



DEPARTMENT OF THE AIR FORCE  
AIR FORCE RESERVE COMMAND

(Do not date until signed)

MEMORANDUM FOR \_\_\_\_\_  
{MEMBER'S NAME & SSN}

FROM: 507 MDS  
7455 Reserve Road  
Tinker AFB, OK 73145  
P: 405-582-6730 Fax: 405-736-3754

SUBJECT: **Request for Medical Information**

1. PRIVACY ACT STATEMENT. Authority: Title 10, U.S.C., Sections 10204 and 10205, and E. O. 9397. Principle Purpose: To maintain essential records of Air Force Reservists, and identify specific personal capabilities. Routine Uses: Disclosure may be made to any Department of Defense component or, upon request, to other Federal, state, or local agencies in pursuit of their official duties and may be used for other lawful purposes including law enforcement and litigation. Disclosure: MANDATORY. Failure to respond could cause incorrect priority for recall in the event of national mobilization and is a violation of Federal law.

2. COMPLETE MEDICAL HISTORY OF THE CONDITION.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

3. DIAGNOSIS (Include ICD 10 Code)

\_\_\_\_\_  
\_\_\_\_\_

4. TREATMENT PLAN.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

5. LIMITATIONS (Include social and industrial impairments [S&I] for psychiatric conditions. If no limitations, state so.)

\_\_\_\_\_  
\_\_\_\_\_

Check and specific military related activities the member **CANNOT** perform.

- |                              |                               |  |
|------------------------------|-------------------------------|--|
| ___ Run 1.5 Mile             | ___ Push-ups                  | ___ Stand ≥12 hrs.                         |
| ___ Abdominal Crunches       | ___ High Impact Activities    | ___ Walk 2 kilometers/1.25 mi              |
| ___ Maximum effort 100yd run | ___ Bend, crawl, stoop, climb | ___ Carry, drag, lift, push, & pull ≥40lbs |

ANTICIPATED RELEASE DATE \_\_\_\_\_

6. RECOMMENDATION OF THE PATIENT'S ABILITY TO PERFORM DUTIES IN A STRESSFUL AND PHYSICALLY DEMANDING ENVIRONMENT.

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7. CONFIRMATORY DATA: Please attach all clinical/treatment notes, results of any imaging studies, laboratory, additional testing, consultations or other data which substantiates the information on this form regarding the diagnosis or limitations. DO NOT submit letters or memos. These documents may be faxed directly to the 507th Medical Squadron at 405-736-3754.

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Physician's Name and Title (Type or Print)

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Signature

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Date