NROTC ANNUAL PHYSICAL CONDITION CERTIFICATE

Date: ___________________

Instructions:

This certificate is to be completed annually by members of the NROTC Program as required by the Naval Administrative Manual (NAM). The intentional failure to disclose an illness or disease could be construed as an intent to defraud the Government and could result in the member's loss of disability benefits or be the basis for administrative action according to the NAM.

Type or clearly print member's name (last, first, middle initial); social security number; and unit to which assigned.

The member shall complete the appropriate responses, sign in ink, and date.

1. Last Name, First Name, Middle Init.			2. SSN		3. Rate/Rank
4. Designator/MOS/NEC	5. Sex	6. Age	7. Date of Birth		
8. Known Allergies			9. Unit or School and UIC		
10. Home Address Street			City		
11. State Zip + 4 Code			Home Phone Number		Work Phone Number
12. Location of Health Record			13. Location of Dental Record		
14. Date of last Complete Physical Examination			15. Purpose of Examination		
16. Date of last Dental Exam	17. Type of Examination		18. Class	19. Date of last PAP and results	20. Date of last Mammogram and results
21. Date of last HIV Blood Test	22. Body Fat %		23. Height		24. Weight

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1. Have you had any injury, illness or disease within the past 12 months which required hospitalization or caused you to be absent from school, duty or civilian occupation for more than 3 consecutive days?
   ( ) NO ( ) YES If yes, explain: ______________________________

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2. Are you now, or have you been under a physician's care during the 12 past months?
   ( ) NO ( ) YES If yes, explain: ______________________________

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3. Have you taken prescription medications (other than birth control) in the past 12 months?
   ( ) NO ( ) YES If yes, what are they? ______________________________

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4. Do you have any physical defect(s), family or mental problems which might restrict your performance on active duty or prevent your mobilization?
   ( ) NO ( ) YES If yes, explain: ______________________________

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5. Additional comments: ______________________________

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Upon completion of indicated action, file completed certificate in member's Health Record and a copy in member's Dental Record.

I certify that the information contained in this form is true and complete to the best of my knowledge and belief.

MEMBER'S SIGNATURE: ______________________________

PRT COORDINATOR: ______________________________

COMMANDING OFFICER'S SIGNATURE: ______________________________
(WHEN REQUIRED)

REVIEWING OFFICER'S COMMENTS: ______________________________

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