MEB Worksheet

THE PROPONENT AGENCY FOR THIS FORM IS THE DEPT. OF DISABILITY EVALUATION SERVICES, CARL R. DARNALL ARMY MEDICAL CENTER, FT HOOD, TEXAS

PRIVACY ACT OF 1974

AUTHORITY: S.U.S.C. Sections 301: 10 US c, Section 1071 and 1201 and Executive Order 9397.

PRINCIPAL PURPOSE: To determine medical fitness for continued Army active service. To review Board findings when required and to determine if the individual should be discharged, temporarily or permanently retired for disability, or retained for active service.

Name (Last, First MI)	Rank/Grade	DOB	SSN
Division	Brigade	Battalion	Co/Btry/Trp

If assigned to CRDAMC, are you MEDCEN Physician? Yes_______ No________ Clinic/Dept.______________________________

If assigned to Warrior Transition Brigade, date of assignment *(mm/dd/yy):* ____________________________

Home address (Local or Barracks)	Duty phone number (NOT YOUR CELL PHONE):
Home/cell/alternated phone numbers: Cellular: ( ) Home: ( )	Government Email (not civilian): AKO: @us.army.mil CONUS: @conus.army.mil

I am currently: (check one) AD Army __________ NG ______________ USAR _________ AGR _________ OTHER (specify) __________

If NG/USAR called to Active Duty, provide date of activation/mobilization *(mm/dd/yy)* : _______________________________

Did you deploy in support of: (check one) Operation Noble Eagle __________ Operation Enduring Freedom __________

Operation Iraqi Freedom __________ N/A __________

Date of deployment w/your unit *(mm/dd/yy)* : Dates: ____________________ to ___________________ N/A ______

Were you injured during your deployment: Yes _______ No _______

Were you deployed when the illness occurred: Yes _______ No _______

Were you pending deployment when the injury/illness occurred: Yes _______ No _______

BASD *(mm/dd/yy)*	PEBD *(mm/dd/yy)*	ETS Date *(mm/dd/yy)*	MOS/ASI (complete)

Did you complete a MMRB: Yes _______ No _______ If yes, date completed *(mm/dd/yy)* : _________________

Do you have upcoming TDY, FTX or PCS orders (list & give dates - use back of form, if needed)?

List any significant medical problems, injuries, or surgeries you feel will be pertinent to your Disability Evaluation case (include dates & use back of form, if needed):

DATE	SIGNATURE