ARMY RESERVE MEDICAL MANAGEMENT CENTER

AR-MMC MAIN PHONE LINE (910)771-5175

PROFILE REQUEST
LETTER OF INSTRUCTION (LOI)

This form is subject to Privacy Act of 1974. The proponent is USARC SURGEONS OFFICE

Complete the following information. All fields are mandatory.

*****ALL FIELDS IN THIS SECTION REQUIRED*****

NAME (Last, First, MI): DOD ID NUMBER

1. MIL EMAIL ADDRESS CIV EMAIL ADDRESS PHONE NUMBER

2. Unit POC Unit POC Email Unit POC Number

CDR Name and Rank: CDR EMAIL & Phone Number: Unit Name and UIC:

---

3. Profile Request Type: (must select one) ○ Permanent ○ Temporary

Profile Request Status: (must select one) ○ New ○ Continue

Profile for Condition(s): **list all**

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4. **Required Document Checklist (check all items submitted with this packet)**

☐ Summary of Care by Civilian Provider Form (see pages 3 and 4)

OR

☐ Personal Provider Letter on Office Letterhead and signed by provider

(Prescription Pad is UNACCEPTABLE) Dated in last 60 days and include items listed below:

- ☐ Diagnosis
- ☐ Specific Limitations
- ☐ APFT limitations (if any)
- ☐ Time length of limitations
- ☐ Diagnostic Imaging Reports
- ☐ Labs
- ☐ Treatments
- ☐ Prognosis for improvement

NOTE: Letters from Chiropractors will be accepted for TEMP musculoskeletal conditions only.

5. **Approved LOD**

☐ **Yes** - include Approval Memo **DODI 1241.01, IAW AR 600-8-4, USARC LOD Policy**

☐ **No** - but Service Member believes injury occurred while in a Qualified Duty Status (QDS). **THE SOLDIER MUST CONTACT THEIR UNIT FOR LOD ASSISTANCE AND PROCESSING.** QDS includes: active duty for a period of 30 days or less; inactive duty training (IDT); performance of funeral honors duty; or while remaining overnight immediately before the commencement of IDT; or while remaining overnight, between successive periods of IDT, at or in the vicinity of the site of the IDT;**(ARMMC does not initiate, track or approve LOD actions).**

☐ **No** - Case will be processed as Non Duty PEB.

6. **CERTIFICATION**

I certify that this Medical Profile Request packet is accurate and complete. I understand that incomplete or inaccurate information will result in return without action.

Signature: Date:

Relationship to the Soldier (select one): Soldier☐ Profiling Officer☐ Commander☐ Other

Email completed documentation to **usarmy.usarc.usarc-hq.mbx.armmc@army.mil**

a. SUBJECT LINE: "Profile Request", Last name

example- **PROFILE REQUEST: Snuffy**

**While not mandatory, use of Military e-mail with encryption is Strongly encouraged

DD FORM 2870

AUTHORIZATION FOR DISCLOSURE OF MEDICAL OR DENTAL INFORMATION

The Form below to be filled out for

Military Medical Facility

or

VA Medical Facility only

AUTHORIZATION FOR DISCLOSURE OF MEDICAL OR DENTAL INFORMATION

PRIVACY ACT STATEMENT

In accordance with the Privacy Act of 1974 (Public Law 93-579), the notice informs you of the purpose of the form and how it will be used. Please read it carefully.
AUTHORITY: Public Law 104-191; E.O. 9397 (SSAN); DoD 6025.18-R.
PRINCIPAL PURPOSE(S): This form is to provide the Military Treatment Facility/Dental Treatment Facility/TRICARE Health Plan with a means to request the use and/or disclosure of an individual's protected health information.
ROUTINE USE(S): To any third party or the individual upon authorization for the disclosure from the individual for: personal use; insurance; continued medical care; school; legal; retirement/separation; or other reasons.
DISCLOSURE: Voluntary. Failure to sign the authorization form will result in the non-release of the protected health information.
This form will not be used for the authorization to disclose alcohol or drug abuse patient information from medical records or for authorization to disclose information from records of an alcohol or drug abuse treatment program. In addition, any use as an authorization to use or disclose psychotherapy notes may not be combined with another authorization except one to use or disclose psychotherapy notes.

SECTION I - PATIENT DATA

1. NAME *(Last, First, Middle Initial)*	2. DATE OF BIRTH *(YYYYMMDD)*	3. SOCIAL SECURITY NUMBER
		XXX-XX-

4. PERIOD OF TREATMENT: FROM - TO *(YYYYMMDD)*	5. TYPE OF TREATMENT *(X one)*
ALL periods	[ ] OUTPATIENT [ ] INPATIENT [X] BOTH

SECTION II - DISCLOSURE

6. I AUTHORIZE All Military Treatment Facilities and Veterans Administration Facilitie TO RELEASE MY PATIENT INFORMATION TO:
(Name of Facility/TRICARE Health Plan)

a. NAME OF PHYSICIAN, FACILITY, OR TRICARE HEALTH PLAN	b. ADDRESS *(Street, City, State and ZIP Code)*
AR-MMC - (Army Reserve Medical Management Center)	2801 Grand Avenue Pinellas Park, FL 33782
c. TELEPHONE *(Include Area Code)* 910-771-5088	d. FAX *(Include Area Code)* 910-771-5354

7. REASON FOR REQUEST/USE OF MEDICAL INFORMATION *(X as applicable)*

[ ] PERSONAL USE [ ] CONTINUED MEDICAL CARE [ ] SCHOOL [✘] OTHER *(Specify)* Military Case Management
[ ] INSURANCE [ ] RETIREMENT/SEPARATION [ ] LEGAL

8. INFORMATION TO BE RELEASED
ALL Armed Forces Health Longitudinal Technical Application(AHLTA)(MTF)medical records and Veterans Administration medical records from all periods necessary for but limited to proper medical case management and possible military medical board processing.

9. AUTHORIZATION START DATE *(YYYYMMDD)*	10. AUTHORIZATION EXPIRATION DATE *(YYYYMMDD)*	[ ] ACTION COMPLETED

SECTION III - RELEASE AUTHORIZATION

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

11. SIGNATURE OF PATIENT/PARENT/LEGAL REPRESENTATIVE	12. RELATIONSHIP TO PATIENT *(If applicable)*	13. DATE *(YYYYMMDD)*

SECTION IV - FOR STAFF USE ONLY *(To be completed only upon receipt of written revocation)*

14. X IF APPLICABLE:	15. REVOCATION COMPLETED BY	16. DATE *(YYYYMMDD)*
[ ] AUTHORIZATION REVOKED		

17. IMPRINT OF PATIENT IDENTIFICATION PLATE WHEN AVAILABLE	
	SPONSOR NAME: **SPONSOR RANK:** **FMP/SPONSOR SSN:** **BRANCH OF SERVICE:** **PHONE NUMBER:**

Reset

DD FORM 2870

AUTHORIZATION FOR DISCLOSURE OF MEDICAL OR DENTAL INFORMATION

The Form below to be filled out for Civilian Medical Facility only

#6 Civilian Medical Facility

#8 ALL medical records from Civilian Medical Facility from all periods necessary for but limited to proper medical case management and possible military medical board processing.

AUTHORIZATION FOR DISCLOSURE OF MEDICAL OR DENTAL INFORMATION

PRIVACY ACT STATEMENT

In accordance with the Privacy Act of 1974 (Public Law 93-579), the notice informs you of the purpose of the form and how it will be used. Please read it carefully.
AUTHORITY: Public Law 104-191; E.O. 9397 (SSAN); DoD 6025.18-R.
PRINCIPAL PURPOSE(S): This form is to provide the Military Treatment Facility/Dental Treatment Facility/TRICARE Health Plan with a means to request the use and/or disclosure of an individual's protected health information.
ROUTINE USE(S): To any third party or the individual upon authorization for the disclosure from the individual for: personal use; insurance; continued medical care; school; legal; retirement/separation; or other reasons.
DISCLOSURE: Voluntary. Failure to sign the authorization form will result in the non-release of the protected health information.
This form will not be used for the authorization to disclose alcohol or drug abuse patient information from medical records or for authorization to disclose information from records of an alcohol or drug abuse treatment program. In addition, any use as an authorization to use or disclose psychotherapy notes may not be combined with another authorization except one to use or disclose psychotherapy notes.

SECTION I - PATIENT DATA

1. NAME *(Last, First, Middle Initial)*	2. DATE OF BIRTH *(YYYYMMDD)*	3. SOCIAL SECURITY NUMBER
		XXX-XX-

4. PERIOD OF TREATMENT: FROM - TO *(YYYYMMDD)*	5. TYPE OF TREATMENT *(X one)*
ALL periods	[ ] OUTPATIENT [ ] INPATIENT [X] BOTH

SECTION II - DISCLOSURE

6. I AUTHORIZE _____ TO RELEASE MY PATIENT INFORMATION TO:
(Name of Facility/TRICARE Health Plan)

a. NAME OF PHYSICIAN, FACILITY, OR TRICARE HEALTH PLAN	b. ADDRESS *(Street, City, State and ZIP Code)*
AR-MMC - (Army Reserve Medical Management Center)	2801 Grand Avenue Pinellas Park, FL 33782
c. TELEPHONE *(Include Area Code)* 910-771-5088	d. FAX *(Include Area Code)* 910-771-5354

7. REASON FOR REQUEST/USE OF MEDICAL INFORMATION *(X as applicable)*

[ ] PERSONAL USE [ ] CONTINUED MEDICAL CARE [ ] SCHOOL [X] OTHER *(Specify)* Military Case Management
[ ] INSURANCE [ ] RETIREMENT/SEPARATION [ ] LEGAL

8. INFORMATION TO BE RELEASED

9. AUTHORIZATION START DATE *(YYYYMMDD)*	10. AUTHORIZATION EXPIRATION DATE *(YYYYMMDD)*	[ ] ACTION COMPLETED

SECTION III - RELEASE AUTHORIZATION

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

11. SIGNATURE OF PATIENT/PARENT/LEGAL REPRESENTATIVE	12. RELATIONSHIP TO PATIENT *(If applicable)*	13. DATE *(YYYYMMDD)*

SECTION IV - FOR STAFF USE ONLY *(To be completed only upon receipt of written revocation)*

14. X IF APPLICABLE:	15. REVOCATION COMPLETED BY	16. DATE *(YYYYMMDD)*
[ ] AUTHORIZATION REVOKED		

17. IMPRINT OF PATIENT IDENTIFICATION PLATE WHEN AVAILABLE	
	SPONSOR NAME: **SPONSOR RANK:** **FMP/SPONSOR SSN:** **BRANCH OF SERVICE:** **PHONE NUMBER:**

Reset

MEDICAL RECORD - CONSENT FORM
Authorization To Send And Receive Medical Information By Electronic Mail

For use of this form see, MEDCOM Supplement 1 to AR 40-66; the proponent agency is MCHO

SECTION I - PATIENT DATA

1. NAME (Last, First, Middle Initial)	2. DATE OF BIRTH (YYYYMMDD)	3. SOCIAL SECURITY NUMBER (Last four only)
4. E-MAIL ADDRESS		5. TELEPHONE NUMBER

SECTION II - CONDITIONS FOR USE OF E-MAIL

Health care providers cannot guarantee but will use reasonable means to maintain security and confidentially of electronic mail (E-mail) information sent and received. You must acknowledge and consent to the following conditions:

1. E-mail is not appropriate for urgent or emergency situations. Healthcare providers will respond within _____.
   Contact the clinic telephonically if you have not received a response after _____.
2. E-mail must be concise. You should schedule an appointment if the issue is complex or sensitive precluding discussion by E-mail.
3. E-mail should not be used for communications regarding sensitive medical conditions such as sexually transmitted diseases. HIV/AIDS, spouse or child abuse, chemical dependency, etc.
4. Medical or dental treatment facility staff may receive and read your messages.
5. E-mails related to health consultation will be copied, pasted, and filed.

SECTION III - RISKS OF USING E-MAIL

Transmitting information by E-mail has risks that you should consider these include, but are not limited to the following risks:

1. E-mails can be intercepted, altered, forwarded. or used without authorization or detection.
2. E-mails can be circulated, forwarded and stored in paper and electronic files.
3. E-mail senders can easily type in the wrong E-mail address.
4. E-mail may be lost due to technical failure during composition, transmission, and/or storage.

SECTION IV - PATIENT GUIDELINES

To communicate by E-mail, the patient shall:

1. Place the category (topic) of the communication in the subject line of the E-mail (for example, appointment, prescription, medical advice, etc.)
2. Include the patient's name, telephone number, family member prefix, and the last 4 numbers of the sponsor's social security number (for example: 30/0858) in the body of the E-mail.
3. Acknowledge receipt of the E-mail when requested to do so by a health care provider.
4. Inform the medical or dental treatment facility of changes in E-mail address by completing a new consent form.
5. Notify the health care provider of any types of information considered by the patient to be inappropriate for E-mail.
6. Take precautions to preserve the confidentiality of E-mail.

SECTION V - PATIENT ACKNOWLEDGEMENT AND AGREEMENT

I have read and fully understand the information in this authorization form. I consent to the E-mail conditions and agree to abide by the guidelines listed above. I futher understand that this E-mail relationship may be terminated if I repeatedly fail to adhere to these guidelines.

I understand and accept the risks associated with the use of unsecure E-mail communications. I further understand that, as with all means of electronic communication, there may be instances beyond the control of the family and the health care provider where information may be lost or inadvertently exposed, such as during technical failures, acts of God, acts of war, and so forth.

I understand that I have he right to revoke this authorization, in writing, at any time.

By signing this form I acknowledge the privacy risks associated with using E-mail and authorize health care providers to communicate with me or any minor dependent/ward for purpose of medical advice, education, and treatment.

(Date)	SIGNATURE of Patient or Parent/Guardian	RELATIONSHIP (if other than patient)

PATIENT IDENTIFICATION *(For typed or written entries note: Name-last, first, middle initial; hospital or medical facility)*	Patient's Name		Sex
	Year of Birth	Relationship to Sponsor	Component/Status
	Depart/Service	Sponsor's Name	
	Rank/Grade	FMP-SSAN (Last four only)	
	Organization		

MEDCOM FORM 756, DEC 2004 MC PE v1.02

SUMMARY OF CARE BY NON-MILITARY MEDICAL PROVIDER

For use of this form, see PAM 40-502; the proponent agency is OTSG.

PURPOSE: The Summary of Care by Non-Military Medical Provider form provides the Army Healthcare team with essential current and relevant medical information for Soldiers seen by civilian network partners, to ensure that any functional limitation(s) is/are documented in a physical profile (DA Form 3349) when warranted. Appropriate and consistent Soldier profiles promote transparency and contribute to overall readiness of the Army. This form is applicable for Soldiers in the United States Army National Guard (ARNG), United States Army Reserves (USAR), and those on Active Duty receiving care covered by the Military Health System but at non-Military Treatment Facilities.

The following steps need to be taken to satisfy the requirement of completing the Summary of Care by Non-Military Medical Provider Form:

1. The Soldier will communicate with his/her Chain of Command within 7 business days any medical concerns being treated by a non-military healthcare provider that could negatively impact their physical capacity, deployability, or ability to perform satisfactorily. The Unit CDR or designee will provide a blank Summary of Care by Non-Military Provider Form to the Soldier, who will ensure completion by each civilian provider who performs any medical examination, evaluation, treatment, or consultation.
2. The civilian provider will complete the form based on the healthcare service(s) rendered.
3. The completed Summary of Care by Non-Military Medical Provider form and any additional available substantiating and supporting medical documents must be delivered by the Soldier to his/her Primary Care Manager (PCM) and the Regional Care Coordinator (RCC) within 7 business days of the civilian care encounter. Soldiers must also provide the form to his/her unit chain of command.
4. After review by the Soldier's PCM or RCC, appropriate processing will be made to ensure the form becomes part of the Soldier's Service Treatment Record (STR).

NOTE TO MEDICAL PROVIDER: ANY CONDITION(S) RESULTING IN FUNCTIONAL LIMITATIONS MAY LEAD TO THE ISSUANCE OF A TEMPORARY OR PERMANENT PROFILE AND MAY DIRECTLY IMPACT THE SOLDIER'S MEDICAL READINESS CLASSIFICATION AND ABILITY TO DEPLOY.

PRIVACY ACT STATEMENT

AUTHORITY: 5 USC 552e(3)(A); AR 40-501 Standards of Medical Fitness.

PRINCIPAL PURPOSE(S): This form is used to assess a Soldier's physical and functional capacity and limitations on both a temporary and permanent basis. Following this assessment, this form will be provided to the Soldier's physician and unit chain of command for the potential development of a temporary or permanent profile.

ROUTINE USE(S): Information in your records may be disclosed to:

- Private physicians and Federal agencies, including the Department of Veterans Affairs, Health and Human Services, and
- Homeland Security (with regard to members of the Coast Guard), in connection with your medical care;
  Government agencies to determine your eligibility for benefits and entitlements;
- Government and nongovernment third parties to recover the cost of MHS provided care;
- Public health authorities to document and review occupational and environmental exposure data; and
- Government and nongovernment organizations to perform DoD-approved research.

Information in your records may be used for other lawful reasons which may include teaching, compiling statistical data, and evaluating the care rendered. Use and disclosure of your records outside of DoD may also occur in accordance with 5 U.S.C. 552a(b) of the Privacy Act of 1974, as amended, which incorporates the DoD Blanket Routine Uses published at: http://dpcld.defense.gov/Privacy/SORNsIndex/Blanket-Routine-Uses/

Any protected health information (PHI) in your records may be used and disclosed generally as permitted by the HIPAA Privacy Rule (45 CFR Parts 160 and 164), as implemented within DoD by DoD 6025.18-R. Permitted uses and disclosures of PHI include, but are not limited to, treatment, payment, and healthcare operations.

WHETHER DISCLOSURE IS MANDATORY OR VOLUNTARY AND EFFECT ON INDIVIDUAL OF NOT PROVIDING INFORMATION:
Failure to provide information or sign may delay development of a Soldier's profile.

SUMMARY OF CARE BY NON-MILITARY MEDICAL PROVIDER

For use of this form, see PAM 40-502; the proponent agency is OTSG.

I. PATIENT DATA *(TO BE COMPLETED BY SOLDIER. PLEASE PRINT LEGIBLY)*

1. NAME *(Last, First, Middle Initial)*		2. PATIENT HOME ADDRESS *(Street, Apt Number, City, State, and ZIP Code)*	
3. DOD ID NUMBER	4. RANK/GRADE /	5. DOB *(YYYYMMDD)*	6. PHONE NUMBER *(Include Area Code)*
7. COMPONENT: ☐ AC	☐ ARNG (☐ AGR ☐ IDT/M-Day ☐ ING)	☐ USAR (☐ AGR ☐ TPU ☐ IMA ☐ IRR)	

8. Are you receiving any VA disability benefits? ☐ YES ☐ NO, IF YES, please list medical condition(s) with overall rating %:

II. EXAM *(TO BE COMPLETED BY MEDICAL PROVIDER. PLEASE PRINT LEGIBLY)*

9. What did you see the Soldier for today? For acute injuries, please describe how the injury occurred, including where and when:

☐ Soldier is here For Periodic Health Assessment (PHA)

10. Please attach lab and x-ray results and provide brief summary of physical, radiological, and lab exam findings when available: Attach Lab and X-Ray Results

☐ See PHA for Pertinent Documentation

11. Does the Soldier have any allergies to medications, food, insects (bees, wasps, fire ants), grass, plants, or other? If YES, please list:

12. Does the Soldier take any medications, including prescription, over the counter, vitamins/minerals, and supplements? If YES, please list:

III. HAS THE SOLDIER BEEN DIAGNOSED WITH ANY OF THE FOLLOWING CONDITIONS? *(TO BE COMPLETED BY MEDICAL PROVIDER)*

13.	YES		YES		YES		YES
a. ADD/ADHD	☐	b. Anxiety	☐	c. Arthritis/Joint Pain	☐	d. Asthma/Shortness of Breath	☐
e. Concussion/TBI/Head Trauma	☐	f. Depression	☐	g. Diabetes/High blood sugar	☐	h. Dizziness	☐
i. Fainting	☐	j. Headaches/Migraines	☐	k. High blood pressure	☐	l. High cholesterol	☐
m. Insomnia	☐	n. PTSD	☐	o. Seizures	☐	p. Sleep apnea	☐

q. Other *(e.g. additional pertinent medical history, past surgeries)*: _____

IV. IS SOLDIER ABLE TO PERFORM THE FOLLOWING FUNCTIONAL ACTIVITIES?

	YES	NO
14. Physically and mentally able to carry and fire an individual assigned weapon (~8 lbs) that requires crouching, kneeling on one or both knees, lying prone or standing all while wearing a helmet (~3 lbs), body armor (~30 lbs), and load bearing equipment (~10 lbs)?	☐	☐
15. Ride in a military vehicle wearing helmet (~3 lbs), body armor (~30 lbs), and load bearing equipment (~10 lbs) without worsening condition?	☐	☐
16. Wear helmet (~3 lbs), body armor (~30 lbs), and load bearing equipment (~10 lbs) without worsening condition?	☐	☐
17. Able to wear a protective mask & full protection outfit (HAZMAT) against chemical or biologic agents for at least 2 continuous hours per day?	☐	☐
18. Move greater than 40 lbs (backpack/duffel bag) while wearing a helmet (~3 lbs), body armor (~30 lbs), and load bearing equipment (~10 lbs) up to 100 yards?	☐	☐
19. Live and function, without restrictions, in ANY geographical or climatic area (Desert, Jungle, Arctic, or Urban) without worsening condition?	☐	☐
20. Lifting/Carrying Restriction: Maximum weight restriction in lbs: _____	☐	☐
21. Standing Limitation in minutes: _____	☐	☐
22. Walking Limitations/Restriction in all terrains with Standard Field Gear (40 lbs) for _____ minutes or _____ miles.	☐	☐
Questions 23-25 are the events in the Army Physical Fitness Test (APFT)		
23. Able to perform two minute timed **sit-ups**?	☐	☐
24. Able to perform two minute timed **push-ups**?	☐	☐
25. Able to perform timed **2-mile run**? If unable to perform the timed **2-mile run**, can Soldier participate in a timed alternate aerobic event? *(check all that apply)* ☐ 2.5 Mile Timed Walk ☐ 6.2 Mile Timed Stationary Bike ☐ 800 Yard Timed Swim	☐	☐

V. DIAGNOSIS *(TO BE COMPLETED BY MEDICAL PROVIDER. PLEASE PRINT LEGIBLY)*:

THE FOLLOWING SECTION MUST BE COMPLETED AND SIGNED BY THE EXAMINING MEDICAL PROVIDER.
Your evaluation of this Soldier's Functional Limitations in section IV is important. Please complete all items below.

26. Diagnosis:

27. Treatment Plan *(example: X Rays, Physical Therapy, Medication)*:

28. Follow Up:

29. Functional Limitations are:

☐ Permanent or ☐ Temporary: the expected duration of the limitation(s) is for _____ Days (Max 90)

Can Soldier take record Army Physical Fitness Test **now** (Refer to 23-25 above)?

☐ Yes ☐ No If No, anticipation date to take the APFT? _____

MEDICAL PROVIDER'S FULL NAME *(PRINT OR TYPE)*	MEDICAL PROVIDER'S MEDICAL DEGREE *(MD, DO, NP, PA)*	
MEDICAL PROVIDER'S SPECIALTY	DATE OF EVALUATION	EMAIL ADDRESS

OFFICE PHONE NUMBER *(Include Area Code)*	FAX NUMBER *(Include Area Code)*	SIGNATURE	DATE SIGNED

CONTINUATION
(Please use this area to complete any response from the previous pages.)

ACFT limitations

ACFT Limitation Profiles will NOT be issues unless one of the two following conditions are met:

1. Soldier has existing APFT limitations

2. Medical Documentation is provided to support a new PERMANENT profile.

Please email all profile requests with only ACFT limitations to usarmy.usarc.usarc-hq.mbx.armmc-acft@army.mil

Functional Capability Form – Army Combat Fitness Test (ACFT) 3.0

Please complete this form for PERMANENT ACFT limitations ONLY.

Clear Form

Soldier's Name: _____ Soldier's DoD ID Number: _____

Event #1 - Maximum Dead Lift (MDL)

Given this Soldier's permanent joint condition or restriction is he/she able to:

a. Squat to touch the hands to mid-calf level while maintaining a flat back?

b. If female, lift a weighted bar of 120 pounds (minimum) from the floor with the arms straight at the side 3 times?

c. If male, lift a weighted bar of up to 140 pounds (minimum) from the floor with the arms straight at the side 3 times?

d. **Can Soldier participate in ACFT Event #1 (MDL) - 3-rep Maximum Dead Lift?**

☐ **May Participate**
☐ **May NOT Participate**

Event #2 – Standing Power Throw (SPT)

Given this Soldier's permanent joint condition or restriction is he/she able to:

a. Grasp a 10 pound medicine ball with both hands and bend at the hips/knees to lower it between the legs?
b. Throw a 10 pound medicine ball backward and overhead?

Can Soldier participate in ACFT Event #2 (SPT) – Standing Power Throw?

☐ **May Participate**
☐ **May NOT Participate**

Event #3 – Hand Release Push-up (HRP)

Given this Soldier's permanent joint condition or restriction is he/she able to:

a. Perform a standard push-up from start to finish?
b. Lie down in a push-up position and move both arms out to the side, extending the elbows to a T position?

Can Soldier participate in ACFT Event #3 (HRP) – Hand Release Push-up?

☐ **May Participate**
☐ **May NOT Participate**

Event #4 – Sprint Drag Carry (SDC)

Given this Soldier's permanent joint condition or restriction is he/she able to:

a. Sprint 50 meters?
b. Grasp a two-handled strap and move backwards pulling a sled with two 45-pound weights?
c. Move in a lateral direction while leading with the left foot and repeat while leading with the right foot?
d. Move in a forward direction while carrying a 40 pound kettle bell in each hand?

Can Soldier participate in ACFT Event #4 (SDC) – Sprint-Drag-Carry?

☐ **May Participate**
☐ **May NOT Participate**

Functional Capability Form – Army Combat Fitness Test (ACFT)

Event #5 –tfl·y⁆

Given this Soldier's permanent joint condition or restriction is he/she able to:

I·℗ [λŜ λy⁀I· LJℕ2yŜ LJdžǎKπdžLJπfλ⁆Ŝ LJ2ǎλúλ2y΢ ǿλúK úKŜ ō2Řè℔ǎ ǿŜλ∃Kú ō2ℕyŜ 2y⁀ŧ2ℕŜI·ℕY⁀ǎ΢ Ŝfō2ǿǎ΢ I·yŘ ű2Ŝǎ ǿKλfŜ
Y⁀I·λyúI·λyλy∃ I· ∃ŜyŜℕally straight line from heels to shoulders for a minimum of 1 Min 10 Seconds?

Cl·y⁀Soldieℕ participate in ACFT Event #5 (PLK) – PlankK

☐ **May Participate**
☐ **May NOT Participate**

Event #6 – 2 Mile Run (2MR)

Given this Soldier's permanent joint condition or restriction is he/she able to:

a. Run 2 miles on level terrain?

Check means Soldier may participate in ACFT Event #6 (2MR) – 2 Mile Run

☐ **May Participate**
☐ **May NOT Participate**

Alternate Cardio Event

*** <u>Alternate Cardio Event is only to be included if Soldier is deemed unable to participate in ACFT Event #6 above</u> ***

Given this Soldier's permanent joint condition or restriction is he/she able to: (Swim restriction must be due to physical limitation)

a. Ride a **<u>stationary bike</u>** for up to 25 minutes to an equivalent distance of 12,000 Meters? ☐ Yes ☐ No (bike)
b. Row an ergometric **<u>rowing machine</u>** for up to 25 minutes to an equivalent distance of 5,000 Meters? ☐ Yes ☐ No (row)
c. Swim laps in a pool for up to 25 minutes for a total distance of 1,000 meters? ☐ Yes ☐ No (swim)
d. Walk for up to 36 minutes for a total distance of 2.5 miles? ☐ Yes ☐ No (Walk)

A "yes" in the above boxes means Soldier may participate in that particular alternate cardio event for the ACFT

Soldier's Name: _____ Soldier's DoD ID number: _____

Physician's Name: _____ Physician's Signature: _____

Medical Provider Specialty: _____ Date: _____

* All events should be evaluated from the standpoint of can the individual complete the task without causing further injury to an existing condition.

<u>For overall information on the ACFT and for links to ACFT training apps, visit the link below:</u>

https://www.army.mil/acft/