

MEDICAL EVALUATION BOARD CHECKLIST

(Health Services Administrator must verify completion of all items below, sign and submit the checklist with MEB)

Ref: (a) Physical Disability Evaluations Manual, COMDTINST M1850.2 (series)

Item	Action	Date Completed
1	<p>Complete Medical Board Coversheet, Form CG-5684:</p> <ul style="list-style-type: none"> • Items 1-8: Self-explanatory • Item 9: cause of injury must be complete. For illness put N/A • Item 10: If YES, LOD investigation must be attached • Items 11-14: Self-explanatory • Item 15: Must be completed and signed by a convening authority listed in Art 3.B. of reference (a). • Item 16: Must match date listed on Form CG-4920 • Item 16a - 16f: Include only those diagnoses and the appropriate ICD-9 code for conditions deemed by the MEB convening authority to be unfitting or disqualifying for continued military service. For EPTE codes 1 and 2, evidence must be present in the record to show that the medical condition existed prior to entry. See Art 2.C.5.b.(3) for mental health conditions suspected to EPTE. • Item 17: Self-explanatory • Item 18: Self-explanatory • Item 19: Must be completed IAW Art 3.A.C of reference (a). If there is only one medical officer available please type or handwrite under the Senior Member "Only one Medical Officer available." 	
2	<p>Interacting with the Evaluatee:</p> <ul style="list-style-type: none"> • Obtain determination from MO if appropriate to advise member of findings, opinions and recommendations. • If the information contained in the board's report might have an adverse effect on the member's physical or mental health, then DO NOT advise the member of findings, opinions or recommendations in the report. <p>If the information in the report will not have an adverse effect on the member's physical or mental health, then DO advise the member of findings, opinions and recommendations in the report.</p> <ul style="list-style-type: none"> • Counsel member that if their medical condition may qualify for non-medical care assistance from the Navy Wounded Warrior - Safe Harbor program. Please contact the Health, Safety, Work-Life Service Center at 757-628-4347 for additional information and eligibility. 	

Item	Action	Date Completed
3	<p>Evaluatee's Statement Regarding the Findings of the Medical Board Report, Form CG-4920:</p> <ul style="list-style-type: none"> • The date listed on the form must match the date listed in block 16 of Form CG-5684. • The member may or may not elect to submit a letter (rebuttal). • If the member elects to submit a statement in rebuttal to findings of the MEB report, advise member to provide comments within 21-calendar days and include rebuttal statement or • If member elects to submit a statement in rebuttal and the member does not submit that statement within 21-calendar days, please include a notification to PSD-de that rebuttal was not completed. 	
4	<p>Include Command Endorsement:</p> <ul style="list-style-type: none"> • Command endorsement must be completed IAW Art 3.I. of reference (a). • Command endorsement must be signed by a convening authority listed in Art 3.B.1 of reference (a). • Command endorsements completed by the OINC of a station or ship must be endorsed and signed by the appropriate Sector Commander. • If member is a Reservist, attach a copy of the orders showing entitlement to receive basic pay. Also, evidence of line of duty as per COMDTINST M5830.1A, Administrative Investigations Manual. If in line of duty, provide Letter Incident Report, or CG-3822 (Injury Report) or a CG-4614 (Report of Illness of Reservist). If not in line of duty provide a Letter Incident Report. In addition, a copy of the Mishap Report should be provided if one is available 	
5	<p>Typed Narrative Summary, Form SF-502:</p> <ul style="list-style-type: none"> • The Narrative Summary must be completed IAW Art 3.G.3 of reference (a) • First sentence of Narrative Summary must include if the member is left or right hand dominate. 	
6	<p>Obtain interim duty status determination for member from Medical Officer</p>	

Item	Action	Date Completed
7	Copies of all health record information pertaining to each diagnosed impairment listed on Form CG-5684 and Form CG-4920. To include consultations, reports of x-rays, photographs and video tapes when appropriate. All reports, including consultations must be typewritten or printed legibly and in chronological order from newest to oldest.	
8	Entry Physical/ MEPS: <ul style="list-style-type: none"> • Include a copy of member’s enlistment or commissioning physical exams • If not available, provide memo to file stating Entry Physical/MEPS is unavailable 	
9	In Psychiatric cases the following MUST be included: A mental health evaluation performed by a military or VA mental health care provider. A military or VA mental health care provider is a psychiatrist, a doctoral level clinical psychologist, or doctoral level clinical social worker with necessary and appropriate professional credentials who is privileged to conduct mental health evaluations for the DoD, VA or the CG.	
10	In cardiac cases the following MUST be included: <ol style="list-style-type: none"> a. EKG b. American Heart Association Diagnostic Standards c. METS test d. Ejection Fraction Measurement 	
11.	In hearing impairment cases the following MUST be included: <ol style="list-style-type: none"> a. Audiometric Examination b. Statement as to testing standard used (ASA, ISO, or ANSI), and c. Voice discrimination test results: pure tone audiometry and speech discrimination without hearing aids 	
12	In high blood pressure (hypertension) cases the following MUST be included: <ol style="list-style-type: none"> a. Results of 3-day serial blood pressure check taken twice a day, for three consecutive days, while on medication 	
13	In diabetes mellitus cases the following MUST be included in Narrative Summary: <ol style="list-style-type: none"> a. Type and Frequency of medications administered and observed results. b. Degree and Frequency of any limitations of activities 	

Item	Action	Date Completed
14	In brain surgery cases the following MUST be included: a. Size of hole in skull	
15	In orthopedic cases include the following MUST be included: a. Current ROM (Range of Motion) to include 3 individual active ROM measurements per plane must be documented within Deluca guidelines. See Encl (1) for example. Only complete the applicable affected area listed on the Form CG-5684.	
16	In vision cases include either Goldman kinetic perimetry or automated perimetry using Humphrey Model 750, or later version of these perimetric devices with simulated kinetic Goldman testing ability. The results must be recorded on a standard Goldman chart and the Goldman chart must be included with the examination report.	
17	Distribute the board package as follows: a. Original to PSC-PSD-DE b. Copy to the member (unless results have been withheld from member for cause) c. Copy retained by convening authority and/or CO d. Copy to health record (should only include cover sheet, SF-502, Command Endorsement & member's comments. All other documents are from the health record so there is no need to duplicate.	

Health Services Administrator
Name, Title and Signature

Only perform ROM for conditions listed on
Medical Board Cover Sheet or ordered by the
Physical Evaluation Board

Date: _____ **Deluca ROM for the Thoracolumbar and Cervical Spine**

Thoracolumbar:	1st	2nd	3rd
Forward Flexion			
Extension			
Left Lateral Flexion			
Right Lateral Flexion			
Left Lateral Rotation			
Right Lateral Rotation			

Cervical:	1st	2nd	3rd
Forward Flexion			
Extension			
Left Lateral Flexion			
Right Lateral Flexion			
Left Lateral Rotation			
Right Lateral Rotation			

Deluca ROM for the Shoulder (Bilateral)

Shoulder:	1st	2nd	3rd
Forward Elevation (Flexion) (Left)			
Abduction (Left)			
External Rotation (Left)			
Internal Rotation (Left)			
Forward Elevation (Flexion) (Right)			
Abduction (Right)			
External Rotation (Right)			
Internal Rotation (Right)			

Name and Signature of Provider: _____

Enclosure (1)

Date: _____

Deluca ROM for the Elbow (Bilateral)

Elbow:	1 st	2 nd	3rd
Flexion (Left)			
Flexion (Right)			

Deluca ROM for Forearm (Bilateral)

Forearm:	1 st	2 nd	3rd
Pronation (Left)			
Supination (Left)			
Pronation (Right)			
Supination (Right)			

Deluca ROM for the Wrist (Bilateral)

Wrist	1 st	2 nd	3rd
Dorsiflexion (Extension) (Left)			
Palmar Flexion (Left)			
Ulnar Deviation (Left)			
Radial Deviation (Left)			
Dorsiflexion (Extension) (Right)			
Palmar Flexion (Right)			
Ulnar Deviation (Right)			
Radial Deviation (Right)			

Deluca ROM for the Knee (Bilateral)

Knee:	1 st	2 nd	3rd
Flexion (Left)			
Extension (Left)			
Flexion (Right)			
Extension (Right)			

Name and Signature of Provider: _____

Enclosure (1)

Date: _____

Deluca ROM for the Hip (Bilateral)

Hip:	1 st	2 nd	3rd
Flexion (Left)			
Abduction (Left)			
Flexion (Right)			
Abduction (Right)			

Deluca ROM for the Ankle (Bilateral)

Ankle	1 st	2 nd	3rd
Dorsiflexion (Left)			
Plantar Flexion (Left)			
Dorsiflexion (Right)			
Plantar Flexion (Right)			

Name and Signature of Provider: _____

Enclosure (1)

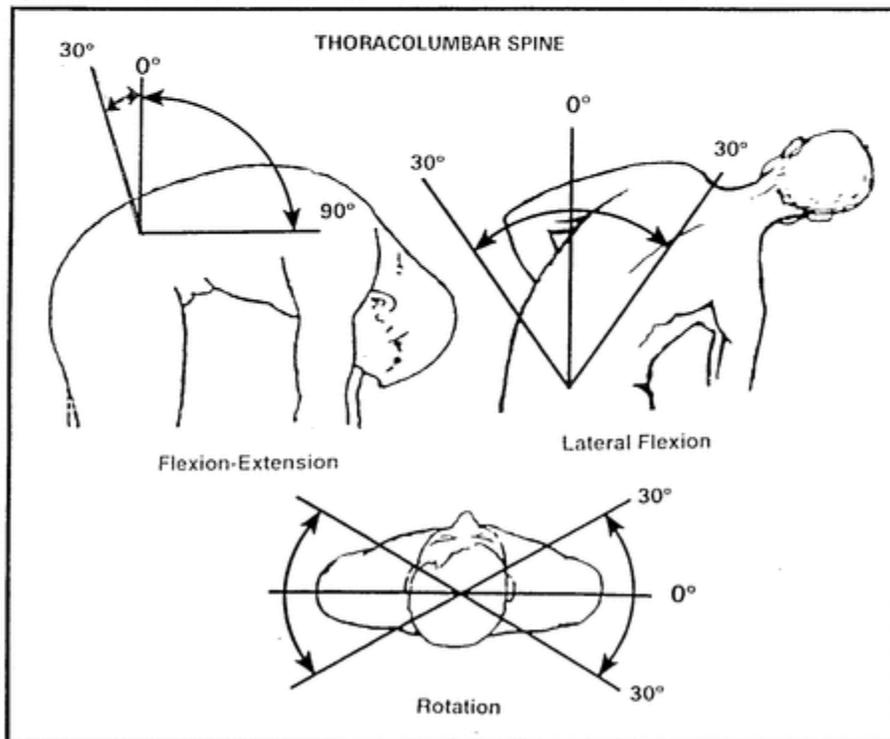
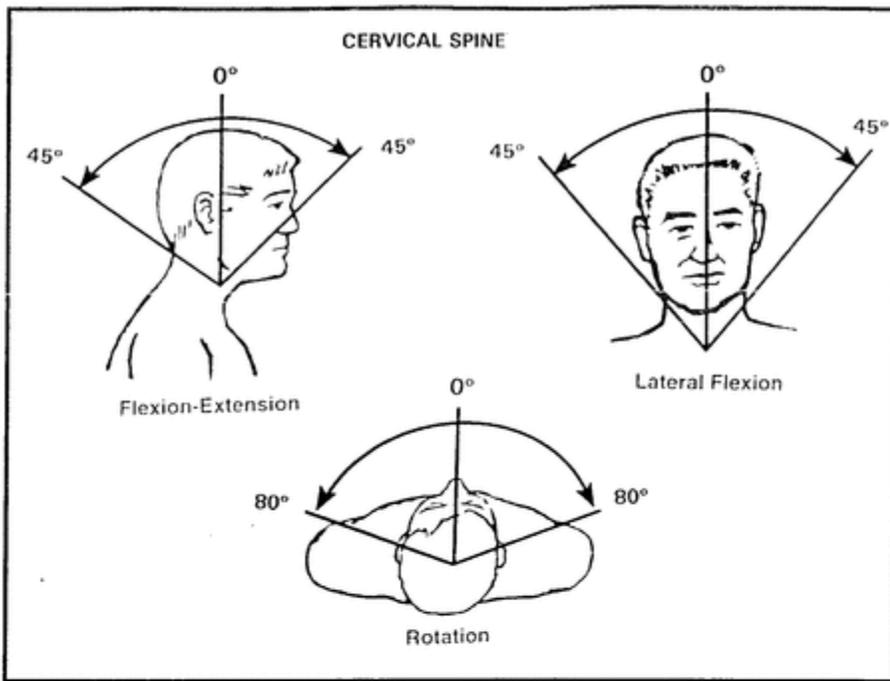
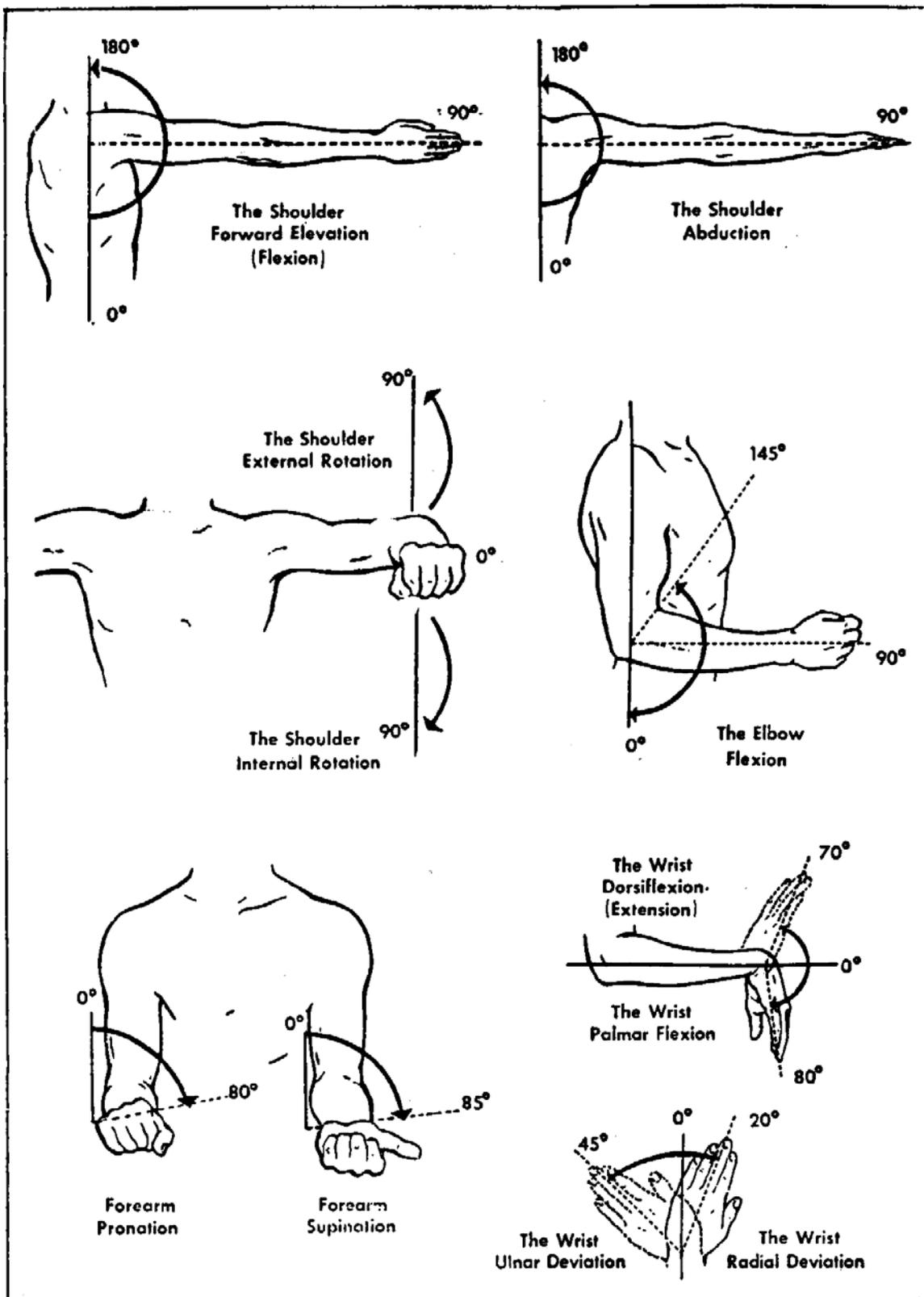


PLATE V
RANGE OF MOTION OF CERVICAL AND THORACOLUMBAR SPINE

Enclosure (1)



Enclosure (1)

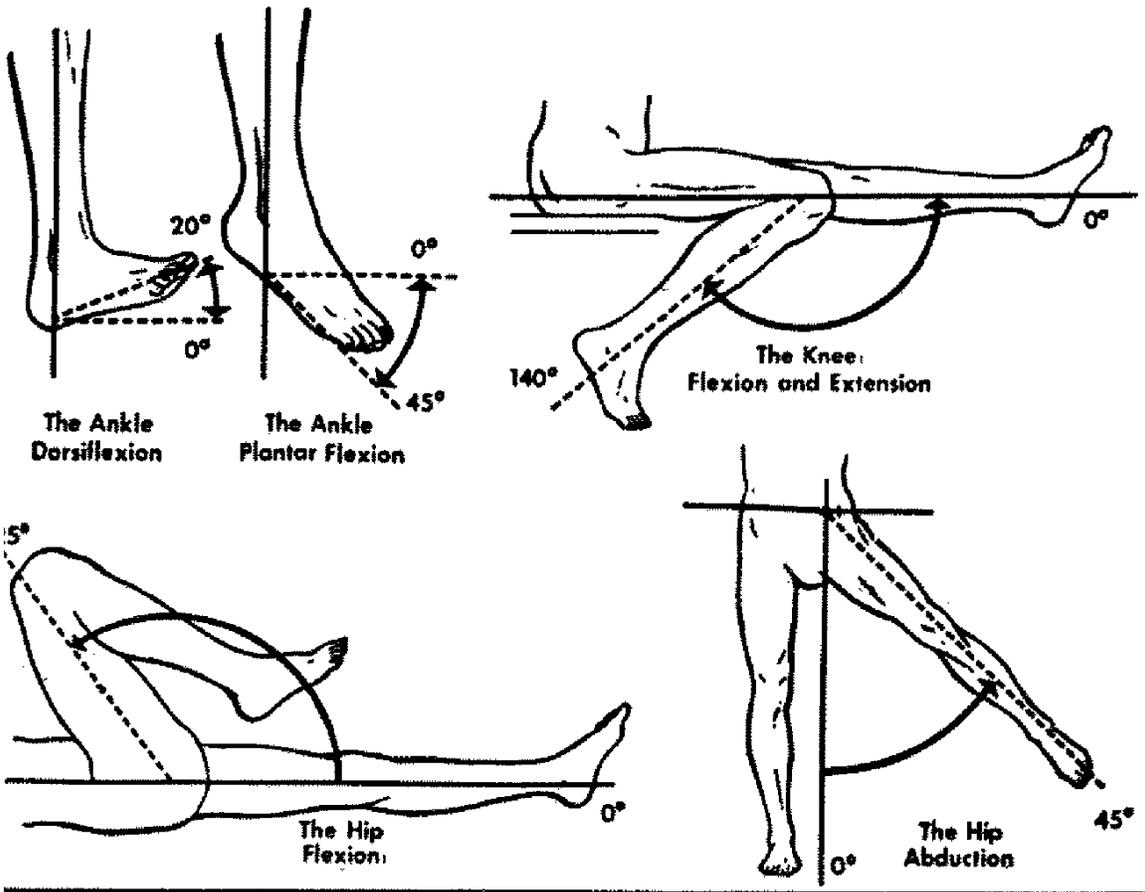


PLATE II

Enclosure (1)