



**DEFENSE HEALTH AGENCY**  
**KELLER ARMY COMMUNITY HOSPITAL**  
 900 WASHINGTON ROAD  
 WEST POINT, NEW YORK 10996-1197

MCUD-PAD

DATE:

**Memorandum for** Keller Army Community Hospital: ATTN: Liaison (PAD),  
 900 Washington Road, West Point NY 10996

SUBJECT: Request for Physical Evaluation

1. The following fields are required. Do not leave any field blank.
  - a. First Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_
  - b. Last Name: \_\_\_\_\_
  - c. DOD or SSN: \_\_\_\_\_
  - d. DOB (MM/DD/YY): \_\_\_\_\_
  - e. Rank/Grade: \_\_\_\_\_ Sex: \_\_\_\_\_
  - f. Religion: \_\_\_\_\_
  - g. Status (check one): National Guard Reserve Prior Service
  - h. Organ Donor: Yes\_\_\_ No\_\_\_
  - i. Soldier's Email: \_\_\_\_\_
  - j. Unit Name and UIC: \_\_\_\_\_
  - k. Duty Station Address: \_\_\_\_\_
  - l. Duty Station POC & Phone #: \_\_\_\_\_
  - m. Home Address \_\_\_\_\_
  - n. Home Phone #: \_\_\_\_\_
  - o. Cell Phone # (OPTIONAL): \_\_\_\_\_
  - p. Line of Duty: Yes\_\_\_ No\_\_\_ (If yes, provide copy)
  - q. Currently On Profile: Yes\_\_\_ No\_\_\_ (If yes, provide copy)
  - r. Other medical documentation attached: Yes\_\_\_ No\_\_\_
  - s. Emergency Contact Name/Relationship \_\_\_\_\_
  - t. Emergency Contact Address \_\_\_\_\_
  - u. Emergency Contact Phone #: \_\_\_\_\_
  
2. **Must** provide a brief description of what medical attention the Soldier requires (e.g., Fit for Duty, PHA, Commissioning Physical, Flight Physical).  
 \_\_\_\_\_
  
3. Additionally, if the Soldier requires a Mental Health evaluation, specify below. If not, please leave unchecked.  
 MH Evaluation          SUDCC Evaluation
  
4. Commanders' signature signifies that he/she authorizes that the Soldier requires this medical attention for military progression.

\_\_\_\_\_ (Signature)  
 \_\_\_\_\_ (Commander Name)  
 \_\_\_\_\_ (Rank, Unit)  
 \_\_\_\_\_ (Title)  
 \_\_\_\_\_ (Email Address)