



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. DODID: _____
 - 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 a brief description of what medical attention the soldier requires (e.g., PHA, Commissioning Physical, Flight Physical).

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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)