

# ANNUAL CERTIFICATE OF PHYSICAL CONDITION

## Privacy Act Statement

**Authority:** The authority to request this information is contained in 5 USC § 301 (Authorizing Forms and Regulations); 10 USC, Subtitle A, Part III, Ch. 103 (Senior ROTC).

**Principal Purpose(s):** This form is intended to inform the Naval Reserve Officers Training Corps (NROTC) unit of any changes to the student's physical condition.

**Routine Use(s):** Information you provide in this application is protected by the Privacy Act and will not be released outside the Department of Defense without your permission unless it comes within an exception to the Act or one of the routine uses in 32 CFR sect 701.112, accessible at <http://www.privacy.navy.mil>.

**Disclosure:** Failure to disclose an injury, illness, disease or physical condition could result loss of disability benefits and be the basis for administrative action, including disenrollment from the program.

## Section I: Personal Information

Last Name, First, MI:		Last 4 SSN:		Today's Date	
<input style="width: 95%;" type="text"/>		<input style="width: 95%;" type="text"/>		<input style="width: 95%;" type="text"/>	
ROTC Unit:		Rank/MIDN Class		Sex	
<input style="width: 95%;" type="text"/>		<input style="width: 95%;" type="text"/>		<input style="width: 95%;" type="text"/>	
Home Address:		Home Phone Number		Cell Phone Number	
<input style="width: 95%;" type="text"/>		<input style="width: 95%;" type="text"/>		<input style="width: 95%;" type="text"/>	
Email Address:		Height (in)	Weight (lbs)	Last Official PFA Result	Date of that PFA
<input style="width: 95%;" type="text"/>		<input style="width: 95%;" type="text"/>	<input style="width: 95%;" type="text"/>	<input style="width: 95%;" type="text"/>	<input style="width: 95%;" type="text"/>

## Section II: Medical History

Type of last physical exam    DoDMERB    MEPS    Special Duty / MTF    Sports / Private Sector   Date of Physical

Note: Sports/Private sector physicals apply only to College Program Basic Students

Since your last military physical examination have you had or been diagnosed with:	Yes	No
1. Eye trouble (to include vision loss, cataract, glaucoma, keratoconus, corneal ectasia, retinal detachment)?	<input type="radio"/>	<input type="radio"/>
2. Surgery to improve vision (PRK, LASIK, LASEC, RK, intraocular lens implant, cross linking)?	<input type="radio"/>	<input type="radio"/>
3. Color vision deficiency?	<input type="radio"/>	<input type="radio"/>
4. Ear trouble (to include perforated ear drum, tubes in ears, or other ENT surgery)?	<input type="radio"/>	<input type="radio"/>
5. Loss of balance or vertigo?	<input type="radio"/>	<input type="radio"/>
6. Hearing loss or use of a hearing aid?	<input type="radio"/>	<input type="radio"/>
7. Nose, throat, or sinus trouble (to include sinusitis, abscess, surgery on nose, sinuses or throat)?	<input type="radio"/>	<input type="radio"/>
8. Orthodontic treatment? (if "yes", include completion or projected date of completion in Section III)	<input type="radio"/>	<input type="radio"/>
9a. Tooth or gum trouble (excluding cavities)?	<input type="radio"/>	<input type="radio"/>
9b. Date of last dental exam:		
10. Breathing trouble (to include asthma, wheezing, shortness of breath, chronic cough, use of inhaler, collapsed lung)?	<input type="radio"/>	<input type="radio"/>
11. Cardiac trouble (to include chest pain, palpitations, heart valve problems, surgery, high or low blood pressure)?	<input type="radio"/>	<input type="radio"/>
12. Gastrointestinal trouble (to include celiac disease, irritable bowel syndrome, ulcer, reflux, esophagitis, gallstones, hernia, or hepatitis)?	<input type="radio"/>	<input type="radio"/>
13. Inflammatory bowel disease (to include Ulcerative colitis or Crohn's disease)?	<input type="radio"/>	<input type="radio"/>

Last Name, First, MI:

Last 4 SSN:

Today's Date

	Yes	No
	<input type="radio"/>	<input type="radio"/>
14a. Gynecologic trouble (including endometriosis, polycystic ovarian disease, abnormal pap smear)?	<input type="radio"/>	<input type="radio"/>
14b. Date of last menstrual period:		
14c. Date of Last PAP smear:		
15. Testicular or prostate trouble?	<input type="radio"/>	<input type="radio"/>
16. Orthopedic problems of the back or neck?	<input type="radio"/>	<input type="radio"/>
17. Orthopedic problems of the upper extremities (fracture, dislocation, sprain, surgery)?	<input type="radio"/>	<input type="radio"/>
18. Orthopedic problems of the lower extremities (fracture, dislocation, sprain, surgery)?	<input type="radio"/>	<input type="radio"/>
19. Vascular trouble (Raynaud's disease, blood clot or deep venous thrombosis, high blood pressure)?	<input type="radio"/>	<input type="radio"/>
20. Skin trouble (to include psoriasis, eczema, atopic dermatitis, severe acne)?	<input type="radio"/>	<input type="radio"/>
21. Prescribed systemic retinoid medications (ie: Accutane)? (List date completed or projected completion date in Section III.)	<input type="radio"/>	<input type="radio"/>
22. Blood disorders (anemia, thrombocytopenia, bleeding disorders, disorder of the spleen)?	<input type="radio"/>	<input type="radio"/>
23. Allergic reaction to food, medications, insects?	<input type="radio"/>	<input type="radio"/>
24. A positive PPD or been treated for tuberculosis?	<input type="radio"/>	<input type="radio"/>
25. Car, train, sea, or air sickness that required prescription medication or avoidance of travel?	<input type="radio"/>	<input type="radio"/>
26. Endocrine disorders (including diabetes, thyroid, osteoporosis)?	<input type="radio"/>	<input type="radio"/>
27. Head injury, memory loss, amnesia?	<input type="radio"/>	<input type="radio"/>
28. Neurologic trouble (including dizziness, fainting spell, seizure, paralysis)?	<input type="radio"/>	<input type="radio"/>
29. Frequent or severe headaches in the past 2 years?	<input type="radio"/>	<input type="radio"/>
30. Sleeping trouble (narcolepsy, sleepwalking, chronic insomnia, sleep apnea)?	<input type="radio"/>	<input type="radio"/>
31. Evaluation or treatment for depressive disorder?	<input type="radio"/>	<input type="radio"/>
32. Evaluation or treatment for anxiety disorder or panic attacks?	<input type="radio"/>	<input type="radio"/>
33. Evaluation or treatment for eating disorders (anorexia or bulimia)?	<input type="radio"/>	<input type="radio"/>
34. Evaluation or treatment for attention deficit hyperactivity disorder, attention deficit disorder, or learning disability?	<input type="radio"/>	<input type="radio"/>
35. Tumor or cancer?	<input type="radio"/>	<input type="radio"/>
36. Cold or heat injury?	<input type="radio"/>	<input type="radio"/>
37. Rhabdomyolysis?	<input type="radio"/>	<input type="radio"/>
38. A medical waiver for the PFA or PFT?	<input type="radio"/>	<input type="radio"/>
39. Have you been prescribed medications in the last 12 months? (if "yes" list names, reason, and approximate dates used in Section III)?	<input type="radio"/>	<input type="radio"/>
40. Have you EVER been hospitalized (including psychiatric)?	<input type="radio"/>	<input type="radio"/>
41. Have you EVER been rejected or discharged for military service for any reason?	<input type="radio"/>	<input type="radio"/>
42. Have you had any significant medical diagnoses or treatments not previously reported on a military physical?	<input type="radio"/>	<input type="radio"/>

Last Name, First, MI:

Last 4 SSN:

Today's Date

### Section III: Midshipman Comments

Explain all "Yes" answers to questions 1-42 above. Begin with the Item Number. Describe answer(s); provide date(s) of problem(s) / condition(s); provide names of Health Care Providers (HCPs), Clinic(s) and/or Hospital(s) along with the City and State; explain what was done (e.g., evaluation and/or treatment); and describe your current medical status (ongoing/resolved). Attach additional sheet(s) if necessary and sign and date each additional page. Obtain and attach copies of applicable medical evaluation and treatment records if requested.

I certify that the information contained in this form is true and complete to the best of my knowledge and belief.

Date Signed

### Section IV: Review

Unit Medical Representative Comments

Unit Medical Representative Signature

Date Signed

Reviewing Officer Comments (if indicated)

Review Officer Signature (if indicated)

Date Signed

If additional records requested from midshipman, provide date of request.

If referred for further medical examination, provide date of referral.

If referred to BUMED for review, provide date of referral.

### Section V: Outcome

- No further action required
- MLOA
- Waiver
- PQ