REQUEST FOR EVALUATION OF DEPENDENT MEDICAL AND EDUCATIONAL PROBLEMS

(Supplement to DA Form 4787, Reassignment Processing)

For use of this form, see AR 612-10; the proponent agency is MILPERCEN.

(SEE REVERSE FOR PRIVACY ACT STATEMENT)

PART I - REQUEST FOR EVALUATION - *(Completed by losing MILPO with input provided by individual)*

1. **TO:**	2. **FROM:**

3. THIS REQUEST IS SUBMITTED IN CONJUNCTION WITH MY APPLICATION FOR
☐ a. DEPENDENT TRAVEL OVERSEAS
☐ b. SPECIAL HOUSING CONSIDERATIONS

4. MY REPORTING DATE/ARRIVAL MONTH TO THE GAINING COMMAND IS _____

5. SPECIAL CONSIDERATIONS
☐ a. AR 614-203 APPLIES *(Handicapped Dependents)*
☐ b. PARA 7-9D, AR 40-501 APPLIES *(Medical Standards)*
☐ c. DEPENDENT IS PREGNANT. EXPECTED DELIVERY DATE IS _____
☐ d. DEPENDENT(s) LISTED BELOW HAS *(have)* ☐ MEDICAL ☐ DENTAL ☐ PHYSICAL ☐ EMOTIONAL ☐ INTELLECTUAL CONDITIONS/PROBLEMS

6. DEPENDENT DATA a. NAME *(Last, first, MI)*	b. BRIEF DESCRIPTION OF PROBLEM/CONDITION

7. ☐ REQUEST THE INCLOSED SUPPORTING DOCUMENTS BE EVALUATED

8. ☐ REQUEST MY DEPENDENT?S(s?) MEDICAL/DENTAL RECORDS BE REVIEWED AND AN EVAL/EXAM BE CONDUCTED AS REQUIRED

9. ☐ ATTACHED IS A RELEASE FROM _____ AUTHORIZING DISCLOSURE OF MEDICAL/DENTAL INFORMATION TO AGENCIES THAT MUST PROCESS MY APPLICATION FOR DEPENDENT TRAVEL AND/OR MY REQUEST FOR SPECIAL HOUSING CONSIDERATIONS.

10. REQUEST COMPLETED FORM WITH INCLOSURES BE RETURNED TO _____ AS SOON AS PRACTICABLE.

11. AUTHENTICATION a. NAME, GRADE AND SSN	b. SIGNATURE	c. DATE

PART II - CERTIFICATE OF MEDICAL AND/OR EDUCATIONAL EVALUATION - *(Completed by medical and/or education authorities)*

SECTION I. MEDICAL CERTIFICATE OF EVALUATING PHYSICIAN

I HAVE REVIEWED THE SUPPORTING DOCUMENTATION AND/OR MEDICAL RECORDS OF THE ABOVE LISTED DEPENDENT(s) AND HAVE ACCOMPLISHED SUCH EVALUATION OR EXAMINATION AS IS NECESSARY *(Complete a, b and c as appropriate)*.

☐ a. DEPENDENT(s) *(has a)* SIGNIFICANT MEDICAL/PHYSICAL CONDITION(s) THAT WARRANT(s) SPECIAL HOUSING CONSIDERATIONS. *(Briefly explain restrictions)*.

b. MEDICAL CLEARANCE FOR TRAVEL TO THE OVERSEA AREA OF ASSIGNMENT ☐IS ☐IS NOT RECOMMENDED. *(If travel is not recommended, briefly explain why and estimate when dependent can travel)*.

☐ c. I AM ATTACHING A SUMMARY OF MEDICAL DATA FOR CONSIDERATION BY THE OVERSEA COMMAND SURGEON IN CONNECTION WITH INDIVIDUAL?S REQUEST FOR OVERSEA MOVEMENT OF DEPENDENT(s).

AUTHENTICATION a. NAME, GRADE AND SSN	b. SIGNATURE	c. DATE

SECTION II. CERTIFICATION OF OVERSEA COMMAND SURGEON

I HAVE REVIEWED THE INCLOSED SUPPORTING MEDICAL DOCUMENTATION AND THE REQUIRED MEDICAL AND/OR SPECIAL CARE ☐ IS ☐IS NOT AVAILABLE IN THE ASSIGNED AREA.

AUTHENTICATION a. NAME, GRADE AND SSN	b. SIGNATURE	c. DATE

SECTION III. CERTIFICATE OF OVERSEA EDUCATION OFFICER

I HAVE REVIEWED THE INCLOSED SUPPORTING DOCUMENTATION AND SPECIALIZED EDUCATION/TRAINING SERVICES ☐ARE ☐ARE NOT AVAILABLE IN THE ASSIGNED AREA.

AUTHENTICATION a. NAME, GRADE AND SSN	b. SIGNATURE	c. DATE

DATA REQUIRED BY THE PRIVACY ACT OF 1974	
AUTHORITY:	Title 10 USC 3012, 8012 and 5031.
PRINCIPAL PURPOSE:	For personnel service support.
ROUTINE USES:	To request medical and educational authorities to evaluate supporting documentation to individual's request for dependent travel to the oversea command or to request special consideration for government family housing.
DISCLOSURE:	Disclosure of requested information is voluntary. However, if not provided, request for travel of dependents and special consideration for government family housing will be disapproved.