



# United States Army Recruiting Command



AECP SAMPLE APPLICATION AND GUIDE



**[WWW.USAREC.ARMY.MIL/MRB/AECP/INDEX.SHTML](http://WWW.USAREC.ARMY.MIL/MRB/AECP/INDEX.SHTML)**

The information contained in this sample application changes frequently. For the most up-to-date information please visit our web-site at [www.usarec.army.mil/mrb/aecp/index.shtml](http://www.usarec.army.mil/mrb/aecp/index.shtml)

**APPLICATION FOR APPOINTMENT**

For use of this form, see AR 135-100, AR 145-1, AR 351-5, and AR 601-100; the proponent agency is DCSPER

**DATA REQUIRED BY THE PRIVACY ACT OF 1974**

**AUTHORITY:** Title 10 United States Code, Section 3012 (Title 5 United States Code, Section 552a)

**PRINCIPAL PURPOSE:** To obtain an appointment as a commissioned or warrant officer in the Regular Army or Army Reserve, or to obtain selection to attend the US Army Officer Candidate School.

**ROUTINE USES:** Basis for determination of qualifications and background information for eligibility for consideration for appointment as a Regular Army or Army Reserve commissioned/warrant officer or for selection for attendance at the US Army Officer Candidate School.

**DISCLOSURE** Disclosure of information requested in DA Form 61 is voluntary. Failure to provide the required information will result in non-acceptability of the application.

<b>1. TYPE OF APPOINTMENT FOR WHICH APPLICATION IS SUBMITTED</b>			2. GOVERNING REGULATION OR CIRCULAR <i>(Specify appropriate section(s) if applicable)</i> <b>AR 601-100</b>												
<input checked="" type="checkbox"/>	COMMISSIONED OFFICER - REGULAR ARMY			3. GRADE FOR WHICH APPLYING <i>(Reserve appointments only)</i>											
<input type="checkbox"/>	COMMISSIONED OFFICER - ARMY RESERVE			4. <b>SOURCE OF APPLICATION</b> <i>(ROTC only)</i>											
<input type="checkbox"/>	WARRANT OFFICER - REGULAR ARMY	<input type="checkbox"/>	DMG	DATE DESIGNATED:											
<input type="checkbox"/>	WARRANT OFFICER - ARMY RESERVE	<input type="checkbox"/>	SCHOLARSHIP - ENTER 1, 2, 3 OR 4 YEARS:												
<input type="checkbox"/>	OFFICER CANDIDATE SCHOOL	5. <b>ONLY FOR APPLICANTS FOR APPOINTMENT AS WARRANT OFFICERS</b> <i>(List choice by MOS code and title)</i>													
<b>6. BRANCH AND SPECIALTY PREFERENCES</b>		a. MOS CODE		b. MOS TITLE											
Regular Army and Officer Candidate applicants and all ROTC graduates: In numerical sequence, indicate 10 branch preferences other than CA and SS.															
USAR applicants: If applying for a specific Reserve vacancy, indicate <i>ONLY</i> the branch of the vacant position; all other applicants may enter more than one branch.															
<b>PERSONAL DATA</b>															
PREFER- ENCE	BRANCH	SPECIALTY	7. NAME <i>(Last, first, middle)(Explain variations from birth certificate in Item 41)</i>			8. GRADE	9a. SOCIAL SECURITY NUMBER								
			Smith, John Doe(include full middle name)			E-4	123-45-6789								
	AD		10. BRANCH <i>(MOS if enl or wo)</i> 68W	11. TOTAL YRS ACTIVE SERVICE 6	12. MARITAL STATUS S, M, D	13. NUMBER OF DEPENDENTS UNDER 18 YEARS OF AGE 1	9b. SELECTIVE SERVICE NUMBER Males only go to www.sss.gov								
	AG		14. DATE OF BIRTH  01 Jan 73	15. PLACE OF BIRTH <i>(City, county, state)</i> Fairfield, Solano, CA Must include "County"	16. SEX  M	17. COMPLETE MILITARY ADDRESS <i>(If presently on active duty) (Include ZIP Code)</i> Applicant's Completed(to include unit name) Unit address&Phone# john.smith@us.army.mil PHONE AND/OR AUTOVON NUMBER 502-616-0381									
	AR														
	AV														
	CA														
	CM														
	EN		18. PERMANENT ADDRESS <i>(Include ZIP Code)</i> 1234 Darnall St"Applicant's home of Record"		19. CURRENT MAILING ADDRESS <i>(If difference from Item 18) (Include ZIP Code)</i> Applicant's current address and phone# (this is where you receive your mail										
	FA		PHONE <i>(Include area code) phone #</i>		PHONE <i>(Include area code) Phone #</i>										
	FI														
	IN		20. US CITIZEN	a. NATIVE	b. <input type="checkbox"/> NATURALIZATION	c. APPLICANT'S CERTIFICATE NO. <i>(If Item b. checked) (Date, place, court)</i>									
	MI		<input checked="" type="checkbox"/> YES	<input checked="" type="checkbox"/> YES	<input type="checkbox"/> DERIVED	"If applicable"									
	MP		<input type="checkbox"/> NO	<input type="checkbox"/> NO	<input type="checkbox"/> IMMIGRANT										
	OD														
	QM														
	SC		21. <b>CIVILIAN EDUCATION</b> <i>(See page 3 for additional requirements for professional personnel)</i>												
	SS		a. HIGH SCHOOL GRADUATE <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	b. NAME AND LOCATION OF HIGH SCHOOL Santa Barbra High school											
	TC		c. NAME AND LOCATION OF EACH COLLEGE OR UNIVERSITY ATTENDED <i>(Include USMA, USNA, USAFA, USCGA, and USMMA)</i>		(1) DEGREE	(2) SEMESTER CREDITS EARNED	(3) YEARS ATTENDED	(4) DATE GRADUATED OR WILL GRADUATE			(5) MAJOR SUBJECT				
I	AN	66H													
	CH														
	DE							Santa Barbra Community College		25		1			General Studies
	JA							Troy University		40		2			Pre-Nursing
	MC		"If you need to add more schooles use block #41 if you run out of room here"												
	MS														
	SP		d. SPECIAL EDUCATIONAL HONORS, SCHOLAR- SHIPS, ETC.		e. IF YOU HAVE EVER BEEN EXPELLED FROM SCHOOL, OR PLACED ON PROBATION, EITHER FOR ACADEMIC OR DISCIPLINARY REASONS, EXPLAIN <i>(Continue in Item 41(Remarks))</i>										
	VC														
<b>22. HIGHEST LEVEL SERVICE SCHOOL ATTENDED</b>															
a. NAME OF SCHOOL			b. COURSE		c. DATES <i>(Mo-Yr)</i>		COMPLETED		d. IF NOT COMPLETED GIVE REASON						
					FROM	TO	YES	NO							
GRAF NCO Academy			WLC		03/06	04/06	<input checked="" type="checkbox"/>	<input type="checkbox"/>							
23a. FOREIGN LANGUAGES AND DEGREE OF PROFICIENCY Spanish 2/2+ or List NONE								b. ALAT SCORE <i>(If applicable)</i>							

24. ARE YOU NOW, OR HAVE YOU EVER BEEN A CONSCIENTIOUS OBJECTOR?  YES  NO (If yes, attach affidavit)

25.  I UNDERSTAND THAT, IF I AM SELECTED FOR APPOINTMENT, I WILL BE EXPECTED TO ACCEPT SUCH ASSIGNMENTS AS ARE IN THE BEST INTEREST OF THE SERVICE REGARDLESS OF MY MARITAL STATUS AND/OR RESPONSIBILITY FOR DEPENDENTS; AND IT IS MY RESPONSIBILITY TO MAKE APPROPRIATE ARRANGEMENTS FOR THE CARE OF MY DEPENDENTS SHOULD I BE REQUIRED TO PERFORM DUTY IN AN AREA WHERE DEPENDENTS ARE NOT PERMITTED.

26. HAVE YOU EVER UNDER EITHER MILITARY OR CIVILIAN LAW BEEN INDICTED OR SUMMONED IN TO COURT AS A DEFENDANT IN A CRIMINAL PROCEEDING (Including any proceedings involving juvenile offenses, article 15, UCMJ, and any court-martial) REGARDLESS OF THE RESULT OF TRIAL, OR CONVICTED, FINED, IMPRISONED, PLACED ON PROBATION, PAROLED OR PARDONED, OR HAVE YOU EVER BEEN ORDERED TO DEPOSIT BAIL OR COLLATERAL FOR THE VIOLATION OF ANY LAW, POLICE REGULATION OR ORDINANCE? (Exclude traffic violations involving a fine or forfeiture of \$100 or less).

YES  NO IF YES, ATTACH REQUEST FOR WAIVER LISTING THE DATE, THE NATURE OF EACH ALLEGED OFFENSE OR VIOLATION, THE NAME AND LOCATION OF THE COURT OR PLACE OF HEARING, AND THE PENALTY IMPOSED OR OTHER DISPOSITION OF EACH CASE AND FURNISH COPY OF COURT ACTION OR DETAILED STATEMENT IN AFFIDAVIT FORM AS TO THE OUTCOME OF EACH CASE.

27. ACTIVE MILITARY SERVICE (Indicate tour with each organization separately - show ROTC Camps in Item 39)

	a. ORGANIZATION (US Armed Forces, USCG, NOAA, US Public Health Service, Peace Corps)	b. DATES (Day, Month, Year)		c. BRANCH/MOS (As appropriate)	d. PRIOR SERVICE NO. (If applicable)	e. HIGHEST GRADE AND COMPONENT
		FROM	TO			
ENLISTED	US Armed Forces	01012008	Present	68WM6	NA	E-4 / ARMY
	US Armed Forces	01102005	11102008	879P	NA	E-4 / USAF
WARRANT OFFICER						
COMMISS- SIONED						

f. DATE CURRENT ACTIVE DUTY TOUR TERMINATES 01012016 g. DATE OF LAST ADL PROMOTION 01012008

28. RESERVE OR NATIONAL GUARD SERVICE (Not on active duty)

	a. ORGANIZATION (US Armed Forces, USCG, NOAA, US Public Health Service, Peace Corps)	b. DATES (Day, Month, Year)		c. BRANCH/MOS (As appropriate)	d. PRIOR SERVICE NO. (If applicable)	e. HIGHEST GRADE AND COMPONENT
		FROM	TO			
ENLISTED	US Armed Forces	01032005	01092005	92G	NA	E-2 / ARNG
WARRANT OFFICER						
COMMISS- SIONED						

29. SOURCE OF CURRENT COMMISSION (If applicable)  OTHER

ARNGUS:  OCS  DIRECT APPOINTMENT

USAR:  ROTC  ROTC (ECP)  ROTC (SMP)  OCS  DIRECT APPOINTMENT

30. AWARDS (Do not list theater or service medals)  
1-ARCOM, 2-AAM, EFMB

31. HAVE YOU EVER APPLIED AND NOT BEEN SELECTED FOR: a. ROTC  YES  NO b. OCS  YES  NO

c. APPOINTMENT IN RESERVE COMPONENT (USAR/ARNG)	YES		NO		d. APPOINTMENT IN REGULAR ARMY	YES		NO	
AS A WARRANT OFFICER				X	AS A WARRANT OFFICER				X
AS A COMMISSIONED OFFICER				X	AS A COMMISSIONED OFFICER				X

e. IF ANSWER IS "YES", EXPLAIN FULLY

32. ARE YOU NOW OR HAVE YOU EVER BEEN IN THE MILITARY SERVICE OF OR BEEN EMPLOYED BY A FOREIGN GOVERNMENT (If yes, give dates, country and type of service or employment) NO

33. HAVE YOU EVER RESIGNED OR BEEN ASKED TO RESIGN IN LIEU OF ELIMINATION PROCEEDINGS; BEEN DISCHARGED IN LIEU OF ELIMINATION, FURLOUGHED (other than regular furlough or leave), OR PLACED ON INACTIVE STATUS WHILE SERVING IN THE US ARMED FORCES; OR, HAVE YOU EVER RESIGNED OR BEEN ASKED TO RESIGN FROM A POSITION WHILE IN PRIVATE OR GOVERNMENT EMPLOYMENT? (If yes, state circumstances; if more space is required, continue on separate sheet).

YES  NO

<b>34. APPLICANTS FOR JUDGE ADVOCATE GENERAL'S CORPS ONLY</b>	<b>35. APPLICANTS FOR CHAPLAINS BRANCH ONLY</b>
BARS OF WHICH YOU ARE A MEMBER <i>(Specify dates)</i>	RELIGIOUS DENOMINATION BY WHICH YOU WILL BE ENDORSED

<b>36. APPLICANTS FOR MEDICAL AND DENTAL CORPS ONLY</b>				
a. TRAINING		b. NAME AND LOCATION OF HOSPITAL	c. DATES <i>(Month and Year)</i>	
LEVEL	TYPE		FROM	TO
INTERNSHIP				
RESIDENCY TNG				
SPECIALTY TNG				
d. SPECIALTY BOARDS			e. DATES OF CERTIFICATION <i>(Day, Month, Yr)</i>	
f. PLACE IN WHICH CURRENTLY LICENSED				

<b>37. APPLICANTS FOR ARMY NURSE CORPS AND ARMY MEDICAL SPECIALIST CORPS ONLY</b>				
a. NAME OF NURSING OR ACCREDITED PROFESSIONAL SCHOOL			b. LOCATION	
c. DATES OF ATTENDANCE <i>(Mo, Yr)</i>		d. STATE AND CURRENT REGISTRATION NUMBER		e. STATE AND DATE OF INITIAL REGISTRATION <i>(Day, Month, Year)</i>
FROM	TO			
f. POSTGRADUATE COURSES <i>(Include courses at general hospitals, service schools, and short courses)</i>				
(1) SUBJECT OR COURSE	(2) NAME AND LOCATION OF SCHOOL OR HOSPITAL	(3) SEMESTER CREDITS EARNED	(4) DATES OF ATTENDANCE <i>(Month, Year)</i>	
			FROM	TO
38. HAVE YOU BEEN EMPLOYED BY THE US ARMY AS A DIETITIAN, OCCUPATIONAL OR PHYSICAL THERAPIST? <i>(If yes, give dates)</i>				
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				

<b>39. ARMY ROTC</b> <i>(To be completed only by prospective ROTC graduates applying for appointment in USAR or RA)</i>				
SUCCESSFULLY COMPLETED AROTC PROGRAM AS FOLLOWS				
COURSE	DATES ATTENDED <i>(Month and Year)</i>		c. CAMP TRAINING	
	FROM	TO		
a. BASIC			(1) INSTALLATION <i>(Basic)</i>	COMPLETION DATE <i>(Month, Year)</i>
b. ADVANCED			(2) INSTALLATION <i>(Advanced/Ranger)</i>	COMPLETION DATE <i>(Month, Year)</i>

<b>40. MAIN CIVILIAN EMPLOYMENT</b>				
a. NAME AND ADDRESS OF EMPLOYER			b. JOB TITLE	
USAR and ARNG applicants only			c. MONTH AND YEAR	
			FROM	TO
b. PRINCIPAL DUTIES <i>(Describe briefly)</i>				

41. REMARKS <i>(Experience, proficiencies and special abilities not shown elsewhere in this application. Those required to enter primary entry specialties, see Para 1-27d,e, AR 601-100). (If more space is required, attach additional sheet)</i>				
1) If you answered yes on question #26 ensure you follow directions and provide all court, police record documents, and art 15 paperwork for all of the offenses.				
2) You must use digital signature with this form.				

42. THE INFORMATION CONTAINED HEREIN IS TRUE TO THE BEST OF MY KNOWLEDGE AND BELIEF.	DATE	SIGNATURE OF APPLICANT
	21111018	YOUR DIGITAL SIGNATURE

**PREBOARD APPLICATION CHECKLIST**

(For use of this form see USAREC Reg 601-37)

NAME (Last, first, MI): Smith, John D.		RANK: SPC	MOS: 68W
AGE: 38	SEX: M	E-MAIL ADDRESS: john.smith@us.army.mi	
WORK TELEPHONE: 502-626-0381		HOME TELEPHONE: 502-626-1234	

**TAB 1. Record of Medical Examination, Health History, and Waivers**

- js DA Form 61
- js Commissioning physical examination (DD Form 2807-1 and DD Form 2808) in accordance with AR 40-501, chapter 2, less than 2 years old at time of board
- js Request for waiver worksheet(s) (age, conviction, medical)
- js Affidavits (if applicable)
- js Other supporting documentation

**TAB 2. Letter of Purpose and Intent**

- js Letter of purpose and intent

**TAB 3. Professional Evaluations and Recommendations**

- js USAREC Forms 195 or letters of recommendation
- js Applicant's commander
- js Applicant's immediate supervisor
- js Chief nurse (all applicants)
- js Others not to exceed two

**TAB 4. Education Documents**

- js Letter of Acceptance (  Conditional  Unconditional)
- js Academic plan memo
- js DA Form 2125
- js One set of official transcripts from all schools attended
- js Academic worksheet (USAREC Form 1235 with calculations)

**TAB 5. Personnel Service Records**

- js AKO documents
- js Sergeants and above, last three NCOERs
- js Last three DA Forms 1059 from all schools
- js Any professional certifications or licensures
- js DD Form 214 and/or NGB Form 22 (prior service)

**TAB 6. Enlisted Records Brief**

- js Certified copy of Enlisted Records Brief (ERB) (S1 certified) (E6 and below)
- js DA photo
- js CV
- js DA Form 705 (  DA Form 5500 or  DA Form 5501 (as applicable))

**TAB 7. Statements of Vacancy and Understanding**

- js DA Form 4187 (signed by battalion commander)
- js DD Form 368 (for all AGR, USAR, and NG Soldiers)

**TAB 8. Verification of Eligibility**

- js Verification of security clearance
- js MILPO eligibility statement
- js Copy of last PCS orders

COMPLETED BY (Signature): your signature	VERIFIED BY CDR O-3 OR ABOVE (Signature) (Last, First, Middle and Rank): Your Commander's digital signature
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<b>REPORT OF MEDICAL EXAMINATION</b>	1. DATE OF EXAMINATION (YYYYMMDD) 20111104	2. SOCIAL SECURITY NUMBER 123-45-6789
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**PRIVACY ACT STATEMENT**

**AUTHORITY:** 10 USC 504, 505, 507, 532, 978, 1201, 1202, and 4346; and E.O. 9397.

**PRINCIPAL PURPOSE(S):** To obtain medical data for determination of medical fitness for enlistment, induction, appointment and retention for applicants and members of the Armed Forces. The information will also be used for medical boards and separation of Service members from the Armed Forces.

**ROUTINE USE(S):** None.

**DISCLOSURE:** Voluntary; however, failure by an applicant to provide the information may result in delay or possible rejection of the individual's application to enter the Armed Forces. For an Armed Forces member, failure to provide the information may result in the individual being placed in a non-deployable status.

3. LAST NAME - FIRST NAME - MIDDLE NAME (SUFFIX)  Smith, John Doe	4. HOME ADDRESS (Street, Apartment Number, City, State and ZIP Code) 1 Airbone Way APT #2 Fort Knox, KY 40121	5. HOME TELEPHONE NUMBER (Include Area Code) (502) 626-0381
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6. GRADE E-6	7. DATE OF BIRTH (YYYYMMDD) 19830331	8. AGE 28	9. SEX <input type="checkbox"/> Female <input checked="" type="checkbox"/> Male	10.a. RACIAL CATEGORY (X one or more) <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White	b. ETHNIC CATEGORY <input checked="" type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Not Hispanic/Latino
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11. TOTAL YEARS GOVERNMENT SERVICE a. MILITARY 5 b. CIVILIAN	12. AGENCY (Non-Service Members Only)	13. ORGANIZATION UNIT AND UIC/CODE Organization: MRB UIC code:
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14.a. RATING OR SPECIALTY (Aviators Only)	b. TOTAL FLYING TIME	c. LAST SIX MONTHS
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15.a. SERVICE <input checked="" type="checkbox"/> Army <input type="checkbox"/> Coast Guard <input type="checkbox"/> Navy <input type="checkbox"/> Marine Corps <input type="checkbox"/> Air Force	b. COMPONENT <input checked="" type="checkbox"/> Active Duty <input type="checkbox"/> Reserve <input type="checkbox"/> National Guard	c. PURPOSE OF EXAMINATION <input type="checkbox"/> Enlistment <input type="checkbox"/> Medical Board <input type="checkbox"/> Other <input checked="" type="checkbox"/> Commission <input type="checkbox"/> Retirement <input type="checkbox"/> Retention <input type="checkbox"/> U.S. Service Academy <input type="checkbox"/> Separation <input type="checkbox"/> ROTC Scholarship Program	16. NAME OF EXAMINING LOCATION, AND ADDRESS (Include ZIP Code) Ireland Community Hospital 121 Wilson RD Fort Knox, KY 40121
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**CLINICAL EVALUATION** (Check each item in appropriate column. Enter "NE" if not evaluated.)

	Nor- mal	Ab- norm	NE	44. NOTES: (Describe every abnormality in detail. Enter pertinent item number before each comment. Continue in item 73 and use additional sheets if necessary.)
17. Head, face, neck, and scalp	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
18. Nose	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
19. Sinuses	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
20. Mouth and throat	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
21. Ears - General (Int. and ext. canals/Auditory acuity under item 71)	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
22. Drums (Perforation)	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
23. Eyes - General (Visual acuity and refraction under items 61 - 63)	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
24. Ophthalmoscopic	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
25. Pupils (Equality and reaction)	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
26. Ocular motility (Associated parallel movements, nystagmus)	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
27. Heart (Thrust, size, rhythm, sounds)	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
28. Lungs and chest (Include breasts)	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
29. Vascular system (Varicosities, etc.)	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
30. Anus and rectum (Hemorrhoids, Fistulae) (Prostate if indicated)	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
31. Abdomen and viscera (Include hernia)	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
32. External genitalia (Genitourinary)	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
33. Upper extremities	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
34. Lower extremities (Except feet)	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
35. Feet (See Item 35 Continued)	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
36. Spine, other musculoskeletal	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
37. Identifying body marks, scars, tattoos	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
38. Skin, lymphatics	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
39. Neurologic	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
40. Psychiatric (Specify any personality deviation)	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
41. Pelvic (Females only)	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
42. Endocrine	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

43. DENTAL DEFECTS AND DISEASE (Please explain. Use dental form if completed by dentist. If dental examination not done by dental officer, explain in Item 44.) <input checked="" type="checkbox"/> Acceptable <input type="checkbox"/> Not Acceptable Class <u>1</u>	35. FEET (Continued) (Circle category) <input checked="" type="checkbox"/> Normal Arch <input type="checkbox"/> Mild <input type="checkbox"/> Asymptomatic <input type="checkbox"/> Pes Cavus <input type="checkbox"/> Moderate <input type="checkbox"/> Symptomatic <input type="checkbox"/> Pes Planus <input type="checkbox"/> Severe
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LAST NAME - FIRST NAME - MIDDLE NAME (SUFFIX) Smith, John D.						SOCIAL SECURITY NUMBER 123-45-6789											
74.a. EXAMINEE/APPLICANT (check one) <input checked="" type="checkbox"/> IS QUALIFIED FOR SERVICE For Commissioning <input type="checkbox"/> IS NOT QUALIFIED FOR SERVICE IAW AR 40-501 CH.2						75. I have been advised of my disqualifying condition. a. SIGNATURE OF EXAMINEE b. DATE (YYYYMMDD)											
b. PHYSICAL PROFILE																	
P		U		L		H		E		S		X		PROFILER INITIALS		DATE (YYYYMMDD)	
1		1		1		1		1		1				jd		20111104	
76. SIGNIFICANT OR DISQUALIFYING DEFECTS																	
ITEM NO.	MEDICAL CONDITION/DIAGNOSIS				ICD CODE	PROFILE SERIAL	RBJ DATE (YYYYMMDD)	QUALIFIED	DIS-QUALIFIED	EXAMINER INITIALS	WAIVER RECEIVED						
											SERVICE	DATE (YYYYMMDD)					
77. SUMMARY OF DEFECTS AND DIAGNOSES (List diagnoses with item numbers) (Use additional sheets if necessary.)																	
doctor's comments																	
78. RECOMMENDATIONS - FURTHER SPECIALIST EXAMINATIONS INDICATED (Specify) (Use additional sheets if necessary.)																	
doctor's comments																	
79. MEPS WORKLOAD (For MEPS use only)																	
WKID		ST		DATE (YYYYMMDD)		INITIAL		WKID		ST		DATE (YYYYMMDD)		INITIAL			
80. MEDICAL INSPECTION DATE			HT	WT	%BF	MAX WT	HCG	QUAL	DISQ	PHYSICIAN'S SIGNATURE							
81.a. TYPED OR PRINTED NAME OF PHYSICIAN OR EXAMINER Doe, John MD						b. SIGNATURE md-signature											
82.a. TYPED OR PRINTED NAME OF PHYSICIAN OR EXAMINER						b. SIGNATURE											
83.a. TYPED OR PRINTED NAME OF DENTIST OR PHYSICIAN (Indicate which) Doe, John MD						b. SIGNATURE md-signature											
84.a. TYPED OR PRINTED NAME OF REVIEWING OFFICER/APPROVING AUTHORITY						b. SIGNATURE											
85. This examination has been administratively reviewed for completeness and accuracy.																	
a. SIGNATURE						b. GRADE			c. DATE (YYYYMMDD) 20111104								
86. WAIVER GRANTED (If yes, date and by whom)										87. NUMBER OF ATTACHED SHEETS							
<input type="checkbox"/> YES																	
<input type="checkbox"/> NO																	

**REPORT OF MEDICAL HISTORY**  
 (This information is for official and medically confidential use only  
 and will not be released to unauthorized persons.)

OMB No. 0704-0413  
 OMB approval expires  
 Mar 31, 2010

The public reporting burden for this collection of information is estimated to average 10 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing the burden, to the Department of Defense, Executive Services Directorate (0704-0413). Respondents should be aware that notwithstanding any other provision of law, no person shall be subject to any penalty for failing to furnish a collection of information if it does not display a currently valid OMB control number.

**PLEASE DO NOT RETURN YOUR FORM TO THE ABOVE ORGANIZATION. RETURN COMPLETED FORM AS INDICATED ON PAGE 2.**

**PRIVACY ACT STATEMENT**

**AUTHORITY:** 10 USC 504, 505, 507, 532, 978, 1201, 1202, and 4346; and E.O. 9397 (SSAN).

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**ROUTINE USE(S):** None.

**DISCLOSURE:** Voluntary; however, failure by an applicant to provide the information may result in delay or possible rejection of the individual's application to enter the Armed Forces. For an Armed Forces member, failure to provide the information may result in the individual being placed in a non-deployable status.

**WARNING:** The information you have given constitutes an official statement. Federal law provides severe penalties (up to 5 years confinement or a \$10,000 fine or both), to anyone making a false statement. If you are selected for enlistment, commission, or entrance into a commissioning program based on a false statement, you can be tried by military courts-martial or meet an administrative board for discharge and could receive a less than honorable discharge that would affect your future.

<b>1. LAST NAME, FIRST NAME, MIDDLE NAME (SUFFIX)</b> Smith, John Doe	<b>2. SOCIAL SECURITY NUMBER</b> 123-45-6789	<b>3. TODAY'S DATE (YYYYMMDD)</b> current date
<b>4.a. HOME ADDRESS (Street, Apartment No., City, State, and ZIP Code)</b> 1 Airbone Way Apt 2 Fort Knox, KY 40121	<b>5. EXAMINING LOCATION AND ADDRESS (Include ZIP Code)</b> Ireland Military Community Hospital 121 Wilson Rd Fort Knox, KY 40121	
<b>b. HOME TELEPHONE (Include Area Code)</b> (502) 626-0381		

<b>X ALL APPLICABLE BOXES:</b>			<b>7.a. POSITION (Title, Grade, Component)</b> SR Medic/E-6/RA
<b>6.a. SERVICE</b> <input checked="" type="checkbox"/> Army <input type="checkbox"/> Navy <input type="checkbox"/> Marine Corps <input type="checkbox"/> Air Force <input type="checkbox"/> Coast Guard	<b>6.b. COMPONENT</b> <input checked="" type="checkbox"/> Active Duty <input type="checkbox"/> Reserve <input type="checkbox"/> National Guard	<b>6.c. PURPOSE OF EXAMINATION</b> <input type="checkbox"/> Enlistment <input checked="" type="checkbox"/> Commission <input type="checkbox"/> Retention <input type="checkbox"/> Separation <input type="checkbox"/> Medical Board <input type="checkbox"/> Retirement <input type="checkbox"/> U.S. Service Academy <input type="checkbox"/> Other (Specify) <input type="checkbox"/> ROTC Scholarship Program	<b>b. USUAL OCCUPATION</b>

<b>8. CURRENT MEDICATIONS (Prescription and Over-the-counter)</b> NONE	<b>9. ALLERGIES (Including insect bites/stings, foods, medicine or other substance)</b> NONE
---	---

**Mark each item "YES" or "NO". Every item marked "YES" must be fully explained in Item 29 on Page 2.**

HAVE YOU EVER HAD OR DO YOU NOW HAVE:	YES	NO	12. (Continued)	YES	NO
10.a. Tuberculosis	<input type="checkbox"/>	<input checked="" type="checkbox"/>	f. Foot trouble (e.g., pain, corns, bunions, etc.)	<input type="checkbox"/>	<input checked="" type="checkbox"/>
b. Lived with someone who had tuberculosis	<input type="checkbox"/>	<input checked="" type="checkbox"/>	g. Impaired use of arms, legs, hands, or feet	<input type="checkbox"/>	<input checked="" type="checkbox"/>
c. Coughed up blood	<input type="checkbox"/>	<input checked="" type="checkbox"/>	h. Swollen or painful joint(s)	<input type="checkbox"/>	<input checked="" type="checkbox"/>
d. Asthma or any breathing problems related to exercise, weather, pollens, etc.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	i. Knee trouble (e.g., locking, giving out, pain or ligament injury, etc.)	<input type="checkbox"/>	<input checked="" type="checkbox"/>
e. Shortness of breath	<input type="checkbox"/>	<input checked="" type="checkbox"/>	j. Any knee or foot surgery including arthroscopy or the use of a scope to any bone or joint	<input type="checkbox"/>	<input checked="" type="checkbox"/>
f. Bronchitis	<input type="checkbox"/>	<input checked="" type="checkbox"/>	k. Any need to use corrective devices such as prosthetic devices, knee brace(s), back support(s), lifts or orthotics, etc.	<input type="checkbox"/>	<input checked="" type="checkbox"/>
g. Wheezing or problems with wheezing	<input type="checkbox"/>	<input checked="" type="checkbox"/>	l. Bone, joint, or other deformity	<input type="checkbox"/>	<input checked="" type="checkbox"/>
h. Been prescribed or used an inhaler	<input type="checkbox"/>	<input checked="" type="checkbox"/>	m. Plate(s), screw(s), rod(s) or pin(s) in any bone	<input type="checkbox"/>	<input checked="" type="checkbox"/>
i. A chronic cough or cough at night	<input type="checkbox"/>	<input checked="" type="checkbox"/>	n. Broken bone(s) (cracked or fractured)	<input type="checkbox"/>	<input checked="" type="checkbox"/>
j. Sinusitis	<input type="checkbox"/>	<input checked="" type="checkbox"/>	13.a. Frequent indigestion or heartburn	<input type="checkbox"/>	<input checked="" type="checkbox"/>
k. Hay fever	<input type="checkbox"/>	<input checked="" type="checkbox"/>	b. Stomach, liver, intestinal trouble, or ulcer	<input type="checkbox"/>	<input checked="" type="checkbox"/>
l. Chronic or frequent colds	<input type="checkbox"/>	<input checked="" type="checkbox"/>	c. Gall bladder trouble or gallstones	<input type="checkbox"/>	<input checked="" type="checkbox"/>
11.a. Severe tooth or gum trouble	<input type="checkbox"/>	<input checked="" type="checkbox"/>	d. Jaundice or hepatitis (liver disease)	<input type="checkbox"/>	<input checked="" type="checkbox"/>
b. Thyroid trouble or goiter	<input type="checkbox"/>	<input checked="" type="checkbox"/>	e. Rupture/hernia	<input type="checkbox"/>	<input checked="" type="checkbox"/>
c. Eye disorder or trouble	<input type="checkbox"/>	<input checked="" type="checkbox"/>	f. Rectal disease, hemorrhoids or blood from the rectum	<input type="checkbox"/>	<input checked="" type="checkbox"/>
d. Ear, nose, or throat trouble	<input type="checkbox"/>	<input checked="" type="checkbox"/>	g. Skin diseases (e.g. acne, eczema, psoriasis, etc.)	<input type="checkbox"/>	<input checked="" type="checkbox"/>
e. Loss of vision in either eye	<input type="checkbox"/>	<input checked="" type="checkbox"/>	h. Frequent or painful urination	<input type="checkbox"/>	<input checked="" type="checkbox"/>
f. Worn contact lenses or glasses	<input type="checkbox"/>	<input checked="" type="checkbox"/>	i. High or low blood sugar	<input type="checkbox"/>	<input checked="" type="checkbox"/>
g. A hearing loss or wear a hearing aid	<input type="checkbox"/>	<input checked="" type="checkbox"/>	j. Kidney stone or blood in urine	<input type="checkbox"/>	<input checked="" type="checkbox"/>
h. Surgery to correct vision (RK, PRK, LASIK, etc.)	<input type="checkbox"/>	<input checked="" type="checkbox"/>	k. Sugar or protein in urine	<input type="checkbox"/>	<input checked="" type="checkbox"/>
12.a. Painful shoulder, elbow or wrist (e.g. pain, dislocation, etc.)	<input type="checkbox"/>	<input checked="" type="checkbox"/>	l. Sexually transmitted disease (syphilis, gonorrhea, chlamydia, genital warts, herpes, etc.)	<input type="checkbox"/>	<input checked="" type="checkbox"/>
b. Arthritis, rheumatism, or bursitis	<input type="checkbox"/>	<input checked="" type="checkbox"/>	14.a. Adverse reaction to serum, food, insect stings or medicine	<input type="checkbox"/>	<input checked="" type="checkbox"/>
c. Recurrent back pain or any back problem	<input type="checkbox"/>	<input checked="" type="checkbox"/>	b. Recent unexplained gain or loss of weight	<input type="checkbox"/>	<input checked="" type="checkbox"/>
d. Numbness or tingling	<input type="checkbox"/>	<input checked="" type="checkbox"/>	c. Currently in good health (If no, explain in Item 29 on Page 2.)	<input checked="" type="checkbox"/>	<input type="checkbox"/>
e. Loss of finger or toe	<input type="checkbox"/>	<input checked="" type="checkbox"/>	d. Tumor, growth, cyst, or cancer	<input type="checkbox"/>	<input checked="" type="checkbox"/>

LAST NAME, FIRST NAME, MIDDLE NAME (SUFFIX) Smith, John Doe	SOCIAL SECURITY NUMBER 123-45-6789
--	---------------------------------------

**Mark each item "YES" or "NO". Every item marked "YES" must be fully explained in Item 29 below.**

HAVE YOU EVER HAD OR DO YOU NOW HAVE:	YES	NO		YES	NO
15.a. Dizziness or fainting spells	<input type="checkbox"/>	<input checked="" type="checkbox"/>	19. Have you been refused employment or been unable to hold a job or stay in school because of:		
b. Frequent or severe headache	<input type="checkbox"/>	<input checked="" type="checkbox"/>	a. Sensitivity to chemicals, dust, sunlight, etc.	<input type="checkbox"/>	<input checked="" type="checkbox"/>
c. A head injury, memory loss or amnesia	<input type="checkbox"/>	<input checked="" type="checkbox"/>	b. Inability to perform certain motions	<input type="checkbox"/>	<input checked="" type="checkbox"/>
d. Paralysis	<input type="checkbox"/>	<input checked="" type="checkbox"/>	c. Inability to stand, sit, kneel, lie down, etc.	<input type="checkbox"/>	<input checked="" type="checkbox"/>
e. Seizures, convulsions, epilepsy or fits	<input type="checkbox"/>	<input checked="" type="checkbox"/>	d. Other medical reasons (If yes, give reasons.)	<input type="checkbox"/>	<input checked="" type="checkbox"/>
f. Car, train, sea, or air sickness	<input type="checkbox"/>	<input checked="" type="checkbox"/>	20. Have you ever been treated in an Emergency Room? (If yes, for what?)	<input type="checkbox"/>	<input checked="" type="checkbox"/>
g. A period of unconsciousness or concussion	<input type="checkbox"/>	<input checked="" type="checkbox"/>	21. Have you ever been a patient in any type of hospital? (If yes, specify when, where, why, and name of doctor and complete address of hospital.)	<input type="checkbox"/>	<input checked="" type="checkbox"/>
h. Meningitis, encephalitis, or other neurological problems	<input type="checkbox"/>	<input checked="" type="checkbox"/>	22. Have you ever had, or have you been advised to have any operations or surgery? (If yes, describe and give age at which occurred.)	<input type="checkbox"/>	<input checked="" type="checkbox"/>
16.a. Rheumatic fever	<input type="checkbox"/>	<input checked="" type="checkbox"/>	23. Have you ever had any illness or injury other than those already noted? (If yes, specify when, where, and give details.)	<input type="checkbox"/>	<input checked="" type="checkbox"/>
b. Prolonged bleeding (as after an injury or tooth extraction, etc.)	<input type="checkbox"/>	<input checked="" type="checkbox"/>	24. Have you consulted or been treated by clinics, physicians, healers, or other practitioners within the past 5 years for other than minor illnesses? (If yes, give complete address of doctor, hospital, clinic, and details.)	<input type="checkbox"/>	<input checked="" type="checkbox"/>
c. Pain or pressure in the chest	<input type="checkbox"/>	<input checked="" type="checkbox"/>	25. Have you ever been rejected for military service for any reason? (If yes, give date and reason for rejection.)	<input type="checkbox"/>	<input checked="" type="checkbox"/>
d. Palpitation, pounding heart or abnormal heartbeat	<input type="checkbox"/>	<input checked="" type="checkbox"/>	26. Have you ever been discharged from military service for any reason? (If yes, give date, reason, and type of discharge; whether honorable, other than honorable, for unfitness or unsuitability.)	<input type="checkbox"/>	<input checked="" type="checkbox"/>
e. Heart trouble or murmur	<input type="checkbox"/>	<input checked="" type="checkbox"/>	27. Have you ever received, is there pending, or have you ever applied for pension or compensation for any disability or injury? (If yes, specify what kind, granted by whom, and what amount, when, why.)	<input type="checkbox"/>	<input checked="" type="checkbox"/>
f. High or low blood pressure	<input type="checkbox"/>	<input checked="" type="checkbox"/>	28. Have you ever been denied life insurance?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
17.a. Nervous trouble of any sort (anxiety or panic attacks)	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<b>29. EXPLANATION OF "YES" ANSWER(S)</b> (Describe answer(s), give date(s) of problem, name of doctor(s) and/or hospital(s), treatment given and current medical status.)  Reminder females only for Block #18.		
b. Habitual stammering or stuttering	<input type="checkbox"/>	<input checked="" type="checkbox"/>			
c. Loss of memory or amnesia, or neurological symptoms	<input type="checkbox"/>	<input checked="" type="checkbox"/>			
d. Frequent trouble sleeping	<input type="checkbox"/>	<input checked="" type="checkbox"/>			
e. Received counseling of any type	<input type="checkbox"/>	<input checked="" type="checkbox"/>			
f. Depression or excessive worry	<input type="checkbox"/>	<input checked="" type="checkbox"/>			
g. Been evaluated or treated for a mental condition	<input type="checkbox"/>	<input checked="" type="checkbox"/>			
h. Attempted suicide	<input type="checkbox"/>	<input checked="" type="checkbox"/>			
i. Used illegal drugs or abused prescription drugs	<input type="checkbox"/>	<input checked="" type="checkbox"/>			
18. FEMALES ONLY. Have you ever had or do you now have:					
a. Treatment for a gynecological (female) disorder	<input type="checkbox"/>	<input checked="" type="checkbox"/>			
b. A change of menstrual pattern	<input type="checkbox"/>	<input checked="" type="checkbox"/>			
c. Any abnormal PAP smears	<input type="checkbox"/>	<input checked="" type="checkbox"/>			
d. First day of last menstrual period (YYYYMMDD)	<input type="checkbox"/>	<input checked="" type="checkbox"/>			
e. Date of last PAP smear (YYYYMMDD)	<input type="checkbox"/>	<input checked="" type="checkbox"/>			

**NOTE: HAND TO THE DOCTOR OR NURSE, OR IF MAILED MARK ENVELOPE "TO BE OPENED BY MEDICAL PERSONNEL ONLY."**





DEPARTMENT OF THE ARMY  
YOUR UNIT INFO

DDMMYYYY

MEMORANDUM FOR Commander, USAREC 1307 Third Ave, Fort Knox, KY 40121-2726

SUBJECT: AMEDD Enlisted Commissioning Program (AECP) request for waiver for SSG Public, John Q., 123-45-6789.

1. In accordance with AR 601-100 and the AMEDD Enlisted Commissioning Program FY 12 Guidelines, I request a waiver for Age in Grade. I will be \_\_\_\_ years of age (age) when the FY 12 AECP selection board convenes on 2-4 August 2011. Please give favorable consideration to this waiver so that I may be considered for acceptance under the auspices of the AMEDD Enlisted Commissioning Program. My Basic Active Service Date (BASD) is (date).
2. I can be reached at the following address: 1010 Meadow Road, Anywhereville, ND 45678, DSN 123-4567, commercial 123-456-7890, or email at [john.q.public@us.army.mil](mailto:john.q.public@us.army.mil)

John Q. Public  
SSG, USA  
Medical Supply Technician

"ARMY STRONG"



**DEPARTMENT OF THE ARMY**  
YOUR UNIT INFO

DDMMYY

MEMORANDUM FOR Commander, USAREC 1307 Third Ave, Fort Knox, KY 40121-2726

SUBJECT: AMEDD Enlisted Commissioning Program (AECPP) request for waiver for SSG Public, John Q., 123-45-6789.

1. In accordance with AR 601-100 and the AMEDD Enlisted Commissioning Program FY 12 Guidelines, I request a waiver for (conviction). Explain in detail the incident, when, who, where, etc. Also, name and location of police agency involved, court name and location. State amount of fine, probation and/or confinement). Please give favorable consideration to this waiver so that I may be considered for acceptance under the auspices of the AMEDD Enlisted Commissioning Program. My Basic Active Service Date (BASD) is (date).
2. I can be reached at the following address: 1010 Meadow Road, Anywhereville, ND 45678, DSN 123-4567, commercial 123-456-7890, or email at [john.q.public@us.army.mil](mailto:john.q.public@us.army.mil)

John Q. Public  
SSG, USA  
Medical Supply Technician

\*Note you will also need to provide all court and police records related to the incident(s). If the records are not available then you will need to do a sworn notarized statement stating as such.

\*\* Note also if you have more than 1 charge then you will need to do a separate MFR for each incident. If all charges were received at the same time as the result of a single incident i.e. charged with speeding, reckless driving, DUI, etc. then only 1 MFR is required listing all charges.

**"ARMY STRONG"**



**DEPARTMENT OF THE ARMY**  
**YOUR UNIT INFO**

DDMMYYYY

MEMORANDUM FOR Commander, USAREC 1307 Third Ave, Fort Knox, KY 40121-2726

SUBJECT: AMEDD Enlisted Commissioning Program (AECP) request for waiver for SSG Public, John Q., 123-45-6789.

1. In accordance with AR 40-501 and the AMEDD Enlisted Commissioning Program (AECP) FY 12 Guidelines, I request a waiver for (type of Medical Condition). Explain the details of the injury, disorder or condition. Please give favorable consideration to this waiver so that I may be considered for acceptance under the auspices of the AMEDD Enlisted Commissioning Program. My Basic Active Service Date (BASD) is (date).
2. I can be reached at the following address: 1010 Meadow Road, Anywhereville, ND 45678, DSN 123-4567, commercial 123-456-7890, or email at [john.q.public@us.army.mil](mailto:john.q.public@us.army.mil)

John Q. Public  
SSG, USA  
Medical Supply Technician

**"ARMY STRONG"**



**DEPARTMENT OF THE ARMY**  
HEADQUARTERS AND HEADQUARTERS BATTERY  
3<sup>RD</sup> BATTALION, 43<sup>RD</sup> AIR DEFENSE ARTILLERY  
FORT BLISS, TX 79916

REPLY TO  
ATTENTION OF

AFVL-SKH

DATE

MEMORANDUM FOR AECF FY 2012 Selection Board, USAREC 1307 Third Ave, Fort Knox, KY 40121-2726

SUBJECT: AMEDD Enlisted Commissioning Program (AECF) Letter of Intent for SPC DOE, Jane A., 123-45-6789

1. I request to be selected into the AMEDD Enlisted Commissioning Program (AECF). I should be considered because of my motivation and dream of being a nurse. I aspire to be an Army nurse because I want to continue to serve my country, use my acquired medical skills where I am needed, and be a proud member of the Army Nurse Corps.

2. Respect, selfless service, and personal courage are the most important Army values to me. I uphold the utmost respect for everyone, regardless of the situation. This value to me means practicing unconditional respect. Secondly, selfless service to me means putting the mission before oneself. As an Army medic I continue to provide selfless service to the soldiers in need of medical care satisfying one of my many missions. As a medic and aspiring medical officer, this value is crucial in order to bestow ample medical care as well as teach medical soldiers knowledge, military and medical. Lastly, personal courage, the most important army value to me. I attain from this value to continue to complete the mission despite encountered hardship. I show personal courage by moving forward to my goal of being an Army nurse despite any obstacle.

3. In order to present clarification to my application, over the course of the next few months I will be satisfying each of the necessary prerequisite courses in order to allow me to start school in 2012. I know I will complete my bachelor's degree in nursing effectively because I have a passion for the medical field. I love to learn and to excel. I have excelled as an enlisted soldier in my minimal amount of time in the military. With less than two years in the military, I feel I have accomplished a significant amount and am certain I would continue as a medical officer.

4. I can be reached at the following address: Bldg. 2449, HHB 3-43 ADA, Ft. Bliss, TX, 79916, commercial 502 626-0381, or email at [jane.doe22@us.army.mil](mailto:jane.doe22@us.army.mil).

FirstNAME, LAST  
SPC, USA  
Title

# APPLICANT EVALUATION WORKSHEET

(For use of this form see USAREC Reg 601-37)

NAME OF APPLICANT: \_\_\_\_\_

The above named individual is applying for a position in the Army Medical Department, and has given us your name as a reference. Please complete this reference form and return in the envelope provided.

1. What is this applicant's current specialty? \_\_\_\_\_

2. Date began employment in this specialty (mmyy)? \_\_\_\_\_

3. Is this applicant (check one)  private practice/self-employed  employed full-time  part-time or  stipend employee? If part-time or stipend, please provide the average hours worked per week: \_\_\_\_\_

4. a. If the applicant is a nurse, describe the size/type of health care facility:

\_\_\_\_\_

b. Describe the applicant's current work environment. If a student/resident describe course and clinical setting:

\_\_\_\_\_

\_\_\_\_\_

5. Select only one:

(mmyy)

(mmyy)

I evaluate/have evaluated this applicant.

From \_\_\_\_\_ To: \_\_\_\_\_

I am/have been a peer/coworker of this applicant.

From \_\_\_\_\_ To: \_\_\_\_\_

I am/have been an instructor/preceptor for this applicant.

From \_\_\_\_\_ To: \_\_\_\_\_

I know/have known this applicant. Specify in what capacity you have known this applicant:

From \_\_\_\_\_ To: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

6. Would the applicant make a good Army Officer? Overall impression of the applicant:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

7. Would you hire/rehire/work with this applicant?  Yes  No If no, please explain:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

8. The attributes listed below are important for Army Medical Department Officers. Compare this applicant with others who work in the same capacity, and have the same experience level (student/residents). Rate each attribute on a scale of 1 to 7, with 1 being the lowest and 7 being the highest. If the attribute cannot be evaluated or does not apply, circle NA.

ATTRIBUTE	SCORE								REMARKS
	Lowest				Highest				
Adaptability/Resourcefulness	1	2	3	4	5	6	7	NA	
Clinical Judgment	1	2	3	4	5	6	7	NA	
Clinical Knowledge	1	2	3	4	5	6	7	NA	
Clinical Skills	1	2	3	4	5	6	7	NA	
Honesty/Integrity	1	2	3	4	5	6	7	NA	
Initiative	1	2	3	4	5	6	7	NA	
Interaction with Coworkers	1	2	3	4	5	6	7	NA	
Leadership Ability/Potential	1	2	3	4	5	6	7	NA	
Managerial Ability/Potential	1	2	3	4	5	6	7	NA	
Manner in Accepting Criticism	1	2	3	4	5	6	7	NA	
Professional Appearance	1	2	3	4	5	6	7	NA	
Professional Demeanor	1	2	3	4	5	6	7	NA	
Reliability	1	2	3	4	5	6	7	NA	
Stability Under Pressure	1	2	3	4	5	6	7	NA	
Stamina (Mental and Physical)	1	2	3	4	5	6	7	NA	
Tact	1	2	3	4	5	6	7	NA	
Analytical Skills	1	2	3	4	5	6	7	NA	
Conceptual Skills	1	2	3	4	5	6	7	NA	
Communication Skills	1	2	3	4	5	6	7	NA	
Maturity	1	2	3	4	5	6	7	NA	
Assumes Responsibility	1	2	3	4	5	6	7	NA	
Judgment	1	2	3	4	5	6	7	NA	

9. Dietetic Internship Students may use (ADA) American Dietetic Association Recommendation Form instead of this form.

10. Additional Comments/Remarks:

Name (*Print*): \_\_\_\_\_ Telephone Number: \_\_\_\_\_  
 Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
 Position/Title/Specialty: \_\_\_\_\_  
 Business Address: \_\_\_\_\_

The Army Medical Department appreciates your time and effort in providing an honest appraisal of this individual.

**REPORT TO TRAINING AGENCY**

For use of this form, see AR 621-1; the proponent agency is DCS, G-1.

**DATA REQUIRED BY THE PRIVACY ACT OF 1974**

**AUTHORITY:** Section 301, Title 5, USC; and Section 3013, Title 10.

**PRINCIPAL PURPOSE:** To provide a continuing contact with the military student while in attendance at a civilian school under a military sponsored program.

**ROUTINE USES:** Data collected is used to identify the school; to monitor the subject studies; to obtain student response to selected question; to identify the Army program; to obtain course title /s/, credit hours and grades; to obtain academic plan including faculty advisor awareness; and to establish an address including home phone whereby the military student can be contacted since, normally, the student will reside off-post.

**DISCLOSURE:** Disclosure of information is mandatory. If required information is not provided removal from the school could result or military student could be subject to a violation of Article 92 UCMJ.

Last Name - First Name - Middle Initial Smith, John D.	Grade E-4	Social Security No. 123-45-6789	Branch/MOS RA/68W
---	--------------	------------------------------------	----------------------

Current Mailing Address (Include ZIP Code) 1307 3rd AVE Fort Knox, KY 40121	Home Phone (Include Area Code) 502-626-0381	Army Program (Check one) <input checked="" type="checkbox"/> Fully Funded <input type="checkbox"/> Scholarship <input type="checkbox"/> Degree Completion <input type="checkbox"/> Cooperative Degree
---	--	---

Name of School (City & State) University of Kansas Lawrence, KS	Electronic Mail Address john.smith22@us.army.mil	Type System (Check one) <input checked="" type="checkbox"/> Semester <input type="checkbox"/> Quarter <input type="checkbox"/> Other
--	---	---

Official Title of Degree Which You Expect to Receive BACHELOR OF SCIENCE OF NURSING	Date Expected DEC 2013	Department and Major Field of Study SCHOOL OF NURSING, NURSING
--	---------------------------	---

QUARTER, SEMESTER OR TERM JUST COMPLETED		QUARTER, SEMESTER OR TERM UPCOMING	
Began	Ended	Begins 13 JAN 2012	Will End 18 MAY 2012

SUBJECTS STUDIED DURING ABOVE PERIOD				SUBJECTS TO BE STUDIED		
Course No.	Course Title	GRADE	Credit Hours	Course No.	Course Title	Credit Hours
				304	Introduction to Professional Nursing Practice	4
				305	Pathopharmacology	5
				320	Science and Research for Nursing Practice	3
				333	Health Assess, EMT	3

Give reason for any absence which may affect your ability to keep up with your studies (Sickness, leave, or other emergencies)

If you are having any difficulty with your academic work, give pertinent details

If any subjects have been dropped since last report, give reasons

If any subjects outside of normal prescribed course have been added since last report, give complete information (If added course will necessitate a change in present contract, clearance must be obtained from the training agency.)

Remarks (Enter any recommendations, observations, or requests you desire to make)

**NOTE:** The reverse side of this form will be completed by the student and faculty advisor initially upon entry into school and when changes to academic programs are required.

Date Current Date	Signature of Student Your digital signature here
----------------------	---



## AMEDD ACADEMIC PROGRAM WORKSHEET

(For use of this form see USAREC Reg 601-37)

### PRIVACY ACT STATEMENT

**AUTHORITY:** 10 USC 3013; 10 USC 4301; Executive Order 9397.

**PRINCIPAL PURPOSE:** Required to document the educational requirements of the AMEDD Academic Program.

**ROUTINE USES:** Used by selection board in considering applicants on a competitive basis and selecting those considered best qualified. SSN required for identification for record purposes and for contact purposes.

**MANDATORY OR VOLUNTARY DISCLOSURE:** Disclosure of personal information is voluntary. However, failure to provide the requested information may result in nonconsideration.

1. NAME (Last, first, MI) Who, you R	2. SSN 123-45-6789	3. MOS or AOC 68W
---	-----------------------	----------------------

4. OTHER NAMES LISTED ON TRANSCRIPTS list all names use if different from your name now	5. DATE COMPLETED current date
--	-----------------------------------

**SECTION I** - List all colleges and universities attended and the dates of attendance (semester and year, e.g., Fall 1996).  
You must have an official transcript from each institution forwarded to USAREC prior to application deadline.

6. COLLEGE OR UNIVERSITY AND LOCATION	7. DATES OF ATTENDANCE	8. TOTAL NUMBER OF CREDITS	9. DEGREE GRANTED
University of Kansas, Lawrence, KS	08/13/10-12/20/10	17	None

**SECTION II** - List all course work currently in progress.

10. COLLEGE OR UNIVERSITY AND LOCATION	11. COURSE IN PROGRESS	12. ANTICIPATED DATE OF COMPLETION
ETC, Elizabethtown, KY	Micro-Biology W/lab	16 Dec 2011
ETC, Elizabethtown, KY	History 101	16 Dec 2011
ETC, Elizabethtown, KYO	Human Anatomy	16 Dec 2011

**SECTION III** - List all courses attempted, including those failed, under the appropriate heading.  
List the semester hours of each course.

Quarter hours should be converted to semester hours according to the following scale:

Quarter Hours	Semester Hours	Quarter Hours	Semester Hours
1	.7	6	4.0
2	1.3	7	4.7
3	2.0	8	5.3
4	2.7	9	6.0
5	3.3		

Technical courses such as typing, welding, and courses taken for certification (Emergency Medical Technician or Licensed Practical Nursing) are not accepted. Do not list these courses. List additional courses in the Remarks section if more space is required.

Part A - English and Literature					
13. COURSE TITLE	14. SEM HRS	15. GRADE	16. COLLEGE	17. DATE COMPLETED (Semester and Year)	18. USAREC USE ONLY
ENG 101	3	B	University of Kansas	16 Dec 2010	
ENG 102	3	B	University of Kansas	16 Dec 2010	

19. SUBJECT GPA:

**Part B - Biological Sciences**  
(Anatomy and Physiology, Biology, Microbiology, Genetics, Immunology, etc.)

20. COURSE TITLE	21. SEM HRS	22. GRADE	23. COLLEGE	24. DATE COMPLETED (Semester and Year)	25. USAREC USE ONLY
Biology with Lab	5	A	University of Kansas	16 Dec 2010	

26. SUBJECT GPA:

**Part C - Chemistry**

27. COURSE TITLE	28. SEM HRS	29. GRADE	30. COLLEGE	31. DATE COMPLETED (Semester and Year)	32. USAREC USE ONLY

33. SUBJECT GPA:

**Part D - Other Science Courses**  
*(Physics, Botany, Nutrition, Geology, Geography, Astronomy, etc.)*

34. COURSE TITLE	35. SEM HRS	36. GRADE	37. COLLEGE	38. DATE COMPLETED <i>(Semester and Year)</i>	39. USAREC USE ONLY

40. SUBJECT GPA:

**Part E - Mathematics**

41. COURSE TITLE	42. SEM HRS	43. GRADE	44. COLLEGE	45. DATE COMPLETED <i>(Semester and Year)</i>	46. USAREC USE ONLY
College Algebra	3	A	University of Kansas	16 Dec 2010	

47. SUBJECT GPA:

**Part F - Psychology**

48. COURSE TITLE	49. SEM HRS	50. GRADE	51. COLLEGE	52. DATE COMPLETED <i>(Semester and Year)</i>	53. USAREC USE ONLY
Psychology	3	B	University of Kansas	16 Dec 2011	

54. SUBJECT GPA:





**SAMPLE CURRICULUM VITAE FORMAT**

Name: Rank: MOS/AOC:

SSN:

Current Address/Home Phone Number:

Home of Record: City & State

Date and Place of Birth:

Age (as of 1 August 2011):

Sex: Race: Citizenship: Marital Status:

Dependents <18 y/o: Dependents >18 y/o (not including spouse):

Basic Active Service Date:

Time in Service (as of 1 August 2011):

Pay Entry Basic Date:

Present Assignment/Phone Number (both commercial and DSN):

E-mail Address: **(This will be the primary means of communication. Must be an AKO email address.**

Expiration of Term of Service:

Active Duty Service Obligation (ADSO):

Date of Last PCS:

Military Education (list all schools attended):

Military Decorations/Awards and Year Awarded:

Promotions: Date:

Military Assignments (begin with current and work backwards, and include short description of duties, to and from dates, unit name, and location):

Civilian Education: (list only post secondary):

Civilian Work Experience/Occupations:

Professional Organizations:

Board Certifications (if applicable):

Professional Licenses/certifications/registrations held/year of initial issue (if applicable):

Publications:

Honors/Civilian Awards/Accomplishments:

.....

# Army Physical Fitness Test Scorecard

For use of this form, see FM 21-20; the proponent agency is TRADOC

NAME (LAST, FIRST MIDDLE)

SSN

GENDER

UNIT

TEST ONE			TEST TWO			TEST THREE			TEST FOUR		
DATE	GRADE	AGE									
HEIGHT (IN INCHES)	BODY COMPOSITION		HEIGHT (IN INCHES)	BODY COMPOSITION		HEIGHT (IN INCHES)	BODY COMPOSITION		HEIGHT (IN INCHES)	BODY COMPOSITION	
	WEIGHT: _____ lbs GO / NO-GO <input type="checkbox"/> <input type="checkbox"/>	BODY FAT: _____ % GO / NO-GO <input type="checkbox"/> <input type="checkbox"/>		WEIGHT: _____ lbs GO / NO-GO <input type="checkbox"/> <input type="checkbox"/>	BODY FAT: _____ % GO / NO-GO <input type="checkbox"/> <input type="checkbox"/>		WEIGHT: _____ lbs GO / NO-GO <input type="checkbox"/> <input type="checkbox"/>	BODY FAT: _____ % GO / NO-GO <input type="checkbox"/> <input type="checkbox"/>		WEIGHT: _____ lbs GO / NO-GO <input type="checkbox"/> <input type="checkbox"/>	BODY FAT: _____ % GO / NO-GO <input type="checkbox"/> <input type="checkbox"/>
PU RAW SCORE	INITIALS	POINTS									
SU RAW SCORE	INITIALS	POINTS									
2MR RAW SCORE	INITIALS	POINTS									
ALTERNATE AEROBIC EVENT EVENT _____ TIME _____ GO <input type="checkbox"/> NO-GO <input type="checkbox"/>		TOTAL POINTS	ALTERNATE AEROBIC EVENT EVENT _____ TIME _____ GO <input type="checkbox"/> NO-GO <input type="checkbox"/>		TOTAL POINTS	ALTERNATE AEROBIC EVENT EVENT _____ TIME _____ GO <input type="checkbox"/> NO-GO <input type="checkbox"/>		TOTAL POINTS	ALTERNATE AEROBIC EVENT EVENT _____ TIME _____ GO <input type="checkbox"/> NO-GO <input type="checkbox"/>		TOTAL POINTS
NCOIC/OIC SIGNATURE			NCOIC/OIC SIGNATURE			NCOIC/OIC SIGNATURE			NCOIC/OIC SIGNATURE		
COMMENTS			COMMENTS			COMMENTS			COMMENTS		

**SPECIAL INSTRUCTION: USE INK**

**LEGEND:** PU - PUSHUPS      2MR - 2 MILE RUN  
SU - SIT UPS      APFT - ARMY PHYSICAL FITNESS TEST

**Data Required by the Privacy Act of 1974**

Title DA form 705  
Authority 5 USC Section 301  
Disclosure of requested information is mandatory.

Individuals not providing information cannot be rated/scored. The principal purpose and routine use of this information are to maintain a record of individual scores on physical fitness events.

## BODY FAT CONTENT WORKSHEET - (Female)

For use of this form, see AR 600-9; the proponent agency is DCS, G-1.

<b>NAME</b> (Last, First, Middle Initial)		<b>SSN</b>	<b>RANK</b>	Note: 1/4" = .25 1/2" = .50 3/4" = .75
<b>HEIGHT</b> (to nearest 0.50 inch)		<b>WEIGHT</b> (to nearest pound)	<b>AGE</b>	
<b>STEP</b>	<b>FIRST</b>	<b>SECOND</b>	<b>THIRD</b>	<b>AVERAGE</b> <small>(to nearest 0.50 in.)</small>
1. Measure neck just below level of larynx ( <i>Adam's apple</i> ) to nearest 0.50 inch. Repeat three times, then average.				0.00
2. Measure waist ( <i>abdomen</i> ) at the point of minimal abdominal circumference. Round down to the nearest 0.50 inch. Repeat three times, then average.				0.00
3. Measure hips at point where the gluteus muscles ( <i>buttocks</i> ) protrude backward the most. Round down to nearest 0.50 inch. Repeat three times, then average.				0.00
4. CALCULATIONS			<b>REMARKS</b>  Soldier's Actual Weight _____ <u>0</u> Screening Table Weight _____ <u>#N/A</u> Over/Under _____ <u>#N/A</u> Soldier's Body Fat % _____ <u>#N/A</u> Authorized Body Fat % _____ <u>#N/A</u> Over/Under _____ <u>#N/A</u>	
A. Enter average waist circumference	0.00			
B. Enter average hip circumference	0.00			
C. TOTAL (4A + 4B)		0.00		
D. Enter average neck circumference	0.00			
E. Enter circumference value (4C - 4D)		0.00		
F. Find the height in Table 3-1 ( <i>Height Factor</i> ). Enter height in inches.	0.00			
G. Find the Soldier's circumference value ( <i>line 4E</i> ) and height ( <i>line 4F</i> ) in Figure B-6 (Percentage Fat Estimation for Women). Enter the body fat value that intercepts with the circumference value and height. This is the Soldier's Percent Body Fat.		#N/A		

**CHECK ONE**

#N/A Individual is in compliance with Army Standards;

#N/A is not in compliance with the standards

#N/A Recommended monthly weight loss is 3-8 lbs.

<b>PREPARED BY</b> (Signature)	<b>RANK</b>	<b>DATE</b> (YYYYMMDD)	<b>APPROVED BY SUPERVISOR</b>	<b>RANK</b>	<b>DATE</b> (YYYYMMDD)
			<small>(Printed Name and Signature)</small>		

## BODY FAT CONTENT WORKSHEET - (Male)

For use of this form, see AR 600-9; the proponent agency is DCS, G-1

<b>NAME</b> (Last, First, Middle Initial)	<b>SSN</b>	<b>RANK</b>		Note: 1/4" = .25 1/2" = .50 3/4" = .75
<b>HEIGHT</b> (to nearest 0.50 inch)	<b>WEIGHT</b> (to nearest pound)	<b>AGE</b>		
<b>STEP</b>	<b>FIRST</b>	<b>SECOND</b>	<b>THIRD</b>	<b>AVERAGE</b> (to nearest 0.50 in.)
1. Measure abdomen at the level of the navel ( <i>belly button</i> ) Round down to the nearest 0.50 inch. ( <i>Repeat 3 times.</i> )				0.00
2. Measure neck just below the level of larynx ( <i>Adam's apple</i> ) Round up to the nearest 0.50 inch. ( <i>Repeat 3 times.</i> )				0.00
3. Enter the average abdominal circumference.				0.00
4. Enter the average neck circumference.				0.00
5. Enter circumference value ( <i>step 3 - step 4</i> ).				0.00
6. Find the height in Table 3-1 ( <i>Height Factor</i> ). Enter height in inches.				0.00
7. Find the Soldier's circumference value ( <i>step 5</i> ) and height ( <i>step 6</i> ) in figure B-5 ( <i>Percent Fat Estimation for Men</i> ). Enter the percent body fat value that intercepts with the circumference value and height. This is the Soldier's Percent Body Fat.				#N/A

**REMARKS**

Soldier's Actual Weight	0
Screening Table Weight	#N/A
Over/Under	#N/A
Soldier's Actual Body Fat %	#N/A
Authorized Body Fat %	#N/A
Over/Under	#N/A

**CHECK ONE**

**#N/A** Individual is in compliance with Army Standards;                      **#N/A** is not in compliance with the standards

**#N/A** Recommended monthly weight loss is 3-8 lbs.

<b>PREPARED BY</b> (Signature)	<b>RANK</b>	<b>DATE</b> (YYYYMMDD)	<b>APPROVED BY SUPERVISOR</b> (Printed Name and Signature)	<b>RANK</b>	<b>DATE</b> (YYYYMMDD)
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**PERSONNEL ACTION**

For use of this form, see AR 600-8-6 and DA PAM 600-8-21; the proponent agency is ODCSPER

**DATA REQUIRED BY THE PRIVACY ACT OF 1974**

**AUTHORITY:** Title 5, Section 3012; Title 10, USC, E.O. 9397.

**PRINCIPAL PURPOSE:** Used by soldier in accordance with DA PAM 600-8-21 when requesting a personnel action on his/her own behalf (*Section III*).

**ROUTINE USES:** To initiate the processing of a personnel action being requested by the soldier.

**DISCLOSURE:** Voluntary. Failure to provide social security number may result in a delay or error in processing of the request for personnel action.

1. THRU ( <i>Include ZIP Code</i> ) Commander 111st FA BN 1111 RN Rd Ft. Knox, KY 40121	2. TO ( <i>Include ZIP Code</i> ) CDR, HQ, USAREC 1307 Third Ave Fort Knox, KY 40121	3. FROM ( <i>Include ZIP Code</i> ) Commander A 111st FA BN 2222 RN Rd Fort Knox, KY 40121
---	---	--

**SECTION I - PERSONAL IDENTIFICATION**

4. NAME ( <i>Last, First, MI</i> ) Who, You R.	5. GRADE OR RANK/PMOS/AOC E-5/68W	6. SOCIAL SECURITY NUMBER 111-22-3333
---	--------------------------------------	--

**SECTION II - DUTY STATUS CHANGE (AR 600-8-6)**

7. The above soldier's duty status is changed from \_\_\_\_\_ to \_\_\_\_\_ effective \_\_\_\_\_ hours, \_\_\_\_\_

**SECTION III - REQUEST FOR PERSONNEL ACTION**8. I request the following action: (*Check as appropriate*)

<input type="checkbox"/> Service School ( <i>Enl only</i> )	<input type="checkbox"/> Special Forces Training/Assignment	<input type="checkbox"/> Identification Card
<input type="checkbox"/> ROTC or Reserve Component Duty	<input type="checkbox"/> On-the-Job Training ( <i>Enl only</i> )	<input type="checkbox"/> Identification Tags
<input type="checkbox"/> Volunteering For Oversea Service	<input type="checkbox"/> Retesting in Army Personnel Tests	<input type="checkbox"/> Separate Rations
<input type="checkbox"/> Ranger Training	<input type="checkbox"/> Reassignment Married Army Couples	<input type="checkbox"/> Leave - Excess/Advance/Outside CONUS
<input type="checkbox"/> Reassignment Extreme Family Problems	<input type="checkbox"/> Reclassification	<input type="checkbox"/> Change of Name/SSN/DOB
<input type="checkbox"/> Exchange Reassignment ( <i>Enl only</i> )	<input type="checkbox"/> Officer Candidate School	<input checked="" type="checkbox"/> Other ( <i>Specify</i> ) AECP
<input type="checkbox"/> Airborne Training	<input type="checkbox"/> Asgmt of Pers with Exceptional Family Members	

9. SIGNATURE OF SOLDIER (*When required*)

10. DATE (YYYYMMDD)

**SECTION IV - REMARKS (Applies to Sections II, III, and V) (Continue on separate sheet)**

- 1) Current Height \_\_\_\_\_ and Weight \_\_\_\_\_ is within standard IAW AR 600-9. Also list Body Fat % if applicable and attach Body Fat Content Worksheet as well.
- 2) APFT taken (date) PASS/FAIL
- 3) Previous participation in any commissioning program(s) i.e. OCS/ROTC/IPAP, etc Yes or No. If yes state circumstances regarding non completion.
- 4) I have completely read and understand the AECP Guidelines: initials

**SECTION V - CERTIFICATION/APPROVAL/DISAPPROVAL**11. I certify that the duty status change (*Section II*) or that the request for personnel action (*Section III*) contained herein -

HAS BEEN VERIFIED  RECOMMEND APPROVAL  RECOMMEND DISAPPROVAL  IS APPROVED  IS DISAPPROVED

12. COMMANDER/AUTHORIZED REPRESENTATIVE	13. SIGNATURE	14. DATE (YYYYMMDD)
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# REQUEST FOR CONDITIONAL RELEASE

(Read Privacy Act Statement and Instructions on back before completing this form.)

## SECTION I - REQUEST FOR RELEASE

### 1. SERVICE MEMBER DATA

a. NAME (Last, First, Middle Initial) Who, You R.	b. PAY GRADE E-5	c. SSN 123-45-6789	d. SERVICE COMPONENT USAR	
e. CURRENT UNIT/ COMMAND Your unit	f. ADDRESS (1) STREET put your unit address all			
	(2) CITY these blocks	(3) STATE -----	(4) ZIP CODE -----	

### 2. RECRUITING OFFICE ADDRESS

a. STREET 1307 3rd AVE	b. CITY FT Knox	c. STATE KY	d. ZIP CODE 40121
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### 3. ACKNOWLEDGEMENT OF SERVICE MEMBER

a. I request a conditional release to process for entrance into another component of the Military Service. If I am a member of the National Guard or Reserve, I understand that I must attend all scheduled training until such time as I am enlisted or appointed into another Service. I also understand that I am to keep my current commander informed of any change in my status.

b. OFFICER MEMBER ONLY. I hereby tender my resignation from the \_\_\_\_\_ (losing component); request that it be accepted contingent upon actual appointment or enlistment in the \_\_\_\_\_ (gaining component), and be effective the day preceding the date of my acceptance of appointment or enlistment.

c. ENLISTED MEMBER ONLY. I understand I will be discharged from my current status effective the day preceding the date of my enlistment or appointment.

d. MEMBER SIGNATURE Your Signature	e. DATE SIGNED current date
---------------------------------------	--------------------------------

### 4. RECRUITER REQUEST FOR CONDITIONAL RELEASE

a. Request conditional release to enlist/appoint member into the Regular Army (Service/Component).

b. NAME OF RECRUITER (Last, First, Middle Initial) McDavitt, Carmen M.	c. SIGNATURE	d. DATE SIGNED
e. TITLE SFC, AECF Program Manager		

## SECTION II - APPROVAL/DISAPPROVAL

### 5. (X as applicable)

<input type="checkbox"/> a. APPROVED. Individual is recommended and conditional release is granted. The release is valid until _____.
<input type="checkbox"/> b. DISAPPROVED. Release is not granted. (Explain in "Remarks.")

### 6. AUTHORIZING OFFICIAL

a. NAME (Last, First, Middle Initial)	b. TITLE			
c. TELEPHONE NUMBER (Include area code)	d. ADDRESS (1) STREET	(2) CITY	(3) STATE	(4) ZIP CODE
e. SIGNATURE				f. DATE SIGNED

## SECTION III - NOTIFICATION OF ENLISTMENT/APPOINTMENT ACTION

7. The member was administered the oath of enlistment or appointment into \_\_\_\_\_.  
THIS FORM AND A COPY OF THE OATH MUST BE RETURNED TO THE ADDRESS IN ITEM 6.d. TO EFFECT THE MEMBER'S DISCHARGE OR WITHDRAWAL OF FEDERAL RECOGNITION.

### 8. CERTIFYING OFFICIAL

a. NAME (Last, First, Middle Initial)	b. TITLE	c. UNIT/COMMAND		
d. TELEPHONE NUMBER (Include area code)	e. ADDRESS (1) STREET	(2) CITY	(3) STATE	(4) ZIP CODE
f. SIGNATURE				g. DATE SIGNED

**SECTION IV - REMARKS**

**PRIVACY ACT STATEMENT**

**AUTHORITY:** Title 10 USC Sec 261, 269, 271, 512, 516, 595, 651, 716, 1005, 3013, 8013, 12105, 12106, 12107, and 12213; Title 32 USC Sec 323 and Title 50 USC App 454.

**PRINCIPAL PURPOSE(S):** To obtain clearance from one component and discharge upon entry into another component of the Military Services.

**ROUTINE USE(S):** None.

**DISCLOSURE:** Voluntary; however, failure to furnish information will result in delay or denial of release from current component.

**INSTRUCTIONS**

**GENERAL INSTRUCTIONS.**

When this form is not computer generated, use typewriter or dark ink for all entries. Enter all dates in YYMMDD format. Use full street address, city, state and ZIP code for addresses. Use last name, first name, and middle initial format. Use short title Service/Component names: USA, ARNGUS, USAR, USN, USNR, USMC, USMCR, USAF, ANGUS, USAFR, USCG, USCGR.

**SECTION I.** Completed by recruiter and applicant.

Item 1. Enter applicant's name, pay grade, Social Security Number, current Service/Component, and current unit/command address.

Item 2. Enter recruiter's office address, if applicable.

Item 3. For item 3.b., complete the name of the gaining and losing components. Member signs and dates appropriate blocks.

Item 4. Recruiter, if applicable, completes 4.a. through 4.e. and sends this document to the address in Item 1.e.

**SECTION II.** Completed by applicant's unit commander or designated representative within 30 days of receipt.

Item 5. If block 5.a. is marked, enter the ending date of this conditional release. If block 5.b. is marked, indicate in Section IV, "Remarks," the reason for disapproval and return to the originator not later than the expiration date in Item 5.a.

Item 6. Enter name, title, signature and date for authorizing official. Indicate in Items 6.c. and d. the address and telephone number for returning completed Section III. Send completed Section II to the address in Item 2.

**SECTION III.** Completed by enlisting/appointing official within 10 days of enlistment or appointment.

Item 7. Indicate service to which applicant was enlisted/appointed.

Item 8. Completed by individual certifying enlistment/appointment action. Certifying official ensures a copy of the completed DD Form 368 and a copy of the oath are mailed to the address in Item 6.d.

**SECTION IV - REMARKS.**

Use as necessary. Reference each item on the form to which the remark pertains. (For example: "Item 5.b. Disapproved for the following reason: .....")



REPLY TO  
ATTENTION OF:

**FOR OFFICIAL USE ONLY**

**DEPARTMENT OF THE ARMY**  
(UNIT ORGANIZATION ADDRESS)

(Office Symbol)

(Date)

MEMORANDUM FOR Commander, U.S. Army Recruiting Command, ATTN: RCHS-AN-AECP,  
Fort Knox, KY 40121-2725

SUBJECT: Security Clearance Verification for (Last Name, First Name, Middle Initial)

1. References:

a. AR 380-67, Personnel Security Program, 9 Sep 88.

2. (Rank, Last Name, First Name, Middle Name, Social Security Number) was granted (Type of security clearance for example TS/SCI) eligibility on (date clearance was granted) by the Army Central Clearance Facility (CCF). (Rank Last Name) had a PPR closed on (date investigation was closed)

3. The point of contact for this memorandum is (Your S2/ Security Manager's Name, Phone Number, and E-mail address).

**S2/Security Manager's Signature block with Signature**

**FOR OFFICIAL USE ONLY**

This document and personal information contained herein is protected by the Privacy Act of 1974,  
Section 5 U.S. C sub 552a as amended

**POST-BOARD APPLICATION CHECKLIST**

(For use of this form see USAREC Reg 601-37)

NAME: Who, You R. RANK: SGT E-MAIL (AKO): you.who@us.army.mil PHONE: 502-626-0381  
*(Last, first, MI)*  
SCHOOL NAME: Unversity of Kansas START DATE: 13 Jan 2012 END DATE: 20 Dec 2013  
*(day, month, year)* *(day, month, year)*  
SCHOOL ADDRESS: STREET: 1450 Jayhawk BLVD. CITY: Lawrence STATE: KS ZIP CODE: 66045

**TAB 1. Letter of Acceptance**

yw Unconditional letter of acceptance from school to include breakdown of tuition costs by semester

**TAB 2. Class Breakdown**

yw DA Form 2125

**TAB 3. AECP Contract**

yw USAREC Form 1281

**TAB 4. AECP Statement of Understanding**

yw USAREC Form 1280

**TAB 5. Updates and/or changes**

yw Any updates or changes to submitted information

Completed By:  
Signature Your digital signature

Verified By Commander 0-3 or Above:  
Signature Your Company Commander's Signature



**ARMY MEDICAL DEPARTMENT ENLISTED COMMISSIONING PROGRAM  
STATEMENT OF UNDERSTANDING**  
(For use of this form see USAREC Reg 601-37)

1. I request to be considered for participation in the Army Medical Department Enlisted Commissioning Program (AECP). I will, if selected, enroll in a BSN program that meets all the criteria of the AECP including program completion in 24 months. If appointment as a commissioned officer is not tendered or should I fail to complete the degree program or fail to meet program requirements while in the program, I understand that I will be required to serve in an enlisted status for the period specified by my enlistment, reenlistment, enlistment extension, or service obligation incurred by participation in the AECP.
2. I understand that the active duty obligation for participation in the program is 4 years. I further understand that the minimum service obligation as a commissioned officer is 4 years.
3. I understand my appointment as an officer in the Army Nurse Corps will be in Regular Army status for an indefinite period.
4. Soldiers who have received an enlistment bonus or selective reenlistment bonus will give the end date of the bonus and will add the following statement: "I understand that, if selected for this training, I may be required to refund the percentage of my bonus equal to the percentage of obligated service I will not perform in the specified MOS. My eligibility for bonus pay ceases on the date I depart my current duty station."
5. I meet all basic prerequisites listed in the AECP guidelines.
6. I have received and reviewed my enlisted record brief (ERB) personnel qualification record. It is current and accurate.
7. I understand that courses required by the school prior to entry into the nursing program will be at my own expense.
8. I understand that there is a tuition limit of \$9,000 per academic year. I further understand that for no reason will this amount be waived. I am aware of the fact that I will pay for any courses that must be repeated once an approval to be extended in the AECP has been given and I understand that I cannot use the GI Bill or any other Government financial support in conjunction with the AECP.
9. In return for acceptance into the AECP, I understand that I am required to take my nursing degree training in English only.
10. I am not currently on assignment or pending assignment. I have contacted my branch manager and informed them of the intent to apply for the AECP and have asked for my AEA code to reflect this action.
11. I am not currently scheduled for or attending MOS training as a result of reclassification or reenlistment retraining contract. I have not applied for reclassification or reenlistment retraining and will not apply for such training while an applicant for this program. My current service remaining requirement, for my most recent training, expired (or will expire) on leave blank (enter a date).
12. I have submitted all transcripts and documents identifying all post high school courses of instruction.
13. If my current or subsequent application for another service school is approved and I attend training, I understand that I may incur an additional service remaining requirement. I further understand I may be ineligible for enrollment into the AECP until all or parts of my service remaining requirements are met.
14. I can be reached at the following addresses: (Include unit of assignment, DSN and commercial work telephone numbers, residence address, home telephone number, and AKO e-mail address.) I accept the responsibility to inform HQ USAREC, ATTN: RCHS-AN (AECP) of all changes of assignments and addresses in a timely manner.

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**AECP STUDENT INFORMATION:**

NAME: Who, you Are	RANK: your rank
SIGNATURE: your digital signature	DATE: current date

**WITNESSING OFFICER INFORMATION:**

NAME: Co Cdr's full name	RANK: Commander's rank
SIGNATURE: Co Cdr's digital signature	DATE: Current date