DEPARTMENT OF THE ARMY
U.S. ARMY MEDICAL DEPARTMENT ACTIVITY
WEST POINT, NEW YORK 10996

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 information is provided as required:
   a. First name: _____
   b. Middle name:_____
   c. Last name:_____
   d. DOD or SSN: _____
   e. DOB (MM/DD/YY): _____
   f. Rank/Grade: _____
   g. Sex: _____
   h. Status(check one): ☐National Guard ☐Reserve ☐Applicant
   i. Organ Donor: Yes☐ No☐
   j. Soldier's email: _____
   k. Unit Name and UIC: _____
   l. Duty Station Address: _____
   m. Duty Station POC & Phone #: _____
   n. Home Address _____
   o. Home Phone #: _____
   p. Cell Phone # (OPTIONAL): _____
   q. LOD: Yes☐ No☐ (If yes, provide copy)
   r. Currently On Profile: Yes☐ No☐ (If yes, provide copy)
   s. Other medical documentation attached: Yes☐ No ☐
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.
   ☐BH Evaluation ☐SUDCC Evaluation
4. Commanders' **DIGITAL** signature signifies that he/she authorizes that the Soldier requires this medical attention for military progression.

_____ (Digital Signature)
_____ (Commander Name)
_____ (Rank, Unit)
_____ (Title)
_____ (Email Address)