United States Army Student Detachment

Student Out-Processing (OCONUS ACCOMPANIED)

SOLDIER INFORMATION

Last Name, First Name **Rank**	**PCS Location:** **Report date:** **Requested Leave date:**
☐ **TDY Enroute Location:** **Start Date:**	**EFMP Warranted: Yes or No (circle one)**

ADMINISTRATION CHECKLIST

DOCUMENTS NEEDED IF PCSing ACCOMPANIED:

- ☐ (DA 31) Request and Authority for Leave (Leave Form)
- ☐ (DA 5121, Mar 2007) Overseas Tour Election Statement
- ☐ (DA 4036, Mar 2007) Medical and Dental Preparation for Overseas Movement
- ☐ (DA 4787, Mar 2007) Reassignment Processing
- ☐ (DA 5888, Sep 2002) Family Member Deployment Screening Sheet
- ☐ (DA 7246, Jun 2009) Exceptional Family Member Program (EFMP) Screening Questionnaire
- ☐ Family Member Overseas Screening Physical Exam Letter or (SF 506) Physical Examination
- ☐ Family Member's Verification Letter
- ☐ **(DD 2792, Apr 2011) Exceptional Family Member Medical Summary (If applicable)**
- ☐ **(DD 2792-1, Apr 2011) EFMP Special Education/Early Intervention Summary (If applicable)**
- ☐ (DA 7415) Exceptional Family Member Program (EFMP) Query Sheet

IMPORTANT: If you were issued a CAC Card Reader it must be returned prior to out-processing USASD (Within 30 days of completing your course of study/training.)

REQUIRED FORM IF TDY ENROUTE

THIS FORM MUST BE SUBMITTED IN ORDER TO PROCESS PCS ORDERS.

- ☐ TDY Option Statement

OPTIONAL FORMS

THESE ITEMS MUST BE SUBMITTED NO LESS THAN 20 WORKING DAYS PRIOR TO YOUR SIGN OUT DATE. IF FORMS ARE RECEIVED AFTER THE 20 WORKING DAYS PRIOR FORMS WILL BE RETURNED WITHOUT ACTION, IAW DFAS STANDARDS.

- ☐ PCS Advance Request Form
- ☐ DD Form 2560-Advance Pay Request

FOR USE BY USASD PERSONNEL ONLY

DATE SENT SM NOTIFICATION:	
GRAD DATE:	**SUSPENSE DATE:**
POR PACKET RECEIVED BY:	**DATE:**
DATE SENT TO EFMP:	**DATE SENT TO COUNTRY:**
REMARKS:	

REQUEST AND AUTHORITY FOR LEAVE

This form is subject to the Privacy Act of 1974. For use of this form, see AR 600-8-10.
The proponent agency is DCS, G-1. *(See instructions on reverse.)*

1. CONTROL NUMBER

PART I

2. NAME *(Last, First, Middle Initial)*	3. SSN	4. RANK	5. DATE

6. LEAVE ADDRESS *(Street, City, State, ZIP Code and Phone No.)*	7. TYPE OF LEAVE	8. ORGN, STATION, AND PHONE NO.
	☑ ORDINARY ☐ EMERGENCY ☐ PERMISSIVE TDY ☐ OTHER Permanent Change of Station Leave	USASD Fort Jackson, SC 29207 (803) 751-5540/5321

9. NUMBER DAYS LEAVE				10. DATES	
a. ACCRUED	b. REQUESTED	c. ADVANCED	d. EXCESS	a. FROM	b. TO

11. SIGNATURE OF REQUESTOR	12. SUPERVISOR RECOMMENDATION/SIGNATURE ☐ APPROVAL ☐ DISAPPROVAL	13. SIGNATURE AND TITLE OF APPROVING AUTHORITY

14. DEPARTURE		
a. DATE	b. TIME	c. NAME/TITLE/SIGNATURE OF DEPARTURE AUTHORITY

15. EXTENSION		
a. NUMBER DAYS	b. DATE APPROVED	c. NAME/TITLE/SIGNATURE OF APPROVAL AUTHORITY

16. RETURN		
a. DATE	b. TIME	c. NAME/TITLE/SIGNATURE OF RETURN AUTHORITY

17. REMARKS

Chargeable leave is from _____ to _____

PART II - EMERGENCY LEAVE TRANSPORTATION AND TRAVEL

18. You are authorized to proceed on official travel in connection with emergency leave and upon completion of your leave and travel will return to home station *(or location)* designated by military orders. You are directed to report to the Aerial Port of Embarkation *(APOE)* for onward movement to the authorized international airport designated in your travel documents. All additional travel is chargeable to leave. Do not depart the installation without reservations or tickets for authorized space required transportation. File a no-pay travel voucher with a copy of your travel documents or boarding pass within 5 working days after your return. Submit request for leave extension to your commander. The American Red Cross can assist you in notifying your commander of your request for extension of leave.

19. INSTRUCTIONS FOR SCHEDULING RETURN TRANSPORTATION:

For return military travel reservations in CONUS call the MAC Passenger Reservation Center *(PRC)*:

Should you require other assistance call PAP:

20. DEPARTED UNIT	21. ARRIVED APOD	22. ARRIVED APOE *(return only)*	23. ARRIVED HOME UNIT

24. **PART III - DEPENDENT TRAVEL AUTHORIZATION**

25. ☐ *(Space available or required cash reimbursable)* ☐ ONE WAY ☐ ROUND TRIP

☐ *(Space required)* TRANSPORTATION AUTHORIZED FOR DEPENDENTS LISTED IN BLOCK NO. 25

DEPENDENT INFORMATION

a. DEPENDENTS *(Last name, First, MI)*	b. RELATIONSHIP	c. DATES OF BIRTH *(Children)*	d. PASSPORT NUMBER

PART IV - AUTHENTICATION FOR TRAVEL AUTHORIZATION

26. DESIGNATION AND LOCATION OF HEADQUARTERS	27. ACCOUNTING CITATION

28. DATE ISSUED	29. TRAVEL ORDER NUMBER	30. ORDER AUTHORIZING OFFICIAL *(Title and signature)* OR AUTHENTICATION

REQUEST AND AUTHORITY FOR LEAVE

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1. CONTROL NUMBER

PART I

2. NAME *(Last, First, Middle Initial)*	3. SSN	4. RANK	5. DATE

6. LEAVE ADDRESS *(Street, City, State, ZIP Code and Phone No.)*	7. TYPE OF LEAVE	8. ORGN, STATION, AND PHONE NO.
	☑ ORDINARY ☐ EMERGENCY ☑ PERMISSIVE TDY ☐ OTHER Permanent Change of Station Leave	USASD Fort Jackson, SC 29207 (803) 751-5540/5321

9. NUMBER DAYS LEAVE				10. DATES	
a. ACCRUED	b. REQUESTED	c. ADVANCED	d. EXCESS	a. FROM	b. TO

11. SIGNATURE OF REQUESTOR	12. SUPERVISOR RECOMMENDATION/SIGNATURE ☐ APPROVAL ☐ DISAPPROVAL	13. SIGNATURE AND TITLE OF APPROVING AUTHORITY

14. DEPARTURE		
a. DATE	b. TIME	c. NAME/TITLE/SIGNATURE OF DEPARTURE AUTHORITY

15. EXTENSION		
a. NUMBER DAYS	b. DATE APPROVED	c. NAME/TITLE/SIGNATURE OF APPROVAL AUTHORITY

16. RETURN		
a. DATE	b. TIME	c. NAME/TITLE/SIGNATURE OF RETURN AUTHORITY

17. REMARKS

"I understand that this absence is not directed by any official of the U.S. Government. I further understand that I cannot conduct public business under this authorization. Accordingly, I will not be entitled to reimbursement for travel, per diem, or any other expenses. I understand that I have the right to cancel it at any time and return to my regular place of duty".

Chargeable leave is from _____ to _____

PART II - EMERGENCY LEAVE TRANSPORTATION AND TRAVEL

18. You are authorized to proceed on official travel in connection with emergency leave and upon completion of your leave and travel will return to home station *(or location)* designated by military orders. You are directed to report to the Aerial Port of Embarkation *(APOE)* for onward movement to the authorized international airport designated in your travel documents. All additional travel is chargeable to leave. Do not depart the installation without reservations or tickets for authorized space required transportation. File a no-pay travel voucher with a copy of your travel documents or boarding pass within 5 working days after your return. Submit request for leave extension to your commander. The American Red Cross can assist you in notifying your commander of your request for extension of leave.

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20. DEPARTED UNIT	21. ARRIVED APOD	22. ARRIVED APOE *(return only)*	23. ARRIVED HOME UNIT

24. **PART III - DEPENDENT TRAVEL AUTHORIZATION**

25. ☐ *(Space available or required cash reimbursable)* ☐ ONE WAY ☐ ROUND TRIP

☐ *(Space required)* TRANSPORTATION AUTHORIZED FOR DEPENDENTS LISTED IN BLOCK NO. 25

DEPENDENT INFORMATION

a. DEPENDENTS *(Last name, First, MI)*	b. RELATIONSHIP	c. DATES OF BIRTH *(Children)*	d. PASSPORT NUMBER

PART IV - AUTHENTICATION FOR TRAVEL AUTHORIZATION

26. DESIGNATION AND LOCATION OF HEADQUARTERS	27. ACCOUNTING CITATION

28. DATE ISSUED	29. TRAVEL ORDER NUMBER	30. ORDER AUTHORIZING OFFICIAL *(Title and signature)* OR AUTHENTICATION

PRIVACY ACT STATEMENT	
AUTHORITY:	Title 5, USC, Section 301.
PRINCIPAL PURPOSE(S):	To authorize military leave, document start and stop of such leave; record address and telephone number where a Soldier may be contacted in case of an emergency during leave; and certify leave days chargeable to a Soldier's leave account.
ROUTINE USES:	To update a Soldier's military leave and pay records. Information furnished may be disclosed to DOD officials or employees who need this information to perform their duties; to federal, state, and local law enforcement authorities in appropriate cases; the American Red Cross; and relatives. The social security number is used for positive identification.
DISCLOSURE:	Voluntary. Disclosure of SSN is voluntary. However, this form will not be processed without a Soldier's SSN, since the Army identifies members by SSN for pay or leave purposes.

INSTRUCTIONS TO INDIVIDUAL

1. AUTHORITY FOR LEAVE. A Soldier on leave must carry this form while on leave.

2. CHANGES. A Soldier who desires changes in authorized leave or does not begin leave on schedule will notify commander.

3. REPORTING. A Soldier will report to duty station not later than 2400 on the last day of leave *(block 10b) (even if PCS orders contain a later reporting date)*.

4. DEPARTURE/RETURN. A Soldier will begin and end leave on post, at the duty location, or from the place he or she regularly commutes to work.

5. CHARGEABLE LEAVE. If a Soldier works over one-half of the normally scheduled working hours on the day of his or her departure or return, that day is not a chargeable leave day. *(Soldier's commander may authorize early departure or late arrival.)* If he or she returns on a normally scheduled nonduty day, that day is not chargeable to leave.

6. TRAVEL EXPENSES. A Soldier on leave pays for all his or her travel expenses, to include return to duty station. He or she must have sufficient funds to pay all expenses. A Soldier without sufficient funds to return to duty station reports to the nearest military installation.

7. LEAVE EXTENSIONS. A Soldier must request leave extension prior to end of leave.

a. If disapproved, 3 above applies.

b. If approved, complete block 15a - 15c. Attach written notification of extension when received.

8. LOST OR DESTROYED LEAVE FORM EN ROUTE PCS. Request a reconstructed form from the losing station. Continue with required travel and reporting dates.

9. CASUAL PAY. A Soldier who needs a casual pay while on leave should contact the servicing FAO for information and assistance.

10. MEDICAL TREATMENT.

a. A Soldier who requires medical treatment while on leave, report to the nearest military medical facility. In the absence of such a facility, report to a uniformed services treatment facility or Veteran's Administration facility, if possible.

b. Medical treatment at Government expense at other than federal facilities is authorized only for emergencies when treatment cannot be obtained from Government facilities or when prior approval is obtained.

c. If a Soldier becomes hospitalized by a civilian physician, the Soldier or someone acting for him or her contact the Patient Administration Office of the nearest military medical facility as soon as possible. A Soldier may seek assistance from the nearest U.S. Army recruiting station or local chapter of the American Red Cross. Information provided must include nature of illness or injury, date and place of hospitalization, and name and telephone number of attending physician.

d. If a Soldier is placed sick-in-quarters by a civilian physician he or she will --

(1) Contact the Patient Administration Office of the nearest military medical facility.

(2) Obtain written statement from attending physician *(military or civilian)* verifying condition and including dates of treatment. Provide statement to leave approving authority upon return to duty.

OVERSEAS TOUR ELECTION STATEMENT

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

PRIVACY ACT STATEMENT

Authority:	Title 10, USC, Sections 3010, 8012 and 5031, and Title 5, USC, Section 301.
Principal Purpose:	For personnel service support.
Routine Uses:	(1) To conduct initial screening of reassignment cycle to determine soldier's eligibility to comply; and (2) basis for initiating specific assignment processing *(deletion/deferments; additional service; or any other special processing required).*
Disclosure:	Disclosure of information is voluntary. However, failure to disclose this data may result in unnecessary hardship on the soldier and/or family members. Failure to disclose data will not automatically exempt soldier from selected reassigment.

INSTRUCTIONS: Prepare this form in two copies. Place the original in the Action Pending section of the soldier's MPRJ and place the copy in the soldier's Reassignment File.

1. NAME	2. SSN	3. GRADE/RANK

4. FOR ALL SOLDIERS

Having been advised that I am scheduled for a permanent change of station assignment _____

_____ , I understand that I must elect to serve either an "all others" or a "with dependents" tour.

If I elect to serve the "all others" tour, I understand that Government transportation of my family members to or from my overseas duty station will not be authorized during the tour. I also understand that if my family members travel at their own expense to reside at or near the area of my assignment *(except for a visit for a period not exceeding 3 continuous months),* I will no longer be entitled to Family Separation Allowance. I also understand that under this tour election, I am authorized movement of my family members to a designated location at Government expense. However, after my family members make a move to a designated location at Government expense, I cannot request to change my tour to the "with dependents" tour in order to request movement of my family members to my overseas area unless extreme personal problems arise which are fully documented.

AND

If I elect to serve the "with dependents" tour, I understand I am not authorized to move my family members and/or household goods to a designated location in CONUS. I understand that I must apply promptly for concurrent travel of my family members in order to receive Family Separation Allowance in the event concurrent travel is not approved. I understand that, if concurrent/deferred travel is not approved, I may apply for nonconcurrent travel for my family members after I arrive in my overseas area, if I am able to obtain suitable quarters, or I may elect to have my family members remain in CONUS. I understand I must have sufficient remaining service to complete the "with dependents" tour length requirements upon my arrival in the overseas area. If not, I will be required to serve an "all others" tour and will not be entitled to Government transportation of my family members to my overseas duty station.

5. FOR INVOLUNTARY EXTENSION

I further understand that I will be involuntarily extended in the overseas command if:

I am an obligated volunteer officer *(OBV)* and do not wish to extend my Active Duty Service Obligation and the end date of my ADSO follows my date eligible for return from overseas *(DEROS)* within 11 months *(long tour area)* or six months *(short tour area).*

I will be returned to the continental U.S. *(CONUS)* transition point in sufficient time to process my separation. To be reassigned to CONUS at my normal DEROS, I must be eligible for and take action to acquire sufficient service to have the required months remaining at DEROS.

6. FOR ALL ARMY SOLDIERS MARRIED TO OTHER ARMY SOLDIERS

I have been briefed and understand the joint domicile requirements.

7. FOR USAR OBV OFFICERS

I understand that if I currently have insufficient remaining service to complete the "with dependents" tour, that by electing the "with dependents" option below, I am concurrently volunteering herewith to extend my ADSO until completion of the prescribed tour.

8. FOR ALL SOLDIERS

Regarding my option to elect either the "all others" or the "with dependents" tour, I choose the following actions, to include any additional involuntary extended time in the overseas command.

a. ☐ I elect to serve a tour for a period_____ months in an "all others" status.

b. ☐ I elect to serve a tour for a period_____ months in an "with dependents" status.

9. SIGNATURE OF SOLDIER	10A. SIGNATURE OF WITNESS	8. DATE *(YYYYMMDD)*

MEDICAL AND DENTAL PREPARATION FOR OVERSEAS MOVEMENT

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

PRIVACY ACT STATEMENT

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

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

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

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

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

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

NAME	NAME

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

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

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

MEDICAL STATUS

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

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

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

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

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

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

YES	NO		
		24A. Is the member dentally qualified?	B. IF "NO", BRIEFLY EXPLAIN. IF CONDITION IS TEMPORARY, EXPECTED DATE THE MEMBER WILL BE ELIGIBLE FOR ASSIGNMENT
		25A. Does the member require remedial dental care?	B. IF "YES", INDICATE DATE, TIME, AND LOCATION OF APPOINTMENT
		21A. If item 10 is checked "yes", can the member be assigned to an area where dental facilities are limited or nonexistent?	B. IF "YES", THE MEMBER *(and family members, if applicable)* MUST BE SCHEDULED FOR A FOLLOW-UP EVALUATION OF MEDICAL STATUS WITHIN 30 CALENDAR DAYS OF THE ANTICIPATED DATE OF LOSS *(Item 9)*. INDICATE DATE, TIME, AND LOCATION OF APPOINTMENT(S)

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

REASSIGNMENT PROCESSING

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

PRIVACY ACT STATEMENT

Authority: Title 10, USC, Sections 3010, 8012, and 5031; Title 5, USC, Section 301; and EO 9397 *(SSN)*.

Principal Purpose: To make assignment decisions, evaluate family member travel to overseas commands and assign family housing.

Routine Uses: General disclosures permitted by the Privacy Act and the Army's systems of records notices apply.

Disclosure: Disclosure of information is voluntary. If the information is not provided, commanders will not be aware of family member travel and housing requests, and will result in no government travel and housing for family members.

PART A - PERSONNEL AND ASSIGNMENT MANAGEMENT DATA *(To be Completed by Losing MPD/PSC)*

1. TO	2. FROM		
3. NAME *(Last, Middle, First)*	4. SSN	5. GRADE	6. PMOS
6A. CURRENT UNIT/STATION	7A. REASSIGNED TO *(Unit/UIC/APO/Country)*		
6B. TELEPHONE NO. *(Include Area Code)*	7B. RSG AUTH	7C. PERS CON NO.	7D. REPORT DATE *(YYYYMMDD)*
6C. AKO EMAIL ADDRESS			

8. TDY Enroute *(Complete only if applicable)*

A. MOS/SSI/SQI/ASI	B. PURPOSE OF TDY	C. GRAD/TERM. DATE *(YYYYMMDD)*

9. Married Army Couples Program ***(Complete only if joint domicile will be requested)***

9A. NAME OF MILITARY SPOUSE	9B. SSN	9C. GRADE	9D. PMOS
9E. CURRENT UNIT/STATION		9F. TELEPHONE NO. *(Include Area Code)*	

PART B - HOUSING AND FAMILY TRAVEL DATA

10. I do ☐ do not ☐ have family members with physical, emotional, developmental or intellectual problems.

11. ☐ I am a sole parent. *(Check only if applicable)*

12. Application for Family Member Travel to Overseas Command ***(Check only one)***

a. ☐ I desire concurrent travel and will accept economy quarters if government quarters are not available.

b. ☐ I desire concurrent travel but will not accept economy quarters.

13. Family Members Who Will Travel to Next Permanent Duty Station ***(If more space is needed, continue on a separate sheet.)***

A. NAME *(Last, First, MI)*	B. RELATIONSHIP	C. SEX	D. DATE OF BIRTH *(YYYYMMDD)*	E. CITIZENSHIP

14. ANY RELATIVE IN GAINING OVERSEAS AREA WHERE FAMILY MEMBERS MAY RESIDE PENDING AVAILABILITY OF HOUSING AT OR NEAR DUTY STATION *(Include name, relationship, address and phone number).*

15A. ADDRESS WHERE MY FAMILY IS CURRENTLY LOCATED	16A. ADDRESS WHERE MY FAMILY MAY BE CONTACTED WHILE ON LEAVE
15B. TELEPHONE NO. *(Include Area Code)*	16B. TELEPHONE NO. *(Include Area Code)*

17. The soldier is administratively qualified and available for assignment. Control sheets/forms prescribed by the regulation *(or their equivalents)* have been completed. A request for deletion or deferment is ☐ anticipated ☐ not anticipated.

17A. SOLDIER'S SIGNATURE	17B. MPD/PSC OFFICIAL'S SIGNATURE	17C. REASSIGNMENT WORK CENTER EMAIL ADDRESS *(Agency Specific)*	17D. DATE *(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

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 1986, 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

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
	HOME ADDRESS	DUTY ADDRESS
PROJECTED PCS DATE		

LIST ALL FAMILY MEMBERS	FAMILY MEMBER PREFIX	SEX	DATE OF BIRTH *(YYYYMMDD)*	CHECK IF ENROLLED IN EFMP
				☐
				☐
				☐
				☐
				☐

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 ☐

4. Are any family members, excluding service member, taking any prescribed medication other than birth control pills on a regular basis? YES ☐ NO ☐

NAME	PRESCRIBED MEDICATION

5. In the past five *(5)* years, have any members of your family, excluding service member, been treated for, or had any problems related to any of the following? *(You will have an opportunity to discuss all "YES" answers with a screener.)*

		YES	NO			YES	NO
a.	Problems with sight *(other than corrected by glasses)*	☐	☐	g.	Asthma, allergies or other respiratory problems	☐	☐
b.	Problems with hearing	☐	☐	h.	Cerebral Palsy	☐	☐
c.	Heart condition	☐	☐	i.	Delayed Speech	☐	☐
d.	Seizure disorder	☐	☐	j.	Sickle Cell Trait/Disease	☐	☐
e.	Loss of mobility *(requiring use of a wheelchair/ walker or aid in mobility)*	☐	☐	k.	Cancer	☐	☐
				l.	High blood pressure	☐	☐
f.	Diabetes	☐	☐	m.	Other, if yes, explain	☐	☐

MENTAL HEALTH:

6. In the past five *(5)* years, have any members of your family, excluding service member, been treated for, or had any problems related to any of the following? *(You will have an opportunity to discuss all "YES" answers with a screener.)*

		YES	NO			YES	NO
a.	Referral to, diagnosed by, or therapy with a Psychiatrist, Psychologist, or Social Worker in reference to a mental health problem	☐	☐	d.	Alcohol and drug use or abuse	☐	☐
				e.	Emotional problems	☐	☐
b.	Depression	☐	☐	f.	Behavioral problems/acting out behavior	☐	☐
c.	Suicidal thoughts/ideas, gestures, attempts	☐	☐	g.	Received therapy *(marital, family, individual or group counseling)*	☐	☐

7. Have any members of your family, excluding service member, been in any of the following? Inpatient Psychiatric Facility, Residential Treatment Center, Group Homes, Day Treatment Centers, Drug and Alcohol Treatment Rehabilitation Center. If Yes, please explain: YES ☐ NO ☐

EDUCATION

8. Do any of your children now have, or have they ever had, any of the following?

		YES	NO			YES	NO
a.	Slow development *(infants and preschoolers)*	☐	☐	d.	Counseling services for school-related problems	☐	☐
b.	Learning problems *(school)*	☐	☐				
c.	Special services *(i.e., OT, PT, Speech, etc.)* for special education	☐	☐	e.	Mental retardation	☐	☐

9. Are any of your children receiving Special Education help in school *(not in regular class placement and on an Individual Education Plan (IEP))*? If yes, who? YES ☐ NO ☐

According to AR 608-75, Exceptional Family Member Program, soldiers will provide accurate information as required when requested to do so by Army officials. Knowingly providing false information in this regard may be the basis for disciplinary or administrative action. For soldiers, refusal to provide information may preclude successful processing of an application for family travel or command sponsorship.

Commanders will take appropriate action against soldiers who knowingly provide false information, or who knowingly fail or refuse to enroll family members that meet the criteria for enrollment. *(A false official statement is a violation of Article 107, Uniform Code of Military Justice (UCMJ).)* These actions will include, at a minimum, a general officer letter of reprimand.

All the above information is true and correct to the best of my knowledge. I understand that it is my responsibility to provide any information about changes in medical or educational status for all members of my family, after the date indicated below, and prior to PCS move.

PRINTED NAME OF MILITARY SPONSOR OR SPOUSE COMPLETING THIS FORM	SIGNATURE OF MILITARY SPONSOR OR SPOUSE COMPLETING THIS FORM	DATE *(YYYYMMDD)*
PRINTED NAME OF PHYSICIAN OR MEDICAL PRACTITIONER IF UNDER THE SUPERVISION OF A PHYSICIAN	SIGNATURE OF PHYSICIAN OR MEDICAL PRACTITIONER IF UNDER THE SUPERVISION OF A PHYSICIAN	DATE *(YYYYMMDD)*

MEDICAL RECORD	PHYSICAL EXAMINATION					
DATE OF EXAM	HEIGHT	WEIGHT			TEMPERATURE	PULSE	BLOOD PRESSURE
		AVERAGE	MAXIMUM	PRESENT			

INSTRUCTIONS - Describe (1) General Appearance and Mental Status; (2) Head and Neck (General); (3) Eyes; (4) Ears; (5) Nose; (6) Mouth; (7) Throat; (8) Teeth; (9) Check (General); (10) Breast; (11) Lungs; (12) Cardiovascular; (13) Abdomen; (14) Hemmia; (15) Genitalia; (16) Pelvic; (17) Rectal; (18) Prostate; (19) Back; (20) Extremities; (21) Neurological; (22) Skin; (23) Lymphatics.

(Continue on reverse side)

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME			SPONSOR'S ID NUMBER *(SSN or Other)*
	LAST	FIRST	MI	

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

PATIENT'S IDENTIFICATION: *(For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade.)*	REGISTER NO.	WARD NO.

PHYSICAL EXAMINATION
Medical Record

STANDARD FORM 506 (REV. 2-99)
Prescribed by GSA/ICMR FPMR (41 CFR) 101-11.203(b)(10)
USAPA V1.00

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

PHYSICAL EXAMINATION

INITIAL IMPRESSION

SIGNATURE OF PHYSICIAN	NAME OF PHYSICIAN

DEPARTMENT OF THE ARMY
UNITED STATES ARMY STUDENT DETACHMENT
5450 Strom Thurmond Boulevard Room 244
Fort Jackson, South Carolina 29207

FAMILY MEMBER'S VERIFICATION LETTER

DATE: _____

Soldier/Soldier's spouse has full legal custody of the following named family members:

Name: _____ DOB: _____

Name: _____ DOB: _____

Name: _____ DOB: _____

Name: _____ DOB: _____

Name: _____ DOB: _____

Name: _____ DOB: _____

Name (Print):_____

Signature: _____

NOTE:
A soldier who has step-children, divorced with children who reside with the natural mother/father or sole parent(s) must have full legal custody of family member(s) for family travel. Soldier having legal documentation stating custody settlement, a copy of the document(s) is/are required. If there are no legal documents awarding custody, the family member's verification form is required.

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.

The addenda to the medical summary are completed only if noted in Item 10 of the Demographics/Certification section (p.3).

The Exceptional Family Member Program (EFMP)/ Special Needs Identification and Clearance (SNIAC) Screening Coordinator and the Parent/Guardian or Person of Majority Age sign Items 6.b and 13.b only after all addenda have been completed and the form reviewed for completeness and accuracy.

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. 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).

Items 1. Self-explanatory.

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

Item 2.b. Self-explanatory.

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

Items 2.d. - i. Self-explanatory.

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

Item 4.a. Answer Yes if both spouses are on active duty; otherwise answer No.
If Yes, complete Items 4.b. - e. All items refer to the active duty spouse. Self-explanatory.

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

Item 6.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 forms are completed and attached before signing.**

Item 7. Purpose for Completing the Form (X one). Initial Screening Enrollment - Review of medical history for the family member noted for the purpose of determining eligibility for EFMP. Request for government sponsored travel and/or command sponsorship review of projected location(s). Update to previous evaluation for the family member. Qualifies for a change in EFMP status. Used to disenroll an EFMP when he/she no longer has the medical condition that requires enrollment, or when the EFM no longer qualifies as a dependent.

Item 8. Indicate status of medical condition.

Item 9.a. If yes, complete b. - c.

Item 10. Required Addenda. This addendum is completed only if applicable to the patient described. Indicate in block 1 Yes or No. If Yes, proceed with addendum and sign. If No, do not complete addendum. **SIGNATURE of Qualified Medical Provider is REQUIRED.** Each Military Service may additionally indicate need to complete addenda in item 10, page 3, when determining the purpose of completing this form and may be completed by a different provider than pages 4 - 7, if necessary.

Items 11.a. - h. Mark (X) all services being provided to the family member.

Item 12.a. Additional Family Member. Answer Yes if there is any member of the family, not including this patient, who has been identified as having special needs.

Item 12.b. Indicate the number of other family members who have been identified as an EFM. **Do not include the individual named in this summary in the count of family members.**

Items 13.a. - e. EFMP/SNIAC/Screening Coordinator or Advisor name, signature, date, facility address, telephone number. Self-explanatory. **Coordinator must ensure that all forms are complete and attached before signing.**

Item 13.f. This area is reserved for Service-specific guidance to validate the form.

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.

Item 1.a. - c. Pertains to children under 6 years of age. Self-explanatory.

Items 2.a. - d. Temporary Conditions. Self-explanatory.

Item 3.a. Diagnosis. Enter the diagnosis(es), one per line. With the exception of asthma, cancer or mental health, identify all diagnoses that have been active within the last year. For asthma, cancer or mental health, identify all diagnoses active within the last 5 years.

Item 3.b. ICD or DSM. Enter ICD-9-CM or DSM IV designations. **REQUIRED.**

Item 3.c. Medications and Therapies. Self-explanatory. Additional information may be included in item 11 if more space is required.

Item 3.d. Enter per diagnosis the number of outpatient visits, ER visits, hospitalizations and ICU admissions for the last 12 months.

Item 4. Prognosis. Self-explanatory. Additional information may be included in item 11 if more space is required.

Item 5. Treatment Plan. Self-explanatory. Additional information may be included in item 11 if more space is required.

Item 6. Cancer. Self-explanatory.

Item 7. Minimum Health Care Specialty. Codes in the first column are used by Army coding teams only. In column 1, indicate with an X those specialists essential (required) to meet the needs of the patient. For example, if a developmental pediatrician is a child's primary care provider, but a pediatrician can meet the needs, do not mark developmental pediatrician. In column 2, indicate frequency of care. Enter A - Annually; B - Biannually; Q - Quarterly; M - Monthly; Bi - Bimonthly; W - Weekly.

Item 8 - Artificial Openings. Self-explanatory.

Item 9 - Environmental/Architectural Considerations. Self-explanatory.

Item 10. Adaptive Equipment/Special Medical Equipment. Self-explanatory.

Item 11. Comments. Enter any additional information that would assist in determining necessary treatment.

Item 12.a. - f. Provider Information. Official Stamp or printed name and signature of the provider completing this summary, and the date the summary was signed. Self-explanatory.

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. Indicate in block 1 Yes or No. If Yes, proceed with addendum and sign. If No, do not complete addendum . **SIGNATURE of Qualified Medical Provider is REQUIRED.** Each military Service may additionally indicate need to complete addenda in item 10, page 3, when determining the purpose of completing this form and may be completed by a different provider than pages 4 - 7, if necessary.

Item 1. Self-explanatory.

Items 2.a.- d. Self-explanatory.

Items 3.a.- k. Self-explanatory.

Items 4.a. - f. Self-explanatory.

Items 5.a. - d. Self-explanatory.

Items 6.a. - f. Provider Information. Official Stamp or printed name and signature of the provider completing this summary, and date the summary was signed. Self-explanatory.

ADDENDUM 2 - MENTAL HEALTH SUMMARY (pp. 9 - 10). To be completed by a qualified clinical provider.

This addendum is completed only if applicable to the patient described. Indicate in block 1 Yes or No. If Yes, proceed with addendum and sign. If No, do not complete addendum . **SIGNATURE of Qualified Medical Provider is REQUIRED.** Each military Service may additionally indicate need to complete addenda in item 10, page 3, when determining the purpose of completing this form and may be completed by a different provider than pages 4 - 7, if necessary.

Item 1. Self-explanatory.

Items 2.a. - d. Self-explanatory. Item 2.b. ICD or DSM is **REQUIRED.**

Item 3. Self-explanatory.

Item 4.a. - i. History. Self-explanatory.

Item 5. Prognosis. Self-explanatory. Additional information may be included in Item 9 if more space is required.

Item 6. Treatment Plan. Self-explanatory. Additional information may be included in Item 9 if more space is required.

Item 7. Expected treatment needs within the next year. Mark only one box considering all diagnoses. Self-explanatory.

Item 8. Required Providers and Frequency of Visits. Mark all providers who are required to implement the treatment plan.

Item 9. Comments. Enter any additional information that would assist in determining necessary treatment.

Items 10.a - f. Provider Information. Official Stamp or printed name and signature of the provider completing this summary, and date the summary was signed. Self-explanatory.

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. Indicate in block 1 Yes or No. If Yes, proceed with addendum and sign. If No, do not complete addendum . **SIGNATURE of Qualified Medical Provider is REQUIRED.** Each military Service may additionally indicate need to complete addenda in item 10, page 3, when determining the purpose of completing this form and may be completed by a different provider than pages 4 - 7, if necessary.

Item 1. Self-explanatory.

Items 2.a.- b. Diagnosis(es). Self-explanatory.

Items 3. Self-explanatory.

Item 4. Coexisting Diagnoses. Indicate coexisting diagnosis.

Item 5. Current Medications. Self-explanatory.

Item 6. Current Interventions/Therapies. Indicate current interventions/therapies, if known.

Item 7. Communication. Self-explanatory.

Item 8. Other Interventions/Theraples Used by the Family. Specify any alternate or complementary therapies used.

Item 9. Behavior. Answer yes if the child exhibits high risk or dangerous behaviors. Additional information may be included in item 14 if more space is required.

Item 10. Cognitive Ability. Indicate appropriate intelligence quotient (IQ), if known.

Item 11. Education. Self-explanatory.

Item 12. Required Medical Services. Self-explanatory.

Item 13. Respite Care Received. Provide the number of hours per month, and the source, e.g., EFMP Respite Care Program, ECHO or Medicaid.

Item 14. General Comments. Self-explanatory.

Item 15. Provider Information. Official Stamp or printed name and signature of the provider completing this summary and date the summary was signed. 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 Mar 31, 2014

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://privacy.defense.gov/notices.

ROUTINE USE(S): The DoD "Blanket Routine Uses" found at http://privacy.defense.gov/blanket_uses.shtml apply.

DISCLOSURE: Voluntary for civilian employees and applicants for civilian employment.
Mandatory for military personnel: failiure 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 noted 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 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, 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.
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/Special Needs 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.

e. Failure to release this information or any subsequent revocation may result in ineligibility for community based services, and/or 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 *(If applicable)*	DATE *(YYYYMMDD)*

DEMOGRAPHICS/CERTIFICATION: To be completed by the Sponsor, Parent or Guardian, or Patient

1. PURPOSE OF THIS FORM *(X one)*

- ☐ EFMP REGISTRATION/ENROLLMENT UPDATE
- ☐ REQUEST CHANGE IN EFMP STATUS
- ☐ SUMMARIZE MEDICAL INFORMATION FOR OFFICIAL USES
- ☐ NO LONGER HAVE PREVIOUSLY IDENTIFIED CONDITION
- ☐ FAMILY MEMBER DECEASED*
- ☐ REQUEST FOR GOVERNMENT SPONSORED TRAVEL AND/OR COMMAND SPONSORSHIP
- ☐ NO LONGER QUALIFIES AS A DEPENDENT*
- ☐ DIVORCE/CHANGE IN CUSTODY*
- ☐ OTHER *(Explain)*:

*(*Maintain 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. FAMILY MEMBER PREFIX (FMP)	d. SPONSOR SSN

e. FAMILY MEMBER GENDER *(X)*	f. FAMILY MEMBER DATE OF BIRTH *(YYYYMMDD)*	g. CURRENT FAMILY MEMBER MAILING ADDRESS *(Street, Apartment Number, City, State, ZIP Code, APO/FPO)*
☐ MALE ☐ FEMALE		
h. HOME TELEPHONE NUMBER *(Include Area Code/Country Code)*	i. 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)*
☐ ARMY ☐ AIR FORCE	☐ REGULAR ACTIVE SERVICE MEMBER ☐ RESERVIST ☐ CIVILIAN
☐ NAVY ☐ MARINE CORPS	☐ ACTIVE GUARD RESERVE PROGRAM (AGR) ☐ NATIONAL GUARD

f. SPONSOR'S CURRENT UNIT MAILING ADDRESS

g. SPONSOR'S OFFICIAL E-MAIL ADDRESS	h. DUTY TELEPHONE NUMBER *(Include Area Code/CountryCode)*	i. MOBILE NUMBER *(Include Area Code/Country Code)*

j. DOES FAMILY MEMBER RESIDE WITH SPONSOR *(X one. If No, explain.)*

- ☐ YES
- ☐ NO

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

	b. ACTIVE DUTY SPOUSE'S NAME *(Last, First, Middle Initial)*	c. BRANCH OF SERVICE	d. RANK/RATE	e. SPOUSE SSN
☐ YES ☐ NO				

5.a. IS FAMILY MEMBER ENROLLED IN DEERS UNDER A DIFFERENT SPONSOR'S NAME? *(Military only) (X one)*

	b. IF YES, UNDER WHAT SSN	c. NAME OF SPONSOR *(Last, First, Middle Initial)*	d. BRANCH OF SERVICE
☐ YES ☐ NO			

6. CERTIFICATION. **DO NOT CERTIFY BEFORE COMPLETING ENTIRE FORM AND ADDENDA.**

By signing below, we certify that the information submitted on this DD Form 2792 (Medical Summary and the addenda checked below) is complete and accurate.

PARENT/GUARDIAN OR PERSON OF MAJORITY AGE:

a. PRINTED NAME	b. SIGNATURE	c. DATE *(YYYYMMDD)*

FAMILY MEMBER/PATIENT NAME	SPONSOR NAME	FAMILY MEMBER PREFIX	SPONSOR SSN

FOR ADMINISTRATIVE USE ONLY

7. REQUIRED ACTIONS *(X one)*

- ☐ FIRST REVIEW OF MEDICAL HISTORY FOR THE FAMILY MEMBER
- ☐ REQUEST FOR GOVERNMENT SPONSORED TRAVEL AND/OR COMMAND SPONSORSHIP - REVIEW PROJECTED LOCATION(S)
- ☐ UPDATE TO A PREVIOUS EVALUATION FOR THE FAMILY MEMBER
- ☐ OTHER *(e.g., Extended Care Health Option Eligibility)*:

☐ QUALIFIES FOR CHANGE IN EFMP STATUS:

- ☐ FAMILY MEMBER NO LONGER HAS PREVIOUSLY IDENTIFIED CONDITION
- ☐ FAMILY MEMBER NO LONGER QUALIFIES AS A DEPENDENT*
- ☐ FAMILY MEMBER DECEASED*
- ☐ DIVORCE/CHANGE IN CUSTODY*

*(*Maintain documentation to verify change in status - do not update medical information.)*

8. SUMMARY *(X one)*

☐ ONGOING MEDICAL CONDITIONS ☐ TEMPORARY MEDICAL CONDITIONS ☐ BOTH

9.a. DOES THIS FAMILY MEMBER RECEIVE CASE MANAGEMENT SERVICES? *(X one)*

☐ YES ☐ NO *(If Yes, complete 9.b. and c.)*

b. LOCATION OF CASE MANAGER *(X)* ☐ MTF ☐ TRICARE ☐ CIVILIAN

c. CASE MANAGER CONTACT INFORMATION

(1) NAME *(Last, First, Middle Initial)*	(2) TELEPHONE NUMBER *(Include Area Code/Country Code)*	(3) ADDRESS *(Include ZIP Code or APO/FPO)*

10. REQUIRED ADDENDA. Complete Item 1 on Addendum 1 (page 8) and item 1 on Addendum 2 (page 9) and item 1 on Addendum 3 (page 11) AND X box below if:

- ☐ ASTHMA ADDENDUM 1 IS REQUIRED AND ☐ ATTACHED
- ☐ MENTAL HEALTH SUMMARY ADDENDUM 2 IS REQUIRED AND ☐ ATTACHED
- ☐ AUTISM SPECTRUM DISORDER/DEVELOPMENTAL DELAY ADDENDUM 3 IS REQUIRED AND ☐ ATTACHED

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

- ☐ a. POSSIBLE SPECIAL EDUCATION/EARLY INTERVENTION *(If marked, DD Form 2792-1 must be completed)*
- ☐ b. RECEIVING TRICARE EXTENDED CARE HEALTH OPTION (ECHO) BENEFITS
- ☐ c. RECEIVING SUPPLEMENTAL SOCIAL SECURITY INCOME (SSI) FROM THE SOCIAL SECURITY ADMINISTRATION
- ☐ d. RECEIVING SOCIAL SECURITY DISABILITY INSURANCE (SSDI) FROM THE SOCIAL SECURITY ADMINISTRATION
- ☐ e. RECEIVING STATE MEDICAID OR MEDICARE WAIVER SERVICES
- ☐ f. RECEIVING VOCATIONAL REHABILITATION SERVICES
- ☐ g. RECEIVING SPECIAL CHILD CARE ACCOMMODATIONS
- ☐ h. OTHER *(Specify)*

12.a. ARE THERE OTHER EFMP MEMBERS IN THE FAMILY *(Not including this family member)*?

☐ YES ☐ NO b. IF YES, HOW MANY? _____

13. ADMINISTRATIVE CERTIFICATION

a. PRINTED NAME *(Last, First, Middle Initial)*	b. TITLE	c. SIGNATURE	d. DATE *(YYYYMMDD)*

e. FACILITY ADDRESS *(Include ZIP Code or APO/FPO)*	f. TELEPHONE NUMBER *(Include area code/Country Code)*	g. OFFICIAL STAMP

FAMILY MEMBER/PATIENT NAME	SPONSOR NAME	FAMILY MEMBER PREFIX	SPONSOR SSN

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)*

1. FOR CHILDREN UNDER AGE 6 ONLY

a. IF PATIENT IS LESS THAN 12 MONTHS OLD, WAS IT A PREMATURE BIRTH? *(X one)*

☐ YES ☐ NO

b. DATE OF LAST WELL-CHILD EXAMINATION *(YYYYMMDD)*

c. WERE ALL DEVELOPMENTAL MILESTONES WITHIN NORMAL LIMITS? *(X one. If No, please explain.)*

☐ YES ☐ NO

2. TEMPORARY CONDITIONS THAT MAY IMPACT TRAVEL CONSIDERATIONS IN THE NEXT YEAR

a. DIAGNOSIS	b. ICD OR DSM REQUIRED	c. MEDICATIONS AND SPECIAL THERAPIES

d. TIME FRAME *(Explain anticipated duration of temporary condition and identify any limitations for activities of daily living and travel limitations.)*

3. DIAGNOSIS(ES) Please complete as accurately as possible using ICD-9-CM or DSM IV Use item 11 (Comments) if more space is needed.

If Asthma or RAD is noted, also complete Asthma Addendum 1.
If Mental Health is noted, to include Attention Deficit Disorders, also complete Mental Health Addendum 2.
If Autism Spectrum Disorder(ASD)/Developmental Delay (DD) is noted, also complete Addendum 3.

a. ACTIVE DIAGNOSIS REQUIRING CARE WITHIN LAST YEAR *(If Asthma, Cancer or Mental Health within last 5 years)*	b. ICD OR DSM REQUIRED	c. MEDICATIONS AND SPECIAL THERAPIES *(Also annotate rare or special consideration medications used within specified time period)*	d. COMPLETE FOR THE LAST 12 MONTHS:	
				(1) NUMBER OF OUTPATIENT VISITS
				(2) NUMBER OF ER VISITS
				(3) NUMBER OF HOSPITALIZATIONS
				(4) NUMBER OF ICU ADMISSIONS
				(1) NUMBER OF OUTPATIENT VISITS
				(2) NUMBER OF ER VISITS
				(3) NUMBER OF HOSPITALIZATIONS
				(4) NUMBER OF ICU ADMISSIONS
				(1) NUMBER OF OUTPATIENT VISITS
				(2) NUMBER OF ER VISITS
				(3) NUMBER OF HOSPITALIZATIONS
				(4) NUMBER OF ICU ADMISSIONS
				(1) NUMBER OF OUTPATIENT VISITS
				(2) NUMBER OF ER VISITS
				(3) NUMBER OF HOSPITALIZATIONS
				(4) NUMBER OF ICU ADMISSIONS
				(1) NUMBER OF OUTPATIENT VISITS
				(2) NUMBER OF ER VISITS
				(3) NUMBER OF HOSPITALIZATIONS
				(4) NUMBER OF ICU ADMISSIONS

FAMILY MEMBER/PATIENT NAME	SPONSOR NAME	FAMILY MEMBER PREFIX	SPONSOR SSN

4. PROGNOSIS FOR EACH ACTIVE DIAGNOSIS IDENTIFIED IN PART A, ITEM 3 *(Include expected length of treatment, required participation of family members, and if treatment is ongoing)*

5. TREATMENT PLAN FOR EACH ACTIVE DIAGNOSIS *(Medical, mental health, surgical procedures or therapies planned over the next three years)*

6. CANCER, ADDITIONAL INFORMATION *(If not addressed in Items 3, 4, and 5) (Indicate date of diagnosis, types of treatment, responses to treatment, if treatment is active and if treatment completed.)*

IF TREATMENT COMPLETED, DATE *(YYYYMMDD)* _____

FAMILY MEMBER/PATIENT NAME	SPONSOR NAME	FAMILY MEMBER PREFIX	SPONSOR SSN

MEDICAL SUMMARY *(Continued)*: To be completed by a Qualified Medical Professional

PART B - REQUIRED CARE

7. MINIMUM HEALTH CARE SPECIALTY REQUIRED FOR CARE

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

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

FAMILY MEMBER/PATIENT NAME	SPONSOR NAME	FAMILY MEMBER PREFIX	SPONSOR SSN

MEDICAL SUMMARY *(Continued)*: To be completed by a Qualified Medical Professional

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

☐ YES IF YES:
☐ NO

☐ F01 - GASTROSTOMY
☐ F02 - TRACHEOSTOMY
☐ F03 - CSF SHUNT
☐ F04 - CYSTOSTOMY
☐ F05 - COLOSTOMY
☐ F06 - ILEOSTOMY
☐ F07 - OTHER UNSPECIFIED PROSTHETICS *(Specify)*
☐ F99 - OTHER UNSPECIFIED OPENING *(Specify)*

9. ENVIRONMENTAL/ARCHITECTURAL CONSIDERATIONS

☐ R01 - LIMITED STEPS *(If Yes, please explain)*
☐ R02 - COMPLETE WHEELCHAIR ACCESSIBILITY
☐ R04 - SINGLE STORY/LEVEL HOUSE
☐ R05 - CARPET PROHIBITED
☐ R99 - OTHER *(Specify)*
☐ R03 - AIR CONDITIONING
☐ R03a - TEMPERATURE CONTROL
☐ R03b - HEPA FILTER
☐ R03c - POLLEN CONTROL
☐ R03d - AIR FILTERING

EXPLANATION OF SPECIAL CONSIDERATIONS:

10. ADAPTIVE EQUIPMENT/SPECIAL MEDICAL EQUIPMENT *(If marked, describe type of equipment in item 11 (Comments) below.)*

☐ L03 - APNEA HOME MONITOR
☐ L21 - CONTINUOUS POSITIVE AIRWAY PRESSURE (CPAP) THERAPY
☐ L20 - HOME DIALYSIS MACHINE
☐ L13 - HOME NEBULIZER
☐ L04 - HEARING AIDS: MAKE: MODEL:
☐ L22 - INSULIN PUMP: MAKE: MODEL:
☐ L23 - PACEMAKER: MAKE: MODEL:
☐ L99 - OTHER *(Specify)*
☐ L07 - SPLINTS, BRACES, ORTHOTICS
☐ L08 - WHEELCHAIR
☐ L12 - HOME OXYGEN THERAPY
☐ L14 - HOME VENTILATOR

EXPLANATION OF SPECIAL CONSIDERATIONS:

11. COMMENTS *(Enter additional information to describe this individual's medical needs.)*

PART C - PROVIDER INFORMATION

12.a. PROVIDER PRINTED NAME OR STAMP	b. SIGNATURE	c. DATE *(YYYYMMDD)*

d. TELEPHONE NUMBERS *(Include Area Code/Country Code)*			e. MAILING ADDRESS *(Include ZIP Code)*
(1) COMMERCIAL	(2) DSN *(Military only)*	(3) FAX NUMBER	
f. OFFICIAL E-MAIL ADDRESS			

FAMILY MEMBER/PATIENT NAME	SPONSOR NAME	FAMILY MEMBER PREFIX	SPONSOR SSN

ADDENDUM 1 - ASTHMA/REACTIVE AIRWAY DISEASE SUMMARY: To be completed by a Qualified Medical Professional

1. PATIENT HAS BEEN EVALUATED OR TREATED FOR ASTHMA WITHIN THE PAST 5 YEARS.

☐ NO ☐ YES IF YES, CONTINUE COMPLETION OF ASTHMA ADDENDUM ITEMS 2 - 6.

2. MEDICATION HISTORY

a. MEDICATION	b. DOSAGE	c. FREQUENCY	d. APPROXIMATE DATE MEDICATION LAST USED

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

YES	NO	
		a. ARE THERE ANY TRIGGERS FOR THE FAMILY MEMBER'S ASTHMA ATTACKS *(stress, environment, exercise)*?
		b. DOES THE FAMILY MEMBER ROUTINELY *(greater than 10 days per month/four months per year)* USE INHALED ANTI-INFLAMMATORY AGENTS AND/OR BRONCHODILATORS?
		c. HAS THE FAMILY MEMBER TAKEN ORAL STEROIDS DURING THE PAST YEAR *(prednisone, prednisolone)*? IF YES, NUMBER OF DAYS IN PAST YEAR:
		d. HAS THE FAMILY MEMBER EVER EXPERIENCED UNCONSCIOUSNESS OR SEIZURES ASSOCIATED WITH ASTHMA ATTACKS?
		e. HAS THE FAMILY MEMBER 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:
		f. HAS THE FAMILY MEMBER BEEN HOSPITALIZED FOR PULMONARY DISEASE *(pneumonia, bronchitis, bronchiolitis, croup, RSV)* DURING THE PAST YEAR? IF "YES', INDICATE THE DATE(S) OF HOSPITALIZATION *(YYYYMMDD)*:
		g. DOES THE FAMILY MEMBER HAVE A HISTORY OF ONE OR MORE HOSPITALIZATIONS FOR ASTHMA RELATED CONDITIONS WITHIN THE PAST 5 YEARS? IF "YES', HOW MANY? INDICATE DATE OF LAST ADMISSION *(YYYYMMDD)*:
		h. HAS THE FAMILY MEMBER REQUIRED MECHANICAL VENTILATION *(Intubation/use of respirator)* DURING THE PAST 3 YEARS?
		i. DOES THE FAMILY MEMBER HAVE A HISTORY OF INTENSIVE CARE ADMISSIONS?

j. HOW MANY DAYS HAS THE FAMILY MEMBER MISSED SCHOOL/WORK/PLAY DUE TO ASTHMA-RELATED PROBLEMS *(including visits to physicians)* DURING THE PAST YEAR?

k. HOW OFTEN DOES THE FAMILLY MEMBER USE HIS/HER RESCUE INHALER OR NEBULIZER MEDICATION *(such as Albuterol or Levalbuterol)* FOR INCREASED OR ACUTE SYMPTOMS?

4. DISRUPTION OF ACTIVITY. How often does asthma disrupt the following activities? *(X as applicable)*

(1) ACTIVITY	(2) NEVER A PROBLEM	(3) 2 TIMES A YEAR OR LESS	(4) 3 - 7 TIMES A YEAR	(5) 8 - 10 TIMES A YEAR	(6) AT LEAST MONTHLY	(7) AT LEAST WEEKLY	(8) ALMOST DAILY
a. SLEEP							
b. QUIET ACTIVITY							
c. SOCIALIZING WITH FRIENDS							
d. SCHOOL OR WORK ATTENDANCE							
e. OUTDOOR ACTIVITIES							
f. VIGOROUS/PLAY ACTIVITIES							

5. SEVERITY LEVEL. What is the family member'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.)*

☐	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 ≥ 80% predicted; variability <20%.
☐	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 ≥ 80% predicted; variability 20 - 30%.
☐	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 ≥ 60% and 80% predicted; variability > 30%.
☐	d. **SEVERE PERSISTENT.** Continuous symptoms. Frequent exacerbations. Frequent nighttime asthma symptoms. Physical activities limited by asthma symptoms. PEF or FEV1 ≤ 60% predicted; variability > 30%.

6.a. PROVIDER PRINTED NAME OR STAMP	b. SIGNATURE	c. DATE *(YYYYMMDD)*

d. TELEPHONE NUMBERS *(Include Area Code/Country Code)*			e. MAILING ADDRESS *(Include ZIP Code)*
(1) COMMERCIAL	(2) DSN *(Military only)*	(3) FAX NUMBER	
f. OFFICIAL E-MAIL ADDRESS			

FAMILY MEMBER/PATIENT NAME	SPONSOR NAME	FAMILY MEMBER PREFIX	SPONSOR SSN

ADDENDUM 2 - MENTAL HEALTH SUMMARY: To be Completed by a Qualified Clinical Provider

1. PATIENT HAS CURRENT OR PAST *(within the last 5 years)* **HISTORY OF MENTAL HEALTH DIAGNOSIS** *(To include attention deficit disorders)*

☐ NO ☐ YES IF YES, CONTINUE WITH COMPLETION OF MENTAL HEALTH ADDENDUM.

2. DIAGNOSIS(ES) Please complete as accurately as possible using ICD-9-CM or DSM IV.

a. DIAGNOSIS	b. ICD OR DSM REQUIRED	c. AGE AT DIAGNOSIS	d. COMPLETE FOR THE LAST 5 YEARS
			☐ (1) NUMBER OF OUTPATIENT VISITS ☐ (2) NUMBER OF HOSPITALIZATIONS ☐ (3) NUMBER OF RESIDENTIAL TREATMENT ADMISSIONS DATE OF LAST ADMISSION:
			☐ (1) NUMBER OF OUTPATIENT VISITS ☐ (2) NUMBER OF HOSPITALIZATIONS ☐ (3) NUMBER OF RESIDENTIAL TREATMENT ADMISSIONS DATE OF LAST ADMISSION:
			☐ (1) NUMBER OF OUTPATIENT VISITS ☐ (2) NUMBER OF HOSPITALIZATIONS ☐ (3) NUMBER OF RESIDENTIAL TREATMENT ADMISSIONS DATE OF LAST ADMISSION:
			☐ (1) NUMBER OF OUTPATIENT VISITS ☐ (2) NUMBER OF HOSPITALIZATIONS ☐ (3) NUMBER OF RESIDENTIAL TREATMENT ADMISSIONS DATE OF LAST ADMISSION:

3. MEDICATION HISTORY RELATED TO THE DIAGNOSIS LISTED ABOVE; THERAPIES RECEIVED OR RECOMMENDED
(Including frequency of medication and therapy, and their effectiveness)

4. HISTORY

YES	NO	WITHIN THE LAST 5 YEARS, HAS THE PATIENT HAD:
		a. HISTORY OF SUICIDAL GESTURES/ATTEMPTS?
		b. HISTORY OF SUBSTANCE ABUSE?
		c. HISTORY OF ADDICTIVE BEHAVIORS?
		d. HISTORY OF EATING DISORDERS?
		e. HISTORY OF OTHER COMPULSIVE BEHAVIORS?
		f. HISTORY OF PROBLEMS WITH LEGAL AUTHORITY? *(If Yes, specify)*
		g. HISTORY OF PSYCHOTIC EPISODES?
		h. HISTORY OF SERVICES RECEIVED FOR ALLEGATIONS OF FAMILY MALTREATMENT? *(If Yes, and services are delivered by Family Advocacy, note case determination.)*

i. COMMENTS

FAMILY MEMBER/PATIENT NAME	SPONSOR NAME	FAMILY MEMBER PREFIX	SPONSOR SSN

ADDENDUM 2 - MENTAL HEALTH SUMMARY *(Continued)*: To be Completed by a Qualified Clinical Provider

5. PROGNOSIS *(Include past compliance with treatment programs, expected length of treatment, required participation of family members, and if treatment is ongoing.)*

6. TREATMENT PLAN *(Medical, mental health, surgical procedures or therapies related to the patient's mental health condition planned over the next three years)*

7. TREATMENT NEEDS WITHIN THE NEXT YEAR *(Consider increased stressors of residing in new environment (e.g.,stressors of family relocation, isolated posts, deployments, foreign cultures, restricted travel, separation from nuclear family, cost of living.)*

8. PROVIDERS REQUIRED TO IMPLEMENT TREATMENT PLAN AND FREQUENCY OF VISITS

☐ PSYCHIATRIST	☐ PSYCHOLOGIST	☐ SOCIAL WORKER	☐ OTHER *(Specify)*
☐ WEEKLY	☐ WEEKLY	☐ WEEKLY	☐ WEEKLY
☐ BI-MONTHLY	☐ BI-MONTHLY	☐ BI-MONTHLY	☐ BI-MONTHLY
☐ MONTHLY	☐ MONTHLY	☐ MONTHLY	☐ MONTHLY
☐ QUARTERLY	☐ QUARTERLY	☐ QUARTERLY	☐ QUARTERLY
☐ ANNUALLY	☐ ANNUALLY	☐ ANNUALLY	☐ ANNUALLY

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

10. PROVIDER INFORMATION *(Authorization by patient included on Page 1 of this form.)*

a. PRINTED NAME OR STAMP	b. SIGNATURE	c. DATE *(YYYYMMDD)*

d. TELEPHONE NUMBERS *(Include Area Code)*			e. MAILING ADDRESS *(Include ZIP Code)*
(1) COMMERCIAL	(2) DSN *(Military only)*	(3) FAX NUMBER	
f. OFFICIAL E-MAIL ADDRESS			

FAMILY MEMBER/PATIENT NAME	SPONSOR NAME	FAMILY MEMBER PREFIX	SPONSOR SSN

ADDENDUM 3 - AUTISM SPECTRUM DISORDERS AND SIGNIFICANT DEVELOPMENTAL DELAYS

To be Completed by a Qualified Medical Professional

1. PATIENT HAS BEEN EVALUATED OR RECEIVED TREATMENT(S) FOR AUTISM SPECTRUM DISORDERS AND/OR SIGNIFICANT DEVELOPMENTAL DELAYS *(X one)*

☐ NO ☐ YES IF YES, CONTINUE WITH COMPLETION OF AUTISM AND SIGNIFICANT DEVELOPMENTAL DELAYS ADDENDUM 3, ITEMS 2 - 15.

2.a. DIAGNOSIS(ES) *(X and complete as applicable)*

☐ AUTISTIC DISORDER
☐ ASPERGER'S SYNDROME
☐ OTHER *(Specify)*
☐ PERVASIVE DEVELOPMENTAL DISORDER/NOS

b. AGE WHEN DIAGNOSED

3. DATE OF BIRTH *(YYYYMMDD)*

c. DIAGNOSED BY:

☐ CHILD PSYCHOLOGIST ☐ CHILD PSYCHIATRIST ☐ DEVELOPMENTAL PEDIATRICIAN ☐ MEDICAL MULTIDISCIPLINARY TEAM ☐ OTHER PHYSICIAN ☐ SCHOOL-BASED TEAM ☐ OTHER *(Specify)*

4. COEXISTING DIAGNOSES *(X all that apply)*

☐ CHROMOSOMAL ABNORMALITIES
☐ OBSESSIVE COMPULSIVE DISORDER
☐ ATTENTION DEFICIT/HYPERACTIVITY DISORDER
☐ INTERMITTENT EXPLOSIVE DISORDER
☐ CIRCADIAN-RHYTHM SLEEP DISORDER
☐ GENERALIZED ANXIETY DISORDER, ANXIETY DISORDER, NOS
☐ MAJOR DEPRESSIVE DISORDER, DEPRESSIVE DISORDER, NOS
☐ SEIZURE DISORDER
☐ OTHER *(Specify)*

5. CURRENT MEDICATIONS *(Used to treat diagnoses on this page)*

6. CURRENT INTERVENTION THERAPIES

(1) TYPE	(2) SCHOOL HOURS/WEEK *(If known)*	(3) TRICARE HOURS/WEEK *(If known)*	(4) OTHER SOURCE HOURS/WEEK *(If known)*	(5) OTHER *(Identify)*
a. SPEECH THERAPY				
b. OCCUPATIONAL THERAPY				
c. PHYSICAL THERAPY				
d. PSYCHOLOGICAL/COUNSELING				
e. INTENSIVE BEHAVIORAL INTERVENTION *(Includes ABA)*				
f. OTHER *(Specify)*				

7. COMMUNICATION *(X)*

☐ VERBAL ☐ NON-VERBAL *(Uses:)*
☐ SIGNING
☐ PICTURE EXCHANGE COMMUNICATION SYSTEM (PECS)
☐ COMMUNICATION DEVICE
☐ COMBINATION

8. OTHER INTERVENTIONS/THERAPIES USED BY THE FAMILY *(Specify alternate or complementary therapies)*

9. BEHAVIOR: CHILD EXHIBITS HIGH RISK OR DANGEROUS BEHAVIOR

☐ YES ☐ NO *(If Yes, provide details in Item 14 below)*

10. COGNITIVE ABILITY *(X)*

☐ <50 ☐ 50 - 70 ☐ >70 ☐ UNKNOWN ☐ INDETERMINATE

11. EDUCATION *(X)*

☐ RECEIVES EARLY INTERVENTION
☐ RECEIVES SPECIAL EDUCATION
☐ ATTENDS SPECIAL PRIVATE SCHOOL
☐ ATTENDS PUBLIC SCHOOL
☐ ATTENDS PRIVATE SCHOOL
☐ IS HOME SCHOOLED

12. REQUIRED MEDICAL SERVICES *(X)*

☐ CHILD PSYCHOLOGY ☐ CHILD PSYCHIATRY ☐ OTHER *(Specify)*
☐ CHILD NEUROLOGY ☐ DEVELOPMENTAL PEDIATRICS

13. RESPITE CARE RECEIVED

a. HOURS PER MONTH	b. SOURCE

14. GENERAL COMMENTS *(Include Functional Levels)*

15. PROVIDER INFORMATION

a. PRINTED NAME OR STAMP	b. SIGNATURE	c. DATE *(YYYYMMDD)*

d. TELEPHONE NUMBERS *(Include Area Code)*			e. MAILING ADDRESS *(Include ZIP Code)*
(1) COMMERCIAL	(2) DSN *(Military only)*	(3) FAX NUMBER	
f. OFFICIAL E-MAIL ADDRESS			

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 (SSN) 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://privacy.defense.gov/notices.

ROUTINE USE(S): The DoD "Blanket Routine Uses" found at http://privacy.defense.gov/blanket_uses.shtml 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.
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 noted 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 exceptional family member (EFM) application for the family member or to update a previous EFM evaluation for the family member.
- Government sponsored travel and/or Command Sponsorship.
- Change in EFMP Status.

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

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

Item 3.k. Is family member enrolled in DEERS? Military only. Self-explanatory.

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

Item 5. Completed for children age birth to 3 only. Self-explanatory.

Item 6. Completed for children ages 3 to 21 only. Self-explanatory.

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

Items 8.a. - f. Administrative Review. Completed by EFMP/Special Needs Office resonsible 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. Completed by sponsor or spouse. Self-explanatory.

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

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

Items 4.a. - g. School Information. Completed by school personnel. 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 EIP and school personnel. Self-explanatory.

Item 8. Completed by EIP 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 Mar 31, 2014

PLEASE DO NOT RETURN YOUR FORM TO THE ABOVE ORGANIZATION.

DEMOGRAPHICS

1. REQUEST *(X one)*

- ☐ EFMP Registration/Enrollment Update
- ☐ Government Sponsored Travel and/or Command Sponsorship
- ☐ Change in EFMP Status:
  - ☐ No longer requires IEP/IFSP services
  - ☐ No longer qualifies as a dependent*
  - ☐ Divorce/change in custody*
- ☐ Other *(Explain)*:

*(*Provide documentation for change in status)*

2.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. CHILD/STUDENT DATE OF BIRTH *(YYYYMMDD)*	e. CHILD/STUDENT GENDER *(X one)* ☐ MALE ☐ FEMALE	
f. FAMILY HOME E-MAIL ADDRESS	g. HOME TELEPHONE NUMBER *(Include Area Code/Country Code)*	

3.a. SPONSOR RANK OR GRADE	b. DESIGNATION/NEC/MOS/AFSC *(Military only)*	c. INSTALLATION OF CURRENT ASSIGNMENT
d. SPONSOR'S OFFICIAL E-MAIL ADDRESS	e. DUTY TELEPHONE NUMBER *(Include Area Code/Country Code)*	f. MOBILE NUMBER *(Include Area Code/Country Code)*

g. SPONSOR'S CURRENT UNIT MAILING ADDRESS

h. STATUS *(X one)*

- ☐ Regular Active Service Member
- ☐ Active Guard/Reserve Program (AGR)
- ☐ Reservist
- ☐ National Guard
- ☐ Civilian

d. BRANCH OF SERVICE *(Military only)*

- ☐ Army
- ☐ Air Force
- ☐ Navy
- ☐ Marine Corps

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

☐ YES ☐ NO

k. 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)*

☐ YES ☐ NO	b. ACTIVE DUTY SPOUSE'S NAME *(Last, First, Middle Initial)*	c. BRANCH OF SERVICE	d. RANK/RATE

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 2.)

6. FOR STUDENTS AGES 3 - 21 WHO ARE ELIGIBLE FOR ELEMENTARY AND SECONDARY EDUCATION:

☐ YES ☐ NO a. Is your child being home-schooled? *(X one. If No, sign Item 7 and take Page 2 to your child's school. If Yes, complete the following and sign Item 7.)*

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

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

_____

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

7.a. SIGNATURE	b. PRINTED NAME *(Last, First, Middle Initial)*	c. DATE *(YYYYMMDD)*

8. ADMINISTRATIVE REVIEW *(Completed after review of entire form by local military MTF or office receiving form)*

STAMP

a. SPONSOR SSN	b. SPOUSE SSN *(If dual military)*	c. SSN USED IN DEERS *(If different from sponsor's)*	
d. FAMILY MEMBER PREFIX	e. MILITARY MTF OR OFFICE RECEIVING COMPLETED FORM		f. 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 family 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) or Section 504 Plan to this page.)*

1. RELEASE OF INFORMATION *(To be completed by sponsor, spouse, 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 OF SPONSOR, SPOUSE, OR STUDENT WHO HAS REACHED THE AGE OF MAJORITY	b. PRINTED NAME	c. RELATIONSHIP TO CHILD/ STUDENT	d. DATE *(YYYYMMDD)*

2. CHILD/STUDENT INFORMATION *(To be completed by sponsor or spouse)*

a. NAME OF CHILD/STUDENT *(Last, First, Middle Initial)*	b. CURRENT GRADE LEVEL *(If school age)*	c. DATE OF BIRTH *(YYYYMMDD)*	d. GENDER *(X one)*
			☐ FEMALE ☐ MALE

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

YES	NO	
		a. Is the child currently being evaluated for early intervention services? *(If Yes, go directly to Item 8.)*
		b. Does this child receive early intervention services under a current Individualized Family Services Plan (IFSP)?

(If Yes, please attach current IFSP.) Date of next annual review *(YYYYMMDD)*: _____

c. Basis for eligibility: ☐ Developmental delay ☐ High probability for developmental delay

d. Identified disability for diagnosis: _____

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

YES	NO	
		a. Is the student receiving services under a 504 plan? *(If Yes, please attach a copy of the current 504 plan.)*
		b. Has this child ever been evaluated for, or been offered, special education services by your school? *(If No, skip to Item 8.)*
		c. Is this student currently being evaluated for special education services? *(If Yes, skip to Item 8.)*
		d. If your school determined the student eligible for special education services within the past 3 years, did the parent decline special education services? *(If Yes, complete eligibility information in Item 5 and proceed to Item 8.)*
		e. Does this child/student receive special education services under a current Individualized Education Program (IEP)? *(If Yes, please attach a copy of the current IEP, and complete Items 5 and following.)* Date of next annual review *(YYYYMMDD)*: _____
		f. Were IEP services terminated by the IEP team within the last 2 years? *(If Yes, skip to Item 8.)* Date of IEP termination *(YYYYMMDD)*: _____
		g. Was the IEP terminated at the request of the parents within the last year (parents withdrew student from special education)? *(If Yes, complete Items 5 and following.)*

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

	N07	Autism Spectrum Disorder:		N09	Communication Impaired:		N12	Specific Learning Disability
		Autism			Articulation		N10	Emotionally Impaired
		PDD-NOS			Dysfluency		N16	Behavioral/Conduct Disorder
		Asperger's Syndrome			Voice		N04	Mental Retardation:
	N01	Deaf			Language/Phonology			Mild/Moderate
	N02	Blind		N05	Traumatic Brain Injury			Moderate/Severe
	N13	Deaf/Blind		N03	Hearing Impaired			Severe/Profound
	N11	Visually Impaired		N06	Orthopedically Impaired		N08	Other Health Impaired *(Specify)*

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
☐	R01 Counseling			per	
☐	R02 Occupational Therapy			per	
☐	R03 Physical Therapy			per	
☐	R04 Speech Therapy			per	
☐	R05 Intensive Behavioral Intervention *(Such as ABA)*			per	

☐ R06 Special Transportation *(Describe)*:

☐ R07 Other *(Describe)*:

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

YES	NO	
		a. Child exhibits high risk or dangerous behavior.
		b. Child is verbal *(If No, answer c.-f. The student uses:)*
		c. Signing *(Specify language or system)*
		d. Picture Exchange Communication System (PECS)
		e. Communication Device *(Specify)*
		f. Other *(Specify)*

g. COMMENTS

8. PROVIDER/SCHOOL INFORMATION

a. NAME OF EARLY INTERVENTION PROGRAM OR SCHOOL	b. SCHOOL DISTRICT
c. ADDRESS *(Street, City, State,ZIP Code, APO/FPO)*	d. TELEPHONE NUMBER *(Include Area Code/ Country Code)*

e. FAX NUMBER *(Include Area Code/ Country Code)*	f. E-MAIL ADDRESS	g. NAME OF INDIVIDUAL COMPLETING THIS SECTION

h. SIGNATURE	i. TITLE	j. DATE SIGNED *(YYYYMMDD)*

EXCEPTIONAL FAMILY MEMBER PROGRAM (EFMP) QUERYING SHEET

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

PRIVACY ACT STATEMENT

AUTHORITY: 5 USC Section 301, Departmental Regulations; 10 USC1071-1085; 10 USC Section 3013, Secretary of the Army; and Army Regulation 608-75, EFMP.

PRINCIPAL PURPOSE: To identify soldiers that have family members for enrollment in the EFMP.

ROUTINE USES: To federal, state, and local medical agencies in order to provide an exceptional family member with medical treatment when the Department of the Army does not have a suitable treatment facility.

DISCLOSURE: Disclosure of the requested information is mandatory. Failure to provide the information may result in disciplinary and/or administrative action. Additionally, failure to provide the information may result in an EFM not receiving necessary medical care.

1. NAME OF SOLDIER	2. RANK

3. UNIT

4a. HOME ADDRESS	b. HOME PHONE NUMBER

5a. DUTY ADDRESS	b. DUTY PHONE NUMBER
	c. FAX NUMBER

d. EMAIL ADDRESS

6. Do you have a family member *(child or adult)* with a physical, emotional, developmental, or intellectual disorder that requires special treatment, therapy, education, training, counseling, equipment, assistance or medical care above the level of a general practitioner? ☐ YES ☐ NO

7. If the answer to the above question is yes, is the family member enrolled in EFMP? ☐ YES ☐ NO

8. The EFMP works with the other military and civilian agencies to provide comprehensive, coordinated community support, educational, housing, personnel, and medical services to families with special needs. Enrollment in EFMP is mandatory and benefits the family by considering medical and special education needs in the military personnel assignment process. Medical needs are considered in the worldwide assignment process whereas special education needs are only considered in overseas assignments.

9. The above information is true and correct to the best of my knowledge.

a. SIGNATURE OF SOLDIER	b. DATE SIGNED *(YYYYMMDD)*

United States Army Student Detachment

TDY OPTION STATEMENT

SOLDIER INFORMATION	
Last Name, First Name Rank	**TDY Enroute Location:** **Start Date: End Date:**
Family will reside or relocate (circle one). **City_____ State ___ Zip Code_____**	**Transportation Option (Circle One):** **a. Drive POC b. Government transportation**

IAW AR 600-8-11 Para 4-2, Soldiers who are authorized movement of Family members at Government expense and are directed to TDY schooling with PCS assignment will have the following options for locating their Family members while they perform their TDY:

____*A.* Elect that dependent(s) currently residing in Government quarters be permitted to remain in Government quarters until completion of TDY period. Under this option Soldier is authorized Government travel to and from TDY station and his or her commander may authorize up to 10 duty days to prepare to move dependent(s) upon return from TDY prior to signing out of the present CONUS station (applies CONUS to CONUS, and CONUS to overseas PCS movements).

____*B.* Elect to move dependent(s) from present CONUS and/or overseas station to new CONUS duty station prior to reporting to the TDY station. The gaining commander may authorize up to 10 duty days to settle Soldier's dependent(s), in Government quarters (if available) or on the local economy. Soldier will sign into the new CONUS duty station then proceed TDY for schooling. Soldier will be authorized Government transportation to and from TDY station (applies to CONUS to CONUS, and overseas to CONUS PCS movements).

____*C.* Elect to return to present duty station upon completion of TDY to move dependent(s), who currently live on the local economy (CONUS), to the new duty station. Under this option Soldier is authorized Government travel to and from TDY station, and his or her commander may authorize up to 10 duty days upon return from TDY to prepare to move dependent(s) prior to signing out of the present CONUS station (applies to CONUS to CONUS, and CONUS to overseas PCS movements).

____*D.* Elect to clear current permanent station prior to departure for TDY station; and have dependent(s), at personal expense, accompany Soldier to TDY station or travel to some other location. Soldier may not be given a certificate of non-availability of Government quarters at the TDY station if adequate Government housing is available. Soldier's entitlement for dependent transportation will be based on the most direct routing between the old permanent station and the new permanent station (applies CONUS to CONUS, CONUS to overseas and overseas to CONUS PCS movements). Soldiers who are being reassigned overseas must be medically and dentally qualified for assignment.

I ELECT TDY OPTION ____. (INITIAL BESIDE YOUR CHOICE)

IMPORTANT: I HAVE READ AND UNDERSTAND THE TDY OPTIONS AVAILABLE TO ME. I UNDERSTAND THAT THIS DECISION IS FINAL. AMENDMENTS WILL NOT BE MADE TO THIS ORDER UNLESS CIRCUMSTANCES ARE BEYOND MY CONTROL.

SERVICE MEMBER (SM) CONFIRMATION	
NAME: Last, First Middle Initial	RANK:
SIGNATURE:	DATE:
REMARKS: (Use this block for multiple TDY locations)	

PCS Travel Advance Request Form

All requests must have PCS orders attached

(Privacy Act: Authority: AR 37-106, chapter 5 Purpose: To obtain information about individual's travel. Uses: Posting information to IATS/ DD 1588/Computation of advance travel. Disclosure: Mandatory. Will be denied payment if failure to provide information requested.

For prompt payment of your advance please complete this form at least twenty working days prior to sign out date. All travel advances are paid @ 80% with the money being direct deposited into your current military pay account approximately five days prior to your sign out date. There are NO cash or check payments.

Name: _____ **SSN:** _____ **Sign Out Date:** _____
Rank: _____ **Daytime Phone #:** _____
Current Address: Street: _____ **City, ST, Zip:** _____
Spouse's name _____
Is Spouse Military YES NO
SSN: (For Military Spouse Only) _____

Please list NAME and Date of Birth (day, month, year) of children traveling with you:

NAME _____ **DOB** _____		**NAME** _____ **DOB** _____	
NAME _____ **DOB** _____		**NAME** _____ **DOB** _____	
NAME _____ **DOB** _____		**NAME** _____ **DOB** _____	

PLEASE READ AND COMPLETE ONLY SPACES THAT IS APPLICABLE TO YOUR PCS MOVE .

1.) Are you requesting an advance for your travel: Yes No
Is any of your travel going to be by POV? YES NO
If yes, number of POV's used for this PCS move. 1 2
If yes, then POV travel is from (City,ST) _____ To(City,ST) _____
Are you buying your own ticket: YES NO Cost $ _____
Ticket you purchased is from (City, ST) _____ To(City, ST,Country) _____
Will you be taking the Alaska Ferry System? YES NO
If yes, what port will you be departing From: _____ Arriving: _____

2.) Are your dependents relocating? YES NO What date? _____
Are you requesting an advance for your dependent travel? YES NO
Is any of your travel going to be by POV? YES NO
If yes, number of POV's used for this PCS move. 1 2
If yes, then POV travel is from (City,ST) _____ To(City, ST) _____
Are you buying your own ticket: YES NO Cost $ _____
Ticket you purchased is from (City, ST) _____ To(City, ST, Country) _____
Will you be taking the Alaska Ferry System? YES NO
If yes, what port will you be departing From: _____ Arriving to: _____

3) Are you requesting an advance for Dislocation Allowance (DLA) YES NO
(No advance DLA will be given for single service members E-5 and below who will not be residing off post at the new duty station.)

4) Are you Requesting Advance for a DITY move (Attach DD Form 2278) YES NO

Soldier's Signature _____ DATE _____
Finance Clerk Signature _____ DATE _____

ADVANCE PAY CERTIFICATION/AUTHORIZATION

Privacy Act Statement

AUTHORITY: 37 U.S.C. 1006 et seq; E.O. 9397 November 1943 (SSN).

PRINCIPAL PURPOSES: To document a member's request for, and subsequent authorization of, an advance of pay to meet extraordinary expenses incident to a PCS move. It is also used to inform the member of the purposes and restrictions of such advances, and to establish repayment schedules.

ROUTINE USES: Information collected on this form becomes part of the Joint Uniform Military Pay System *(JUMPS)*, and Reserve component pay systems and is subject to all of the routine disclosures which are more fully described in Service regulations. Routine recipients of JUMPS disclosures include, but are not limited to, Red Cross, State and local government for tax and welfare purposes.

DISCLOSURE: Voluntary; however, failure to provide the SSN will result in denial of payment since it is used to identify you for pay purposes.

PART I. REQUEST

1. NAME *(Last, First, Middle Initial)*	2. SOCIAL SECURITY NO.	3. GRADE

4. I REQUEST:	5. I REQUEST A REPAYMENT SCHEDULE OF:	6. I REQUEST PAYMENT OF THE ADVANCE PAY:
☐ a. ONE MONTH ADVANCE PAY *(See Policy Guidance on reverse.)*	☐ a. 12 MONTHS OR LESS *(Specify number of months)*	☐ a. WITHIN 30 DAYS OF PCS OR 60 DAYS AFTER REPORTING TO MY NEXT PDS.
☐ b. MORE THAN 1 MONTH BUT LESS THAN 3 MONTHS BASIC PAY LESS DEDUCTIONS *(Parts II and V must be completed.) (Specify amount)* $	☐ b. 13 - 24 MONTHS *(Parts III and V must be completed regardless of pay grade. NOTE: Repayment schedule cannot exceed member's date of separation.) (Specify number of months)*	☐ b. 31 - 90 DAYS BEFORE MY PCS *(Parts II and V must be completed.)*
		☐ c. 61 - 180 DAYS AFTER ARRIVAL AT MY PDS *(Parts II and V must be completed.)*

PART II. CERTIFICATION OF EXPENSES *(Actual or Anticipated) (Continue in Item 23 on reverse if necessary.)*

7. EXPENSE	8. AMOUNT	10. EXPLANATION OF THE CIRCUMSTANCES WHERE GREATER-THAN-NORMAL EXPENSES MIGHT BE INCURRED OR CIRCUMSTANCES REQUIRING AN EARLY OR LATE PAYMENT OF ADVANCE PAY *(Up to 90 days before and 180 days after).*
a.	$	
b.	$	
c.	$	
d.	$	
e.	$	
f.	$	
9. TOTAL	$ 0.00	

PART III. JUSTIFICATION FOR MORE THAN 12 MONTHS PAYBACK

(Justification must demonstrate that severe hardship would result if the advance is paid back in 12 months)

11. NO. OF DEPENDENTS	12. LIST SPECIFICS OF YOUR FINANCIAL SITUATION, INCLUDING OUTSTANDING DEBTS AND MONTHLY PAYMENT AMOUNTS THAT INDICATE A SEVERE HARDSHIP IN REPAYING THE ADVANCE IN THE NORMAL 12-MONTH TIME PERIOD *(Continue in Item 23 on reverse if necessary.)*

PART IV. MEMBER CERTIFICATION

Penalty: The penalty for willfully making a false claim/statement is ***a maximum of $10,000 or maximum imprisonment of five years, or both (U.S. Code, Title 18, Section 287).***

If I am separated prior to my ETS, I consent to withholding from current pay, final pay, or any other money due me to satisfy this indebtedness. I further consent to such withholding at a rate sufficient to satisfy this indebtedness no later than my separation, and understand that this could result in the withholding of 100% of any current pay, final pay, or other money due me.

I have read and understood the policy on advance pay incident to a PCS contained on the reverse of this form. I hereby certify that the intended use of these funds meets the stated purpose. I have attached one copy of my PCS orders or assignment notification.

13. SIGNATURE	14. DATE *(YYMMDD)*

PART V. APPROVAL OF MEMBER'S COMMANDER

15. I HEREBY APPROVE THIS REQUEST FOR ADVANCE PAY OF:	16. WITH LIQUIDATION OVER:	17. AND PAYMENT OF THIS ADVANCE:
☐ a. ONE MONTH BASIC PAY LESS DEDUCTIONS	☐ a. 12 MONTHS OR LESS *(Specify number of months)*	☐ a. WITHIN 30 DAYS OF PCS OR 60 DAYS AFTER REPORTING AT PDS
☐ b. AN AMOUNT SPECIFIED NOT TO EXCEED 3 MONTHS BASIC PAY LESS DEDUCTIONS *(Specify amount)* $	☐ b. 13 - 24 MONTHS *(Specify number of months)*	☐ b. NOT PRIOR TO _____ *(date)* WHICH IS 31 - 90 DAYS BEFORE PCS
		☐ c. 61 - 180 DAYS AFTER REPORTING TO NEW PDS

18. APPROVING OFFICIAL NAME *(Last, First, Middle Initial)*	19. SIGNATURE OF OFFICIAL	
20. TITLE	**21. GRADE**	**22. DATE *(YYMMDD)***

23. REMARKS

POLICY GUIDANCE

The purpose of an advance of pay incident to PCS is to provide a Servicemember with funds to meet the extraordinary expenses of a Government-ordered relocation, per DODPM Part 4.

An advance of pay shall not be authorized for the specific out-of-pocket expenses covered by advances of other pays and entitlements if such advances are used. The Servicemember may be authorized an advance of pay to the extent that incurred or anticipated expenses exceed those covered by the following advances or reimbursements, or are outside the scope of those entitlements:

a. Overseas station housing allowance;

b. Servicemember and/or dependent travel allowances and per diem;

c. Dislocation allowance;

d. Basic allowance for quarters and/or variable housing allowance.

An advance of pay for a PCS move in the same geographic area of a Servicemember's prior duty station, or place from which ordered to active duty, is only authorized when the Servicemember moves his/her household effects at Government expense. Proof of HHG shipment is required before advance pay for PCS moves in the same geographic area is paid.

An advance is not intended to provide funds for such items as investments, vacations, or the purchase of consumer goods that are not the result of direct expenses resulting from the Servicemember's PCS orders. Except under extraordinary conditions, an advance pay must be repaid before an advance for a subsequent PCS may be paid.

Servicemembers should consult appropriate Service regulations concerning grade levels requiring Commander's approval of a PCS advance that does not exceed 1 month's pay.

AIR FORCE MEMBERS ONLY: E4/SRA and below must have Commander's approval for all PCS advance pay payments.