Prescribed by: DoDI 1304.2

Fire Fighter

REPORT OF MEDICAL EXAMINATION

1. DATE OF EXAMINATION (YYYYMMDD)	2a. SOCIAL SECURITY NUMBER	2b. DoD ID NUMBER (If applicable)
Mandatory Field	Mandatory Field	Mandatory Field

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; E.O. 9397 (SSN) and 10 U.S.C. 1204, Members on Active Duty for 30 Days or Less or on Inactive Duty Training: Retirement, 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.

3. LAST NAME - FIRST NAME - MIDDLE NAME (Suffix)	4. HOME ADDRESS (Street, Apartment Number, City, State and Zip Code)	5a. HOME TELEPHONE NUMBER (Include Area Code)	5b. E-MAIL ADDRESS
Mandatory Field	Mandatory Field	Mandatory Field	Mandatory Field

6. GRADE/ RANK	7. DATE OF BIRTH (YYYYMMDD)	8. AGE	9a. BIRTH SEX	9b. PREFERRED GENDER	10a. ETHNIC CATEGORY	10b. RACIAL CATEGORY (Select one)
Mandatory Field	Mandatory Field	Mandatory Field	☐ Male ☐ Female (Mandatory Field)	☐ Male ☐ Female (Mandatory Field)	☐ Hispanic/Latino ☐ Non Hispanic/Latino	☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ White ☐ Native Hawaiian or Other Pacific Islander

11. TOTAL YEARS GOVERNMENT SERVICE		12. AGENCY (Non-Service Members Only)	13. ORGANIZATION UNIT AND UIC/CODE
a. MILITARY	b. CIVILIAN		

14a. RATING OR SPECIALTY (Aviators Only)	14b. TOTAL FLYING TIME	14c. LAST SIX MONTHS

15a. SERVICE (Mandatory Field)	15b. COMPONENT (Mandatory Field)	15c. PURPOSE OF EXAMINATION
☐ Army ☐ Air Force ☐ Marine Corps ☐ Navy ☐ Coast Guard	☐ Active Duty ☐ Reserve ☐ National Guard	☐ Enlistment ☐ Retirement ☐ Commission ☐ U.S. Service Academy ☐ Retention ☐ ROTC Scholarship Program ☐ Separation ☐ Medical Board ☐ Other Mandatory Field

16. NAME OF EXAMINING LOCATION, AND ADDRESS (Include Zip Code)
Mandatory Field

MEDICAL EVALUATION (Check each item in appropriate column. Enter "NE" if not evaluated.) Mandatory Field

	Normal	Abnormal	NE
17. Head, face, neck and scalp	☐	☐	☐
18. Nose	☐	☐	☐
19. Sinuses	☐	☐	☐
20. Mouth and throat	☐	☐	☐
21. Ears - General *(Int. and ext. canals/Auditory acuity under item 71)*	☐	☐	☐
22. Tympanic Membranes *(Perforation)*	☐	☐	☐
23. Eyes - General	☐	☐	☐
24. Ophthalmoscopic	☐	☐	☐
25. Pupils *(Equality and reaction)*	☐	☐	☐
26. Ocular motility *(Associated parallel movements, nystagmus)*	☐	☐	☐
27. Heart *(Thrust, size, rhythm, sounds)*	☐	☐	☐
28. Lungs and chest *(Include breasts)*	☐	☐	☐
29. Vascular system *(Varicosities, etc.)*	☐	☐	☐
30. Anus and rectum *(Hemorrhoids, Fistulae) (Prostate if indicated)*	☐	☐	☐
31. Abdomen and viscera *(Include hernia)*	☐	☐	☐
32. External genitalia *(Genitourinary)*	☐	☐	☐
33. Upper extremities	☐	☐	☐
34. Lower extremities *(Except feet)*	☐	☐	☐
35. Feet *(Check category)*	☐	☐	☐
35a. ☐ Normal Arch ☐ Pes Planus ☐ Pes Cavus			
35b. ☐ Mild ☐ Moderate ☐ Severe			
35c. ☐ Asymptomatic ☐ Symptomatic ☐ Rigid			
36. Spine, other musculoskeletal	☐	☐	☐
37. Body marks, scars, tattoos	☐	☐	☐
38. Skin, lymphatics	☐	☐	☐
39. Neurologic	☐	☐	☐
40. Psychiatric *(Specify any personality disorder)*	☐	☐	☐
41. Pelvic *(Females only)*	☐	☐	☐
42. Endocrine	☐	☐	☐

43. DENTAL DEFECTS AND DISEASE *(Please explain. Use dental form if completed by dentist. If abnormality noted, explain in item 44.)*
Mandatory Field

Acceptable ☐
Not Acceptable ☐
Class _____

44. NOTES: *(Mandatory comment for every abnormality identified in items 17 - 43. Enter pertinent item number before each comment. Continue comments or use drawings in item 89 and use additional sheets if necessary.)*

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LAST NAME - FIRST NAME - MIDDLE NAME (Suffix)	SOCIAL SECURITY NUMBER	DoD ID NUMBER
Mandatory Field	Mandatory Field	Mandatory Field

LABORATORY FINDINGS

45. URINALYSIS	a. Albumin	b. Sugar	46. URINE HCG	47. H/H	48. BLOOD TYPE
	Mandatory Field	Mandatory Field	Mandatory Field If Female	N/A	N/A

TESTS	RESULTS	HIV SPECIMEN ID LABEL	DRUG TEST SPECIMEN ID LABEL
49. HIV	Date HIV Drawn	HIV Barcode	N/A
50. DRUGS	N/A		
51. ALCOHOL	N/A		
52. OTHER (PFT)	Mandatory Field		
a. PAP SMEAR	N/A		
b. EKG	Mandatory Field		
c. CXR	Mandatory Field		

MEASUREMENTS AND OTHER FINDINGS

53. HEIGHT *(in.)*	54. WEIGHT *(lbs.)*	55a. MIN WGT	55b. MAX WGT	55c. MAX BF %	55d. BMI	56. TEMPERATURE	57. HEART RATE
Mandatory Field	Mandatory Field						Mandatory Field

58. BLOOD PRESSURE Mandatory Field			59. RED/GREEN Ishihara Test Mandatory Field	60. OTHER VISION TEST
a. 1ST	b. 2ND	c. 3RD		
SYS. Mandatory Field	SYS. N/A	SYS. N/A		
DIAS. Mandatory Field	DIAS. N/A	DIAS. N/A		

61. DISTANCE VISION Mandatory Field		62. REFRACTION ☐ AUTO ☐ MANIFEST ☐ CYCLO			63. NEAR VISION Mandatory Field		
Right Uncorr. 20/	Corr. to 20/	Sph:	Cyl:	Axis:	Right Uncorr. 20/	Corr. to 20/	Add:
Left Uncorr. 20/	Corr. to 20/	Sph:	Cyl:	Axis:	Left Uncorr. 20/	Corr. to 20/	Add:

64. HETEROPHORIA

ES	EX	R.H.	L.H.	Prism div.	Prism Conv CT	NPR	PD

65. ACCOMMODATION		66. COLOR VISION *(Pass/Fail and Score)* Ishihara Test			67. DEPTH PERCEPTION *(Pass/Fail and Score)* Mandatory Field	
Right	Left	PIP Mandatory Field	RED/ GREEN Mandatory Field	Color Dx Mandatory Field	AFVT Mandatory Field	RANDOT/ MCST Mandatory Field

68. FIELD OF VISION	69. NIGHT VISION	70. INTRAOCULAR PRESSURE	
		O.D.	O.S.

71a. AUDIOMETER Unit Serial Number Mandatory Field	71b. Unit Serial Number	72a. READING ALOUD TEST: ☐ SAT ☐ UNSAT
Date Calibrated *(YYYYMMDD)* Mandatory Field	Date Calibrated *(YYYYMMDD)*	72b. VALSALVA: ☐ SAT ☐ UNSAT

HZ	500	1000	2000	3000	4000	6000
Left	Mandatory Field					
Right	Mandatory Field					

HZ	500	1000	2000	3000	4000	6000
Left	x	x	x	x	x	x
Right	x	x	x	x	x	x

72c. OTHER TESTING

73. NOTES AND/OR INTERVAL HISTORY

N/A

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LAST NAME - FIRST NAME - MIDDLE NAME (Suffix)	SOCIAL SECURITY NUMBER	DoD ID NUMBER
Mandatory Field	Mandatory Field	Mandatory Field

74. EXAMINEE	75. I have been advised of my disqualifying condition(s).
☐ IS MEDICALLY QUALIFIED ☐ IS NOT MEDICALLY QUALIFIED Mandatory Field	75a. SIGNATURE OF EXAMINEE / 75b. DATE *(YYYYMMDD)*

76. PHYSICAL PROFILE

P	U	L	H	E	S	X	D	PROFILER INITIALS	DATE *(YYYYMMDD)*

77. SIGNIFICANT OR DISQUALIFYING MEDICAL DIAGNOSES

ITEM NO.	MEDICAL DIAGNOSIS	ICD CODE	PROFILE SERIAL	RBJ DATE *(YYYYMMDD)*	QUALIFIED	DISQUALIFIED	EXAMINER INITIALS	WAIVER RECEIVED	
								SERVICE	DATE *(YYYYMMDD)*

78. SUMMARY OF MEDICAL DIAGNOSES *(List diagnoses with item numbers) (Use additional sheets if necessary).*

79. RECOMMENDATIONS *(Specify) (Use additional sheets if necessary).*

80. MEPS WORKLOAD *(For MEPS use only)*

WKID	ST	DATE *(YYYYMMDD)*	INITIALS	WKID	ST	DATE *(YYYYMMDD)*	INITIALS

81. MEDICAL INSPECTION DATE	HT	WT	%BF	MAX WT	HCG	QUAL	DISQ	EXAMINER'S NAME AND SIGNATURE

82a. TYPED OR PRINTED NAME OF PHYSICIAN OR EXAMINER	82b. Signature
Mandatory Field	Mandatory Field
83a. TYPED OR PRINTED NAME OF PHYSICIAN OR EXAMINER	**83b. Signature**
84a. TYPED OR PRINTED NAME OF DENTIST OR PHYSICIAN *(Indicate which)*	**84b. Signature**
85a. TYPED OR PRINTED NAME OF REVIEWING OFFICER/APPROVING AUTHORITY *(Indicate which)*	**85b. Signature**

86. This examination has been administratively reviewed for completeness and accuracy.

a. SIGNATURE	b. GRADE	c. DATE *(YYYYMMDD)*

87. WAIVER GRANTED *(If yes, date and by whom)*	YES ☐	NO ☐	88. NUMBER OF ATTACHED SHEETS

89. ADDITIONAL REMARKS

Remarks if it applies to the provider or N/A