105. Admission to a hospital for any behavioral/mental health condition	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
TUMORS AND MALIGNANCIES:							
106. Any cancer, malignancy, tumor, or cyst	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
MISCELLANEOUS:							
107. Cold/heat intolerance or injury such as frostbite or heatstroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
SUPPLEMENTAL QUESTIONS:							
108. Prosthetic body part or joint	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
109. Any medical treatment/surgery from a Hospital, Emergency Room, Surgical Center or Urgent Care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
110. Previous medical disqualification for Military Service	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
111. Discharge from Military Service for any reason (provide reason, date, and type of discharge)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
112. Disability award or compensation for an injury or other medical condition	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				

CUI (when filled in)

LAST NAME – FIRST NAME – MIDDLE INITIAL (Suffix)	SOCIAL SECURITY NUMBER	DoD ID NUMBER (<i>If applicable</i>)
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SECTION IV – APPLICANT COMMENTS

Explain all "YES" answers to questions above. Write the item number and provide details to include the following: description of the problem/condition, date of onset of the problem/condition, date of treatment, name of health care provider, clinic, center, hospital along with City and State. Comment on the current status of the problem/condition. Attach additional sheet(s) if necessary, and sign and date each additional sheet. Attach copies of all applicable medical records.

CUI (when filled in)

LAST NAME – FIRST NAME – MIDDLE INITIAL (Suffix)	SOCIAL SECURITY NUMBER	DoD ID NUMBER (<i>If applicable</i>)
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SECTION V – MEDICAL PROVIDER SUMMARY

The medical provider will review all applicant comments on "YES" answers, and all submitted supporting medical documentation. The provider will comment below on each "YES" answer. Attach additional sheets if necessary.

CUI (when filled in)

LAST NAME – FIRST NAME – MIDDLE INITIAL (Suffix)	SOCIAL SECURITY NUMBER	DoD ID NUMBER (If applicable)
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SECTION VI - PRESCREEN PROCESSING DETERMINATION

1.a. MEDICAL PROCESSING STATUS				1.b. REVIEWER INITIALS	1.c. DATE (YYYYMMDD)
PA	PH	RJ	METR		

KEY: PA = Processing Authorized; PH = Processing Hold; RJ = Return Justified; METR = Medical Evaluation and/or Treatment Records

2. AUTHORIZING MEDICAL PROVIDER

a. NAME (Last, First, Middle Initial)	b. SIGNATURE	c. DATE SIGNED (YYYYMMDD)	d. NUMBER OF ADDITIONAL SHEETS ATTACHED
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SECTION VII – INTERVIEWING MEDICAL PROVIDER COMMENTS

3. INTERVIEWING MEDICAL PROVIDER			
a. NAME (Last, First, Middle Initial)	b. SIGNATURE	c. DATE SIGNED (YYYYMMDD)	

CIVIL CONVICTION QUESTIONNAIRE

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