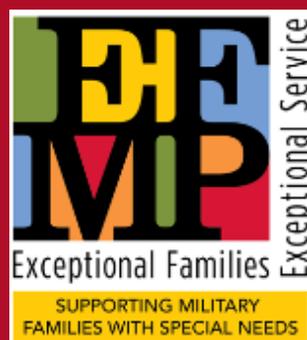


Quick Reference Guide

Navigate and understand:

- EFMP Enrollment
- EFMP Family Support
- Family Travel Screening

September
2016



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Table of Contents

This guide provides staff with reference information and instructions to assist family members with special needs with enrollment into the EFMP, EFMP Family Support, and Family Member Travel Screening processes for the Army, Marine Corps, Navy, and Air Force. For your reference, search tools for contact information, Family Support contact information, and relevant forms can also be found in this guide.

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1. INTRODUCTION TO THE EFMP ENROLLMENT PROCESS

Enrollment in the EFMP is mandatory for Active Duty Service members. When a family member is identified with special medical and/or educational needs, the special needs are documented through enrollment in the EFMP. Enrollment ensures that the family member's documented medical and educational needs are considered during the assignment process.

This section provides instructions to navigate the enrollment process for the Army, Marine Corps, Navy, and Air Force. Copies of enrollment forms for each Service can be found in the Appendix.

NOTE: Members of the Guard or Reserves may enroll in the EFMP according to Service-specific guidance.



ARMY EFMP ENROLLMENT

1. The completed [DD 2792](#) and/or [DD 2792-1](#) forms and any applicable attachments are submitted to an Army Medical Treatment Facility (MTF) to the attention of the EFMP Case Coordinator, using the contact information listed below.
2. The EFMP Case Coordinator conducts an administrative review of the forms.
3. Following the administrative review, the EFMP Case Coordinator forwards the forms to the appropriate Regional Health Command (RHC).
4. The RHC reviews the forms to determine medical and/or educational eligibility.
5. If eligible, the RHC enters the data into an automated EFMP database on the Army Personnel Network. The EFMP Case Coordinator notifies the Soldier of enrollment.

NOTE: Soldiers are responsible for ensuring that the EFMP enrollment information is current. Updates are required when a registered family member's special medical or education needs change, or at least every three years, whichever occurs first.

CONTACTS:

ATTN EFMP Case Coordinator

Nearest MTF for more information ([Search](#))

NOTE: Instructions for the TRICARE MTF Locator can be found on [pages 18-19](#) of this guide.

FORMS:

- [DD 2792](#) Family Member Medical Summary
- [DD 2792-1](#) Special Education/Early Intervention Summary



MARINE CORPS EFMP ENROLLMENT

1. The completed [DD 2792](#) and/or [DD 2792-1](#) forms are submitted to the local Military Treatment Facility (MTF), Installation EFMP Office, or HQMC, using the contact information listed below.
2. MTF staff or installation EFMP offices complete an administrative review of the documents prior to forwarding to HQMC.
3. Upon receipt, HQMC reviews the forms and documentation to determine medical and/or educational eligibility and completes enrollment determination.
4. Marines are notified of enrollment determination via letter to their government email account. If the marine does not have a government email, a letter will be sent to the address listed in the Marine Corps Total Force System.

NOTE: Enrollees must update enrollment information every three years, or sooner, if there is a change in status for any family member enrolled in the EFMP.

CONTACTS:

Nearest MTF for more information ([Search](#))

NOTE: Instructions for the TRICARE MTF Locator can be found on [pages 18-19](#) of this guide.

Email: HQMC.efmp@usmc.mil

Fax: 703-784-9821

FORMS:

- [DD 2792](#) Family Member Medical Summary
- [DD 2792-1](#) Special Education/Early Intervention Summary



NAVY EFMP ENROLLMENT

1. The completed [DD 2792](#) and/or [DD 2792-1](#) forms and any applicable attachments are submitted to the EFMP Coordinator at the Military Treatment Facility (MTF), using the contact information listed below.
2. The EFMP Coordinator at the MTF conducts an administrative review of the forms.
3. Following the administrative review, the EFMP Coordinator forwards the application to the appropriate Central Screening Committee (CSC) via mail, fax, or the Navy Family Accountability Assessment System (NFAAS), using the contact information listed below.
4. The CSC reviews the enrollment forms to determine medical and/or educational eligibility, recommends an assignment category, and forwards the application to the Navy Personnel Command (PERS-456).
5. The Navy's EFMP Manager at PERS-456 reports enrollment to the officer and enlisted detailers and annotates the sponsor's personnel records in the EFMP database.
6. For proof of enrollment, the Active Duty sponsor will contact their Case Liaison.

NOTE: Enrollees must update enrollment information every three years and/or with a change of status of a family member enrolled in the EFMP.

CONTACTS:

Nearest MTF for more information ([Search](#))

NOTE: Instructions for the TRICARE MTF Locator can be found on [pages 18-19](#) of this guide.

If family member lives east of the Mississippi River in the continental United States, Europe, Africa, South America, and the Caribbean:

Central Screening Committee East
 Exceptional Family Member Program
 Naval Medical Center
 620 John Paul Jones Circle Portsmouth, VA 23708-2197
 Commercial (757) 953-5900

If family member lives west of the Mississippi River in the continental United States or in Alaska, South Pacific, Asia, and Hawaii:

Central Screening Committee West
 Naval Medical Center, San Diego
 34800 Bob Wilson Drive
 San Diego, CA 92134-6200
 Commercial (619) 532-8586

FORMS:

- [DD 2792](#) Family Member Medical Summary
- [DD 2792-1](#) Special Education/Early Intervention Summary



AIR FORCE EFMP ENROLLMENT

1. The completed [DD 2792](#) and/or [DD 2792-1](#) forms, any applicable attachments, and the [AF 2523](#) form are submitted to the Airman's PAS-coded Air Force Medical Treatment Facility (MTF) to the attention of the Special Needs Coordinator (SNC), using the contact information listed below.
2. The SNC at the MTF conducts an administrative review of the forms.
3. Following the administrative review, the SNC reviews the forms to determine medical and/or educational eligibility.
4. If eligible for the EFMP, the SNC sends a letter to the Military Personnel Section (MPS).
5. The MPS Staff adds a Q-code to the Airman's record in MiIPDS, designating enrollment in the EFMP.

NOTE: Airmen are responsible for ensuring that the EFMP enrollment information is current. Updates are required when a family member's medical or special education needs change or during an assignment relocation action.

CONTACTS:

ATTN Special Needs Coordinator

Nearest Airman's PAS-coded Air Force MTF (contact Headquarters Air Force Personnel (HAF A1)

Nearest MTF for more information ([Search](#))

NOTE: Instructions for the TRICARE MTF Locator can be found on [pages 18-19](#) of this guide.

FORMS:

- [AF 2523](#) Exceptional Family Member Program-Medical (EFMP-M) Information Form
- [DD 2792](#) Family Member Medical Summary
- [DD 2792-1](#) Special Education/Early Intervention Summary



2. INTRODUCTION TO EFMP FAMILY SUPPORT

INTRODUCTION TO EFMP FAMILY SUPPORT

EFMP family support assists families with special needs by helping them identify and access programs and services. EFMP family support includes, but is not limited to: information and referral for military and community programs and services, non-clinical case management, and warm handoffs when a family transfers to a new location.

While enrollment in the EFMP is mandatory for Active Duty Service members, EFMP family support will provide services to Service members not enrolled in the EFMP and will refer families with special needs to the program.

CONTACTS:

Instructions to use the online search tool for EFMP Family Support contact information can be found on [pages 16-17](#) in this guide. Additionally, family support contact information for each Service can be found in the Appendix, on [pages 20-29](#) in this guide.

- EFMP Family Support Contact Information online search tool, [pages 16-17](#)
- Army Family Support Contact Information, [pages 20-23](#)
- Marine Corps Family Support Contact Information, [page 24](#)
- Navy Family Support Contact Information, pages [25-28](#)
- Air Force Family Support Contact Information, pages [29-32](#)

RESOURCES:

For further information about providing EFMP family support services please access the [EFMP: Family Support Reference Guide](#).



3. INTRODUCTION TO FAMILY MEMBER TRAVEL SCREENING (FMTS)

Family Member Travel Screening helps to ensure that Service members are assigned to locations that can support their families' needs.

Family Member Travel Screening is required for ALL families being considered for accompanied OCONUS assignments, regardless of EFMP enrollment. The availability of medical and/or educational services to support the needs of family members must be verified for all locations prior to travel approval. Depending on Service-specific guidance, Family Member Travel Screening may also be conducted for families enrolled in the EFMP for CONUS assignments.

As part of the Family Member Travel Screening process, the Service member and his/her family complete a medical and educational screening. If a special medical and/or educational need is identified during the screening, enrollment in the EFMP should be initiated.

This section provides instructions to prepare families for the Family Member Travel Screening process for the Army, Marine Corps, Navy, and Air Force. Screening forms are listed on each page, as applicable, and copies of the screening forms can be located in the Appendix.



ARMY FMTS (OCONUS SCREENING)

1. The Soldier obtains the authenticated [DA 5888](#) and [DA 7246](#) from the losing Military Personnel Division (MPD) at the Levy Briefing.
2. The Soldier or spouse schedules an OCONUS screening appointment with the EFMP Case Coordinator at the nearest Army Medical Treatment Facility (MTF). **NOTE:** If necessary, Case Coordinator will assist the family in scheduling a screening at another DoD MTF.
3. The EFMP Case Coordinator conducts the screening appointment at that MTF.
4. A member of the EFMP staff reviews medical records of all family members, and if necessary, arranges for a physical and developmental screening for children 72 months of age and younger, and completes the medical portion of [DA 5888](#).
NOTE: If there is an educational concern, the Soldier or spouse will be asked to have the staff at the child's early intervention program or school complete the [DD 2792-1](#) and attach a copy of the child's Individualized Family Service Plan (IFSP) or Individualized Education Program (IEP).
5. The MPD receives the completed [DA 5888](#) with copies of [DD 2792](#) and, if applicable, [DD 2792-1](#) with IFSP / IEP from the Soldier.
6. The MPD forwards the forms to the overseas travel approval authority and requests command sponsorship/family member travel.
7. As appropriate, the overseas travel approval authority coordinates with the medical point-of-contact and Department of Defense Dependents School (DoDDS) to determine availability of required services and provides decision to the MPD within thirty days.

NOTE: Soldiers who enroll in the EFMP after the receipt of OCONUS assignment instructions need to be aware that enrollment will not affect that assignment. If general medical care is not available, the Soldier may be required to serve an "all others" tour.

CONTACTS:

EFMP Case Coordinator

Nearest MTF for more information ([Search](#))

NOTE: Instructions for the TRICARE MTF Locator can be found on [pages 18-19](#) of this guide.

FORMS:

- [DA 5888](#) Family Member Deployment Screening Sheet
- [DA 7246](#) EFMP Screening Questionnaire
- [DD 2792](#) Family Member Medical Summary
- [DD 2792-1](#) Special Education/Early Intervention Summary



MARINE CORPS FMTS (SUITABILITY SCREENING)

For Marine Corps Family Member Travel Screening, please reference the Navy Family Member Travel Screening on [page 11](#) in this guide.



NAVY FMTS (SUITABILITY SCREENING)

1. The Sailor / Marine contacts the Suitability Screening Coordinator (SSC) at the losing Military Treatment Facility (MTF) to schedule a Suitability Screening.
NOTE: Required for all Overseas, Remote Duty, and Operational assignments.
2. The MTF SSC conducts the preliminary review and completes the [NAVMED 1300/2](#) for each Sailor / Marine and family member.
3. A medical provider conducts the screening and completes the [NAVMED 1300/1](#), PART I and II for each Sailor / Marine and family member.
4. A DD Form 2792-1 is required for all dependent children from birth to 22nd birthday OR high school graduation or equivalent.
5. If a special medical and/or educational need is identified, a DD Form 2792 must be completed and the family will be referred to the EFMP Coordinator for EFMP enrollment.
 - a. If a suitability inquiry is required, the SSC at the losing MTF forwards the screening paperwork to the SSC at the gaining MTF.
6. The SSC at the gaining MTF will determine local healthcare, Educational and Developmental Intervention Services (EDIS), and/or Department of Defense Dependents Schools (DoDDS) capabilities and will respond to the losing MTF within 7 working days.
7. The MTF Commanding Officer or Officer in Charge reviews [NAVMED 1300/1](#), PART I and II and completes and signs [NAVPERS 1300/16](#), PART II.
8. The Transferring Command makes a suitability determination based on the MTF recommendation by completing and signing [NAVPERS 1300/16](#), PART I.

NOTE: Suitability Screening and EFMP enrollment may proceed concurrently but the suitability process does not stop to await EFMP enrollment. Suitability Screening must be completed before the sponsor reports to the new duty location. Family members with special medical and/or educational needs may not be authorized command-sponsored travel if the gaining location does not have the necessary medical and/or special educational capabilities.

CONTACTS:

Nearest Navy MTF for more information ([Search](#))

NOTE: Instructions for the TRICARE MTF Locator can be found on [pages 18-19](#) of this guide.

FORMS:

- [NAVMED 1300/1](#) Medical, Dental and Educational Suitability Screening for Service and Family Members
- [NAVMED 1300/2](#) Medical, Dental, and Educational Suitability Screening Checklist and Worksheet
- [NAVPERS 1300/16](#) Report of Suitability for Overseas Assignment
- [DD 2792](#) Family Member Medical Summary
- [DD 2792-1](#) Special Education/Early Intervention Summary



AIR FORCE FMTS (FAMILY MEMBER RELOCATION CLEARANCE)

1. Airmen are provided an [AF 4380](#) to determine if a Family Member Relocation Clearance (FMRC) is required.

NOTE: All family members of Airmen with accompanied OCONUS assignments must participate in a family member travel screening prior to the issuance of orders.

2. If screening is required, the parent or spouse contacts the Air Force Exceptional Family Member-Medical (EFMP-M) office to determine paperwork needs (DD Form 2792 and / or 2792-1) for the in-person FMRC.
3. The parent or spouse turns in all completed forms to the EFMP-M office for an administrative review of the forms for accuracy.
4. The Family Member Relocation Clearance Coordinator (FMRCC) obtains medical records and schedules an in-person FMRC appointment for all family members accompanying the sponsor. For CONUS assignments, only the family member with special needs requires a FMRC.

NOTE: For OCONUS travel, all accompanying family members' records/documents are screened. For CONUS travel, only family members with special educational and/or medical needs are screened.

5. Required family members attend a joint screening appointment at the MTF with the Medical Review Officer (MRO) and Special Needs Coordinator (SNC).
6. If special needs are identified, the FMRCC develops a Facility Determination Inquiry (FDI) package, which includes the required paperwork, in accordance with Air Force Instruction (AFI) 40-701 and sends it to the gaining EFMP-M office. (Proceed to step 10)
7. If special needs are not identified, the [AF 1466](#) is signed by the MRO, SNC, and the Chief of Medical Services (SGH). The sponsor takes the [AF 4380](#) to the Military Personnel Section (MPS) to issue orders.
8. The gaining EFMP-M office receives the FDI and coordinates with the appropriate entities to determine if medical and/or educational services are available.
9. If the base/community can meet the family's needs, the gaining SGH recommends travel and the FDI is returned to the "losing" EFMP-M office.
10. When one or more services are not available, the SGH does not recommend travel for a family member. If a family member is not recommended for travel to an OCONUS location, the FDI is sent to the MAJCOM Surgeon General's office for review.
11. The FDI is returned to the losing EFMP-M office.
12. The losing EFMP-M office notifies the sponsor of the travel recommendation and directs the sponsor to meet with the MPS to determine assignment options.

NOTE: Sponsors may "appeal" the non-travel recommendation within 21 days of being notified of the non-travel recommendation for the family member(s).

CONTACTS:

ATTN: FMRCC

Nearest Airman's PAS-coded Air Force MTF (contact Headquarters Air Force Personnel (HAF A1)

Nearest MTF for more information ([Search](#))

NOTE: Instructions for the TRICARE MTF Locator can be found on [pages 18-19](#) of this guide.

FORMS:

- [AF 1466](#) Request For Family Member's Medical And Education Clearance For Travel
- [AF 1466D](#) Dental Health Summary
- [AF 4380](#) Air Force Special Needs Screener
- [DD 2792](#) Family Member Medical Summary



- [DD 2792-1](#) Special Education/Early Intervention Summary



4. INTRODUCTION TO EFMP CONTACT INFORMATION

Three search tools allow you to locate the contact information for EFMP Enrollment, TRICARE Military Treatment Facilities, and EFMP Family Support available online.

This section provides instructions to use the EFMP Enrollment, TRICARE Military Treatment Facility Locator, and EFMP Family Support search tools.



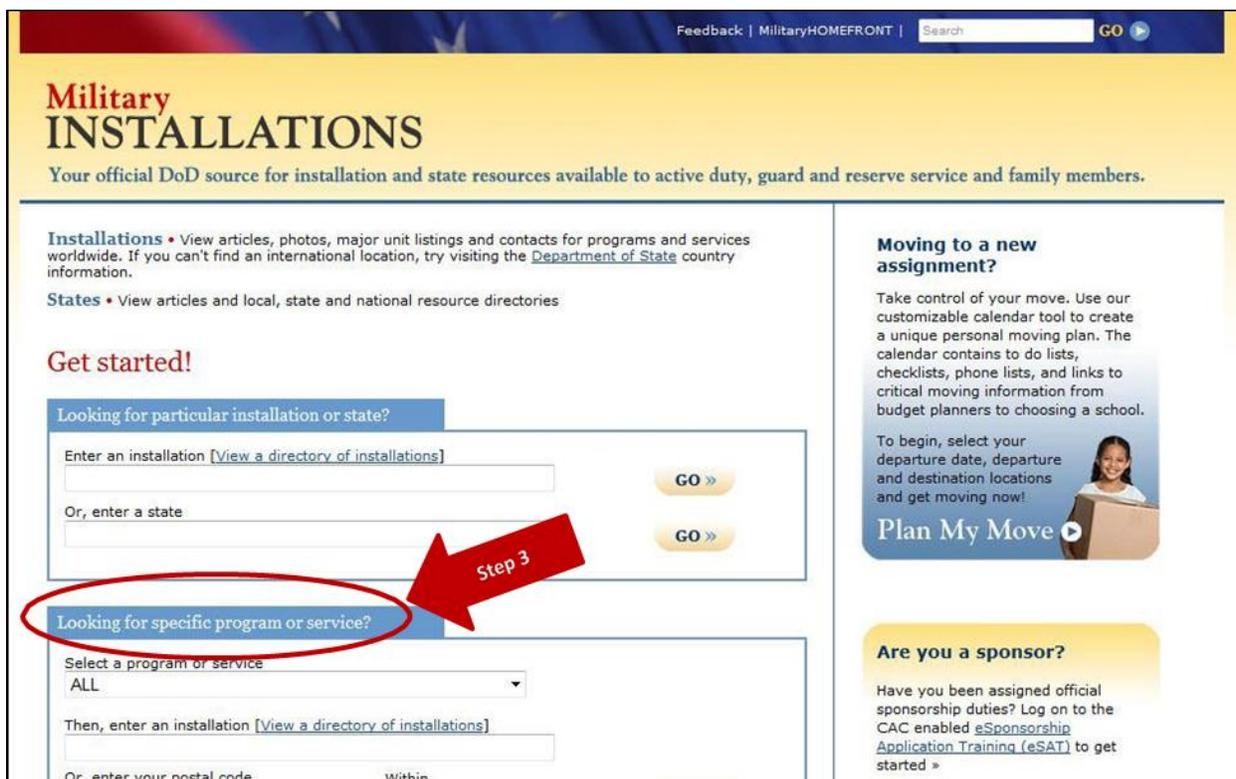
EFMP ENROLLMENT CONTACT INFORMATION

1. Open your Internet browser (for example, Internet Explorer).
2. Type the following web address into your Internet browser: www.militaryinstallations.dod.mil/

Enter the web address in the address bar, as shown below (Step 2 Arrow):



3. This will bring you to the Military Installations homepage, displayed below. Locate the **"Looking for specific program or service?"** box (Step 3 Arrow).





4. In the “**Looking for specific program or service?**” box (shown below), select “**EFMP-Enrollment**” in the dropdown menu under “**Select a program or service**” (Step 4 Arrow).
5. Then, **enter your installation** in the field displayed (Step 5A Arrow) or **enter your postal code** in the field displayed (Step 5B Arrow) to find EFMP Enrollment information for your installation.
6. Click “**Go**” to view results (Step 6 Arrow).

Looking for specific program or service?

Select a program or service
ALL

Then, enter an installation [\[View a directory of installations\]](#)

Or, enter your postal code

Within
10 miles

GO »

*Are you a service provider looking for a program or service across all installations?
Simply select the program or service and then choose any installation or enter any zip code. A downloadable directory for all installations will be available on the results page.*



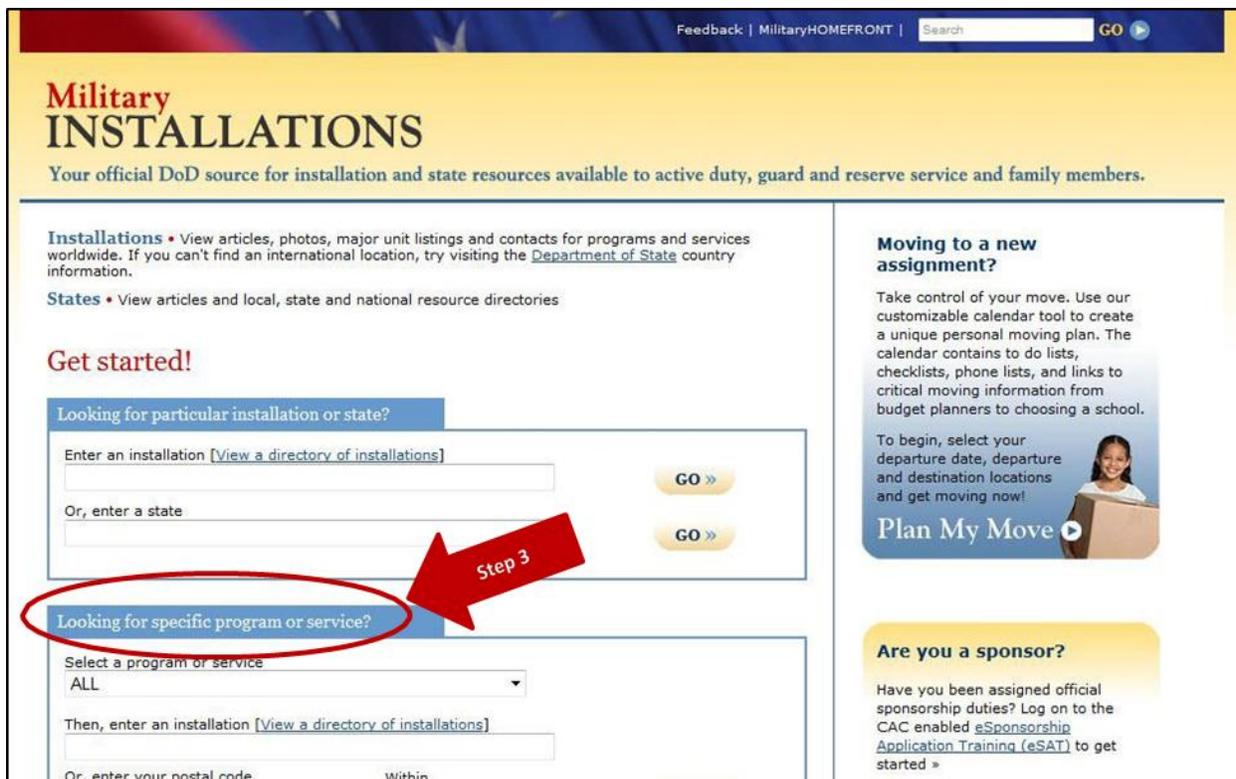
EFMP FAMILY SUPPORT CONTACT INFORMATION

1. Open your Internet browser (for example, Internet Explorer).
2. Type the following web address into your Internet browser: www.militaryinstallations.dod.mil/

Enter the web address in the address bar, as shown below (Step 2 Arrow):



3. This will bring you to the Military Installations homepage, displayed below. Locate the **“Looking for specific program or service?”** box (Step 3 Arrow).





4. In the “**Looking for specific program or service?**” box (shown below), select “**EFMP-Family Support**” in the drop down menu under “**Select a program or service**” (Step 4 Arrow).
5. Then, **enter your installation** in the field displayed (Step 5A Arrow) or **enter your postal code** in the field displayed (Step 5B Arrow) to find EFMP Family Support information for your installation.
6. Click “**Go**” to view results (Step 6 Arrow).

Looking for specific program or service?

Select a program or service
ALL

Then, enter an installation [\[View a directory of installations\]](#)

Or, enter your postal code

Within
10 miles

GO >>

*Are you a service provider looking for a program or service across all installations?
Simply select the program or service and then choose any installation or enter any zip code. A downloadable directory for all installations will be available on the results page.*

TRICARE MILITARY TREATMENT FACILITY CONTACT INFORMATION

If you are familiar with the TRICARE website, go to <http://www.tricare.mil/mtf.aspx> and skip to Step 6. Otherwise, please start with Step 1.

1. Open your Internet browser (for example, Internet Explorer).
2. Type the following web address into your Internet browser: <http://www.tricare.mil/mtf.aspx>.

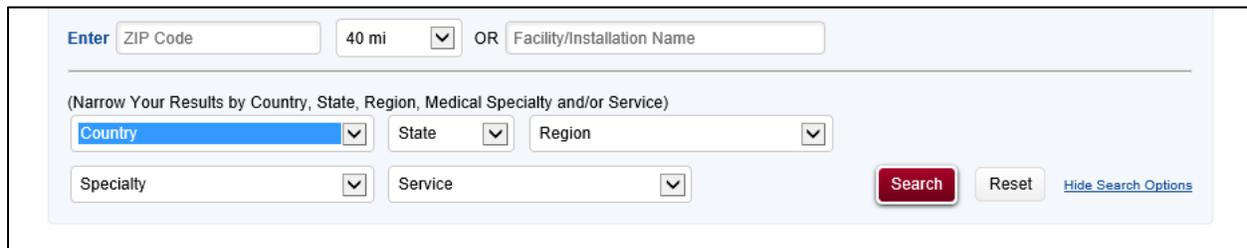
Enter the web address in the address bar, as shown below (Step 2 Arrow):



3. This will bring you to the TRICARE “Find a Military Hospital or Clinic” website (Step 3 Arrow).
4. In the “Find a Military Hospital or Clinic” box (displayed below), search for a MTF by entering your Facility or Installation Name, Region, and/or State/Country (Step 4 Arrow).
5. As appropriate, select the “More Search Options” link (Step 5 Arrow) to use Specialty, Service, and/or Facility options to narrow your search.

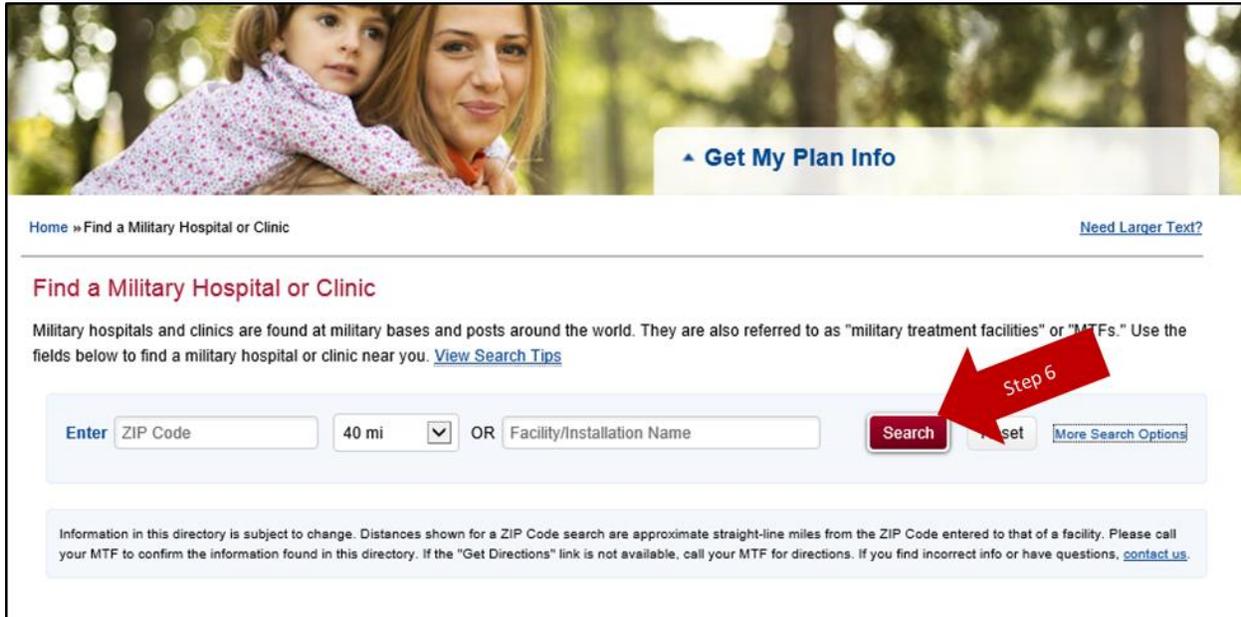


NOTE: Selecting the “More Search Options” link will open the advanced search options (displayed below).





6. Click **“Search”** to view results (Step 6 Arrow).



MTF Locator Search Tips:

- When searching for Facility Name or Installation Name, the search will find ALL of the words that you enter. For example, searching naval health will find anything containing the word naval and health.

Do not use abbreviations, for example, ft. instead of Fort. Using abbreviations will reduce the accuracy of the search. If you would like to search for a phrase, use quotation marks. For example, "Walter Reed" will find anything containing the phrase Walter Reed.



5. APPENDIX: INTRODUCTION TO FAMILY SUPPORT CONTACT INFORMATION

This section contains Family Support contact information for Army, Marine Corps, Navy, and Air Force installations. The information can be used to learn more about an installation or to contact Family Support Staff when a family is moving to a new location.

NOTE: If for any reason the provided phone numbers do not work, please visit the Military Installations website (<http://www.militaryinstallations.dod.mil/>) and search for the installation of your choice for available Family Support information (refer to [pages 16-17](#) of this guide).



Army Family Support Contact Information

IMCOM Headquarters

Installation	Phone
IMCOM G-9 HQ EFMP Manager	210-466-1137
HQ EFMP Specialist	210-466-1154
HQ EFMP Specialist	210-466-1153

IMCOM Central Region

Installation	Phone
Fort Bliss, TX	915-568-3052
Fort Carson, CO	719-526-4590
Detroit Arsenal, MI	586-282-0475
Dugway Proving Ground, UT	435-831-2834
Fort Hood, TX	254-286-6584
Fort Huachuca, AZ	520-533-6871
NTC/Fort Irwin, CA	760-380-3698
CSTC, Fort Hunter Liggett (USAR), CA	831-386-2378
Fort Leonard Wood, MO	573-596-0212
Fort Leavenworth, KS	913-684-2871
Fort McCoy (USAR), WI	608-388-6507
Fort Polk, LA	337-531-2840
Fort Riley, KS	785-239-9435

IMCOM Regional Command

Installation	Phone
Fort Sill, OK	580-442-6818
Joint Base Lewis- McChord, WA	253-967-9704
Joint Base San Antonio, TX	210-221-0497
Presidio of Monterey, CA	831-242-7960



IMCOM Regional Command, continued

Installation	Phone
Rock Island Arsenal, IL	309-782-4736
White Sands Missile Range, NM	575-678-2306
Yuma Proving Ground, AZ	928-328-3224

IMCOM Atlantic Region

Installation	Phone
Aberdeen Proving Ground, MD	410-278-2420
Anniston Army Depot, AL	256-235-7971
Carlisle Barracks, PA	717-245-3775
Fort Belvoir, VA	703-805-4418
Fort Benning, GA	706-545-5521
Fort Bragg, NC	910-907-3395
Fort Buchanan (USAR), PR	787-707-3295
Fort Campbell, KY	270-956-3738
Fort Detrick, MD	301-619-3385
Fort Devens (USAR), MA	978-796-3023
Fort Drum, NY	315-772-5476
Fort Gordon, GA	706-791-4872
Fort Hamilton	718-630-4460
Fort Jackson, SC	803-751 5256
Fort Knox, KY	502-624-4067
Fort Lee, VA	804-734-6393
Fort Meade, MD	301-677-5662
Fort Rucker, AL	334-255-9277
Fort Stewart, GA	912 767-0259
Joint Base Langley-Eustis (Air Force), VA	757-878-1954
Joint Base Little Creek-Story (Navy), VA	757-462-7563

**IMCOM Atlantic Region, continued**

Installation	Phone
Joint Base McGuire- Dix- Lakehurst (Air Force), NJ	609-3754-3154
Joint Base Myer- Henderson Hall, VA	703-696-8467
Natick, MA	508-233-4798
Picatinny Arsenal, NJ	973-724-2145
Redstone Arsenal, AL	256-876-5397
Tobyhanna Army Depot, PA	570-615-7509
USAG Miami, FL	305-437-2734
West Point	845-938-5655

IMCOM Europe Region

Installation	Phone
EUROPE REGION	49-6302-67-5627
USAG Ansbach, Germany	49-9802-83-3629
USAG Baumholder, Germany	49-678368184/ 678368188
USAG Benelux, Belgium	32-65-44-7461
USAG Garmisch, Germany	49-8821-750-3572
USAG Grafenwoehr, Germany	49-9662-83-2881
USAG Hohenfels, Germany	49-9472-83-4907
USAG Kaiserslautern, Germany	49-631-3406-4094
USAG Stuttgart, Germany	49-7031-15-3344
USAG Vicenza, Italy	39-0444-71-8582
USAG Wiesbaden, Germany	49-611-408-5234

IMCOM Pacific Region

Installation	Phone
PACIFIC REGION	808-438-5492
Fort Greely, AK	907-873-4385



IMCOM Pacific Region, continued

Installation	Phone
Fort Wainwright, AK	907-353-4243
Joint Base Elmendorf- Richardson (Air Force), AK	907-384-0225
USAG Camp Zama, Japan	011-81-46-407-4572
USAG Daegu, South Korea	011-82-53-470-8329
USAG Humphreys, South Korea	011-82-333-753-6277
USAG Red Cloud/Camp Casey, South Korea	011-8231-730-6552
USAG Schofield Barracks, HI	808-655-4777
USAG Torii Station, Japan	011-81-611-744-4106
USAG Yongsan, South Korea	011-822-7918-5150



Marine Corps Family Support Contact Information

Installation	Phone
HQMC EFMP, VA	703-784-0298
Albany, GA	229-639-5277
Barstow, CA	760-577-5854
Beaufort/MCRD Parris Island, SC	843-228-7752
Camp Allen, VA	757-445-6876
Camp Butler Okinawa, Japan	011-81-611-745-9237
Camp Lejeune, NC	910-451-9372
Camp Pendleton, CA	760-725-5363
Cherry Point, NC	252-466-7533
Hawaii	808-257-0290
Henderson Hall, VA	703-693-6368
Iwakuni, Japan	011-81-827-79-5601
MCRD San Diego, CA	619-524-6078
Miramar, CA	858-577-8644
New River, NC	910-449-5251
Quantico, VA	571-931-0524
Twentynine Palms, CA	760-830-7740
Yuma, AZ	928-269-2949



Navy Family Support Contact Information

COMMAND: CNRSW

Installation	Phone
China Lake, CA	760-939-4545
Coronado, CA	619-545-6071
El Centro, CA	760-339-2442
Fallon, NV	775-426-3333
Lemoore, CA	559-998-4042
Monterey, CA	831-656-3060
Murphy Canyon, CA	858-277-4259
Navy Region Southwest	619-556-7404
San Diego, CA	619-556-7404
Ventura County/Point Mugu, CA	805-982-5037

COMMAND: CNR HAWAII

Installation	Phone
Joint Base Pearl Harbor-Hickam, HI	808-474-1999 x6108

COMMAND: CNR MID-ATLANTIC

Installation	Phone
Earle, NJ	732-866-2115
JEB Little Creek Fort Story, VA	757-462-7563
Navy Region Mid- Atlantic	757-322-9109
New London, CT	860-694-3383
Newport, RI	401-841-2283
Norfolk, VA	757-444-2102
NSA Mid-South	901-874-5075
NSA Norfolk Northwest Annex, VA	757-421-8770
Oceana, VA	757-433-2912

**COMMAND: CNR MID-ATLANTIC, continued**

Installation	Phone
Portsmouth NSY, ME	207-438-1835
Portsmouth, VA	757-444-2102
Saratoga Springs, NY	518-886-0200
Sugar Grove, WV	304-249-6519
Yorktown/Newport News, VA	757-887-4606

COMMAND: CNR EURAFSWA

Installation	Phone
Bahrain, Kingdom of Bahrain	011-973-1785-4046
CNR EURAFSWA	011-39-081-568-6951
Naples, Italy	011-39-081-811-6372
Rota, Spain	011-34-356-82-3232
Sigonella, Italy	011-39-095-56-4291
Souda Bay, Greece	011-30-28210-21690

COMMAND: CNR SOUTH EAST

Installation	Phone
Corpus Christi, TX	361-961-2372
Guantanamo Bay, Cuba	011-5399-4141
Gulfport, MS	228-871-2581
Jacksonville, FL	904-542-5745
JB Charleston (Air Force Supported), SC	843-963-4406
JRB Forth Worth, TX	817-782-5287
JRB New Orleans, LA	504-678-7569
Key West, FL	305-293-4408
Kings Bay, GA	912-573-4512
Kingsville, TX	361-516-6333



COMMAND: CNR SOUTH EAST, continued

Installation	Phone
Mayport, FL	904-270-6600
Meridian, MS	601-679-2360
Naval Station Great Lakes, IL	847-688-3603
Navy Region Southeast	904-542-9838
Panama City, FL	850-235-5800
Pensacola, FL	850-452-5990
Whiting Field, FL	850-623-7177

COMMAND: CNR NORTHWEST

Installation	Phone
NAS Whidbey Island, WA	360-257-6289
Naval Station Everett, WA	425-304-3735
Navy Region Northwest (NAVBASE KITSAP, WA)	360-396-4115
Smokey Point, WA	425-304-3367

COMMAND: CNR JAPAN

Installation	Phone
Atsugi, Japan	011-81-467-63-3372
Diego Garcia	011-246-3704421
Sasebo, Japan	011-81-956-50-3372
Yokosuka, Japan	011-81-468-16-3372

COMMAND: CNR MARIANAS

Installation	Phone
Guam	671-333-2056

**COMMAND: NAVAL DISTRICT WASHINGTON (NDW)**

Installation	Phone
Naval District Washington	202-433-6235
JB Anacostia- Bolling, DC	202-433-6151 202-767-0450
NAS Patuxent River, MD	301-342-4911
Naval Support Facility Indian Head, MD	800-500-4947
NSA Annapolis, MD	410-293-2641
NSA Bethesda, MD	301-319-4087
NSA South Potomac, DC (Dahlgren, VA)	540-653-1839
Washington Navy Yard (Washington, DC)	202-685-0229



Air Force Family Support Contact Information

MAJCOM: ACC

Installation	Phone
Beale, CA	530-634-2863
Davis Monthan, AZ	520-228-5690
Holloman, NM	575-572-7754
Joint Base Langley- Eustis (Eustis), VA	757-878-1954
Joint Base Langley- Eustis (Langley), VA	757-764-3990
Moody, GA	229-257-4789
Mt Home, ID	208-828-2458
Nellis, NV	702-652-3327
Offutt, NE	402-294-4329
Seymour Johnson, NC	919-722-0691
Shaw, SC	803-895-1163
Tyndall, FL	850-283-4204

MAJCOM: AETC

Installation	Phone
Altus, OK	580-481-7922
Columbus, MS	662-434-2701
Goodfellow, TX	325-654-3893
Joint Base San Antonio - Fort Sam Houston, TX	210-221-0497
Joint Base San Antonio - Lackland, TX	210-671-3722
Joint Base San Antonio - Randolph, TX	210-652-5321
Keesler, MS	228-376-8505
Laughlin, TX	830-298-4788
Luke, AZ	623-856-6550
Maxwell, AL	334-953-3799

**MAJCOM: AETC, continued**

Installation	Phone
Sheppard, TX	940-676-4358
Vance, OK	580-213-6285

MAJCOM: AFDW

Installation	Phone
Andrews, MD	301-981-7088
Pentagon, VA	703-693-9460

MAJCOM: AFGSC

Installation	Phone
Barksdale, VA	318-456-8400
Dyess, TX	325-696-5999
Ellsworth, SD	605-385-4663
FE Warren, WY	307-773-5943
Kirtland, NM	505-853-1717
Malmstrom, MT	406-731-4900
Minot, ND	701-723-3950
Whiteman, MO	660-687-7132

MAJCOM: AFSOC

Installation	Phone
Edwards, CA	661-277-2456
Eglin, FL	850-883-4342
Hanscom, MA	781-225-2765
Hill, UT	801-586-2611
Warner Robins, GA	478-926-1259
Tinker, OK	405-734-5690
Wright Patterson, OH	937-656-0946



MAJCOM: AFSPC

Installation	Phone
Buckley, CO	720-847-6694
Los Angeles, CA	310-653-5193
Patrick, FL	321-494-5676
Peterson, CO	719-556-0458
Schriever, CO	719-567-3920
Vandenberg, CA	805-606-0039

MAJCOM: AMC

Installation	Phone
Joint Base Charleston, SC	843-963-4411
Dover, DE	302-677-3258
Fairchild, WA	509-247-2246
Grand Forks, ND	701-747-6434
Joint Base McGuire- Dix- Lakehurst, NJ	609-754-2023
Little Rock, AR	501-987-8480
MacDill, FL	813-828-0122
McConnell, KS	316-759-3376
Pope, NC	910-394-2538
Scott, IL	618-256-1467
Travis, CA	707-424-4342

MAJCOM: PACAF

Installation	Phone
Eielson, AK	907-377-2178
Joint Base (Elmendorf)- Richardson, AK	907-552-6615
Joint Base Elmendorf- (Richardson), AK	907-384-0225
Kadena, Japan	011-81-98-961-3366

**MAJCOM: PACAF, continued**

Installation	Phone
Misawa, Japan	011-81-317-77-4735
Osan, Korea	011-82-505-784-4813
Yokota, Japan	011-81-311-755- 8725

MAJCOM: USAFA

Installation	Phone
AF Academy, CO	719-333-3444

MAJCOM: USAFE

Installation	Phone
Aviano, Italy	39-0434305407
Geilenkirchen, Germany	49-2451633791
Incirlik, Turkey	90-322-3166755
Lajes Field, Azores	351-295574138
Morón, Spain	39-0434305407
RAF Alconbury, England	44-1480843557
RAF Lakenheath, England	44-1638523847
RAF Menwith Hill, England	44-1423-777730
RAF Mildenhall / RAF Croughton, England	44-1638543406
Ramstein, Germany	49-63714058834
Spangdahlem, Germany	49-6565616422



6. APPENDIX: INTRODUCTION TO EFMP FORMS

Forms are required for enrollment into the EFMP and for the Family Member Travel Screening process. In this section you will find forms for the Army, Marine Corps, Navy, and Air Force. The Department of Defense forms are required for enrollment into the EFMP for all Services.

DEPARTMENT OF DEFENSE FORMS

ENROLLMENT

- [DD 2792](#) Family Member Medical Summary
- [DD 2792-1](#) Special Education/Early Intervention Summary

ARMY FORMS

FAMILY MEMBER TRAVEL SCREENING

- [DA 5888](#) Family Member Deployment Screening Sheet
- [DA 7246](#) EFMP Screening Questionnaire

MARINE CORPS / NAVY FORMS

FAMILY MEMBER TRAVEL SCREENING

- [NAVMED 1300/1](#) Medical, Dental and Educational Suitability Screening for Service and Family Members
- [NAVMED 1300/2](#) Medical, Dental, and Educational Suitability Screening Checklist and Worksheet
- [NAVPERS 1300/16](#) Report of Suitability for Overseas Assignment

AIR FORCE FORMS

ENROLLMENT

- [AF 2523](#) Exceptional Family Member Program-Medical (EFMP-M) Information Form

FAMILY MEMBER TRAVEL SCREENING

- [AF 1466](#) Request For Family Member's Medical And Education Clearance For Travel
- [AF 1466D](#) Dental Health Summary
- [AF 4380](#) Air Force Special Needs Screener

INSTRUCTIONS FOR COMPLETING DD FORM 2792, FAMILY MEMBER MEDICAL SUMMARY

GENERAL.

The DD Form 2792 and attached addenda are completed to identify a family member with special medical needs.

There is a Certification Section on page 3 that should be signed AFTER the entire form is completed by medical provider(s) and the form has been reviewed for completeness and accuracy.

The Parent/Guardian or Person of Majority Age signs block 11b, and the MTF coordinator/authorized reviewer signs block 12b.

A **Qualified Medical Provider** is responsible for assessing whether the services they are eligible to prescribe are within the scope of their practice and their state licensing requirements.

AUTHORIZATION FOR DISCLOSURE (Page 1)

Health Insurance Portability and Accountability Act (HIPAA) Requirement.

Each adult family member must sign for the release of his/her own medical information. The sponsor or spouse cannot authorize the release of information for those dependent family members who have reached the age of majority unless they are court-appointed guardians. Please consult with your military treatment facility (MTF) or dental treatment facility (DTF) privacy/HIPAA coordinator about questions regarding authorizations for disclosure.

DEMOGRAPHICS/CERTIFICATION (Page 2).

Item 1. Self-explanatory.

Item 2.a. Family Member (FM). Name of family member described in subsequent pages.

Item 2.b. Sponsor Name. Name of the military member responsible for the family member identified in Item 2.a.

Items 2.c. - e. Self-explanatory.

Item 2.f. Family Member Prefix (FMP). Applies to Military medical beneficiary only. The Family Member Prefix is assigned when the family member is enrolled in DEERS.

Item 2.g. DoD Benefits Number (DBN). This 11-digit number has two components. The first nine digits are assigned to the sponsor; the last two digits identify the specific person covered under that sponsor. The first nine digits do not reflect the sponsor's nine-digit SSN. The DBN can be found above the bar code on the back of the beneficiary's ID card. If the child has not been issued an ID card, enter the first 9 digits of the parent's DBN.

Items 2.h. - j. Self-explanatory.

Items 3.a. - h. All items refer to the sponsor. Self-explanatory.

Item 3.i. Annotate with an "X" whether the family member resides with the sponsor. If the family member does not, then provide an explanation.

Item 4.a. Answer Yes if both spouses are on active duty or if the enrolling spouse was a former member of the U.S. military. If Yes, complete Items 4.b. - e.

Item 5.a. - d. If Yes, enter SSN, name of sponsor and branch of Service. Military only.

Item 6.a. If Yes, complete b. - c. Self-explanatory.

Item 7. Identify current medically necessary adaptive equipment or special medical equipment used by the family member. Include make and model of the equipment.

Item 8. Required Actions. Self-explanatory.

Item 9. Required Addenda. To be completed by the EFMP/Screening Coordinator completing the administrative review/certification. Please note: Each addenda is completed, and submitted for EFMP review, only if applicable to the patient described. **SIGNATURE of a Qualified Medical Provider is REQUIRED.**

Items 10.a. - c. To be completed by the administrator in consultation with the family. Mark (X) all services being provided to the family member.

Items 11.a. - c. Parent/Guardian or Person of Majority Age. Parent/guardian or person of majority age certifies that the information contained in the DD 2792 is correct. **Individual must ensure that all applicable forms are completed and attached before signing.**

Items 12.a. - f. The MTF authorized case coordinator/administrator name, signature, date, location of military treatment facility or certifying EFMP program, telephone number, and official stamp. Self-explanatory. **Administrator must ensure that all forms are complete and attached before signing.**

MEDICAL SUMMARY beginning on page 4 must be completed by a qualified medical professional. Sponsor, spouse, or family member of majority age must sign release authorization on page 1 before this summary is completed. Please complete as accurately as possible using ICD-9-CM or, when approved, ICD-10-CM. If the patient has an asthma, mental health or autism spectrum disorder/developmental delay diagnosis, enter ONLY the diagnostic description/code on Page 4 and the remainder of the information on the appropriate attached addendum form.

Items 1.a. - c. Place an "X" in the appropriate box if the information is included in an addendum.

Items 2.a. - b. Primary Diagnosis. Enter the primary diagnosis and corresponding diagnostic code for the family member.

Items 3.a. - c. Medication History. Enter all current medications associated with the primary diagnosis, the dosage and frequency medication should be taken.

Items 4.a. - d. Hospital Support for the Last 12 Months. Enter the number of emergency room visits/urgent care visits, hospitalizations, ICU admissions, and number of outpatient visits.

Item 5. Prognosis. Self-explanatory.

Item 6. Treatment Plan for Primary Diagnosis. Include medical and/or surgical procedures, special therapies planned or recommended over the next three years. Also include the expected length of treatment, required participation of family members, and if treatment is ongoing.

Items 7. - 21. Secondary Diagnoses. Follow procedures for Items 2. - 6. above.

Item 22. Minimum Health Care Required. Codes in the first column are used by Army coding teams only. In column 1, mark with an X any specialists **REQUIRED** to meet the patient's needs. If a specialist was used to determine a diagnosis, and is not necessary for ongoing care, **DO NOT** place an X next to that specialist. If a developmental pediatrician is a child's primary care manager, but a pediatrician meets the needs, **DO NOT** mark developmental pediatrician. This section is not a wish list, but should reflect the providers that are necessary to meet the needs of the patient.

Items 23. - 26. Self-explanatory.

Items 27.a. - f. Provider Information. Official stamp or printed name and signature of the provider completing this summary, date the summary was signed, telephone number(s) for the provider, email and medical specialty.

INSTRUCTIONS FOR COMPLETING DD FORM 2792 (Continued)

ADDENDUM 1 - ASTHMA/REACTIVE AIRWAY DISEASE SUMMARY

(p. 8). To be completed by a qualified medical professional. This addendum is completed only if applicable to the patient described.

Item 1. Diagnostic Description Code. Enter the diagnostic description code (ICD-9-CM or, when approved, ICD-10-CM) for patients evaluated or treated for asthma within the past 5 years and continue the completion of the addendum and sign. **Signature of Qualified Medical Provider is REQUIRED** in Item 5.b.

Items 2. - 4. Self-explanatory.

Item 5.a. - f. Provider Information. Official stamp or printed name and signature of the provider completing this addendum, the date the summary was signed, the telephone number(s) for the provider, email, and medical specialty.

ADDENDUM 2 - MENTAL HEALTH SUMMARY (pp. 9 - 10). To be completed and signed by a qualified medical professional. This addendum is completed only if applicable to the patient described.

Items 1.a. - c. Diagnosis(es). Complete as accurately as possible using ICD-9-CM or, when approved, ICD-10-CM if the patient has current or past (within the last 5 years) history of mental health diagnosis (to include attention deficit disorders).

Items 2.a. - c. Medication History. Provide current medications, dosage, and frequency for diagnoses listed in Item 1.a.

Items 2.d. - e. Include any discontinued medication(s) related to the diagnosis(es), with reasons for discontinuing, and the frequency taken.

Items 3.a. - b. Therapy Received or Recommended. Include past compliance with treatment programs, frequency and expected length of treatment, required participation of family members, and if treatment is ongoing.

Items 4.a. - c. Treatment. Insert the number of outpatient visits in the **LAST YEAR**, the number of hospitalizations in the **LAST FIVE YEARS**, and the number of residential treatment admissions in the **LAST FIVE YEARS** (include the date of last admission).

Items 5.a. - h. History. Answer Yes or No, and include additional details as directed on the patient's mental health history for the last five years.

Items 6. - 9. Self-explanatory.

Items 10.a. - f. Provider Information. Official stamp or printed name and signature of the provider completing this addendum, the date the summary was signed, the telephone number(s) for the provider, email and medical specialty.

ADDENDUM 3 - AUTISM SPECTRUM DISORDERS AND SIGNIFICANT DEVELOPMENTAL DELAYS (p.11) . To be completed by a qualified medical professional. This addendum is completed only if applicable to the patient described.

Item 1.a. - c. Indicate the diagnosis(es) using an X. Insert the date when diagnosed and select the appropriate specialty provider(s) or school-based team that diagnosed the patient.

Items 2. - 3. Self-explanatory.

Items 4.a. - d. Current Medications. List all current medications used to treat the diagnosis(es) listed in Items 1 and 3, the dosage, the frequency taken, and the reason prescribed.

Items 5.a. - e. Current Interventions/Therapies. Providing a list of current interventions and therapies is important information for the family travel determination for this patient. The information should be completed by a qualified medical professional in consultation with the family. Self-explanatory.

Item 6. Communication. Using an X, indicate if the patient is verbal or non-verbal. If non-verbal, indicate the appropriate communication methods used.

Item 7. Self-explanatory.

Item 8. Behavior. Answer yes if the child exhibits high risk or dangerous behaviors. Additional information may be included in item 13 if more space is required.

Item 9. Cognitive Ability. Indicate appropriate intelligence quotient (IQ), if known.

Items 10. - 11. Self-explanatory.

Item 12. Respite Care Received. Provide the number of hours per month, and the source, e.g., EFMP Respite Care Program, ECHO or Medicaid.

Item 13. General Comments. Self-explanatory.

Item 14. Provider Information. Official Stamp or printed name, signature, date signed, telephone number(s), official email and medical specialty. Self-explanatory.

FAMILY MEMBER MEDICAL SUMMARY
(To be completed by service member, adult family member, or civilian employee.)
(Read Instructions before completing this form.)

OMB No. 0704-0411
 OMB approval expires
 Jul 31, 2017

The public reporting burden for this collection of information is estimated to average 30 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 (0704-0411). 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; 20 U.S.C. 927; DoDI 1315.19; DoDI 1342.12; and E.O. 9397 (SSN) as amended.

PRINCIPAL PURPOSE(S): Information will be used by DoD personnel to evaluate and document the special medical needs of family members. This information will enable: (1) military assignment personnel to match the special medical needs of family members against the availability of medical services, and (2) civilian personnel officers to advise civilian employees about the availability of medical services to meet the special medical needs of their family members. The personally identifiable information collected on this form is covered by a number of system of records notices pertaining to Official Military Personnel Files, Exceptional Family Member or Special Needs files, Civilian Personnel Files, and DoD Education Activity files. The SORNS may be found at <http://dpclo.defense.gov/Privacy/SORNSIndex/DODComponentNotices.aspx>.

ROUTINE USE(S): DoD Blanket Routine Uses 1, 4, 6, 8, 9, 12, and 15 found at <http://dpclo.defense.gov/Privacy/SORNSIndex/BlanketRoutineUses.aspx> may apply.

DISCLOSURE: Voluntary for civilian employees and applicants for civilian employment. Mandatory for military personnel: failure or refusal to provide the information or providing false information may result in administrative sanctions or punishment under either Article 92 (dereliction of duty) or Article 107 (false official statement), Uniform Code of Military Justice. The Social Security Number of the sponsor (and sponsor's spouse if dual military) allows the Military Healthcare System and Service personnel offices to work together to ensure any special medical needs of your dependent can be met at your next duty assignment. Dependent special needs are annotated in the official military personnel files which are retrieved by name and Social Security Number.

AUTHORIZATION FOR DISCLOSURE OF MEDICAL INFORMATION

By signing this authorization, you confirm you understand your sponsor will have access to the health information contained herein and in addenda. The sponsor may be held accountable for the accuracy and completeness of the DD 2792 and addenda and should review all pages prior to signing on page 2.

I authorize _____ (MTF/DTF/Civilian Provider) (Name of Provider)

to release my patient information to the Relocation or Suitability Screening Office and/or the Exceptional Family Member/Special Needs Program to be used in the family travel review process and/or registration in the Exceptional Family Member Program. The information on this form and addenda may be used for DoD and Service-specific programs to determine whether there are adequate medical, housing and community resources to meet your medical needs at the sponsor's proposed duty locations.

- a. The military medical department will use the information to determine recommendations on the availability of care in communities where the sponsor may be assigned or employed.
- b. Information that you have a special need (not the nature or scope of the need) may be included in the sponsor's personnel record or be maintained in the community office responsible for supporting families with special needs, if EFMP enrollment criteria are met.
- c. The authorization applies to the summary data included on the medical summary form, its addenda and subsequent updates to information on this form. These data may be stored in electronic databases used for medical management or dedicated to the assignment process. Access to the information is limited to representatives from the medical departments, the offices responsible for assignment coordination, and at your request other military agents responsible for care or services. Summary data may be transmitted (e.g., faxing or emailing) using authorized secure media transfer.

Start Date: The authorization start date is the date that you sign this form authorizing release of information.

Expiration Date: The authorization shall continue until enrollment in the Exceptional Family Member Program is no longer necessary according to criteria specified in DoD Instruction 1315.19, or if family member no longer meets the criteria to qualify as a dependent, or the sponsor is no longer in active military service or employment of the U.S. Government overseas, or completion of assignment coordination, or eligibility determination for specialized services if that is the sole purpose for the completion of the form.

I understand that:

- a. I have the right to revoke this authorization at any time. My revocation must be in writing and provided to the facility where my or my child's medical records are kept. I am aware that if I later revoke this authorization, the person(s) I herein name will have used and/or disclosed protected information on the basis of this authorization. My revocation will have no impact on disclosures made prior to the revocation.
- b. If I authorize my or my child's protected health information to be disclosed to someone who is not required to comply with federal privacy protection regulations, then such information may be re-disclosed and would no longer be protected.
- c. I have a right to inspect and receive a copy of my own or my child's protected health information to be used or disclosed, in accordance with the requirements of the federal privacy protection regulations found in the Privacy Act and 45 CFR 164.524. I request and authorize the named provider/treatment facility to release the information described above for the stated purposes.
- d. The Military Health System (which includes the TRICARE Health Plan) may not condition treatment in MTFs/DTFs, payment by the TRICARE Health Plan, enrollment in the TRICARE Health Plan or eligibility for TRICARE Health Plan benefits on failure to obtain this authorization. However, failure to coordinate accompanied assignments prior to OCONUS travel may result in ineligibility for TRICARE Prime status (*does not pertain to civilian employees*).
- e. Failure to release this information or any subsequent revocation may result in ineligibility for accompanied family travel at government expense.
- f. Refusal to sign does not preclude the provision of medical and dental information authorized by other regulations and those noted in this document.

NAME OF PATIENT	SIGNATURE OF PATIENT/PARENT/GUARDIAN	RELATIONSHIP TO PATIENT <i>(if applicable)</i>	DATE (YYYYMMDD)
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DEMOGRAPHICS/CERTIFICATION: To be completed by the Sponsor, Parent or Guardian, or Patient

1. PURPOSE OF THIS FORM (X one)										
<input type="checkbox"/> EFMP Registration/Enrollment Update		<input type="checkbox"/> Request Change in EFMP Status:			<input type="checkbox"/> No Longer Have Previously Identified Condition		<input type="checkbox"/> Family Member Deceased*			
<input type="checkbox"/> Request for Government Sponsored Travel		<input type="checkbox"/> No Longer Qualifies as a Dependent*		<input type="checkbox"/> Divorce/Change in Custody*						
(*Provide documentation to verify change in status - do not update medical information.)										
2.a. FAMILY MEMBER/PATIENT NAME (Last, First, Middle Initial)				b. SPONSOR NAME (Last, First, Middle Initial)			c. SPONSOR SSN			
d. FAMILY MEMBER GENDER (X)		e. FAMILY MEMBER DATE OF BIRTH (YYYYMMDD)			f. FAMILY MEMBER PREFIX (FMP)		g. DOD BENEFITS NUMBER (DBN) (on back of ID Card)			
<input type="checkbox"/> Male <input type="checkbox"/> Female										
h. CURRENT FAMILY MEMBER MAILING ADDRESS (Street, Apartment Number, City, State, ZIP Code, APO/FPO)					i. HOME TELEPHONE NUMBER (Include Area Code/Country Code)					
					j. FAMILY HOME E-MAIL ADDRESS					
3.a. SPONSOR RANK OR GRADE		b. DESIGNATION/NEC/MOS/AFSC (Military only)			c. INSTALLATION OF SPONSOR'S CURRENT ASSIGNMENT					
d. BRANCH OF SERVICE (Military only)				e. STATUS (X one)						
<input type="checkbox"/> Army		<input type="checkbox"/> Navy		<input type="checkbox"/> Air Force		<input type="checkbox"/> Regular Active Service Member		<input type="checkbox"/> Active Reserve		<input type="checkbox"/> Active Guard
<input type="checkbox"/> Marine Corps		<input type="checkbox"/> Coast Guard				<input type="checkbox"/> Reserves		<input type="checkbox"/> National Guard		<input type="checkbox"/> Civilian
f. SPONSOR'S OFFICIAL E-MAIL ADDRESS					g. DUTY TELEPHONE NUMBER (Include Area Code/Country Code)			h. MOBILE NUMBER (Include Area Code/Country Code)		
i. DOES CHILD RESIDE WITH SPONSOR? (X one. If No, explain.)										
<input type="checkbox"/> YES		<input type="checkbox"/> NO								
4.a. ARE YOU DUAL MILITARY OR IS YOUR SPOUSE FORMER MILITARY? (Military only) (X one. If Yes, complete 4.b. - e. below)										
<input type="checkbox"/> YES		b. SPOUSE'S NAME (Last, First, Middle Initial)			c. BRANCH OF SERVICE		d. RANK/RATE		e. SPOUSE SSN	
<input type="checkbox"/> NO										
5.a. IS FAMILY MEMBER ENROLLED IN DEERS OR EVER BEEN ENROLLED IN DEERS UNDER A DIFFERENT SPONSOR'S NAME OR SSN? (Military only) (X one)										
<input type="checkbox"/> YES		b. IF YES, UNDER WHAT SSN?			c. NAME OF SPONSOR (Last, First, Middle Initial)			d. BRANCH OF SERVICE		
<input type="checkbox"/> NO										
6.a. DOES THIS FAMILY MEMBER RECEIVE CASE MANAGEMENT SERVICES? (X one)										
<input type="checkbox"/> YES		<input type="checkbox"/> NO (If Yes, complete 9.b. and c.)			b. LOCATION OF CASE MANAGER (X)		<input type="checkbox"/> MTF	<input type="checkbox"/> TRICARE	<input type="checkbox"/> Civilian	
c. CASE MANAGER CONTACT INFORMATION										
(1) NAME (Last, First, Middle Initial)				(2) EMAIL ADDRESS (if available)			(3) TELEPHONE NUMBER (Include Area Code/Country Code)			
7. MEDICALLY NECESSARY EQUIPMENT (X and complete as applicable)										
a. COCHLEAR IMPLANT		If applicable: (1) MAKE				(2) MODEL				
b. HEARING AIDS		If applicable: (1) MAKE				(2) MODEL				
c. INSULIN PUMP		If applicable: (1) MAKE				(2) MODEL				
d. PACEMAKER		If applicable: (1) MAKE				(2) MODEL				
e. OTHER EQUIPMENT (Specify and include make and model as appropriate.)										

FAMILY MEMBER/PATIENT NAME <i>(Last, First, Middle Initial)</i>	SPONSOR NAME	SPONSOR SSN <i>(Last four)</i>
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FOR ADMINISTRATIVE USE ONLY

8. REQUIRED ACTIONS *(X one)*

<input type="checkbox"/> First Review of Medical History for the Family Member	<input type="checkbox"/> Qualifies for Change in EFMP Status:	<input type="checkbox"/> Family Member No Longer Has Previously Identified Condition	<input type="checkbox"/> Family Member Deceased*
<input type="checkbox"/> Request for Government Sponsorship/Family Travel	<input type="checkbox"/> Family Member No Longer Qualifies as a Dependent*	<input type="checkbox"/> Divorce/Change in Custody*	
<input type="checkbox"/> Update to a Previous Evaluation for the Family Member			
<input type="checkbox"/> Other <i>(e.g., Extended Care Health Option Eligibility):</i>	<i>(*Maintain documentation to verify change in status - do not update medical information.)</i>		

9. REQUIRED ADDENDA.

Verify required addendum is attached and has been signed *(X each that applies)*. Do not submit a blank addendum for EFMP review.

<input type="checkbox"/> Asthma Addendum 1 is required and	<input type="checkbox"/> Attached.
<input type="checkbox"/> Mental Health Summary Addendum 2 is required and	<input type="checkbox"/> Attached.
<input type="checkbox"/> Autism Spectrum Disorder/Developmental Delay (AS/DD) Addendum 3 is required and	<input type="checkbox"/> Attached.

10. SPECIAL ASSIGNMENT CONSIDERATIONS *(X all that apply)*

<input type="checkbox"/> a. Possible Special Education/Early Intervention <i>(If checked, DD Form 2792-1 must be completed)</i>
<input type="checkbox"/> b. Receiving TRICARE Extended Care Health Option (ECHO) Benefits
<input type="checkbox"/> c. Receiving State Medicaid/Medicare Waiver Services

CERTIFICATION

11. CERTIFICATION. DO NOT CERTIFY BEFORE THE MEDICAL PROVIDER COMPLETES THE ENTIRE FORM AND ADDENDA.

By signing below, we certify that the information submitted on this DD Form 2792 is complete and accurate.

PARENT/GUARDIAN OR PERSON OF MAJORITY AGE:

a. PRINTED NAME	b. SIGNATURE	c. DATE <i>(YYYYMMDD)</i>
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12. ADMINISTRATIVE CERTIFICATION

a. PRINTED NAME <i>(Last, First, Middle Initial)</i>	b. SIGNATURE	c. DATE <i>(YYYYMMDD)</i>	f. OFFICIAL STAMP
d. LOCATION OF MILITARY TREATMENT FACILITY OR CERTIFYING EFMP OFFICE		e. TELEPHONE NUMBER <i>(Include area code/Country Code)</i>	

FAMILY MEMBER/PATIENT NAME <i>(Last, First, Middle Initial)</i>	SPONSOR NAME	SPONSOR SSN <i>(Last four)</i>
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MEDICAL SUMMARY: To be completed by a Qualified Medical Professional

PART A - PATIENT STATUS *(Authorization by patient or parent/guardian included on Page 1 of this form)*

Please complete as accurately as possible using ICD-9-CM or, when approved, ICD-10-CM. If the patient has an asthma, mental health, or autism spectrum disorder/developmental delay diagnosis, enter ONLY the diagnostic description/code on this page and the remainder of the information on the appropriate attached addendum form.

1. INFORMATION INCLUDED IN ADDENDUM *(X all that apply)*

<input type="checkbox"/> a. Asthma <i>(Addendum 1)</i>	<input type="checkbox"/> b. Mental Health/ADHD <i>(Addendum 2)</i>	<input type="checkbox"/> c. Autism/Developmental Delay (AS/DD) <i>(Addendum 3)</i>
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2. PRIMARY DIAGNOSIS

a. DIAGNOSIS	b. CODE <input type="text"/> <input type="text"/> <input type="text"/> . <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
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3. MEDICATION HISTORY *(Associated with primary diagnosis)*

a. CURRENT MEDICATION(S)	b. DOSAGE	c. FREQUENCY

4. HOSPITAL SUPPORT FOR THE LAST 12 MONTHS *(Associated with primary diagnosis)*

a. NUMBER OF ER VISITS/URGENT CARE VISITS	b. NUMBER OF HOSPITALIZATIONS	c. NUMBER OF ICU ADMISSIONS	d. NUMBER OF OUTPATIENT VISITS
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5. PROGNOSIS *(X one)*

<input type="checkbox"/> EXCELLENT	<input type="checkbox"/> GOOD	<input type="checkbox"/> FAIR	<input type="checkbox"/> POOR	<input type="checkbox"/> GUARDED	<input type="checkbox"/> UNSTABLE	<input type="checkbox"/> NON-COMPLIANT
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6. TREATMENT PLAN FOR PRIMARY DIAGNOSIS *(Medical, mental health, surgical procedures or therapies planned or recommended over the next three years. For cancer patients, include date of diagnosis, types of treatment, responses to treatment, if treatment is active and if treatment is completed.)*

7. SECONDARY DIAGNOSIS 1

a. DIAGNOSIS	b. CODE <input type="text"/> <input type="text"/> <input type="text"/> . <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
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8. MEDICATION HISTORY *(Associated with secondary diagnosis)*

a. CURRENT MEDICATION(S)	b. DOSAGE	c. FREQUENCY

9. HOSPITAL SUPPORT FOR THE LAST 12 MONTHS *(Associated with secondary diagnosis)*

a. NUMBER OF ER VISITS/URGENT CARE VISITS	b. NUMBER OF HOSPITALIZATIONS	c. NUMBER OF ICU ADMISSIONS	d. NUMBER OF OUTPATIENT VISITS
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10. PROGNOSIS *(X one)*

<input type="checkbox"/> EXCELLENT	<input type="checkbox"/> GOOD	<input type="checkbox"/> FAIR	<input type="checkbox"/> POOR	<input type="checkbox"/> GUARDED	<input type="checkbox"/> UNSTABLE	<input type="checkbox"/> NON-COMPLIANT
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11. TREATMENT PLAN FOR SECONDARY DIAGNOSIS *(Medical, mental health, surgical procedures or therapies planned or recommended over the next three years. For cancer patients, include date of diagnosis, types of treatment, responses to treatment, if treatment is active and if treatment is completed.)*

FAMILY MEMBER/PATIENT NAME <i>(Last, First, Middle Initial)</i>	SPONSOR NAME	SPONSOR SSN <i>(Last four)</i>
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MEDICAL SUMMARY *(Continued): To be completed by a Qualified Medical Professional*

PART A - PATIENT STATUS *(Continued)*

12. SECONDARY DIAGNOSIS 2

a. DIAGNOSIS	b. CODE <input type="text"/> <input type="text"/> <input type="text"/> . <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
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13. MEDICATION HISTORY *(Associated with secondary diagnosis)*

a. CURRENT MEDICATION(S)	b. DOSAGE	c. FREQUENCY

14. HOSPITAL SUPPORT FOR THE LAST 12 MONTHS *(Associated with secondary diagnosis)*

a. NUMBER OF ER VISITS/URGENT CARE VISITS	b. NUMBER OF HOSPITALIZATIONS	c. NUMBER OF ICU ADMISSIONS	d. NUMBER OF OUTPATIENT VISITS
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15. PROGNOSIS *(X one)*

EXCELLENT
 GOOD
 FAIR
 POOR
 GUARDED
 UNSTABLE
 NON-COMPLIANT

16. TREATMENT PLAN FOR THIS DIAGNOSIS *(Medical, mental health, surgical procedures or therapies planned or recommended over the next three years. For cancer patients, include date of diagnosis, types of treatment, responses to treatment, if treatment is active and if treatment is completed.)*

17. SECONDARY DIAGNOSIS 3

a. DIAGNOSIS	b. CODE <input type="text"/> <input type="text"/> <input type="text"/> . <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
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18. MEDICATION HISTORY *(Associated with secondary diagnosis)*

a. CURRENT MEDICATION(S)	b. DOSAGE	c. FREQUENCY

19. HOSPITAL SUPPORT FOR THE LAST 12 MONTHS *(Associated with secondary diagnosis)*

a. NUMBER OF ER VISITS/URGENT CARE VISITS	b. NUMBER OF HOSPITALIZATIONS	c. NUMBER OF ICU ADMISSIONS	d. NUMBER OF OUTPATIENT VISITS
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20. PROGNOSIS *(X one)*

EXCELLENT
 GOOD
 FAIR
 POOR
 GUARDED
 UNSTABLE
 NON-COMPLIANT

21. TREATMENT PLAN FOR THIS DIAGNOSIS *(Medical, mental health, surgical procedures or therapies planned or recommended over the next three years. For cancer patients, include date of diagnosis, types of treatment, responses to treatment, if treatment is active and if treatment is completed.)*

FAMILY MEMBER/PATIENT NAME <i>(Last, First, Middle Initial)</i>	SPONSOR NAME	SPONSOR SSN <i>(Last four)</i>
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MEDICAL SUMMARY *(Continued): To be completed by a Qualified Medical Professional*

PART B - REQUIRED MEDICAL SPECIALTIES

22. MINIMUM HEALTH CARE REQUIRED

INDICATE FREQUENCY OF CARE: A - ANNUALLY B - BIANNUALLY *(Twice a year)* Q - QUARTERLY M - MONTHLY BI - BI-MONTHLY W - WEEKLY

		(1) CARE PROVIDER <i>(X as appropriate)</i>	(2) FREQUENCY <i>(See above)</i>			(1) CARE PROVIDER <i>(X as appropriate)</i>	(2) FREQUENCY <i>(See above)</i>
C01	a.	ALLERGIST/IMMUNOLOGIST		C57	hh.	ORAL SURGEON	
C99	b.	AUDIOLOGIST		C47	ii.	ORTHOPEDIC SURGEON - ADULT	
C52	c.	BEHAVIOR ANALYST		C48	jj.	ORTHOPEDIC SURGEON - PEDIATRIC	
C42	d.	CARDIAC/THORACIC SURGEON		C56	kk.	OTORHINOLARYNGOLOGIST	
C02	e.	CARDIOLOGIST - ADULT		C77	ll.	PAIN CLINIC	
C03	f.	CARDIOLOGIST - PEDIATRIC		C72	mm.	PEDIATRIC NURSE PRACTITIONER	
C70	g.	CLEFT PALATE TEAM - PEDIATRIC		C30	nn.	PEDIATRICIAN	
C05	h.	DERMATOLOGIST		C49	oo.	PEDIATRIC SURGEON	
C06	i.	DEVELOPMENTAL PEDIATRICIAN		C32	pp.	PHYSIATRIST <i>(Physical Rehabilitation)</i>	
C53	j.	DIALYSIS TEAM		C58	qq.	PHYSICAL THERAPIST	
C07	k.	DIETARY/NUTRITION SPECIALIST		C50	rr.	PLASTIC SURGEON - ADULT	
C08	l.	ENDOCRINOLOGIST - ADULT		C71	ss.	PLASTIC SURGEON - PEDIATRIC	
C09	m.	ENDOCRINOLOGIST - PEDIATRIC		C99	tt.	PODIATRIST	
C10	n.	FAMILY PRACTITIONER		C35	uu.	PSYCHIATRIST - ADULT	
C11	o.	GASTROENTEROLOGIST - ADULT		C36	vv.	PSYCHIATRIST - PEDIATRIC	
C12	p.	GASTROENTEROLOGIST - PEDIATRIC		C72	ww.	PSYCHIATRIST NURSE PRACTITIONER	
C43	q.	GENERAL SURGEON		C37	xx.	PSYCHOLOGIST - ADULT	
C14	r.	GENETICS		C38	yy.	PSYCHOLOGIST - PEDIATRIC	
C15	s.	GYNECOLOGIST		C33	zz.	PULMONOLOGIST - ADULT	
C99	t.	GYNECOLOGIST/ONCOLOGIST		C76	aaa.	PULMONOLOGIST - PEDIATRIC	
C17	u.	HEMATOLOGIST/ONCOLOGIST - ADULT		C99	bbb.	RADIATION ONCOLOGIST	
C18	v.	HEMATOLOGIST/ONCOLOGIST - PEDIATRIC		C60	ccc.	RESPIRATORY THERAPIST	
C75	w.	INFECTIOUS DISEASE		C39	ddd.	RHEUMATOLOGIST - ADULT	
C20	x.	INTERNIST		C40	eee.	RHEUMATOLOGIST - PEDIATRIC	
C21	y.	NEPHROLOGIST - ADULT		C61	fff.	SOCIAL WORKER	
C22	z.	NEPHROLOGIST - PEDIATRIC		C62	ggg.	SPEECH AND LANGUAGE PATHOLOGIST	
C23	aa.	NEUROLOGIST - ADULT		C41	hhh.	TRANSPLANT TEAM	
C24	bb.	NEUROLOGIST - PEDIATRIC		C51	iii.	UROLOGIST - ADULT	
C44	cc.	NEUROSURGEON		C78	jjj.	UROLOGIST - PEDIATRIC	
C54	dd.	OCCUPATIONAL THERAPIST - ADULT		C99	kkk.	VASCULAR SURGEON	
C55	ee.	OCCUPATIONAL THERAPIST - PEDIATRIC		C99	lll.	OTHER <i>(Describe)</i>	
C26	ff.	OPHTHALMOLOGIST - ADULT					
C27	gg.	OPHTHALMOLOGIST - PEDIATRIC					

FAMILY MEMBER/PATIENT NAME <i>(Last, First, Middle Initial)</i>	SPONSOR NAME	SPONSOR SSN <i>(Last four)</i>
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MEDICAL SUMMARY - PART B *(Continued): To be completed by a Qualified Medical Professional*

23. ARTIFICIAL OPENINGS/PROSTHETICS *(X all that apply)*

<input type="checkbox"/> YES	IF YES:	<input type="checkbox"/> F01 - GASTROSTOMY	<input type="checkbox"/> F05 - COLOSTOMY	<input type="checkbox"/> F99 - OTHER UNSPECIFIED OPENING <i>(Specify)</i>
<input type="checkbox"/> NO		<input type="checkbox"/> F02 - TRACHEOSTOMY	<input type="checkbox"/> F06 - ILEOSTOMY	
		<input type="checkbox"/> F03 - CSF SHUNT	<input type="checkbox"/> F07 - OTHER UNSPECIFIED PROSTHETICS <i>(Specify)</i>	
		<input type="checkbox"/> F04 - CYSTOSTOMY		

24. MEDICALLY INDICATED *(as indicated in diagnostic information)* ENVIRONMENTAL/ARCHITECTURAL CONSIDERATIONS

<input type="checkbox"/> R01 - LIMITED STEPS <i>(If Yes, please explain)</i>	<input type="checkbox"/> R03 - AIR CONDITIONING
<input type="checkbox"/> R02 - COMPLETE WHEELCHAIR ACCESSIBILITY	<input type="checkbox"/> R03a - TEMPERATURE CONTROL
<input type="checkbox"/> R04 - SINGLE STORY/LEVEL HOUSE	<input type="checkbox"/> R03b - HEPA FILTER
<input type="checkbox"/> R05 - CARPET PROHIBITED	<input type="checkbox"/> R03c - POLLEN CONTROL
	<input type="checkbox"/> R03d - AIR FILTERING
	<input type="checkbox"/> R99 - OTHER <i>(Specify below)</i>

(Specify and provide justifications for environmental/architectural considerations):

25. MEDICALLY NECESSARY ADAPTIVE EQUIPMENT/SPECIAL MEDICAL EQUIPMENT *(Identified in diagnostic information). (If marked, describe.)*

a. TYPE OF EQUIPMENT (X)	b. DESCRIPTION	a. TYPE OF EQUIPMENT (X)	b. DESCRIPTION
L03 - APNEA HOME MONITOR		L14 - HOME VENTILATOR	
L31 - COCHLEAR IMPLANT		L22 - INSULIN PUMP	
L21 - CONTINUOUS POSITIVE AIRWAY PRESSURE (CPAP) THERAPY		L32 - INTERNAL DEFIBRILLATOR	
L33 - FEEDING PUMP		L23 - PACEMAKER	
L04 - HEARING AIDS		L07 - SPLINTS, BRACES, ORTHOTICS	
L20 - HOME DIALYSIS MACHINE		L08 - WHEELCHAIR	
L13 - HOME NEBULIZER		L99 - OTHER <i>(Specify)</i>	
L12 - HOME OXYGEN THERAPY			

26. IDENTIFY ANY LIMITATIONS FOR ACTIVITIES OF DAILY LIVING AND ANY TRAVEL LIMITATIONS *(Please explain.)*

PART C - PROVIDER INFORMATION

27.a. PROVIDER PRINTED NAME OR STAMP		b. SIGNATURE	c. DATE (YYYYMMDD)
d. TELEPHONE NUMBERS <i>(Include Area Code/Country Code)</i>	e. OFFICIAL E-MAIL ADDRESS		f. MEDICAL SPECIALTY
(1) COMMERCIAL	(2) DSN <i>(Military only)</i>		

FAMILY MEMBER/PATIENT NAME <i>(Last, First, Middle Initial)</i>	SPONSOR NAME	SPONSOR SSN <i>(Last four)</i>
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**ADDENDUM 1 - ASTHMA/REACTIVE AIRWAY DISEASE SUMMARY:
To be completed by a Qualified Medical Professional**

Complete addendum if patient has been evaluated or treated for asthma within the past five years.

1. DIAGNOSTIC DESCRIPTION CODE (ICD-9-CM or, when approved, ICD-10-CM)

<input type="text"/>	<input type="text"/>	<input type="text"/>	.	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
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2. MEDICATION HISTORY

a. MEDICATION(S)	b. DOSAGE	c. FREQUENCY

3. HISTORY ASSOCIATED WITH ASTHMA ATTACKS *(X as applicable)*

YES	NO	
<input type="checkbox"/>	<input type="checkbox"/>	a. ARE THERE ANY TRIGGERS FOR THE PATIENT'S ASTHMA ATTACKS <i>(stress, environment, exercise)?</i>
<input type="checkbox"/>	<input type="checkbox"/>	b. DOES THE PATIENT ROUTINELY <i>(greater than 10 days per month/four months per year)</i> USE INHALED ANTI-INFLAMMATORY AGENTS AND/OR BRONCHODILATORS?
<input type="checkbox"/>	<input type="checkbox"/>	c. HAS THE PATIENT TAKEN ORAL STEROIDS DURING THE PAST YEAR <i>(prednisone, prednisolone)?</i> IF "YES", NUMBER OF DAYS IN PAST YEAR: _____
<input type="checkbox"/>	<input type="checkbox"/>	d. HAS THE PATIENT EVER EXPERIENCED UNCONSCIOUSNESS OR SEIZURES ASSOCIATED WITH ASTHMA ATTACKS?
<input type="checkbox"/>	<input type="checkbox"/>	e. HAS THE PATIENT REQUIRED AN URGENT VISIT TO THE ER OR CLINIC FOR ACUTE ASTHMA DURING THE PAST YEAR? IF "YES", INDICATE THE NUMBER OF VISITS IN THE PAST YEAR: _____
<input type="checkbox"/>	<input type="checkbox"/>	f. HAS THE PATIENT BEEN HOSPITALIZED FOR PULMONARY DISEASE <i>(pneumonia, bronchitis, bronchiolitis, croup, RSV)</i> DURING THE PAST YEAR? IF "YES", INDICATE THE DATE(S) OF HOSPITALIZATION <i>(YYYYMMDD)</i> : _____
<input type="checkbox"/>	<input type="checkbox"/>	g. DOES THE PATIENT HAVE A HISTORY OF ONE OR MORE HOSPITALIZATIONS FOR ASTHMA RELATED CONDITIONS WITHIN THE PAST FIVE YEARS? IF "YES", HOW MANY? _____ INDICATE DATE OF LAST ADMISSION <i>(YYYYMMDD)</i> : _____
<input type="checkbox"/>	<input type="checkbox"/>	h. HAS THE PATIENT REQUIRED MECHANICAL VENTILATION <i>(Intubation/use of respirator)</i> DURING THE PAST 3 YEARS?
<input type="checkbox"/>	<input type="checkbox"/>	i. DOES THE PATIENT HAVE A HISTORY OF INTENSIVE CARE ADMISSIONS?
j. APPROXIMATE NUMBER OF DAYS THAT THE PATIENT MISSED SCHOOL/WORK/PLAY DUE TO ASTHMA-RELATED PROBLEMS <i>(including visits to physicians)</i> DURING THE PAST YEAR? _____		
k. HOW OFTEN DOES THE PATIENT USE HIS/HER RESCUE INHALER OR NEBULIZER MEDICATION <i>(such as Albuterol or Levalbuterol)</i> FOR INCREASED OR ACUTE SYMPTOMS?		

4. SEVERITY LEVEL. What is the patient's severity level based on the current treatment plan? *(Select one level of severity. Definitions are examples of severity. Pulmonary function tests are required only if clinically indicated.)*

<input type="checkbox"/>	a. INTERMITTENT ASTHMA. Intermittent symptoms ≤ 1 time per week. Brief exacerbations (from a few hours to a few days). Nighttime asthma symptoms < 2 times a month. Asymptomatic and normal lung function between exacerbations. PEF or FEV1 $\geq 80\%$ predicted; variability $< 20\%$.
<input type="checkbox"/>	b. MILD PERSISTENT ASTHMA. Symptoms ≥ 2 times a week but < 1 time per day. Exacerbations may affect sleep and activity. Nighttime asthma symptoms > 2 times a month. PEF or FEV1 $\geq 80\%$ predicted; variability 20 - 30%.
<input type="checkbox"/>	c. MODERATE PERSISTENT. Symptoms daily. Exacerbations affect sleep and activity. Nighttime asthma > 1 time a week. Daily use of inhaled short-acting B2 agonist. PEF or FEV1 $\geq 60\%$ and 80% predicted; variability $> 30\%$.
<input type="checkbox"/>	d. SEVERE PERSISTENT. Continuous symptoms. Frequent exacerbations. Frequent nighttime asthma symptoms. Physical activities limited by asthma symptoms. PEF or FEV1 $\leq 60\%$ predicted; variability $> 30\%$.

5.a. PROVIDER PRINTED NAME OR STAMP		b. SIGNATURE	c. DATE <i>(YYYYMMDD)</i>
d. TELEPHONE NUMBERS <i>(Include Area Code/Country Code)</i>		e. OFFICIAL E-MAIL ADDRESS	f. MEDICAL SPECIALTY
(1) COMMERCIAL	(2) DSN <i>(Military only)</i>		

FAMILY MEMBER/PATIENT NAME <i>(Last, First, Middle Initial)</i>	SPONSOR NAME	SPONSOR SSN <i>(Last four)</i>
ADDENDUM 2 - MENTAL HEALTH SUMMARY: To be completed by a Qualified Clinical Provider Complete addendum if the patient has current or past <i>(duration of 6 months or longer)</i> history <i>(within the last 5 years)</i> of mental health diagnosis <i>(to include attention deficit disorders)</i> .		
1. DIAGNOSIS(ES). Please complete as accurately as possible using ICD-9-CM or, when approved, ICD-10-CM.		
a. DIAGNOSIS	b. ICD OR DSM (Required)	c. AGE AT DIAGNOSIS
2. MEDICATION HISTORY RELATED TO THE DIAGNOSIS LISTED ABOVE.		
a. CURRENT MEDICATION(S)	b. DOSAGE	c. FREQUENCY
d. DISCONTINUED MEDICATION(S) RELATED TO DIAGNOSIS(ES) <i>(Include reason for discontinuing)</i>	e. FREQUENCY	
3.a. THERAPIES RECEIVED OR RECOMMENDED. <i>(Include past compliance with treatment programs, expected length of treatment, required participation of family members, and if treatment is ongoing.)</i>	b. FREQUENCY	
4. COMPLETE FOR TREATMENT:		
a. NUMBER OF OUTPATIENT VISITS IN THE LAST YEAR:	b. NUMBER OF HOSPITALIZATIONS IN THE LAST FIVE YEARS:	c. NUMBER OF RESIDENTIAL TREATMENT ADMISSIONS IN THE LAST FIVE YEARS:
		DATE OF LAST ADMISSION (YYYYMMDD):
5. HISTORY <i>(X and provide details for each "Yes" answer)</i>		
YES	NO	WITHIN THE LAST 5 YEARS, HAS THE PATIENT HAD A:
<input type="checkbox"/>	<input type="checkbox"/>	a. HISTORY OF SUICIDAL GESTURES/ATTEMPTS? <i>(If Yes, include dates)</i>
<input type="checkbox"/>	<input type="checkbox"/>	b. HISTORY OF SUBSTANCE ABUSE?
<input type="checkbox"/>	<input type="checkbox"/>	c. HISTORY OF ADDICTIVE BEHAVIORS?
<input type="checkbox"/>	<input type="checkbox"/>	d. HISTORY OF EATING DISORDERS?
<input type="checkbox"/>	<input type="checkbox"/>	e. HISTORY OF OTHER COMPULSIVE BEHAVIORS?
<input type="checkbox"/>	<input type="checkbox"/>	f. HISTORY OF PROBLEMS WITH LEGAL AUTHORITY? <i>(If Yes, specify)</i>
<input type="checkbox"/>	<input type="checkbox"/>	g. HISTORY OF PSYCHOTIC EPISODES?
<input type="checkbox"/>	<input type="checkbox"/>	h. HISTORY OF SERVICES RECEIVED FOR ALLEGATIONS OF FAMILY MALTREATMENT? <i>(If Yes, and services are delivered by Family Advocacy, note case determination.)</i>

FAMILY MEMBER/PATIENT NAME <i>(Last, First, Middle Initial)</i>	SPONSOR NAME	SPONSOR SSN <i>(Last four)</i>
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ADDENDUM 2 - MENTAL HEALTH SUMMARY *(Continued): To be completed by a Qualified Clinical Provider*

6. TREATMENT PLAN *(Related to the patient's mental health condition planned over the next three years).*

7. PROGNOSIS *(X one)*

<input type="checkbox"/> EXCELLENT	<input type="checkbox"/> GOOD	<input type="checkbox"/> FAIR	<input type="checkbox"/> POOR	<input type="checkbox"/> GUARDED	<input type="checkbox"/> UNSTABLE	<input type="checkbox"/> NON-COMPLIANT
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8. PROVIDERS REQUIRED TO IMPLEMENT TREATMENT PLAN AND FREQUENCY OF VISITS

<input type="checkbox"/> PSYCHIATRIST	<input type="checkbox"/> PSYCHOLOGIST	<input type="checkbox"/> SOCIAL WORKER	<input type="checkbox"/> OTHER <i>(Specify)</i>
<input type="checkbox"/> WEEKLY	<input type="checkbox"/> WEEKLY	<input type="checkbox"/> WEEKLY	<input type="checkbox"/> WEEKLY
<input type="checkbox"/> BI-MONTHLY	<input type="checkbox"/> BI-MONTHLY	<input type="checkbox"/> BI-MONTHLY	<input type="checkbox"/> BI-MONTHLY
<input type="checkbox"/> MONTHLY	<input type="checkbox"/> MONTHLY	<input type="checkbox"/> MONTHLY	<input type="checkbox"/> MONTHLY
<input type="checkbox"/> QUARTERLY	<input type="checkbox"/> QUARTERLY	<input type="checkbox"/> QUARTERLY	<input type="checkbox"/> QUARTERLY
<input type="checkbox"/> BIANNUALLY	<input type="checkbox"/> BIANNUALLY	<input type="checkbox"/> BIANNUALLY	<input type="checkbox"/> BIANNUALLY
<input type="checkbox"/> ANNUALLY	<input type="checkbox"/> ANNUALLY	<input type="checkbox"/> ANNUALLY	<input type="checkbox"/> ANNUALLY

9. OTHER COMMENTS *(Include additional information that would assist in determining necessary treatments.)*

10.a. PROVIDER PRINTED NAME OR STAMP	b. SIGNATURE	c. DATE <i>(YYYYMMDD)</i>
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d. TELEPHONE NUMBERS <i>(Include Area Code/Country Code)</i>	e. OFFICIAL E-MAIL ADDRESS	f. MEDICAL SPECIALTY
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(1) COMMERCIAL	(2) DSN <i>(Military only)</i>
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FAMILY MEMBER/PATIENT NAME <i>(Last, First, Middle Initial)</i>		SPONSOR NAME		SPONSOR SSN <i>(Last four)</i>	
ADDENDUM 3 - AUTISM SPECTRUM DISORDERS AND SIGNIFICANT DEVELOPMENTAL DELAYS: To be Completed by a Qualified Medical Professional Complete addendum if the patient has been evaluated or received treatment(s) for autism spectrum disorders and/or significant developmental delays.					
1. a. DIAGNOSIS(ES)			b. AGE WHEN DIAGNOSED		2. DATE OF BIRTH <i>(YYYYMMDD)</i>
<input type="checkbox"/> Autism Spectrum Disorder	<input type="checkbox"/> Global Developmental Delay	<input type="checkbox"/> Other <i>(Specify)</i>			
c. DIAGNOSED BY:					
<input type="checkbox"/> Child Psychologist	<input type="checkbox"/> Child Psychiatrist	<input type="checkbox"/> Developmental Pediatrician	<input type="checkbox"/> Other Physician	<input type="checkbox"/> Medical Multidisciplinary Team	<input type="checkbox"/> School-Based Team
<input type="checkbox"/> Other <i>(Specify)</i>					
3. COEXISTING DIAGNOSES <i>(X all that apply)</i>					
<input type="checkbox"/> Chromosomal Abnormalities	<input type="checkbox"/> Intermittent Explosive Disorder	<input type="checkbox"/> Major Depressive Disorder, Depressive Disorder, NOS	<input type="checkbox"/> Obsessive Compulsive Disorder	<input type="checkbox"/> Circadian-Rhythm Sleep Disorder	<input type="checkbox"/> Seizure Disorder
<input type="checkbox"/> Attention Deficit/Hyperactivity Disorder	<input type="checkbox"/> Generalized Anxiety Disorder, Anxiety Disorder, NOS	<input type="checkbox"/> Other <i>(Specify)</i>			
4. CURRENT MEDICATIONS <i>(Used to treat diagnoses on this page)</i>					
a. CURRENT MEDICATION(S)		b. DOSAGE	c. FREQUENCY	d. REASON PRESCRIBED	
5. CURRENT INTERVENTION THERAPIES					
a. TYPE <i>(To be completed by a qualified medical professional in consultation with the family)</i>		b. SCHOOL HOURS/WEEK <i>(if known)</i>	c. TRICARE HOURS/WEEK <i>(if known)</i>	d. OTHER SOURCE HOURS/WEEK <i>(if known)</i>	e. OTHER <i>(Identify)</i>
(1) Speech Therapy					
(2) Occupational Therapy					
(3) Physical Therapy					
(4) Psychological Counseling					
(5) Intensive Behavioral Intervention <i>(Includes ABA)</i>					
(6) OTHER <i>(Specify)</i>					
6. COMMUNICATION <i>(X)</i>		7. OTHER INTERVENTIONS/THERAPIES USED BY THE FAMILY <i>(Specify alternate or complementary therapies)</i>			
<input type="checkbox"/> VERBAL	<input type="checkbox"/> NON-VERBAL <i>(Uses:)</i>	<input type="checkbox"/> Signing	<input type="checkbox"/> Communication Device	<input type="checkbox"/> Picture Exchange Communication System (PECS)	<input type="checkbox"/> Combination
		8. BEHAVIOR: CHILD EXHIBITS HIGH RISK OR DANGEROUS BEHAVIOR			
		<input type="checkbox"/> YES	<input type="checkbox"/> NO <i>(If Yes, provide details in Item 13 below)</i>		
9. COGNITIVE ABILITY <i>(X)</i>		10. EDUCATION <i>(X)</i>			
<input type="checkbox"/> <50	<input type="checkbox"/> 50 - 70	<input type="checkbox"/> >70	<input type="checkbox"/> Unknown	<input type="checkbox"/> Indeterminate	<input type="checkbox"/> Receives Early Intervention
<input type="checkbox"/> Receives Special Education	<input type="checkbox"/> Attends Public School	<input type="checkbox"/> Attends Private School	<input type="checkbox"/> Attends Special Private School	<input type="checkbox"/> Is Home Schooled	
11. REQUIRED MEDICAL SERVICES			12. RESPITE CARE RECEIVED		
(X)	a. TYPE	b. FREQUENCY	(X)	a. TYPE	b. FREQUENCY
	Child Psychology			Child Neurology	
	Child Psychiatry			Developmental Pediatrics	
				a. HOURS PER MONTH	b. SOURCE
13. GENERAL COMMENTS <i>(Include Functional Levels)</i>					
14.a. PROVIDER PRINTED NAME OR STAMP		b. SIGNATURE		c. DATE <i>(YYYYMMDD)</i>	
d. TELEPHONE NUMBERS <i>(Include Area Code/Country Code)</i>		e. OFFICIAL E-MAIL ADDRESS		f. MEDICAL SPECIALTY	
(1) COMMERCIAL	(2) DSN <i>(Military only)</i>				

SPECIAL EDUCATION/EARLY INTERVENTION SUMMARY

PRIVACY ACT STATEMENT

AUTHORITY: 10 U.S.C. 136; 20 U.S.C. 927; DoDI 1315.19; DoDI 1342.12; and E.O. 9397 (as amended).

PRINCIPAL PURPOSE(S): Information will be used by DoD personnel to evaluate and document the special education needs of family members. This information will enable: (1) Military assignment personnel to match the special education needs of family members against the availability of educational services, and (2) Civilian personnel officers to advise civilian employees about the availability of education services to meet the special education needs of their family members. The personally identifiable information collected on this form is covered by a number of system of records notices pertaining to Official Military Personnel Files, Exceptional Family Member or Special Needs files, Civilian Personnel Files, and DoD Education Activity files. The SORNs may be found at <http://dpclo.defense.gov/Privacy/SORNsIndex/DODComponentNotices.aspx>.

ROUTINE USE(S): DoD Blanket Routine Uses 1, 4, 6, 8, 9, 12, and 15 found at <http://dpclo.defense.gov/Privacy/SORNsIndex/BlanketRoutineUses.aspx> may apply.

DISCLOSURE: Voluntary for civilian employees and applicants for civilian employment; however, the information must be provided if you intend to enroll your child with special education needs in a school funded by the Department of Defense or a school in which DoD is responsible for paying the tuition for a space-required family member. Mandatory for military personnel. Failure or refusal to provide the information or providing false information may result in administrative sanctions or punishment under either Article 92 (dereliction of duty) or Article 107 (false official statement), Uniform Code of Military Justice. The Social Security Number of the sponsor (and sponsor's spouse if dual military) allows the DoD Education Activity and Service personnel offices to work together to ensure any special education needs of your dependent can be met at your next duty assignment. Dependent special education needs are annotated in the official military personnel files which are retrieved by name and Social Security Number.

INSTRUCTIONS

The DD Form 2792-1 is completed to identify a family member with special educational/early intervention needs.

DEMOGRAPHICS.

Items 1 - 7. Completed by sponsor or spouse.

Item 1. Request (X one):

- EFMP Registration/Enrollment Update - first enrollment application for the family member or to update a previous evaluation for the family member.
- Government Sponsored Travel.
- Change in EFMP Status.

Items 2.a. - h. Child/Student Information. Self-explanatory.

Items 3.a. - h. Sponsor Information. Self-explanatory.

Item 3.i. Child/student enrolled in DEERS under another sponsor. Self-explanatory.

Items 4.a. - d. Self-explanatory.

Item 5. Completed for children age birth to 3 who have or require an IFSP.

Item 6.a. - e. Completed for children ages 3 to 21 only who have or require an IEP. Children who have IEPs and are ages 3 to 5 should have the DD 2792-1 completed at the school the child would normally attend for kindergarten. High School graduates, students who have passed the G.E.D. and college students are not required to complete the DD 2792-1.

Items 7.a. - c. Signature of sponsor or spouse who completed the form. Self-explanatory.

Items 8.a. - f. Administrative Review. Completed by EFMP responsible for screening or enrollment in the MTF.

SPECIAL EDUCATION/EARLY INTERVENTION SUMMARY

DD Form 2792-1 is completed by the parents and school or early intervention staff. **Only this form should be provided to school or early intervention staff. Do not include medical information forms that may be used for EFMP screening or enrollment.**

Items 1.a. - d. Sponsor Information. Signature of sponsor, spouse, legal guardian, or student who has reached the age of majority is REQUIRED to authorize the school to release information.

Items 2.a. - d. Child/Student Information. Completed by sponsor, spouse, or legal guardian. Self-explanatory.

Items 3.a. - d. EIS Information. Completed by EIS or school personnel. Mark (X) Yes or No for each item. Include additional information as noted.

Items 4.a. - f. School Information. Completed by school personnel at the public school the child attends or would attend. Mark (X) Yes or No for each item. Include additional information as noted.

Item 5. Completed by school personnel. Mark (X) eligibility category. Mark only one. (Codes are for Army coding only.)

Item 6. Completed by school personnel. Mark (X) all related services provided and indicate total time services are provided.

Item 7. Completed by EIS and school personnel. Self-explanatory.

Item 8. Completed by EIS provider/school official information completing form. Self-explanatory.

SPECIAL EDUCATION/EARLY INTERVENTION SUMMARY

(Page 1, Items 1 - 7 to be completed by sponsor, parent or legal guardian.)
(Read Privacy Act Statement and Instructions before completing this form.)

OMB No. 0704-0411
OMB approval expires
Jul 31, 2017

The public reporting burden for this collection of information is estimated to average 25 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 (0704-0411). 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.

DEMOGRAPHICS**1. REQUEST** (X one)

<input type="checkbox"/> EFMP Registration/Enrollment Update	<input type="checkbox"/> Change in EFMP Status:	<input type="checkbox"/> Other (Explain)
<input type="checkbox"/> Government Sponsored Travel	<input type="checkbox"/> No longer requires IEP/IFSP services	
	<input type="checkbox"/> No longer qualifies as a dependent*	
	<input type="checkbox"/> Divorce/change in custody*	

(*Provide documentation for change in status)

2. CHILD/STUDENT INFORMATION (To be completed by sponsor, spouse or legal guardian)

a. CHILD/STUDENT NAME (Last, First, Middle Initial)		b. SPONSOR NAME (Last, First, Middle Initial)		c. CHILD/STUDENT CURRENT MAILING ADDRESS (Street, Apartment Number, City, State, ZIP Code, APO/FPO)	
d. FAMILY MEMBER PREFIX	e. CHILD/STUDENT DATE OF BIRTH (YYYYMMDD)	f. CHILD/STUDENT GENDER (X one)			
		<input type="checkbox"/> MALE	<input type="checkbox"/> FEMALE		
g. FAMILY HOME E-MAIL ADDRESS			h. HOME TELEPHONE NUMBER (Include Area Code/Country Code)		

3. a. SPONSOR RANK OR GRADE		b. INSTALLATION OF CURRENT ASSIGNMENT (Include City, State, Country)			
c. SPONSOR'S OFFICIAL E-MAIL ADDRESS			d. DUTY TELEPHONE NUMBER (Include Area Code/Country Code)		e. MOBILE NUMBER (Include Area Code/Country Code)

f. STATUS (X one)				g. BRANCH OF SERVICE (Military only)				
<input type="checkbox"/> Regular Active Service Member	<input type="checkbox"/> Active Reserve	<input type="checkbox"/> Active Guard	<input type="checkbox"/> Reserves	<input type="checkbox"/> National Guard	<input type="checkbox"/> Civilian	<input type="checkbox"/> Army	<input type="checkbox"/> Navy	<input type="checkbox"/> Air Force
				<input type="checkbox"/> Marine Corps	<input type="checkbox"/> Coast Guard			

h. DOES CHILD RESIDE WITH SPONSOR? (X one. If No, explain.)

YES NO

i. IS THE CHILD/STUDENT ENROLLED IN DEERS UNDER A SPONSOR OTHER THAN THE ONE LISTED ABOVE? (X one. If Yes, provide name of sponsor.)

YES NO

4.a. ARE BOTH SPOUSES ON ACTIVE DUTY? (Military only) (X one. If Yes, answer b. - d. below)

<input type="checkbox"/> YES	<input type="checkbox"/> NO	b. ACTIVE DUTY SPOUSE'S NAME (Last, First, Middle Initial)	c. BRANCH OF SERVICE	d. RANK/RATE
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5. FOR CHILDREN FROM BIRTH TO AGE THREE ONLY:

YES NO Is your child being evaluated for, or receiving, early intervention services on an Individualized Family Service Plan (IFSP)? (X one. If No, sign Item 7 and return to the requesting office. If Yes, have early intervention professional complete Page 3.)

6. FOR STUDENTS AGES 3 - 21 WHO ARE ELIGIBLE FOR ELEMENTARY AND SECONDARY EDUCATION (Includes preschool-aged children):

YES NO **a. Is your child being home-schooled?** (X one. If No, sign Item 7 and take Page 3 to your child's school. If Yes, complete the following and sign Item 7.)

b. Is your child being home-schooled part-time or full-time? (X one) Part-time Full-time

c. When did you start home-schooling? (YYYYMMDD) _____

d. Name/title home school program, if known: _____

e. List any special education-related services received in the last 3 years:

7. a. SIGNATURE	b. PRINTED NAME (Last, First, Middle Initial)	c. DATE (YYYYMMDD)
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8. ADMINISTRATIVE REVIEW (Completed after review of entire form by local military MTF or office receiving form)			f. STAMP
a. SPONSOR SSN	b. SPOUSE SSN (If dual military)	c. SSN USED IN DEERS (If different from sponsor's)	
d. MILITARY MTF OR OFFICE RECEIVING COMPLETED FORM		e. DATE (YYYYMMDD)	

SPECIAL EDUCATION/EARLY INTERVENTION SUMMARY

NOTE TO EDUCATIONAL AUTHORITY COMPLETING THIS FORM:

It is important to the military and to the family that the service member be assigned to a location that can meet the child's educational needs. Your support in completing this form is appreciated. *(If applicable, attach a copy of the child's most recent active Individualized Family Service Plan (IFSP) or Individualized Education Program (IEP) to this page.)*

1. RELEASE OF INFORMATION *(To be completed by sponsor, spouse, legal guardian, or student who has reached the age of majority)*

I hereby authorize the release of information on the DD Form 2792-1, and the attached reports to personnel of the Military Departments. This information will be used to evaluate and document my child/student's needs for educational services for the purpose of assignment coordination, EFMP registration or eligibility for other educationally related benefits.

a. SIGNATURE	b. PRINTED NAME	c. RELATIONSHIP TO CHILD/STUDENT	d. DATE (YYYYMMDD)
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2. CHILD/STUDENT INFORMATION *(To be completed by sponsor, spouse, or legal guardian)*

a. NAME OF CHILD/STUDENT <i>(Last, First, Middle Initial)</i>	b. CURRENT GRADE LEVEL <i>(if school age)</i>	c. DATE OF BIRTH (YYYYMMDD)	d. GENDER <i>(X one)</i>
			<input type="checkbox"/> FEMALE <input type="checkbox"/> MALE

3. EARLY INTERVENTION (EI) SERVICES - FOR CHILDREN UNDER 3 YEARS OF AGE *(To be completed by EI representative)*

YES	NO	
<input type="checkbox"/>	<input type="checkbox"/>	a. Is the child currently being evaluated for early intervention services? <i>(If Yes, go directly to Item 8.)</i>
<input type="checkbox"/>	<input type="checkbox"/>	b. Does this child receive early intervention services under a current Individualized Family Service Plan (IFSP)? <i>(If Yes, please attach current IFSP.)</i> Date of next annual review (YYYYMMDD) _____
c. Basis for eligibility: <input type="checkbox"/> Developmental Delay <input type="checkbox"/> Diagnosed physical or mental condition that has a high probability of resulting in a Developmental Delay		
<input type="checkbox"/>	<input type="checkbox"/>	d. Is there an identified disability? <i>(If known, please specify):</i> _____

4. SCHOOL INFORMATION - FOR STUDENTS AGES 3 - 21 *(To be completed by school representative)*

YES	NO	
<input type="checkbox"/>	<input type="checkbox"/>	a. Has this child ever been evaluated for, or been offered, special education services by your school? <i>(If No, skip to Item 8.)</i>
<input type="checkbox"/>	<input type="checkbox"/>	b. Is this student currently being evaluated for special education services? If Yes, what disability category? _____ <i>(Skip to Item 8)</i>
<input type="checkbox"/>	<input type="checkbox"/>	c. If your school determined the student eligible for special education services within the past 3 years, did the parent decline special education services? <i>(If Yes, complete eligibility information in Item 5 and proceed to Item 8.)</i>
<input type="checkbox"/>	<input type="checkbox"/>	d. Does this child/student receive special education services under a current Individualized Education Program (IEP)? <i>(If Yes, please attach a copy of the current IEP, and complete Items 5 and following.)</i> Date of next annual review (YYYYMMDD) _____
<input type="checkbox"/>	<input type="checkbox"/>	e. Were IEP services terminated by the IEP team within the last 2 years? <i>(If Yes, skip to Item 8.)</i> Date of IEP termination (YYYYMMDD) _____
<input type="checkbox"/>	<input type="checkbox"/>	f. Was the IEP terminated at the request of the parents within the last year <i>(parents withdrew student from special education)?</i> <i>(If Yes, complete Items 5 and following.)</i>

5. ELIGIBILITY CATEGORY FOR CHILDREN 3 TO 21 YEARS OF AGE *(X only one)*

<input type="checkbox"/> N07 Autism Spectrum Disorder:	<input type="checkbox"/> N09 Communication Impaired:	<input type="checkbox"/> N16 Behavioral/Conduct Disorder
<input type="checkbox"/> N01 Deaf	<input type="checkbox"/> Articulation	<input type="checkbox"/> N04 Intellectual Disability <i>(Mental Retardation):</i>
<input type="checkbox"/> N02 Blind	<input type="checkbox"/> Dysfluency	<input type="checkbox"/> Mild
<input type="checkbox"/> N13 Deaf/Blind	<input type="checkbox"/> Voice	<input type="checkbox"/> Moderate
<input type="checkbox"/> N11 Visually Impaired	<input type="checkbox"/> Language/Phonology	<input type="checkbox"/> Severe/Profound
<input type="checkbox"/> N05 Traumatic Brain Injury	<input type="checkbox"/> N15 Developmental Delay	<input type="checkbox"/> N08 Other Health Impaired <i>(Specify)</i>
<input type="checkbox"/> N03 Hearing Impaired	<input type="checkbox"/> N12 Specific Learning Disability	
<input type="checkbox"/> N06 Orthopedically Impaired	<input type="checkbox"/> N10 Emotionally Impaired	

6. RELATED SERVICES ON IEP *(X boxes next to related services and indicate total number of minutes or hours that services are provided.)*

SERVICE: M = Minutes, H = Hours per W = Week, M = Month *(Example:)* 20 M per W

<input type="checkbox"/> R01 Counseling	<input type="checkbox"/> per	<input type="checkbox"/> R06 Special Transportation <i>(Describe)</i>
<input type="checkbox"/> R02 Occupational Therapy	<input type="checkbox"/> per	
<input type="checkbox"/> R03 Physical Therapy	<input type="checkbox"/> per	
<input type="checkbox"/> R04 Speech Therapy	<input type="checkbox"/> per	<input type="checkbox"/> R07 Other <i>(Describe):</i>
<input type="checkbox"/> R05 Intensive Behavioral Intervention <i>(Such as ABA)</i>	<input type="checkbox"/> per	

7. BEHAVIOR/COMMUNICATION *(X all that apply and explain in comments section.)*

YES	NO	
<input type="checkbox"/>	<input type="checkbox"/>	a. Child exhibits high risk or dangerous behavior.
<input type="checkbox"/>	<input type="checkbox"/>	b. Child is verbal <i>(If No, answer c.-f. The student uses:)</i>
<input type="checkbox"/>	<input type="checkbox"/>	c. Signing <i>(Specify language or system)</i>
<input type="checkbox"/>	<input type="checkbox"/>	d. Picture Exchange Communication System (PECS)
<input type="checkbox"/>	<input type="checkbox"/>	e. Communication Device <i>(Specify)</i>
<input type="checkbox"/>	<input type="checkbox"/>	f. Other <i>(Specify)</i>
		g. COMMENTS

8. PROVIDER/SCHOOL INFORMATION

a. NAME OF EARLY INTERVENTION PROGRAM OR SCHOOL		b. SCHOOL DISTRICT	
c. CITY, STATE, COUNTRY		d. TELEPHONE NUMBER <i>(Include Area Code/Country Code)</i>	e. FAX NUMBER <i>(Include Area Code/Country Code)</i>
f. E-MAIL ADDRESS		g. NAME OF INDIVIDUAL COMPLETING THIS SECTION	
h. SIGNATURE		i. TITLE	j. DATE SIGNED (YYYYMMDD)

FAMILY MEMBER DEPLOYMENT SCREENING SHEET

For use of this form, see AR 608-75; the proponent agency is OACSIM

DATA REQUIRED BY THE PRIVACY ACT OF 1974

AUTHORITY: Title 10, USC Section 3013.
PRINCIPAL PURPOSE: Personnel support.
ROUTINE USES: To validate family member deployment screening, and to provide gaining command with data to assist in making an assignment decision.
DISCLOSURE: The provision of requested information is mandatory. Failure to respond may preclude successful processing of an application for family member travel/command sponsorship and may lead to appropriate administrative or disciplinary action against the soldier.

PART A - SOLDIER/FAMILY MEMBER DATA

1. NAME OF SOLDIER (Last, first, MI)	2. SOCIAL SECURITY NUMBER	3a. RANK	3b. MOS/BRANCH
4a. HOME ADDRESS	5a. DUTY ADDRESS		6. DATE OF EDAS CYCLE OR RFO (OFF) DATE
4b. HOME PHONE NO. (Include Area Code)	5b. DUTY PHONE NO. a. DSN b. COMMERCIAL (Include area code)		

7. FAMILY MEMBERS

a. NAME	b. RELATIONSHIP	c. DOB (YYYYMMDD)	d. HOME ADDRESS

8. AUTHENTICATION

a. MILITARY PERSONNEL DIVISION/PERSONNEL SERVICE COMPANY REPRESENTATIVE'S NAME	c. RANK (Grade)	d. SIGNATURE
b. TITLE		e. DATE (YYYYMMDD)

PART B - FAMILY MEMBER SCREENING RESULTS

9. NAME	EXCEPTIONAL FAMILY MEMBER PROGRAM (EFMP) ENROLLMENT (Check one)				
	a. NOT WARRANTED	b. CONSIDERATION WARRANTED (Date sent for Coding)	c. SUBSTANTIAL CHANGE SINCE ENROLLMENT		
			NO	YES	DATE SENT FOR CODING
			<input type="checkbox"/>	<input type="checkbox"/>	
			<input type="checkbox"/>	<input type="checkbox"/>	
			<input type="checkbox"/>	<input type="checkbox"/>	
			<input type="checkbox"/>	<input type="checkbox"/>	

10. ARMY MEDICAL TREATMENT FACILITY (MTF) EFMP MEDICAL PRACTITIONER COMPLETING THIS FORM

a. PRINTED NAME OF MEDICAL PRACTITIONER	b. SIGNATURE 	c. DATE (YYYYMMDD)
d. ADDRESS	e. PHONE NUMBER (Include Commercial and DSN)	

11. ARMY MTF EFMP PHYSICIAN'S AUTHENTICATION (To be signed when a medical practitioner other than a physician completes this form.)		
a. TYPED OR PRINTED NAME OF PHYSICIAN	b. TITLE	c. RANK
d. SIGNATURE 	e. DATE (YYYYMMDD)	

**EXCEPTIONAL FAMILY MEMBER PROGRAM (EFMP)
SCREENING QUESTIONNAIRE**

For use of this form, see AR 608-75; the proponent agency is OACSIM

NAME OF MEDICAL TREATMENT FACILITY

DATA REQUIRED BY THE PRIVACY ACT OF 1974

AUTHORITY: PL 94-142 (Education for all Handicapped Children Act of 1975), PL 95-561 (Defense Dependents' Education Act of 1978); DODI 1342.12 (Education of Handicapped Children in DODDS), 17 December 1981; DODI 1010.13 (Provision of Medically Related Services to Children Receiving or Eligible to Receive Special Education in DOD Dependents Schools Outside the United States), 28 August 1985, 10 USC 3013; 20 USC 921-932 and 1401 et seq.

PRINCIPAL PURPOSE: To obtain information needed to evaluate and document the special education and medical needs of family members. This will permit consideration of special education and medical needs of family members in the personnel assignment process.

ROUTINE USES: Information will be used by personnel of the Military Departments to evaluate and document special education and medical needs of family members for consideration in personnel assignments.

DISCLOSURE: The provision of requested information is mandatory. Failure to respond will preclude U.S. Total Personnel Command from enrolling soldiers in the EFMP. Soldiers who knowingly refuse to enroll exceptional family members will receive, at a minimum, a general officer letter of reprimand. Refusal to provide information may preclude successful processing of an application for family travel/command sponsorship.

SERVICE MEMBER'S NAME/RANK _____ DATE (YYYYMMDD) _____

BRANCH _____ UNIT _____ DUTY PHONE _____

PROJECTED PCS ASSIGNMENT _____ DSN _____ HOME PHONE _____

PROJECTED PCS DATE _____ HOME ADDRESS _____ DUTY ADDRESS _____

LIST ALL FAMILY MEMBERS	FAMILY MEMBER PREFIX	SEX	DATE OF BIRTH (YYYYMMDD)	CHECK IF ENROLLED IN EFMP
				<input type="checkbox"/>

PLEASE ANSWER ALL QUESTIONS - FOR FAMILY MEMBERS ONLY

MEDICAL

1. Do any family members, excluding service member, have any medical records (civilian or military) other than the records you have provided us to screen? If yes, please list conditions/services received and address of provider. YES NO

FAMILY MEMBER	CONDITIONS/SERVICES	NAME/ADDRESS OF PROVIDER

2. In the past five (5) years, have any members of your family, excluding service member, been hospitalized, excluding hospitalization for normal uncomplicated childbirth? If yes, please explain. YES NO

NAME	REASON

3. Are any members of your family, excluding service member, currently receiving medical (includes mental health) or educational services from any providers other than a general practitioner or family practice physician? YES NO

MEDICAL, DENTAL AND EDUCATIONAL SUITABILITY SCREENING FOR SERVICE AND FAMILY MEMBERS

Privacy Act Statement

Authority: 5 U.S.C. 301, Departmental Regulations; and E. O. 9397 (SSN).

Purpose: To identify special, medical, dental or educational needs for the purpose of making a suitability recommendation for an overseas, remote duty, or operational assignment.

Routine uses: This form is completed by a medical treatment facility (MTF)/non-MTF dentist and physician, nurse practitioner, physician assistant, or independent duty corpsman (Service members only). An MTF Medical Screener must counter sign all screenings completed by non-Navy MTF Providers. The MTF Suitability Screening Coordinator (SSC) will place the completed original form in the individual's Service Treatment Record/Non-Service Treatment Record and retain a copy for audit.

Disclosure: Voluntary; however, failure to provide this information may delay the screening process, result in orders held in abeyance until completion of screening or affect the amount of leave in transit.

Refer to BUMEDINST 1300.2B for implementing guidance. **Complete one form for each Service and family member screened.**

SERVICE MEMBER NAME	GRADE / RATE	AGE	SSN
FAMILY MEMBER NAME	FAMILY MEMBER PREFIX	AGE	SSN
NEXT DUTY STATION LOCATION & UNIT IDENTIFICATION CODE (UIC):		TYPE DUTY CLASSIFICATION CODE: (Navy enlisted only)	

PART I

SECTION A. Medical Screening. Completed by the medical provider to identify special needs and determine if a Service or family member is suitable for an overseas, remote duty, or operational assignment. *Attach the completed Report of Medical History (DD 2807-1) to this form.*

Yes	No	N/A	ITEM
			1. All current health records (military and civilian) reviewed?
			2. All physical exams (to include special duty, aviation, submarine, radiation, asbestos, etc.) are current and filed in the Service Treatment Record? a. Type of Physical _____ b. Completion date of physical _____
			3. G-6P-D, PPD and Sickle Cell trait test and Blood Type completed & documented?
			4a. Immunizations are up-to-date and meet destination country requirements?
			4b. Has the individual elected to decline any ACIP recommended immunizations or country required Immunizations? If yes (circle): ACIP Country Specific Date Counseled: _____
			5. Reference audiogram documented on DD 2215?
			6. Latest audiogram (DD 2216) reviewed?
			7. HIV testing completed or drawn?
			8. DNA testing completed and documented?
			9. Are there pending consults or tests that have a bearing on assignment suitability?
			10. Any past limited duty or medical board(s)? (document on DD 2807-1)
			11. For Service members:
			a. Annual periodic health assessment current and documented?
			b. Pregnancy screening (verbal inquiry)? (Also, Command will refer for pregnancy test 30 days prior to departure date)
			c. If pregnant? (EDC: _____)
			12. For family members, U.S. Preventive Services Task Force screening test recommendations current and documented?
			13. If a Special Duty assignment, is there a condition, which by MANMED, chapter 15, section IV, is disqualifying?
			14. Are there any conditions requiring ongoing care in the following areas? (document on DD 2807-1)
			a. Orthopedic conditions (e.g., chronic back, knee, joint pain or weakness)
			b. Cardiovascular conditions (e.g., chest pain/angina, arrhythmia, valve disease, infarction)
			c. Gynecologic/Urologic conditions (e.g., chronic pelvic pain, abnormal PAP, breast mass)
			d. Neurologic conditions (e.g., seizure, pinched nerve, migraine, neuropathy)
			e. Respiratory conditions (e.g., asthma, RAD, chronic sinus, allergies)
			f. Mental health or behavioral conditions (e.g., mood, personality disorder, ADD/ADHD, anxiety, psychosis, autism)
			g. Recurrent or frequent medications not on the standard formulary or require special attention (e.g., injections/infusions every 6-12 months, medication requiring Risk Evaluation and Mitigation Strategies per FD regulations, hormone replacement therapy, or medications requiring close monitoring of therapeutic blood level)? (list on DD 2807-1)
			h. Alcohol or substance abuse or dependence
			i. Developmental concerns (e.g., motor, cognitive, communication, social/emotional, or adaptive development)
			j. Specify other conditions or concerns:
			15. For Service/family members requiring medication.
			a. Does the patient's medication maintenance require a dose adjustment?
			b. Should medication use cease, could the underlying condition become life threatening, pose a risk for dangerous or disruptive behavior or result in a limited duty, MEDEVAC, or early return situation?
			c. Are there concerns about medication management capabilities at the gaining MTF/operational platform if the underlying condition is exacerbated?
			d. Has the service/family member registered with the mail order pharmacy program through TRICARE?

Yes	No	N/A	ITEM
			16. For service/family members with underlying medical conditions:
			a. Is there a requirement for special medical supplies, adaptive equipment, assistive technology devices, special accommodations, etc.?
			b. If exposed to a physically or emotionally demanding environment, could the underlying condition become life threatening, pose a risk for dangerous or disruptive behavior, or result in a limited duty or MEDEVAC situation?
			c. Are there any chronic medical or mental health conditions requiring routine or continuing access to care or access to specialized medical care? (document on DD 2807-1)
			d. Are there any potential environmental concerns or possible health effects at the gaining location? (if yes, communicate to family and document on appropriate SF 600)
			17. For infants and toddlers (birth to 36 months), is the child receiving or undergoing eligibility to receive early intervention services as evidenced by an Individualized Family Service Plan (IFSP)?
			18. For preschool and school age children, is the child receiving or undergoing eligibility to receive special education and/or related services as evidenced by an Individualized Education Program (IEP)?
			19. Explanation of "yes" responses in shaded boxes (include #): Are there any concerns about the gaining MTF/operational platform's capabilities to meet the individual's needs? Specify below: Navy MTF SSC Name, Signature, Stamp, and Date: _____

Non-Navy Medical Providers: STOP and proceed to SECTION C

SECTION B. Medical and Educational Screening Disposition. Completed by the screening Navy MTF medical provider to determine if a Service or family member is suitable for an overseas, remote duty, or operational assignment.

Yes	No	ITEM
		1. Are any of the above shaded blocks in Section A checked? If "yes", submit a suitability inquiry to the gaining MTF or medical department supporting the overseas/remote duty/operational location to determine local capabilities to provide required support. (Attach Reply and answer questions 1a and 1b.) If "no", proceed to question 2.
		a. Does the gaining location have the capabilities to provide the current required medical support?(Service MTFs/TRICARE, etc.)
		b. Does the gaining location have the capabilities to provide the required medical support (diagnostic and therapeutic) if the underlying condition is exacerbated? (To include all Service MTFs/operational platform, TRICARE, etc.)
		2. Is the shaded block of question 18 checked "yes"? If yes, Submit the DD 2792-1 and IEP to the gaining DoDEA Special Education Overseas Screening Coordinator and gaining MTF to determine local capabilities to provide required support. (Attach Reply with POC info and answer question 2a.) If no, proceed to question 3.
		a. Is the DoDEA Special Education Overseas Screening Coordinator recommending travel?
Yes	No	3. IS THE SERVICE/FAMILY MEMBER SUITABLE FOR THE OVERSEAS, REMOTE DUTY OR OPERATIONAL ASSIGNMENT? (Must be completed by an MTF medical screener. Answered after the inquiry is completed.)

SECTION C. Contact Information. Completed by the MTF/non-MTF civilian providers who completed PART I. The Navy MTF medical screener shall review and countersign all suitability screenings completed by non-Navy MTF civilian providers, denoting accountability for a complete and thorough suitability screening document review for each Service/family member.

Navy MTF Medical Screener (Signature) _____	Date _____	Non-Navy MTF/Civilian Medical Screener (Signature) _____	Date _____
Printed Name, Rank or Grade _____		Printed Name _____	
MTF or Duty Station _____		Address _____	
Telephone Number (include area/country code) _____		City, State, and Zip Code _____	
DSN Number _____		Telephone Number (include area/country code) _____	
Office Hours to contact _____		Office Hours to Contact _____	
E-mail Address _____		E-mail Address _____	

PART II

SERVICE / FAMILY MEMBER NAME	GRADE / RATE / FAMILY MEMBER PREFIX	SSN
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SECTION A. Dental Screening. Completed by a dental officer/privileged dentist prior to an overseas, remote duty, or operational assignment for the purpose of assessing and matching the dental needs of a service/family member to the support capabilities of the gaining medical treatment facility. **NOTE: If child does not have teeth -AND- is under the age of 24 months, a pediatrician may perform an oral dental screening.**

Yes	No	ITEM
		1. All current dental records (military and civilian) reviewed?
		2. All dental examinations are current? (If more than 180 days since last T-1 or T-2 dental exam, a dental officer/privileged dentist must, at a minimum, review the dental record and interval medical and dental history.)
		3. Is a reexamination required by a Navy MTF if examined or treated at a non-Navy facility?
		4. If service/family member is in Dental Class 3 or 4, can dental treatment or examination be completed before the transfer?
		5. Is there a requirement for follow-on care such as orthodontics, implants, specialty prosthetics, etc.?
		6. Are there any chronic dental conditions requiring routine or continuing access to care or access to specialized dental care?
		7. Are there any concerns about the gaining MTF/operational platform's capabilities to meet the individual's needs? <i>Specify below:</i>
Navy MTF SSC Name, Signature, Stamp, and Date: _____		

8. Specify Dental Class: *(required for service members)* _____

Dental Classifications: (Per DoDI 6025.19)
Normally considered worldwide deployable:
Class 1 - Patients with a current dental examination, who do not require dental treatment or re-evaluation.
Class 2 - Patients with a current dental examination, who require non-urgent dental treatment or re-evaluation for oral conditions unlikely to result in a dental emergency within 12 months.

Normally not considered worldwide deployable:
Class 3 - Patients who require urgent or emergent dental treatment for oral conditions with a high potential to cause a dental emergency in the next 12 months.
Class 4 - Patients who require a dental examination either because: (1) No type 1 (comprehensive) or type 2 (annual or periodic oral) dental examination was completed by a dental officer/privileged dentist within the past 12 months; (2) A patient's dental record does not exist or; (3) The dental record is not held by the responsible dental treatment facility or Medical Department activity.

SECTION B. Dental Screening Disposition. Completed by the screening MTF provider to determine if a service or family member is suitable for an overseas, remote duty, or operational assignment. **Non-Navy Medical Providers: STOP and proceed to SECTION C.**

Yes	No	ITEM
		1. Are any of the above shaded blocks checked? If yes, submit a suitability inquiry to the gaining MTF or medical department supporting the overseas/remote duty/operational location to determine local dental capabilities to provide required support. <i>(Attach Reply and answer question 2)</i> If no, proceed to question 3.
		2. Does the gaining MTF/operational platform have the capabilities to provide the current required dental support?
Yes	No	3. IS THE SERVICE/FAMILY MEMBER SUITABLE FOR THE OVERSEAS, REMOTE DUTY OR OPERATIONAL ASSIGNMENT? (Must be completed by an MTF dental screener. Answered after the inquiry is completed.)

SECTION C. Contact Information. Completed by the MTF/non-MTF civilian providers who completed PART II. The Navy MTF dental screener shall review and countersign all suitability screenings completed by non-Navy MTF civilian providers, denoting accountability for a complete and thorough suitability screening document review for each Service/family member.

Navy MTF Dental Screener (Signature) _____ Date _____ Printed Name, Rank or Grade _____ MTF or Duty Station _____ Telephone Number (include area/country code) _____ DSN Number _____ Office Hours to Contact _____ E-mail Address _____	Non-Navy Medical Facility/Civilian Dental Screener (Signature) _____ Date _____ Printed Name _____ Address _____ City, State, and Zip Code _____ Telephone Number (include area/country code) _____ Office Hours to Contact _____ E-mail Address _____
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MEDICAL, DENTAL, AND EDUCATIONAL SUITABILITY SCREENING CHECKLIST AND WORKSHEET

Privacy Act Statement: OPNAVINST 1300.14D authorizes collection of this information. The following information and documents, as applicable, are required to conduct medical, dental, and educational screening to determine suitability for an overseas, remote duty, or operational assignment. Complete and current information is essential for completion of screening. Disclosure is voluntary, however, missing or incomplete information may delay the screening process, result in orders held in abeyance until completion of screening, or affect the amount of leave in transit. Refer to BUMEDINST 1300.2B for implementing guidance.

The Suitability Screening Coordinator (SSC) at the military treatment facility (MTF) can assist in obtaining and completing the required information. The SSC will ensure required information and documents are complete and current before referral to a MTF provider for screening and a suitability recommendation. The SSC will place the completed original from in the individual's Service Treatment Record/Non-Service Treatment Record and retain a copy for audit. Medical, dental, and educational suitability screening is valid for 12 months from the date of completion if there were no significant changes in the medical, dental, or educational status of the service or family member. The service member must notify his or her commanding officer or officer in charge of any change in status (including pregnancy).
Complete one form for each Service and family member screened.

SERVICE MEMBER NAME	GRADE/ RATE	SSN
CURRENT UNIT	TELEPHONE NUMBER	
NEXT DUTY STATION LOCATION & UNIT IDENTIFICATION CODE (UIC)	TYPE DUTY CLASSIFICATION CODE (Navy Enlisted Code Only)	
FAMILY MEMBER NAME	FAMILY MEMBER PREFIX	Age

ITEM	SSC Review		
	YES	NO	N/A

A. FOR SERVICE MEMBERS:

<input type="checkbox"/>	1. Legible copy of orders or an Overseas Screening Notification. (For operational assignments, orders should indicate the platform to which assigned and a description of the duty assignment.)			
<input type="checkbox"/>	2. Each family member name, family member prefix, social security number, address and telephone number, if other than the service member's.			

SERVICE TREATMENT RECORD TO INCLUDE:

<input type="checkbox"/>	3. All Physical Exams (to include special duty aviation, submarine, radiation, asbestos, etc.) are current and filed in the Service Treatment Record? a. Type of Physical _____ b. Completion Date of Physical _____			
<input type="checkbox"/>	4. Annual Periodic Health Assessment (PHA) current and documented? Date: _____			
<input type="checkbox"/>	5. Current medical history (DD Form 2807-1)			
<input type="checkbox"/>	6. Hearing (Audiogram)			
<input type="checkbox"/>	7. Vision Examination			
<input type="checkbox"/>	8. G-6P-D Test			
<input type="checkbox"/>	9. PPD Test			
<input type="checkbox"/>	10. Sickle Cell Trait Test			
<input type="checkbox"/>	11. Negative HIV results current to 1 year of transfer Date Drawn: _____ Roster Number: _____			
<input type="checkbox"/>	12. Blood Type: _____			
<input type="checkbox"/>	13. DNA Testing completed and documented?			
<input type="checkbox"/>	14. Required Immunizations (Assignment Specific)			
<input type="checkbox"/>	15. Military Dental Records			
<input type="checkbox"/>	16. Copies of civilian medical, dental, or mental health care records to include narrative summaries of any inpatient admissions in civilian facilities.			
<input type="checkbox"/>	17. Mammogram current and documented. Date: _____			
<input type="checkbox"/>	18. Pregnancy screen (verbal inquiry). (Also, command will refer for pregnancy test 30 days prior to departure date.)			
<input type="checkbox"/>	Other:			

B. FOR FAMILY MEMBERS:

<input type="checkbox"/>	1. Non-Service Treatment Record (medical and dental) and include a completed DD Form 2807-1			
<input type="checkbox"/>	2. Copies of civilian medical, dental, or mental health care records to include narrative summaries of any inpatient admissions in civilian facilities. Include a completed DD Form 2807-1			
<input type="checkbox"/>	3. Recommended ACIP and required country specific immunizations (check current country specific immunization requirements issued by the Centers for Disease Control and Prevention (CDC) i.e. yellow fever)			

ITEM	SSC Review														
C. FOR DEPENDENT CHILDREN:	YES	NO	N/A												
<input type="checkbox"/> 1. DD FORM 2792-1 (Required for ALL children birth to 22 nd Birthday OR High School Graduation)															
FOR INFANTS AND TODDLERS (Birth to 36 Months) ELIGIBLE TO RECEIVE EARLY INTERVENTION SERVICES AS EVIDENCED BY AN INDIVIDUALIZED FAMILY SERVICE PLAN (IFSP):															
<input type="checkbox"/> 2. Copy of the current IFSP and, if available, developmental assessments or evaluations.															
FOR PRESCHOOL OR SCHOOL-AGE CHILDREN (Ages 3 to 22 nd Birthday or High School Graduation) ELIGIBLE TO RECEIVE SPECIAL EDUCATION AND RELATED SERVICES AS EVIDENCED BY AN INDIVIDUALIZED EDUCATION PROGRAM (IEP):															
<input type="checkbox"/> 3. Copy of the current IEP and, if available, developmental assessments or evaluations.															
FOR EACH FAMILY MEMBER ENROLLED OR UNDERGOING ENROLLMENT IN THE EXCEPTIONAL FAMILY MEMBER PROGRAM (EFMP):															
<input type="checkbox"/> 4. Copy of the DD Form 2792 and any EFMP correspondence.															
D. FOR SSC USE ONLY															
1. Date suitability screening conducted. Date: _____															
E. SUITABILITY INQUIRY:															
<input type="checkbox"/> 1. Are any of the shaded blocks checked on NAVMED Form 1300/1? <input type="checkbox"/> YES (Suitability Inquiry required, proceed to question 2) <input type="checkbox"/> NO (Line through question 2 and proceed to section F)															
<input type="checkbox"/> 2. Suitability Inquiry:															
<table style="width:100%; border:none;"> <tr> <td style="width:25%; vertical-align:top;"> Medical Care: <input type="checkbox"/> Potential need identified <input type="checkbox"/> N/A </td> <td style="width:25%; vertical-align:top;"> Date & Time sent: _____ Sent by (Sending SSC): _____ Sent to (Gaining SSC): _____ </td> <td style="width:25%; vertical-align:top;"> Reply date & time: _____ Reply from: _____ Contact #: _____ E-Mail: _____ </td> <td style="width:25%;"></td> </tr> <tr> <td style="vertical-align:top;"> Dental Services: <input type="checkbox"/> Potential need identified <input type="checkbox"/> N/A </td> <td style="vertical-align:top;"> Date & Time sent: _____ Sent by (Sending SSC): _____ Sent to (Gaining SSC): _____ </td> <td style="vertical-align:top;"> Reply date & time: _____ Reply from: _____ Contact #: _____ E-Mail: _____ </td> <td></td> </tr> <tr> <td style="vertical-align:top;"> Special Education Services: <input type="checkbox"/> Potential need identified <input type="checkbox"/> N/A </td> <td style="vertical-align:top;"> Date & Time sent: _____ Sent by (Sending SSC): _____ Sent to (Gaining SSC): _____ Sent to (Gaining DoDEA): _____ </td> <td style="vertical-align:top;"> Reply date & time: _____ Reply from: _____ Contact #: _____ E-Mail: _____ E-Mail: _____ </td> <td></td> </tr> </table>				Medical Care: <input type="checkbox"/> Potential need identified <input type="checkbox"/> N/A	Date & Time sent: _____ Sent by (Sending SSC): _____ Sent to (Gaining SSC): _____	Reply date & time: _____ Reply from: _____ Contact #: _____ E-Mail: _____		Dental Services: <input type="checkbox"/> Potential need identified <input type="checkbox"/> N/A	Date & Time sent: _____ Sent by (Sending SSC): _____ Sent to (Gaining SSC): _____	Reply date & time: _____ Reply from: _____ Contact #: _____ E-Mail: _____		Special Education Services: <input type="checkbox"/> Potential need identified <input type="checkbox"/> N/A	Date & Time sent: _____ Sent by (Sending SSC): _____ Sent to (Gaining SSC): _____ Sent to (Gaining DoDEA): _____	Reply date & time: _____ Reply from: _____ Contact #: _____ E-Mail: _____ E-Mail: _____	
Medical Care: <input type="checkbox"/> Potential need identified <input type="checkbox"/> N/A	Date & Time sent: _____ Sent by (Sending SSC): _____ Sent to (Gaining SSC): _____	Reply date & time: _____ Reply from: _____ Contact #: _____ E-Mail: _____													
Dental Services: <input type="checkbox"/> Potential need identified <input type="checkbox"/> N/A	Date & Time sent: _____ Sent by (Sending SSC): _____ Sent to (Gaining SSC): _____	Reply date & time: _____ Reply from: _____ Contact #: _____ E-Mail: _____													
Special Education Services: <input type="checkbox"/> Potential need identified <input type="checkbox"/> N/A	Date & Time sent: _____ Sent by (Sending SSC): _____ Sent to (Gaining SSC): _____ Sent to (Gaining DoDEA): _____	Reply date & time: _____ Reply from: _____ Contact #: _____ E-Mail: _____ E-Mail: _____													
Other information:															
F. SUITABILITY SCREENING COORDINATOR: Facility _____															
Printed Name: _____	Signature	Date													
E-mail: _____															
Phone: _____															

REPORT OF SUITABILITY FOR OVERSEAS ASSIGNMENTS

Supporting Directive OPNAVINST 1300.14D

1. MEMBER'S NAME:	2. DATE:	3. NUMBER OF DEPENDENTS:
4. PRESENT SHIP/STATION:	5. UIC:	6. OVERSEAS LOCATION:
		7. UIC:

PART I: COMMAND REVIEW - The purpose of the command review is to determine, via record review and personal interview, member and spouse/family member(s)' suitability for overseas duty/life in the assigned overseas location. Refer to MILPERSMAN 1300-302 and 1300-304. Any questions checked "YES" (with the exception of questions 11, 15, and 16) disqualifies member for overseas assignment. Complete PART I and obtain waiver(s) prior to starting PART II (NAVMED 1300/1).

1. Has the member or any spouse/family member previously been reassigned, prior to normal tour completion, due to their unsuitability?	<input type="radio"/> Yes	<input type="radio"/> No
2. (For Enlisted Personnel) Has member obligated for the prescribed DoD tour? If "NO", member is unsuitable. NAVPERS 1070/613 entries for OBLISERV are prohibited. OBLISERV MUST BE COMPLETED WITHIN 30 DAYS OF RECEIPT OF ORDERS. For SRB issues, see the current NAVADMIN. For PFA see current NAVADMIN and OPNAV instruction. Officers and enlisted who REQUEST to separate/retire, will be held to the DoD tour length.	<input type="radio"/> Yes	<input type="radio"/> No
3. (E-5 and above) Does the member, spouse, or family member have serious problems of indebtedness, credit loss, or other financial problems which have not been reconciled with the creditor(s) or interested parties? (E-4 and below) Member must complete debt-to-income (DTI) ratio screening per OPNAVINST 1740.5B. Do not calculate the spouse's income unless guaranteed employment at the overseas location has been obtained. Is the DTI ratio 30% or greater.	<input type="radio"/> Yes	<input type="radio"/> No
4. Has the member ever been convicted of a sex offense? ** Has the member been convicted of any criminal offense (civilian or military) within the last 24 months or has/had any involvement in an ongoing criminal action? **Information regarding whether a person is a sex offender may be found at Dru Sjodin National Sex Offender Public Website (NSOPW) at www.nsopw.gov .	<input type="radio"/> Yes	<input type="radio"/> No
5. Has the spouse or any family member ever been convicted of a sex offense? ** Has the spouse or any family member been convicted of any criminal offense (civilian or military) in the last 24 months or has/had any involvement in an ongoing criminal action? ** Information regarding whether a person is a sex offender may be found at Dru Sjodin National Sex Offender Public Website (NSOPW) at www.nsopw.gov .	<input type="radio"/> Yes	<input type="radio"/> No
6. Does the member have a record of any involvement with illegal drugs or alcohol within the past 24 months? Successful completion of an aftercare program will qualify the member and the question can be answered NO. Waiver of aftercare program does not qualify the member; answer YES.	<input type="radio"/> Yes	<input type="radio"/> No
7. Does the spouse/family member have a record of any involvement with illegal drugs or alcohol within the past 24 months?	<input type="radio"/> Yes	<input type="radio"/> No
8. Is the member or spouse/family member involved in an open Family Advocacy Program (FAP) case that is still under investigation or for which treatment was refused or is still ongoing? (If a local FAP representative is not available to provide a status of any FAP issues, then contact the Commander Navy Installation Command (CNIC), Lead of Case Management Section for FAP, at (901) 874-4361, DSN 882-4361, for this endorsement.) If the CO still wishes to request a waiver, then the gaining command and FFSC must support waiver request.	<input type="radio"/> Yes	<input type="radio"/> No
9. Was the member's spouse previously a member of the Armed Forces and the characterization of separation other than "Honorable"? Explain in the remarks section.	<input type="radio"/> Yes	<input type="radio"/> No
10. Has member failed two or more PFAs in a 3-year period? If yes, comply with OPNAVINST 6110.1H and most recent NAVADMIN, which govern Physical Readiness Program.	<input type="radio"/> Yes	<input type="radio"/> No
11. Are any of the member's dependents covered in a custody agreement? If "NO", go to question 12. a. Does agreement prevent removal of family members from continental United States (CONUS) without prior court approval or agreement between the interested parties? If "NO", go to question 12. b. Has member obtained prior court approval of requisite agreement from other interested party for removal of family members from CONUS, if required by state law? (Please note: Navy policy does not require a separate agreement if not required by state law.)	<input type="radio"/> Yes	<input type="radio"/> No

1. MEMBER'S NAME:		2. DATE:	
12. Single parents/military couples with family members. Is there any reason why the Family Care Plan cannot be executed or is not in accordance with OPNAVINST 1740.4D?		<input type="radio"/> Yes	<input type="radio"/> No
NOTE: While the unique situation of single parents with dependents is not disqualifying, this fact should be pointed out upon submission of suitability determination.			
13. If member is a first-termer and going to an overseas duty station, and has a pre-service moral waiver(s) for drug, alcohol, or criminal conviction, (identified in Section VI remarks of DD 1966 (3-07), Record of Military Processing), then mark block YES.		<input type="radio"/> Yes	<input type="radio"/> No
14. Does member have a history of unsatisfactory or below standard performance (any mark below 3.0) or any NJPs in the last 2 years?		<input type="radio"/> Yes	<input type="radio"/> No
15. Have member and adult dependents received "Level I" Antiterrorism Force Protection (Level III for 0-5/0-6 Commanding Officer Awareness Training), prior to transfer, and recorded on NAVPERS 1070/613?		<input type="radio"/> Yes	<input type="radio"/> No
16. Is dependent spouse a foreign national? If yes, see MILPERSMAN 1300-302 for "Non-US citizen dependents". Case by case coordination for dependents travel documents will be required.		<input type="radio"/> Yes	<input type="radio"/> No
FOR PERSONNEL E-3 AND BELOW: Ensure the members have been counseled that they cannot be assigned accompanied overseas duty. Members will be assigned unaccompanied based on readiness needs. Acquiring family member(s) en route and bringing them without dependent entry approval/command sponsorship will most probably result in return to CONUS at personal expense and servicemembers will complete tour unaccompanied.			
1. I have been counseled on the above: <input type="radio"/> Yes <input type="radio"/> No			
2. MEMBER'S SIGNATURE:		3. DATE:	
4. REMARKS:			
5. I, _____, am aware that the failure to divulge disqualifying information or amplifying information (medical, dental, personal) pertaining to the questions on this checklist may ultimately result in disciplinary action punishable under the UCMJ.			
6. MEMBER (NAME, RANK/RATE):		6. MEMBER (SIGNATURE)	7. DATE:
8. INTERVIEWER (NAME, RANK/RATE, COMMAND TITLE):		9. INTERVIEWER (SIGNATURE):	10. DATE:

1. MEMBER'S NAME:	2. DATE:
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PART II: RECOMMENDATION OF COMMANDING OFFICER (OR OIC) OF MEDICAL TREATMENT FACILITY.

Based on the information available as a result of screening, approved medical/dental waivers received, and on the capabilities of the Medical/Dental Treatment Facility (MTF/DTF) in the area of assignment to which ordered, the following recommendation is forwarded.

1. Medical, dental, and educational screening was conducted per BUMEDINST 1300.2A.

2. Recommendation is based on a review of NAVMED 1300/1, Parts I and II. One form has been completed for each service and family member screened.

3. If a shaded block is checked on NAVMED 1300/1, coordination is required with the gaining MTF/DTF supporting the overseas, remote duty, or operational location; or with the senior medical department representative of an operational platform. Coordination must indicate whether or not required medical, dental, or educational capabilities are available.

4. Family member screening is not required if an unaccompanied tour of 24 months or less (exception: screening is required for Diego Garcia/ Souda Bay, Crete).

5. Do not forward sensitive medical or personal information with this form.

The following recommendation(s) are made based on a review of each NAVMED 1300/1, Parts I and II, and if required, the response from the gaining MTF/DTF or senior medical department representative of the gaining command:

1. SERVICEMEMBER IS SUITABLE FOR THIS ASSIGNMENT. Yes No

FAMILY MEMBERS SUITABILITY FOR THIS ASSIGNMENT.

2. NAME: <input type="radio"/> Yes <input type="radio"/> No	3. NAME: <input type="radio"/> Yes <input type="radio"/> No
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4. NAME: <input type="radio"/> Yes <input type="radio"/> No	5. NAME: <input type="radio"/> Yes <input type="radio"/> No
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6. NAME: <input type="radio"/> Yes <input type="radio"/> No	6. NAME: <input type="radio"/> Yes <input type="radio"/> No
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The following family member(s) were referred for Exceptional Family Member Program (EFMP) enrollment (DO NOT DELAY SCREENING FOR EFM DETERMINATION):

8. NAME (s):

9. NAME OF CO/OIC OR DESIGNEE OF MEDICAL TREATMENT FACILITY:	10. DATE:	9. SIGNATURE OF CO/OIC OR DESIGNEE OF MEDICAL TREATMENT FACILITY:
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1. MEMBER'S NAME:	2. DATE:
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PART III: CMC/COB/SEA ENDORSEMENT

1. On the basis of all available information, I endorse / I do not endorse the member's orders for the overseas assignment.

2. CMC/COB/SEA (NAME AND RANK):	3. SIGNATURE OF CMC/COB/SEA:	4. DATE:
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PART IV: COMMANDING OFFICER'S ENDORSEMENT

1. On the basis of all available information, I endorse / I do not endorse the member's orders for the overseas assignment.

2. COMMANDING OFFICER (NAME AND RANK):	3. SIGNATURE OF COMMANDING OFFICER:	4. DATE:
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5. REMARKS:

If the Commanding Officer still feels member should be considered for overseas assignment, submit waiver (non-medical/dental) request per MILPERSMAN 1300-304.

PRIVACY STATEMENT: THE AUTHORITY TO REQUEST THIS INFORMATION IS CONTAINED IN 5 USC 301 DEPARTMENTAL REGULATIONS. THE INFORMATION WILL BE USED TO ASSIST OFFICIALS AND EMPLOYEES OF THE DEPARTMENT OF THE NAVY IN DETERMINING YOUR FUTURE DUTY ASSIGNMENT.

COMPLETION OF THE FORM IS MANDATORY EXCEPT FOR DUTY AND HOME PHONE NUMBERS, OR FAILURE TO PROVIDE REQUIRED INFORMATION MY RESULT IN DELAY IN RESPONSE TO OR DISAPPROVAL OF YOUR REQUEST.

EXCEPTIONAL FAMILY MEMBER PROGRAM-MEDICAL (EFMP-M) INFORMATION FORM

Welcome to the Exceptional Family Member Program-Medical (EFMP-M). EFMP-M ensures medical and special education information is considered by the appropriate review authorities prior to authorizing government-sponsored travel for family members. EFMP-M implements the Family Member Relocation Clearance (FMRC) process requirements for EFMP-enrolled sponsors at each Permanent Change of Station (PCS), and for all sponsors planning to take family members overseas. EFMP-M supports the Exceptional Family Member Program (EFMP) by determining when EFMP enrollment criteria are met, and by providing necessary support information when an EFMP Reassignment is requested.

A vital part of the FMRC process is to support mobile families through relocation, for families of both Regular Air Force (RegAF) and DoD civilian sponsors. EFMP-M gathers information about family members' health and special education histories from existing data sources and from service providers. EFMP-M determines the availability of medical and special education services in the projected location, based on this review of known family member conditions, to avoid relocating family members to locations that cannot meet their needs. Where special needs are identified, as defined by

Authorizing Special Needs Family Members Travel Overseas at Government Expense, Enclosure 4, the Special Needs Coordinator is required to request an assignment limitation code, "Q", for RegAF sponsors. This "Q-code" provides a level of protection for families with special needs, to ensure deployments and reassignments are considered in conjunction with the family member's therapeutic program. Families of RegAF members may not travel under command sponsorship to OCONUS locations that cannot ensure the protection of their federal and DoD benefits and entitlements. Assignment coordination support offered to all DoD-affiliated families, regardless of sponsor's service category or the presence of a documented special need. However, decisions regarding travel remain with the sponsor for DoD civilians and others who are not RegAF.

For RegAF members, EFMP Reassignments and deferments are two of the options that may be considered when services are not available at a duty station. However, both retention at the current base and assignment to another base are dependent upon vacancies and manning requirements of the Air Force. The EFMP-M process is not a "base of choice" service for the sponsor. RegAF members must still serve overseas when ordered, regardless of the presence of family members with special needs. Members who are selected for overseas assignment to a location where medical or special education services are not available for family members may elect the option of an unaccompanied short tour. AF Personnel Center (AFPC) retains the final authority on all assignment actions.

It is important you know the intended uses of the information you provide and the limitations on confidentiality. Military health care records and administrative records maintained by the Military Treatment Facility, including our separately maintained Special Needs files and logs, are the property of the U.S. Government. The same controls apply to these records as other government documents. Information disclosed by you to the Special Needs Coordinator or Family Member Relocation Clearance Coordinator is considered sensitive information and is treated as such. This means access to this information is allowed for the purpose intended, to coordinate care through relocation, and as required by law, regulation, judicial proceedings, health care facility accreditation or inspection, or when authorized by the identified patient or parent of a minor.

If EFMP enrollment is initiated, a file is created to maintain an ongoing record of services and contacts throughout the length of the sponsor's career, or period of EFMP enrollment. If no EFMP enrollment is warranted, logs and forms used to coordinate relocation are maintained for 2 years after processing for process accountability. Requests for information from sources outside the Department of Defense will not be honored unless you first give written permission for the release of information.

Here are some examples where limits on confidentiality may apply:

1. Release of information may be required by regulation. We will do everything we can to ensure individuals with the right to know find out only what they need to know. If you are RegAF, your commander or higher chain of command may have the need to know some of the information you disclose to us.
2. If you tell us of a situation involving a violation of military regulations, the Uniformed Code of Military Justice (UCMJ), or civil law, we may be required to divulge that information to the chain of command and/or other authorities.
3. If you voice a threat to harm yourself or someone else, or if family maltreatment is alleged or suspected, we may share information as needed to ensure safety.
4. Where there is a need to know, other DoD health care professionals associated with your family's care may have access to some EFMP-M process information in order to coordinate health care delivery.
5. Exceptional Family Member Program-Family Support (EFMP-FS) may be informed of the presence of Q-code status without accompanying medical information, in order for EFMP-FS to assist families with potential support services that may be available.
6. As part of EFMP case reviews, information may be shared with medical staff and EFMP-FS Coordinators in order to assist with family service plan development.
7. Qualified individuals authorized to conduct officially sanctioned research, administrative and/or legal reviews may review EFMP-M records to evaluate services or to conduct other research toward improving processes or services. Research findings or administrative/process improvement reviews NEVER include individual names or other identifying information.
8. The work of EFMP-M staff is reviewed after each client contact to ensure quality services are provided and standards of care are met.

In accordance with the above guidelines, we will strive to safeguard information obtained from you and ensure only authorized sources with a valid need to know have access.

Please ask the EFMP-M staff any questions you have on EFMP-M or about the use of information obtained in the EFMP-M processes.

**EXCEPTIONAL FAMILY MEMBER PROGRAM-MEDICAL (EFMP-M)
INFORMATION FORM**

(Cont'd)

Statement of Understanding

I have read the EFMP-M information Form and understand that information about family members' health and special education needs will be safeguarded, acknowledging the limitations of confidentiality mentioned above and IAW the Privacy Act of 1974 (DD Form 2005).

Sponsor Signature:

Date: _____

Adult Family Member Signature, if briefed on EFMP-M process:

Date: _____

Adult Family Member Signature, if briefed on EFMP-M process:

Date: _____

I have reviewed the EFMP-M process and purposes to the above-identified client(s) to ensure understanding and have discussed the limits of confidentiality.

EFMP-M Staff member Signature:

Date: _____

REQUEST FOR FAMILY MEMBER'S MEDICAL AND EDUCATION CLEARANCE FOR TRAVEL

PRIVACY ACT STATEMENT

AUTHORITY: 10 USC 3013, 5013, and 8013; 20 USC 921 - 932; and EO 9397.

PRINCIPAL PURPOSE(S): Information will only be used by personnel of the Military Departments to evaluate and document the medical and educational needs of family members. This information will enable: (1) Military assignment personnel to authorize family member travel at government expense based on availability of needed services at the gaining installation; and (2) Civilian personnel offices to determine the availability of medical/educational services to meet the medical needs of family members of DoD and Military Department civilian employees.

ROUTINE USE(S): None.

DISCLOSURE: Voluntary for civilian employees and applicants for civilian employment; failure to respond will preclude the successful processing of an application for family travel/command sponsorship. Mandatory for military personnel; failure or refusal to provide the information or providing false information may result in administrative sanctions or punishment under either Article 92 (dereliction of duty) or Article 107 (false official statement), Uniform Code of Military Justice.

AUTHORIZATION FOR DISCLOSURE OF MEDICAL INFORMATION

Authority - Public 104-191, "Health Insurance Portability and Accountability Act (HIPAA)", August 21, 1996.

This form will not be used for authorization to disclose psychotherapy notes, alcohol or drug abuse patient information from medical records or for authorization to disclose information from records of an alcohol or drug abuse treatment program.

I authorize _____ (MTF/DTF) to release my patient information to the Exceptional Family Member/Special Needs Program to be used in the assignment coordination process. The information on this form and addenda will be used to determine whether there are adequate medical, housing and community resources to meet your special medical needs at the sponsor's proposed duty locations.

- a. The military medical department will use the information to make recommendations on the availability of care in communities where the sponsor may be assigned or employed.
b. Information that you have a special need (not the nature or scope of the need) may be included in the sponsor's personnel record or be maintained in the community office responsible for supporting families with special needs.
c. The authorization applies to the summary data included on the medical summary form, its addenda and subsequent updates to information on this form. These data may be stored in electronic databases used for medical management or dedicated to the assignment coordination process. Only representatives from the medical department and the offices responsible for EFMP assignment coordination will have access to the information.

Start Date: The authorization start date is the date that you sign this form authorizing the release of information.

Expiration Date: The authorization shall continue until you no longer meet the criteria to qualify as a dependent (active duty family members) or no longer desire to travel overseas at government expense (civilian employee family members), or the sponsor is no longer in active military service or employment of the U.S. Government overseas.

I understand that:

- a. I have the right to revoke this authorization at any time. My revocation must be in writing and provided to the facility where my medical records are kept. I am aware that if I later revoke this authorization, the person(s) I herein name will have used and/or disclosed my protected information on the basis of this authorization.
b. If I authorize my protected health information to be disclosed to someone who is not required to comply with federal privacy protection regulations, then such information may be re-disclosed and would no longer be protected.
c. I have a right to inspect and receive a copy of my own protected health information to be used or disclosed, in accordance with the requirements of the federal privacy protection regulations found in the Privacy Act and 45 CFR § 164.524. I request and authorize the named provider/treatment facility to release the information described above to the named individual/organization indicated.
d. The Military Health System (which includes the TRICARE Health Plan) may not condition treatment in MTFs/DTFs, payment by the TRICARE Health Plan, enrollment in the TRICARE Health Plan or eligibility for TRICARE Health Plan benefits on failure to obtain this authorization.

Table with 3 columns: SIGNATURE OF PATIENT/PARENT/GUARDIAN, RELATIONSHIP TO PATIENT(S) (If applicable), DATE (YYYYMMDD). It contains four rows of blank lines for signature, relationship, and date.

REQUEST FOR FAMILY MEMBER'S MEDICAL AND EDUCATION CLEARANCE FOR TRAVEL

(This Form is Subject to the Privacy Act of 1974 - USE BLANKET PAS - DD FORM 2005.)

SECTION I - SPONSOR'S DATA

A. NAME (Last, First, Middle Initial)		B. GRADE	C. SSN
D. DUTY / HOME PHONE	E. PRESENT UNIT/LOCATION	F. CURRENT MPF LOCATION OF SPONSOR	G. MO/YR OF SPONSOR TRAVEL: ____ / ____
H. PROJECTED UNIT / LOCATION/PAS CODE	I. JOIN SPOUSE ASSIGNMENT <input type="checkbox"/> YES <input type="checkbox"/> NO	J. GAINING MAJCOM	K. PROJECTED AFSC
M. If Spouse is Active Duty: Name: Branch: SSN:			L. PREVIOUSLY Q-CODED <input type="checkbox"/> YES <input type="checkbox"/> NO
N. IS THE MEMBER BEING ASSIGNED TO STATE DEPARTMENT DUTIES OR OTHER GEOGRAPHICALLY REMOTE LOCATIONS? YES <input type="checkbox"/> NO <input type="checkbox"/>			

If family destination is other than a catchment area for an AF MTF, the sending installation must refer to EFMP-M guidance on areas of responsibility for remote clearances and embassy/attache' clearance processing.

SECTION II - FAMILY MEMBERS NOT TRAVELING

I hereby certify the following family members will NOT accompany me as command-sponsored dependents at any time during this assignment. I understand that if these plans change, I must reaccomplish this form to include the following family members and notify the Special Needs Coordinator at my current base of assignment..

FAMILY MEMBER'S NAME (Last, First, Middle Initial)	RELATIONSHIP	AGE

The above listed _____ (number) family members will NOT accompany me at the gaining location.

Sponsor's Signature _____

SECTION III - FAMILY MEMBERS REQUESTING COMMAND SPONSORSHIP TO TRAVEL

INSTRUCTIONS

Sponsors are required to list all family members requesting command sponsorship for the purpose of accompanying the military sponsor in the projected duty location. Page 3 of this form must be completed in its entirety for each family member listed to avoid delays in travel recommendation processing.

Additionally:

- A. ALL sponsors with school-aged children, including those who are home-schooled, and those enrolled in Early Intervention who intend to travel OCONUS must complete DD Form 2792-1, Family Member Special Education/Early Intervention Summary. Attach copies of Individualized Education Plan (IEP) and/or Individualized Family Service Plan (IFSP), where applicable.
- B. Sponsors must submit completed DD Form 2792, Family Member Medical Summary with Addendum 1, Asthma/Reactive Airway Disease Summary, Addendum 2, Mental Health Summary Addendum 3, Autism, for each family member with a special medical need who is requesting travel. If no special need is known for a family member, sponsor must check "None". OCONUS locations may require the use of these forms for travel considerations for ALL family members requesting OCONUS travel.
- C. Sponsors must complete AF Form 1466D, *Dental Health Summary*, for all EFMP family members over the age of 2 traveling to any location and all members over the age of two traveling OCONUS. OCONUS locations may require the use of these forms for travel considerations for ALL family members requesting OCONUS travel.
- D. Definitions:

- 1. Medical - Potentially life-threatening conditions and/or chronic medical/physical conditions within the last five years, requiring follow-up support more than once a year, or specialty care.
- Emotional/Behavioral - Any of the following: current or chronic mental health conditions; inpatient or intensive outpatient mental health services within the last 5 years; greater than one visit monthly for more than 6 months required at the present time. This includes medical care from any mental health provider, a primary care manager, other health care provider, or legal social service involvement.
- 2. Dental - Care beyond routine annual dental exam or cleaning.
- 3. Educational - Any child using or intending to use special education services, including any child with an IEP or an IFSP, or a child (aged birth - 3 years) with a high probability of having a developmental delay.
- 4. Early Intervention or Related Services - Occupational Therapy, Physical Therapy, Speech Therapy, Mental Health, Audiological, or other related services recommended on an IEP or IFSP for the support of appropriate education, as would be covered by State Part B or Part C Services under IDEA. Mark if ever received.
- 5. Modified Housing/Environmental modifications - Special housing requirements for documented needs, such as wheelchair accessibility.
- 6. None - No known medical conditions AND no specialized educational services needed. Requires only annual/semi-annual routine visits to primary care manager.

- E. Location of medical records: For each family member listed in Section IV, indicate the location of stored medical records. Check "Copies Provided" if the sponsor and/or family member has provided copies of medical records not normally available through the MTF to support consideration of travel.
- F. Month and Year of projected travel to Projected Location: Submit dates of travel of family members if different than travel date of sponsor shown in Section I.G. above.

SPONSOR (Last, First MI):

SSN:

SECTION IV - FAMILY MEMBERS REQUESTING COMMAND SPONSORSHIP TO TRAVEL (Continued)

FAMILY MEMBERS ACCOMPANYING SPONSOR							CHECK ALL CONDITIONS THAT APPLY					
FAMILY MEMBER'S NAME (Last, First, Middle Initial)	RELATIONSHIP	AGE	GRADE IN SCHOOL	LOCATION OF MEDICAL RECORDS	COPIES PROVIDED	MONTH / YEAR OF TRAVEL	MEDICAL / EMOTIONAL / BEHAVIORAL	DENTAL	EDUCATIONAL	EI or RS SERVICES	MODIFIED HOUSING	NONE
					<input type="checkbox"/>	___/___/___	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
					<input type="checkbox"/>	___/___/___	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
					<input type="checkbox"/>	___/___/___	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
					<input type="checkbox"/>	___/___/___	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
					<input type="checkbox"/>	___/___/___	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
					<input type="checkbox"/>	___/___/___	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
					<input type="checkbox"/>	___/___/___	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
					<input type="checkbox"/>	___/___/___	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
					<input type="checkbox"/>	___/___/___	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
					<input type="checkbox"/>	___/___/___	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
					<input type="checkbox"/>	___/___/___	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
					<input type="checkbox"/>	___/___/___	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
					<input type="checkbox"/>	___/___/___	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
					<input type="checkbox"/>	___/___/___	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
					<input type="checkbox"/>	___/___/___	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
					<input type="checkbox"/>	___/___/___	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
					<input type="checkbox"/>	___/___/___	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
					<input type="checkbox"/>	___/___/___	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
					<input type="checkbox"/>	___/___/___	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
					<input type="checkbox"/>	___/___/___	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
					<input type="checkbox"/>	___/___/___	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

SECTION V - CERTIFICATION OF APPLICANT

I certify that I have read and understand the previous instructions and that those entries made by me are true, complete, and correct to the best of my knowledge and belief.

- Initials _____
- ___ I understand that I must inform the Special Needs Coordinator (SNC) of any changes to health/educational conditions prior to travel of family member listed in Section IV.
- ___ I understand that insufficient and/or inaccurate information may affect family member travel.
- ___ I understand that a knowing and willful false statement on this form can be punishable by fine or imprisonment. (See U.S. Code, Title 18, Section 1001; Title 10, Section 907; Article 107 UCMJ, Article 92 UCMJ).
- ___ I have disclosed to the SNC all known medical or special educational conditions for all family members planning travel.
- ___ I understand that failure to report these conditions may result in disciplinary action as a false official statement. Attempts to obtain a benefit, to include medical care or government sponsored travel by withholding information regarding my family member care histories may be reported to my commander.
- ___ I understand that choosing to take family members who are not recommended for government sponsored travel, at my own expense, may result in disciplinary action, significant personal expense, and may place family member in a location where necessary care or services are not available to them.
- ___ I understand I may request EFMP Reassignment via vMPF if one or more of my family members are not recommend for travel, or elect OCONUS travel unaccompanied.

DATE	PRINTED NAME AND GRADE OF SPONSOR	SIGNATURE
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SPONSOR NAME (Last, First MI):

SSN:

SECTION VI - MEDICAL PROVIDER EVALUATION

Inquiry

- A. All Family Members' Medical Records Reviewed? (If NO, comments required below).
- B. All Family Members in Section IV Interviewed? (If NO, comments required below).
- C. Special Medical Conditions Identified? (If YES, complete DD Form 2792).
- D. All Family Members' AF Form 1466D reviewed? (If NO, comments required below).
- E. Any unresolved dental care needs/problems identified on the AF Form 1466D?

YES	NO
<input type="checkbox"/>	<input type="checkbox"/>

I have confirmed the following presence or absence of specialty consultations and of pharmacy data indicating further review or potential special needs may be warranted. Comments required.

COMMENTS:

I have seen and interviewed all family members requesting travel and determined that FDI is is not required.

____ Number of DD Form 2792s attached. ____ Number of DD Form 2792-1s attached. ____ Number of AF Form 1466Ds attached

DATE	TYPE/PRINT NAME AND GRADE OF MEDICAL PROVIDER	SIGNATURE

SECTION VII - SPECIAL NEEDS COORDINATOR ENDORSEMENT

INQUIRY

- A. History of Family Advocacy Involvement? (If YES, complete DD Form 2792, Addendum 2)
- B. History of Mental Health Needs? (If YES, complete DD Form 2792, Addendum 2)
- C. Has artificial openings / requires prosthetics? (If YES, complete DD Form 2792. Ensure Part B, Section 8, is completed.)
- D. Requires Modified Housing? (If YES, complete DD Form 2792. Ensure Part B, Section 9, is completed.)
- E. Requires Adaptive Equipment / Special Medical Equipment? (If YES, complete DD Form 2792. Ensure Part B, Section 10, is completed.)
- F. Has Individualized Education Plan for Special Education? (If YES, complete DD Form 2792-1)
- G. Has Individualized Family Service Plan or high probability for development delay. (If YES, complete DD Form 2792-1)

YES	NO
<input type="checkbox"/>	<input type="checkbox"/>

COMMENTS REQUIRED

DATE	TYPE/PRINT NAME AND GRADE OF SPECIAL NEEDS COORDINATOR	SIGNATURE

SECTION VIII - CERTIFICATION BY LOSING BASE MDG / SGH

Any YES response in Sections VI C or VII require forwarding this AF FORM 1466 to the gaining base for review via Facility Determination Inquiry.

Comments Required:

I have reviewed all information collected and find it sufficient for medical decision making.

Comments reviewed and determined that FDI is ____ is not ____ required.

____ Number of DD Form 2792s attached.
 ____ Number of AF Form 1466Ds attached.
 ____ Number of DD Form 2792-1s attached.

DATE	NAME & GRADE OF LOSING SGH	SIGNATURE

SPONSOR NAME (Last, First MI):

SSN:

SECTION IX - FACILITY DETERMINATION INQUIRY, DISPOSITION BY MDG / SGH

Family member(s) travel is recommended.

Family member(s) require(s) FDI. Note: Orders may not be issued until FDI completed by Gaining SGH.

DATE

TYPE / PRINT NAME AND GRADE OF LOSING BASE SGH

SIGNATURE

Name of Losing Installation (PRINT LEGIBLY)

Family member(s) travel is recommended.

Family member(s) travel is not recommended.

ADDITIONAL COMMENTS

Check all that apply:

Family Member Name	Care available in MTF	Care available in local area	Care/Services not available	Recommend Care Coordination through PCS	Other

DATE

TYPE / PRINT NAME AND GRADE OF GAINING BASE SGH

SIGNATURE

Name of Gaining Installation (PRINT LEGIBLY)

DENTAL HEALTH SUMMARY *(To be completed by dental provider)*
(This Form is subject to the Privacy Act of 1974 ☐ USE BLANKET PAS ☐ DD FORM 2005)

PRINCIPAL PURPOSE: An assessment by a dentist is needed to determine your dental health as part of the family member relocation clearance for travel.
 If you are enrolled in the TRICARE Dental Plan, your **civilian dentist completes this form.**
 If you are not enrolled in the TRICARE Dental Plan, your **military dental treatment facility** completes this form.

1a. PATIENT NAME (Last, First, Middle Initial)	b. SPONSOR SSN	c. FAMILY MEMBER PREFIX
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2. DENTAL EXAMINATION RESULTS
 Dear Doctor,

The individual you are examining is a family member of an active duty member of the United States Armed Forces. This family member needs your assessment of his/her dental health for a pending duty assignment. Please mark (X) **the block** that best describes the condition of the family member, using as a suggested minimum a clinical examination with mirror and probe, and bitewing radiographs. This form is meant to determine the oral fitness for prolonged assignment without ready access to dental care of the family member, it is not intended to address the member's comprehensive dental needs.

<input type="checkbox"/>	(1) Patient has good oral health and is not expected to require dental treatment or reevaluation for 12 months.
<input type="checkbox"/>	(2) Patient has some oral conditions, but you <u>do not</u> 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).
<input type="checkbox"/>	(3) Patient has oral conditions that you <u>do</u> expect to result in dental emergencies within 12 months if not treated. Examples of such conditions are: <i>(X the applicable block or specify in the space provided)</i>
<input type="checkbox"/>	(a) Infections: Acute oral infections, pulpal or periapical pathology, chronic oral infections, or other pathologic lesions and lesions requiring biopsy or awaiting biopsy report.
<input type="checkbox"/>	(b) Caries/Restorations: Dental caries or fractures with moderate or advanced extension into dentin; baby bottle tooth decay/early childhood caries; defective restorations or temporary restorations that patients cannot maintain for 12 months.
<input type="checkbox"/>	(c) Missing Teeth: Edentulous areas requiring immediate prosthodontic treatment for adequate mastication, communications, or acceptable esthetics.
<input type="checkbox"/>	(d) Periodontal Conditions: Acute gingivitis or pericoronitis, active moderate to advanced periodontitis, periodontal abscess, progressive mucogingival conditions, moderate to heavy subgingival calculus, or periodontal manifestations of systemic disease or hormonal disturbances.
<input type="checkbox"/>	(e) Oral Surgery: Unerupted, partially erupted, or malposed teeth with historical, clinical, or radiographic signs or symptoms of pathosis that are recommended for removal.
<input type="checkbox"/>	(f) Other: Temporomandibular disorders or myofascial pain dysfunction requiring active treatment.
<input type="checkbox"/>	(4) Patient is undergoing active orthodontics treatment

3. If you selected Block (3) or (4) above, please circle the condition(s) you identified in this patient if they appear above, or briefly describe the condition(s) and recommended treatment (s) below:

4. Were x-rays consulted?	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO	If yes, date x-ray was taken (YYYYMMDD)
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5a. DENTAL PROVIDER NAME	b. SIGNATURE	c. DATE (YYYYMMDD)
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AIR FORCE SPECIAL NEEDS SCREENER

(Completed by all Sponsors with Family Members)

(This Form is Subject the the Privacy Act of 1974 - USE BLANKET PAS - DD FORM 2005)

AUTHORITY: 10 U.S.C. 55, 10 U.S.C. 8013 and E.O. 9397 (SSN) as amended.

PURPOSE(S): Used to document, plan, and coordinate the health care of family members during relocation; determine eligibility and suitability for benefits for various programs; and compile statistical data.

ROUTINE USE: Used to accumulate information for determining family member special needs.

DISCLOSURE: Voluntary; however, failure to provide SSN or other requested information may delay screening of family member's suitability for relocation at government expense or delay issuance of PCS orders.

TO: SPECIAL NEEDS COORDINATOR AND AIR FORCE PERSONNEL CENTER (AFPC)

FROM: Air Force Family Member Special Needs Identification Screener

The Air Force makes an effort to ensure specialized medical and educational services are available for all military family members. In order to help us do this, we need to know if any special medical and/or educational needs exist for your family members. You are required to complete this form as part of your relocation processing, if you have family members, whether they are living with you or not.

SPONSOR'S INFORMATION

(enter last 4 digits only)

Sponsor's Name (Last, First, MI)

Rank

Social Security Number (SSN)
(Last 4 digits only)

Current Unit and Duty Station

Duty Telephone Number

Telephone Number

Projected Installation If Relocating

Projected Departure Date

SPONSOR'S FAMILY INFORMATION

Please read and answer all questions. Indicate (X) the appropriate box. Thank you.

1. Are you currently enrolled in any Service's Exceptional Family Member Program (EFMP)? Yes No
If yes, stop here.
2. Do any of your children receive Special Education Services? Yes No
3. Do any of your children receive Early Intervention Services? Yes No
4. Do any of your family members receive speech therapy, occupational therapy, physical therapy, or counseling services? Yes No
5. Has any dependent member of your family been hospitalized for the same condition more than once? Yes No
6. Has any dependent member of your family been seen by a medical provider or mental health provider for the same condition more than once times in the last year? Yes No
7. Do any of your family members have a chronic medical condition that requires at least annual evaluation or follow-up by a specialist, other than a PCM (such as cardiology, internist, psychology, neurology, Yes No
8. Do any of your dependent family members have reactive airway disease or asthma? Yes No
9. Do any of your family members require specialized equipment or modified housing? Yes No

If YES to any questions numbered 2 - 8, please contact the Exceptional Family Member Program (EFMP-M) Office at the Military Treatment Facility for assistance prior to pursuing any further relocation actions.

I certify that this information is complete and accurate to the best of my knowledge. I understand that insufficient and/or inaccurate information may affect family member travel at government expense. I understand that making a knowing and willful false official statement can be punishable by fine or imprisonment. (See U.S. Code, Title 18, Section 1001; Title 10, Section 907; Article 107 UCMJ).

Sponsor's Signature

Date