MEDICAL AND DENTAL PREPARATION FOR OVERSEAS MOVEMENT

For use of this form, see AR 600-8-11; the proponent agency is DCS, G-1.

PRIVACY ACT STATEMENT

Authority: Title 10, USC, Sections 3010, 8012 and 5031, and Title 5, USC, Section 301.

Principal Purpose: Information is required on all soldiers being reassigned overseas to determine if they meet medical and dental standards for such assignment.

Routine Uses: (1) For personnel service support; and (2) Information is primarily obtained from review of records unless assignment is to be an isolated area which requires evaluation and personal interview.

Disclosure: Disclosure of information is voluntary. If family members are required to complete medical and dental evaluation and personal interview, but refuse to do so, they will not be permitted to accompany the soldier to the oversea assignment.

1. TO	2. FROM		
3. NAME *(Last, Middle, First)*	4. SSN	5A. GRADE OR RANK	5B. PMOS OR AOC
6. PRESENT UNIT OF ASSIGNMENT	7. PROJECTED UNIT OF ASSIGNMENT *(Include location/country)*		
8. PROJECTED DUTY MOS OR AOC *(9 Position Code)*	9. ANTICIPATED DATE OF LOSS	10. IS MEMBER BEING ASSIGNED TO AN ISOLATED AREA AS DEFINED BY AR 40-501, PARA 5-13C? ☐ Yes ☐ No	

11. IF ANSWER TO ITEM 10 IS "YES" AND IF MEMBER IS REQUESTING FAMILY TRAVEL, ALL FAMILY MEMBERS WILL BE SCREENED BY THE LOCAL MEDICAL TREATMENT FACILITY FOR SPECIAL MEDICAL AND FUNCTIONAL NEEDS. ENTER NAMES OF ALL ACCOMPANYING FAMILY MEMBERS, OTHERWISE ENTER N/A.

NAME	NAME

12. LIST ANY OTHER SPECIAL MEDICAL OR DENTAL INSTRUCTIONS CONTAINED IN THE ASSIGNMENT INSTRUCTIONS

13A. NAME OF MPD/PSC REPRESENTATIVE	B. TITLE	
C. SIGNATURE	D. GRADE	E. DATE *(YYYYMMDD)*

Complete the medical and dental status portions below, return the original and one copy to the MDP/PSC within 21 calendar days of the date shown in item 13E, and forward one copy to the address in item 6.

MEDICAL STATUS

14A. PHYSICAL PROFILE SERIAL CODE *(PULHES)*	B. PHYSICAL CATEGORY CODE	C. MEDICAL RECORDS REVEAL THE FOLLOWING ASSIGNMENT LIMITATIONS

YES	NO	N/A	ITEM	
			15A. Does the member meet the medical fitness standards outlined in AR 40-501? *(If "no" explain briefly.)*	B. IF CONDITION IS TEMPORARY, EXPECTED DATE MEMBER WILL BE ELIGIBLE FOR ASSIGNMENT
			16A. Has member completed HIV screening?	B. DATE, TIME AND LOCATION OF APPOINTMENT
			17A. Is the member pregnant?	B. IF "YES", EXPECTED DATE OF DELIVERY
			18A. All active duty and reserve personnel of PCS assignment to Korea will be vaccinated with hepatitis B vaccine. Does the member require immunization?	B. IF "YES", INDICATE DATE, TIME, AND LOCATION OF APPOINTMENT
			19A. Does the member require remedial medical care?	B. IF "YES", INDICATE DATE, TIME, AND LOCATION OF APPOINTMENT
			20A. Is the member currently undergoing alcohol or drug abuse rehabilitation?	B. IF "YES", INDICATE DATE THE MEMBER ENTERED THE REHABILITATION PROGRAM
			21A. If item 10 is checked "yes", can the member be assigned to an area where medical facilities are limited or nonexistent?	B. IF "YES", THE MEMBER *(and family members, if applicable)* MUST BE SCHEDULED FOR A FOLLOW-UP EVALUATION OF MEDICAL STATUS WITHIN 30 CALENDAR DAYS OF THE ANTICIPATED DATE OF LOSS *(Item 9).* INDICATE DATE, TIME AND LOCATION OF APPOINTMENT(S)

22. Medical Records Indicate the Member Requires the Following *(Check those appropriate)*

REQUIRES	HAS	MISSING	ITEM	DATE, TIME AND LOCATION OF APPOINTMENT, IF NEEDED
			A Two pairs of spectacles	
			B. Protective mask spectacle insert	
			C. Two hearing aids	
			D. Medical warning tag	

23A. NAME OF MEDICAL OFFICER	B. TITLE	
C. SIGNATURE	D. GRADE	E. DATE *(YYYYMMDD)*

DENTAL STATUS *(Complete only if Item 10 is checked "Yes" or if required by item 12.)*

YES	NO		
		24A. Is the member dentally qualified?	B. IF "NO", BRIEFLY EXPLAIN. IF CONDITION IS TEMPORARY, EXPECTED DATE THE MEMBER WILL BE ELIGIBLE FOR ASSIGNMENT
		25A. Does the member require remedial dental care?	B. IF "YES", INDICATE DATE, TIME, AND LOCATION OF APPOINTMENT
		26A. If item 10 is checked "yes", can the member be assigned to an area where dental facilities are limited or nonexistent?	B. IF "YES", THE MEMBER *(and family members, if applicable)* MUST BE SCHEDULED FOR A FOLLOW-UP EVALUATION OF MEDICAL STATUS WITHIN 30 CALENDAR DAYS OF THE ANTICIPATED DATE OF LOSS *(Item 9).* INDICATE DATE, TIME, AND LOCATION OF APPOINTMENT(S)

27A. NAME OF DENTAL OFFICER	B. TITLE	
C. SIGNATURE	D. GRADE	E. DATE *(YYYYMMDD)*