

MEDICAL SUMMARY FORM

PRIVACY ACT STATEMENT: This information is subject to the Privacy Act of 1974 (5 U.S.C. Section 552a). This information may be provided to appropriate Government agencies when relevant to civil, criminal or regulatory investigations or prosecutions. The Social Security Number, authorized by Public Law 93-579 Section 7 (b) and Executive Order 9397, is used as a unique identifier to distinguish between employees with the same names and birth dates and to ensure that each individual's record in the system is complete and accurate and the information is properly attributed.

MILITARY SEALIFT COMMAND
Medical Department (CODE: N02H)
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(757) 443-5760 (757) 443-5767

Mariner Name / Last 4 SSN

MEDICAL SUMMARY FORM

(ALTERNATIVELY, A NARRATIVE SUMMARY ADDRESSING THE ELEMENTS BELOW MAY BE PROVIDED)

Note to examining provider: The seafaring environment is arduous and exposes personnel to many environmental and physical hazards. It is essential that crew members be physically fit to perform the duties of their position worldwide. They may work long shifts, be required to move quickly about the ship, engage in strenuous physical activity, be exposed to temperature extremes for long periods, don emergency gear including respirators and firefighting SCBAs, **and serve for up to 6-months at sea remote from medical care.**

MEDICAL SPECIALTY REQUIRED:**1. MEDICAL PROBLEMS TO BE ADDRESSED:****2. SIGNIFICANT HISTORY AND PHYSICAL FINDINGS:** (HPI, Vital signs, PE results)**3. SIGNIFICANT ANCILLARY TESTING:** (Please provide results of labs, imaging, PFT, EKG, audio, etc.)**4. DIAGNOSIS / DIAGNOSES:**

CONTINUE ON REVERSE OF FORM

Mariner Name / Last 4 SSN

5. TREATMENT PLAN: (LIST ALL MEDICATIONS INCLUDING PRESCRIPTION, HERBAL, SUPPLEMENTS AND OTC), PHYSICAL THERAPY, AND OTHER TREATMENTS

Note: **For medications, please provide a 6-month supply.**

6. RECOMMENDED PHYSICAL LIMITATIONS (if any):

If applicable, estimated date of Maximum Medical Improvement (MMI): _____

AUTHORITY TO RELEASE PRIVILEGED MEDICAL INFORMATION: I hereby authorize release to the Military Sealift Command Medical Department and the Department of Defense Medical Treatment Facilities, privileged medical correspondence and records in my case.

Mariner's signature

Date

Mariner's Phone Number

Mariner's Email Address

EVALUATING / TREATING HEALTHCARE PROVIDER:

Medical/Dental Provider's Name (Print or Stamp)

Medical/Dental Provider's Signature

Medical Specialty: _____

Date Signed: _____

Address: _____

Telephone: _____

Notice to CIVMARs: administrative action including but not limited to progressive discipline or termination will be applied to any MSC CIVMAR that fails to provide medical documentation within 15 days as required.

THIS SECTION FOR MSC INTERNAL USE ONLY

Case Review completed: _____ (date)

Additional Info needed (if any): _____

Duty Status and Date: _____ * / **

* Please see SF-600 entry

** **MSC Medical has final authority for MSC CIVMAR sea-duty medical status determination**