Command Checklist for Overseas Screening

These checklists shall be completed within **TEN DAYS** of receipt of PCS orders.
These checklists shall be faxed to the entry approval point within **FIVE DAYS** of completion.

- Section One shall be completed by the member and spouse (if applicable) prior to the interview.
- Section Two shall be completed by the member prior to the interview.
- Section Three shall be completed by the transferring command.
- Section Four shall be completed by the screener.
- Section Five shall be completed by the medical reviewer and the transferring command C.O.
- The entire completed checklist shall be faxed to the appropriate Entry Approval Point and then filed in part two of the member's SPO PDR.
- The Dependent Medical Review shall be completed by competent medical authority and filed in the member's medical record.

The screening shall be completed by the **most** qualified member available at each unit.

- If possible, the screener should be someone who has been previously assigned overseas.
- The screener shall be an E7 to CWO4 or O3 and above.
- If possible, the screener should be senior to the member being screened.
- The screener shall have a completed copy of section one of the checklist, including the member's remarks section, during the interview and shall review each question with the member and spouse (as applicable.)
- The screener shall ensure that all items of interest are clearly explained in either the member's remarks or in their endorsement.

Section Three (Unit Review) shall be completed by the unit's senior administrator who normally has access to the member's unit SPO PDR. The reviewer shall normally be an E7 or above, except when the XPO is an E6. This review may be conducted by the screener, but it is not required.

The purpose of this screening & review is to determine a member and dependents suitability for travel overseas. This includes determining if the dependents are fully prepared for living overseas. If the screener has any doubts about the member's suitability, they shall bring it to the attention of the member's command. A thorough review of **ALL** questions on this checklist is essential to a successful screening. The screener should contact the applicable Entry Approval Point if they have any questions about how to conduct the screening. The spouse may be interviewed via phone or by another command if necessary, but **only as a last resort**. Every effort should be made to have the interview conducted simultaneously, and by just one screener. The screener should contact the applicable Entry Approval Point if they have any questions about how to conduct the screening.

MEDICAL ISSUES: If any medical issues come up during the interview, the screener shall ensure that the issues are reviewed by the medical authority completing the medical dependent screening portion.

Member's Name			Grade/Rate	EMPLID	Date	
Current Duty Station & Phone Number			New Unit & Phone Number			
Screener's Name			Grade/Rate	Phone Number		
Spouse			Dependent		Age	Gender
Dependent	Age	Gender	Dependent		Age	Gender
Dependent	Age	Gender	Dependent		Age	Gender

Section One – Member & Spouse

For medical or work-life issues, the member and spouse only need disclose that there is an issue to be addressed or resolved. In the interest of privacy, the screener only need know that the problem is being addressed, and by whom. They need not know the specific facts or nature of the issue or concern.

Part A – To be completed by member only.

YES	NO	ITEM
		1. Are you a single parent or married to another service member? **If No →** Continue checklist. **If Yes →** Have dependent care requirements been met per 4-A-6, PERSMAN? **[ ] Yes [ ] No**
		2. Have you ever had an Early Return of Dependents, early transfer due to unsuitability, or a Humanitarian Assignment? **If Yes →** Explain completely, including dates, in remarks section. **If No →**Continue checklist.
		3. Have you been counseled on overseas pay, allowances and travel and household goods entitlements? **If No →** Member shall talk to unit admin personnel about this topic before continuing screening.
		4. Do you have a Government Travel Charge Card? **If NO →, you must apply for it immediately, AND explain in the remarks block.**
		5. Do you possess a valid state driver's license? **If No →** Explain in remarks section. **If Yes →** Continue checklist.

Part B – To be completed by member and spouse (if applicable.)

YES	NO	ITEM
		6. Do you, your spouse, or any dependent(s) have any knowledge of any on-going medical, dental, psychological, physical or educational problem(s) or treatment(s) or special needs? **If Yes →** Screener should refer to appropriate authority for review. **If No →** Continue checklist.
		7. Are you aware of the climate and isolation constraints (darkness, temperature, public transportation, etc.) at the proposed duty station? **If No →** Member shall talk to sponsor about these topics before continuing screening.
		8. Are you aware of the housing availability and constraints on pets, vehicles, household goods? **If No →** Member shall talk to Sponsor and Entry Approval Point about this topic before continuing.
		9. After completing Section Two (Financial Assessment), do you consider yourself financially stable for transfer overseas? **If Yes** – Continue checklist. **If No** – Explain in remarks section.
		10. Have you, your spouse, or dependent(s) been convicted for any civilian felonies or misdemeanors within the last 24 months (including pre-service time); violence, larceny, DUI, assault, etc. **If Yes →** Explain in remarks section. **If No →** Continue checklist.
		11. Have you ensured that the medical needs (prescriptions, equipment, etc.) of your family can be met at the overseas command?
		12. Have you, your spouse or dependents had any family violence incident(s) within or outside of family within the past two years? **If Yes →** Explain in remarks section. **If No →** Continue checklist.
		13. Do you or your spouse have legal custody of dependents other than those listed? **If No →** Continue checklist. **If Yes →** Explain in remarks section, including information on any special needs.
		14. Are any of the dependent's covered in a custody agreement? **If No →** Continue checklist. **If Yes →** Explain in FULL in remarks section, including information about restrictions in relocation of the dependents, and whether or not you have obtained a prior court approval or agreement from other interested parties if required by state law.
		15. Have you contacted your new command to discuss items such as housing, schools, and job opportunities for your spouse, etc? If your spouse will be seeking employment, recommend you contact your sponsor or the local work-life staff for information on the availability of employment in the area.

_____*Check if spouse interview conducted over phone.*
_____*Check if spouse interview conducted by another command.*

Section Two – Financial Statement

The member shall complete this section and submit it to their command. Column A is their current duty station. Column B is their expected duty station. Member should consult with either their sponsor or the Entry Approval Point for estimates where exact information is not available. Compare net income between current and expected duty station to determine the financial impact this assignment will have on your financial status.

Monthly Income	**A – Current**	**B - Expected**
Basic Pay		
Sea/Hardship Duty for Location/FSA		
SDAP/Proficiency/Flight Pay		
BAH/OHA		
BAS		
Cost of Living Allowance (COLA)		
Clothing Allowance		
Spouse's Income		
Part Time Income		
Other Income (rental, investments, etc.)		
TOTAL INCOME		

Monthly Expenses	**A - Current**	**B - Expected**
Housing (Rent or Mortgage)		
Food		
Clothing		
Utilities (Gas, Electric, Water)		
Credit Card Payments		
Loan Payments		
Transportation		
Automobile Payments		
Dependent Support/Care (i.e., child, parents)		
Education		
Other expenditures not listed		
TOTAL EXPENSES		

COMPARISON	**A – Current**	**B - Expected**
Total Income		
-Total Expenses		
=Net Income		

I certify that to the best of my knowledge this information is accurate and current. I have carefully considered the impact this transfer would have on my financial wellbeing.

Signature: _____ **Date:** _____

MEMBER'S REMARKS

I verify that I have answered all questions in Section One of the Overseas Screening Checklist to the best of my ability. I understand that failure to disclose any pertinent information may result in disciplinary action under the UCMJ and may result in my having to serve an unaccompanied tour. I also understand that if my dependents return INCONUS early, my tour length will not be adjusted. I further understand that I must work with the appropriate medical and/or work-life personnel to resolve any pending issues which I did not fully disclose to my screener due to privacy concerns. I acknowledge that I may not be granted entry approval until I have satisfied the Entry Approval Point that these issues have been resolved.

I understand that I must inform my command IMMEDIATELY if any of the information on this checklist changes prior to my departure or will change prior to reporting in at my new duty station.

I am aware that failure to provide any pertinent information, or providing incorrect information on this checklist may result in me not being able to receive command sponsorship and transfer overseas with my dependent(s).

_____ _____

Member Signature **Date**

REMARKS: **Provide amplifying information for any items requiring explanation (use a continuation sheet if necessary):**

Item # **Remarks:**

____ _____

____ _____

____ _____

____ _____

____ _____

____ _____

____ _____

____ _____

____ _____

____ _____

____ _____

____ _____

Section Three – Unit Review

The transferring command shall conduct a local record's check to determine if any disqualifying factors are contained in the member's record. They shall also research the following (if applicable): **Any answers checked in a shaded box require an explanation in the remarks block. The reviewer shall ensure that CGPC is informed if member enrolls in the Special Needs Program or Family Advocacy Program as a result of this screening process.**

Reviewer's Name: _____ Date: _____ Phone #: _____

Yes	No	Item
		1. Is there any evidence of any family problems that have not been resolved? Early return of dependents, HUMS, etc.
		2. Is there any evidence of financial irresponsibility?
		3. Is the member's Government Travel Card account delinquent?
		4. Is there any history or evidence of abuse, or dependency regarding either alcohol or chemical substances? **If NO →** Continue. **If YES →** Has member successfully completed treatment and remained substance free for at least 12 months IAW 4-H-3-c? **If NO →** Explain in remarks. **If YES →** Date treatment completed:
		5. Is there any evidence of unsatisfactory or marginal performance, per 4-B-1-d of PERSMAN.
		6. For single sponsors of dependents or military couples with dependents, have their annual requirements for dependent care been met per 4-A-6 of the Personnel Manual?
		7. Does the member have a record of military offenses? E. g. NJP, unauthorized absence(s), or any major offense.
		8. Are all eligible dependents enrolled in DEERS?
		9. Are all eligible dependents enrolled in Tricare/Tricare Dental Program (TDP)?
		10. Does the member have a spouse or dependent(s) with special needs, or enrolled in a special education program? **IF YES →** Ensure that a Special Needs Enrollment form has been submitted thru the local work-life staff.
		11. Is there any evidence that the member, spouse, or dependent(s) had any family violence incident(s) within or outside of family in the past two years? **If YES →** Ensure that the member has enrolled with the Work-Life Staff's Family Advocacy Rep.
		12. Has the member and dependent(s) completed all applicable medical screenings and physicals?
		13. Does the member meet the family guidelines as outlined in Article 4-H-6-b? **IF NO →** A waiver must be obtained from the Entry Approval Point?
		14. Is the member in compliance with current weight standards?
		15. For enlisted personnel assigned to duties involving flying: Upon reporting, will the member's qualification in the 9D5 Dunker have at least 36 months remaining.
		16. If the member is single, do they plan on acquiring dependents by any means (marriage, adoption, etc.) prior to reporting to their new duty station? **IF YES →** Overseas screenings must include future dependents and member shall be counseled about accompanied tour lengths. Member shall also be counseled on travel and transportation entitlements, including exactly when and how they are accrued for their new dependents.

Remarks:

Section Four – Screener's Endorsement

I have reviewed Sections One, Two and Three of the Overseas Screening Checklist with the member and their spouse. I further verify that the member consulted with medical and work-life personnel about issues they did not wish to discuss with me due to privacy concerns. I have provided the specific names and contact information for those personnel below. *Check **one** of the below:*

☐ To the best of my knowledge, I believe that this member and the spouse are fully informed about their transfer overseas and are prepared for the challenges associated with the new duty location. I recommend them for overseas transfer.

☐ To the best of my knowledge, I believe that this member and/or the spouse are not prepared for, or fully informed about their potential transfer. I recommend that they be more carefully screened by the XO or CO of the transferring command.

Screeners Name & Grade	Screener's Signature	Date

Remarks: (*Include specific contact information (names & phone numbers) for anyone consulted by the member about private issues. Include any amplifying information you believe is important for the Transferring Command or the Entry Approval Point to know when considering this member and their dependents for assignment overseas.*)

Section Five – Medical & Command Endorsement

Member's Name:

Unit/Location to Which Transferring:

Medical Endorsement

Check one box:

☐ I certify that I have reviewed the Dependent Medical Screening form for this member and his/her dependents. I certify that there are no apparent or disclosed medical reasons to delay or prohibit them from transfer to the location above. **Recommend approval**.

☐ I certify that I have reviewed the Dependent Medical Screening form for this member and his/her dependents. There are existing medical conditions or needs that can not be met at the assigned location. **Do not recommend approval**.

Date	**Medical Authority Name/Grade/Signature**	**Phone Number**

Command Endorsement

Check one box:

☐ RECOMMEND APPROVAL. I have reviewed sections one thru four of the checklists for this member. I believe that this member is fully prepared for assignment overseas. I recommend the member for transfer.

☐ RECOMMEND DISAPPROVAL. I have reviewed sections one thru four of the checklist for this member. I do not believe that this member is qualified for assignment overseas, nor can they be made ready in time for this transfer. (Explain in remarks.) I do not recommend the member for transfer. (Contact CGPC.)

Commanding Officer's Signature _____ Date _____

Remarks:

Exhibit 4.H.2. OVERSEAS SCREENING FOR ACTIVE DUTY DEPENDENTS PART I

Family Member Name:	Relationship to Sponsor/Ben Code:	SSN:	Date:

Service Member Name:	Grade/Rate:	SSN:	Current Duty Station:
Overseas Unit A/D member is being assigned:			Reporting Date:

Medical Screening: Is completed by the medical provider to identify any special needs, and determine if a family member is suitable to accompany the active duty member to an overseas unit. (Note: A physical may be required at medical provider's discretion).

YES	NO	ITEM *(list all "YES" answers in the remarks section).*
		1. Have all health records been reviewed by local Tricare Provider?
		2. Are all Immunizations up to date. Do they meet destination requirements?
		3. Are there any pending consults or tests that have a bearing on assignment suitability?
		4. For dependent wives. (List any abnormal results in the remarks section)
		a. Has a pap smear/pelvic and breast exam been performed within the past 12 months? Date of Exam: _____ Results: _____
		b. Mammogram current (based on age)? Date of test: _____ Results: _____
		c. Pregnancy Screening? (Verbal inquiry) Date of test: _____ Results: _____
		d. If pregnant, estimated date of delivery? _____
		e. Are there any foreseen complications of the pregnancy? ( )Yes ( )No If "yes" describe: _____
		5. Are there any conditions requiring ongoing care in the following area? (List under remarks section)
		a. Orthopedic conditions (e.g., chronic back, knee, joint pain or weakness)
		b. Cardiovascular conditions (e.g., chest pain/angina, arrhythmia, valve disease, infarction)
		c. Gynecologic conditions (e.g. chronic pelvic pain, abnormal PAP, breast mass)
		d. Neurological conditions (e.g. seizure, pinched nerve, migraine, neuropathy)
		e. Respiratory condition (e.g. asthma, RAD, chronic sinus, allergies)
		f. Mental health, or behavioral conditions (e.g. depression, adjustment/personality disorder, ADD/ADHD)
		g. Chronic or frequent medication use: (List all medications under remarks section)
		h. Alcohol abuse or dependence
		i. Developmental concerns (e.g., motor, cognitive, communication, social/emotional or adaptive development)
		j. Other conditions or concerns? (e.g. diabetes), explain: _____ _____
		6. For service family members with underlying medical conditions: (List under remarks section)
		a. Is there a requirement for special medical supplies, adaptive equipment, assistive technology devices, special accommodation, etc?
		b. If exposed to a physically or emotionally demanding environment, could the underlying condition become life threatening, pose a risk for dangerous or disruptive behavior, or result in a MEDEVAC situation?

Exhibit 4.H.2.b. OVERSEAS SCREENING FOR ACTIVE DUTY DEPENDENTS PART I

YES	NO	ITEM *(list all "YES" answers in the remarks section).*
		c. Are there any chronic medical or mental health conditions requiring routine or continuing access to care or access to specialized medical care ?
		d. Other concern? (specify in remarks section)
		7. Have all dental records been reviewed by the Dental Provider?
		a. Are there any chronic dental conditions requiring routine or continuing access to care or access to specialized dental care? (e.g., TMJ, periodontal disease)
		b. Is family member under going active orthodontics treatment? Date started: _____ Estimated completion date: _____
		c. Date of last Dental Exam? _____
		d. Other concern? (specify in remarks section)

Dental Provider Remarks: *(Explain all "YES" answers).*

Health Care Provider Remarks: *(Explain all "YES" answers).*

"THE INFORMATION CONTAINED IN THIS QUESTIONNAIRE MAY ONLY BE RELEASED IN ACCORDANCE WITH THE FREEDOM OF INFORMATION AND PRIVACY ACT"

Exhibit 4.H.2. OVERSEAS SCREENING FOR ACTIVE DUTY DEPENDENTS
PART II (Command Endorsements)

Family Member Name:	Relationship to Sponsor/Ben Code:	SSN:	Date:
Service Member Name:	Grade/Rate:	SSN:	Current Duty Station:
Overseas Unit A/D member is being assigned:			Reporting Date:

Medical Provider Comments:		
Medical Provider Name: (print)	Medical Provider/Screener Signature:	Date:
MTF/PCM Name:	Address:	Phone Number:

Dental Provider Comments:		
Dental Provider Name:	**Dental Provider/Screener Signature:**	**Date:**
MTF/PCM Name:	**Address:**	**Phone Number:**

Receiving Command:

1. Can the (MTF/PCM) provide current required medical/dental support? ( ) Yes ( ) No
   If "NO" list reason why: _____
2. Can the (MTF/PCM) provide required medical/dental support (diagnostic, therapeutic and medications) if the underlying condition is exacerbated? ( ) Yes ( ) No
   If "NO" list reason why: _____

Receiving Command Endorsement:

(A copy of this questionnaire must be returned to originating unit prior to orders being executed) Article 4-H-2-3.e.)

( ) Family member is approved to accompany active duty member to this unit.

( ) Family member is not approved to accompany active duty member to this unit.
List reason why: _____

Medical Officer/Health Care Provider Name:	**Signature:**	**Date:**
Receiving Command Name:	**Address:**	Phone:

"THE INFORMATION CONTAINED IN THIS QUESTIONNAIRE MAY ONLY BE RELEASED IN ACCORDANCE WITH THE FREEDOM OF INFORMATION AND PRIVACY ACT"

Exhibit 4.H.2. INSTRUCTION FOR COMPLETION OF OVERSEAS SCREENING FOR ACTIVE DUTY DEPENDENTS

Purpose: The information contained in this is gathered for the purpose of determining the dependent's suitability for overseas assignment and to ascertain whether competent medical care is reasonably available at the overseas location for any preexisting conditions.

Instructions for Releasing Command:

This screening form is comprised of two parts:

PART ONE - Overseas Screening for Active Duty Dependents. This form will be completed by the dependent's Primary Health Care provider. Dependents who are enrolled in TRICARE should contact their provider in order to complete the screening as soon as possible. The following procedure will be followed in order to ascertain the dependents' suitability for overseas transfer and to protect patient health information.

1. **Upon notification of pending transfer to an OCONUS duty station, dependents of active duty military members will schedule an appointment with their Primary Health Care provider. The unit will provide the member/dependent with a copy of the "Overseas Screening for Active Duty Dependents: form and 2 copies of the DD Form 2870 "Authorization for Disclosure of Medical or Dental Information to take to the provider.**

2. **If the provider is not a military treatment facility, the provider will complete the screening in accordance with the Route Physical Examinations procedures of the TRICARE Policy Manual 6010.54-M, August 1, 2002. Upon completion of the screening, the provider will either fax or mail the entire package to the medical representatives listed in Blocks 6a and 6b of DD Form 2870.**

PART TWO – Command Endorsement:

1. **Upon receipt of the completed screening form, the designated medical representative will review the form for completeness and coordinate delivery of the form to the receiving command's medical representative. In the event amplifying information is needed regarding the dependents' medical status, these will addressed solely and directly between medical facilities.**

2. **The receiving command's medical representative will review the screening form and make a determination whether the dependent is considered qualified to accompany the member overseas. Part Two will be returned to the releasing command to serve as notification of dependent's status in regard to eligibility to accompany the member overseas.**

AUTHORIZATION FOR DISCLOSURE OF MEDICAL OR DENTAL INFORMATION

PRIVACY ACT STATEMENT

In accordance with the Privacy Act of 1974 (Public Law 93-579), the notice informs you of the purpose of the form and how it will be used. Please read it carefully.
AUTHORITY: Public Law 104-191; E.O. 9397 (SSAN); DoD 6025.18-R.
PRINCIPAL PURPOSE(S): This form is to provide the Military Treatment Facility/Dental Treatment Facility/TRICARE Health Plan with a means to request the use and/or disclosure of an individual's protected health information.
ROUTINE USE(S): To any third party or the individual upon authorization for the disclosure from the individual for: personal use; insurance; continued medical care; school; legal; retirement/separation; or other reasons.
DISCLOSURE: Voluntary. Failure to sign the authorization form will result in the non-release of the protected health information.
This form will not be used for the authorization to disclose alcohol or drug abuse patient information from medical records or for authorization to disclose information from records of an alcohol or drug abuse treatment program. In addition, any use as an authorization to use or disclose psychotherapy notes may not be combined with another authorization except one to use or disclose psychotherapy notes.

SECTION I - PATIENT DATA

1. NAME *(Last, First, Middle Initial)*	2. DATE OF BIRTH *(YYYYMMDD)*	3. SOCIAL SECURITY NUMBER
4. PERIOD OF TREATMENT: FROM - TO *(YYYYMMDD)*	5. TYPE OF TREATMENT *(X one)* ☐ OUTPATIENT ☐ INPATIENT ☐ BOTH	

SECTION II - DISCLOSURE

6. I AUTHORIZE _____ TO RELEASE MY PATIENT INFORMATION TO:
(Name of Facility/TRICARE Health Plan)

a. NAME OF PHYSICIAN, FACILITY, OR TRICARE HEALTH PLAN	b. ADDRESS *(Street, City, State and ZIP Code)*
c. TELEPHONE *(Include Area Code)*	d. FAX *(Include Area Code)*

7. REASON FOR REQUEST/USE OF MEDICAL INFORMATION *(X as applicable)*
☐ PERSONAL USE ☐ CONTINUED MEDICAL CARE ☐ SCHOOL ☐ OTHER *(Specify)*
☐ INSURANCE ☐ RETIREMENT/SEPARATION ☐ LEGAL

8. INFORMATION TO BE RELEASED

9. AUTHORIZATION START DATE *(YYYYMMDD)*	10. AUTHORIZATION EXPIRATION ☐ DATE *(YYYYMMDD)* ☐ ACTION COMPLETED

SECTION III - RELEASE AUTHORIZATION

I understand that:
a. I have the right to revoke this authorization at any time. My revocation must be in writing and provided to the facility where my medical records are kept or to the TMA Privacy Officer if this is an authorization for information possessed by the TRICARE Health Plan rather than an MTF or DTF. I am aware that if I later revoke this authorization, the person(s) I herein name will have used and/or disclosed my protected information on the basis of this authorization.
b. If I authorize my protected health information to be disclosed to someone who is not required to comply with federal privacy protection regulations, then such information may be re-disclosed and would no longer be protected.
c. I have a right to inspect and receive a copy of my own protected health information to be used or disclosed, in accordance with the requirements of the federal privacy protection regulations found in the Privacy Act and 45 CFR §164.524.
d. The Military Health System (which includes the TRICARE Health Plan) may not condition treatment in MTFs/DTFs, payment by the TRICARE Health Plan, enrollment in the TRICARE Health Plan or eligibility for TRICARE Health Plan benefits on failure to obtain this authorization.
I request and authorize the named provider/treatment facility/TRICARE Health Plan to release the information described above to the named individual/organization indicated.

11. SIGNATURE OF PATIENT/PARENT/LEGAL REPRESENTATIVE	12. RELATIONSHIP TO PATIENT *(If applicable)*	13. DATE *(YYYYMMDD)*

SECTION IV - FOR STAFF USE ONLY *(To be completed only upon receipt of written revocation)*

14. X IF APPLICABLE: ☐ AUTHORIZATION REVOKED	15. REVOCATION COMPLETED BY	16. DATE *(YYYYMMDD)*
17. IMPRINT OF PATIENT IDENTIFICATION PLATE WHEN AVAILABLE	SPONSOR NAME: SPONSOR RANK: FMP/SPONSOR SSN: BRANCH OF SERVICE: PHONE NUMBER:	

DD FORM 2870, DEC 2003

GUIDANCE FOR COMPLETION OF DD Form 2870

Two copies of this document will be completed. Both documents will contain the same information with the exception of Blocks 6a and 6b.

Copy 1: Blocks 6a and 6b will include the name of the current Coast Guard Healthcare Representative (i.e. CG Clinic).

Copy 2: Blocks 6a and 6b will include the name of the receiving command Coast Guard Healthcare Representative. (e.g. for CGC NAUSHON, the receiving clinic would be Ketchikan).

Section I Patient Data

Block 1. Self explanatory
2. Self explanatory
3. Self explanatory
4. Enter date of physical and any follow up care dates (inclusive).
5. Treatment type: Outpatient

Section II Disclosure

Block 6. Enter the name of the facility where the physical is being conducted
6a. Complete as described above.
6b. Complete as described above.
6c. Unit telephone number.
6d. Unit fax number.
7. Reason for request: OTHER: Physical Assessment/Overseas Screening.
8. Information to be release: All medical/dental information required to ensure dependent meets physical requirements for overseas assignment.
9. Start date: Date of appointment.
10. Expiration date should be the reporting date on the member's orders.

Section III Release Authorization

Block 11. Patient signature or guardian if dependent is a minor.
12. Self explanatory.
13. Self explanatory.

Section IV For Medical Staff Use Only.

Entry Approval Points

Entry Approval Point	Units/Location
AIRSTA Sitka	Air Station Sitka
ISC Kodiak	Kodiak / Attu / St Paul / Port Clarence / Unalaska / AVSUPFAC Cordova
ISC Ketchikan	All other Alaska Units/Locations
Sector San Juan	Puerto Rico / Virgin Islands / Caribbean
CGD Fourteen	D14 Staff / CGIS Det Hono / CEU Hono
Sector Honolulu	Sector Hono / WPBs / MSDs / ANT Hono / STA Hono / MSD Am. Samoa
AIRSTA Barbers Point	AIRSTA Barbers Point
ISC Honolulu	All other Hawaii Units / American Samoa
Sector Guam	Guam / Saipan
ACTEUR	Europe (Except Sweden)
PATFORSWA	PATFORSWA
PERSUPDET Yokosuka (INFO CG FEACT)	Japan / Singapore
Sector Miami	Cuba
USDAO STOCKHOLM (INFO ACTEUR)	Sweden