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

REPLY TO
ATTENTION OF

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. Name: _____
   b. SSN: _____
   c. DOB: _____
   d. Rank/Grade: _____
   e. Sex: _____
   f. Status(circle one): National Guard / Reserve / Applicant
   g. Soldier's email: _____
   h. Unit Name and UIC: _____
   i. Duty Station Address: _____
   j. Duty Station POC & Phone #: _____
   k. Home Address _____
   l. Home Phone #: _____
   m. Cell Phone # (OPTIONAL): _____
   n. LOD: Yes___ No___ (If yes, provide copy)
   o. Currently On Profile: Yes___ No___ (If yes, provide copy)
   p. Other medical documentation attached: Yes___ No ___

2. The following is the type of physical examination the Soldier requires (e.g., PHA, Commissioning Physical, Flight Physical).
   _____
   _ _

3. The 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)