**EXAMPLE ONLY**

 *PLACE ON PROVIDER’S LETTERHEAD*

DATE: \_\_\_\_\_\_\_\_

PATIENT NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_\_\_\_\_\_\_\_\_

DIAGNOSIS: (DIAGONOSIS OF CONDITION FOR WHICH YOU ARE SEEING THE SERVICE MEMBER)

PROGNOSIS: (GOOD, FAIR, POOR, ETC.)

TREATMENT PLAN: (PRIOR APPT DATES; PENDING APPOINTMENTS; OR STATE NO FOLLOW UP AT THIS TIME

RESTRICTIONS FOR MILITARY SERVICE: EXAMPLE: IS HE SAFE TO BE AROUND WEAPONS?; EVADE FIRE? (STATE HOW LONG RESTRICTIONS ARE FOR; OR ANY OTHER SPECIFIC LIMITATIONS) PLEASE STATE: NO RESTRICTIONS IF NONE.

MEDICATIONS: LIST NAME OF MEDICATION; DOSE; FREQUENCY OF USE; ROUTE; DURATION; PURPOSE THE MEDICATION WAS GIVEN; AND LEGNTH OF TIME STABLE ON MEDICATION (IF ROUTINE MEDICATION, **HAVE THEY BEEN STABLE ON IT FOR >90 DAYS?**?). PLEASE STATE: NO MEDICATIONS IF NONE.

-----A BRIEF PARAGRAPH OF ANY ISSUES RELATED TO THE ABOVE DIAGNOSIS OR INFORM IF THE SERVICE MEMBER HAS MET MAXIMUM MEDICAL TREATMENT. PLEASE LIST ANY REFERAL.

PLEASE NOTE: INFORMATION IS TO BE USED BY MILITARY PROVIDER TO ASCERTAIN SERVICE MEMBERS STATUS IN REGARDS TO FITNESS FOR DUTY/TEMP OR PERM PROFILE. WE ARE **NOT** ASKING YOU TO DETERMINE FITNESS FOR DUTY.

SIGNATURE OF TREATMENT PROVIDER

CONTACT INFORMATION