SUBMARINE EMBARKATION MEDICAL INFORMATION

E-Mail

PRIVACY ACT STATEMENT

AUTHORITY: 5 U.S.C. 301. Departmental Regulations; DoD 6025.18-R, DoD Health Information Privacy Regulation and SORN N06150-2.
"NOTE: This form contains Personal Identifiable Information. The DoD Health Information Privacy Regulation (DoD 6025.18-R) issued pursuant to the Health Insurance Portability and Accountability Act of 1996, applies to most such health information. DoD 6025-18-R may place additional procedural requirements on the uses and disclosures of such information beyond those found in the Privacy Act of 1974 or mentioned in the system of records notice."
PURPOSE: To help the Medical Department make recommendations to the ship's Commanding Officer regarding the medical compatibility of individuals seeking to embark on submarines in accordance with current Navy directives and the capabilities of the ship's Medical Department.
ROUTINE USES: Information will be accessed by medical personnel with a need to know in order to assess and make recommendations to the Commanding Officer. Limited information may be disclosed to the Commanding officer to support the recommendation.
DISCLOSURE: Voluntary. However, failure to provide the requested information may result in no further action being taken with regard to embarkation request.

Certain medical conditions are not compatible with the Submarine environment and may be beyond the capabilities of the Medical Department if medical intervention is required. The information requested below will help the Medical Department make a recommendation to the ship's Commanding Officer. In accordance with current Navy directives, pregnant females are not eligible for embarkation. You must bring all of your medications in sufficient quantities to cover your entire time aboard the ship.

1. Name *(Last, First MI)*:	2. Age:	3. Telephone Number:
4. Personal Physician or Healthcare System:		5. Telephone Number:

6. Current Medications and Dosage:

7. Drug Allergies:

8. Do you wear a medical alert tag? ☐ Yes ☐ No If "Yes" give reason below.

9. Have you ever had or do you have any of the following? *(Check or circle all that apply)*

☐ Asthma	☐ Heart Disease	☐ Shortness Of Breath	☐ Chronic Lung Disease
☐ Diabetes	☐ Cancer	☐ Bleeding Problems	☐ Clotting Disorders
☐ Stroke	☐ Claustrophobia	☐ Dental Disease	☐ Skin Disorder
☐ Ulcers	☐ Dizzy Spells	☐ Communicable Disease	☐ Previous Surgery
☐ Pacemaker	☐ Chest Pains	☐ Kidney Disease	☐ Severe Motion Sickness
☐ Recent Injury/Illness	☐ Food Allergies		

10. Please explain any checked or circled items.

11. Have you had any other medical conditions not listed above? ☐ Yes ☐ No If "Yes" explain below.

THIS SECTION TO BE COMPLETED BY REQUESTER'S PRIMARY CARE PROVIDER OR EMPLOYEE MEDICAL CLINIC

12. Comments:

13. Medical clearance determination (check or circle one): Individual Medically Cleared; ☐ Cleared ☐ Not Cleared
"Cleared" indicates that the requester has no disqualifying condition as described in enclosure 1 of OPNAVINST 6420.1A

14. Name/Command of Screener:	Date Signed:	Signature of Screener:

15. Individual Medically Cleared (check or circle one): ☐ Cleared ☐ Not Cleared for embarkation.
"Cleared" indicates that the cognizant UMO has certified that the requester meets minimum medical standards to embark for a period up to but not exceeding 12 months.

16. Name/Command of UMO:	Date Signed:	Signature of UMO: