ANNUAL CERTIFICATE OF PHYSICAL CONDITION

Privacy Act Statement

Authority: The authority to request this information is contained in 5 USC § 301 (Authorizing Forms and Regulations); 10 USC, Subtitle A, Part III, Ch. 103 (Senior ROTC).

Principal Purpose(s): This form is intended to inform the Naval Reserve Officers Training Corps (NROTC) unit of any changes to the student's physical condition.

Routine Use(s): Information you provide in this application is protected by the Privacy Act and will not be released outside the Department of Defense without your permission unless it comes within an exception to the Act or one of the routine uses in 32 CFR sect 701.112, accessible at http://www.privacy.navy.mil.

Disclosure: Failure to disclose an injury, illness, disease or physical condition could result loss of disability benefits and be the basis for administrative action, including disenrollment from the program.

Section I: Personal Information

Last Name, First, MI: | Last 4 SSN: | Today's Date

ROTC Unit: Iowa State University | USMC or NAVY & Rank/MIDN Class | Sex | Birthdate

Home Address: | Home Phone Number | Cell Phone Number

Email Address: | Height (in) | Weight (lbs) | Last Official PFA Result | Date of that PFA

Section II: Medical History

Type of last physical exam ☐ DoDMERB ☐ MEPS ☐ Special Duty / MTF ☐ Sports / Private Sector   Date of Physical

Note: Sports/Private sector physicals apply only to College Program Basic Students

Since your last military physical examination have you had or been diagnosed with:	Yes	No
1. Eye trouble (to include vision loss, cataract, glaucoma, keratoconus, corneal ectasia, retinal detachment)?	☐	☐
2. Surgery to improve vision (PRK, LASIK, LASEC, RK, intraocular lens implant, cross linking)?	☐	☐
3. Color vision deficiency?	☐	☐
4. Ear trouble (to include perforated ear drum, cholesteatoma, tubes in ears, or other ENT surgery)?	☐	☐
5. Diagnosed with or tested positive for COVID-19 or other infectious disease/infection?	☐	☐
6. Hearing loss or use of a hearing aid?	☐	☐
7. Nose, throat, or sinus trouble (to include sinusitis, abscess, surgery on nose, sinuses or throat)?	☐	☐
8. Orthodontic treatment? (if "yes", include completion or projected date of completion in Section III)	☐	☐
9a. Tooth or gum trouble (excluding cavities)?	☐	☐
9b. Date of last dental exam:		
10. Breathing trouble (to include asthma, wheezing, shortness of breath, chronic cough, use of inhaler, collapsed lung)?	☐	☐
11. Cardiac trouble (to include chest pain, palpitations, heart valve problems, surgery, high or low blood pressure)?	☐	☐
12. Gastrointestinal trouble (to include celiac disease, irritable bowel syndrome, ulcer, reflux, esophagitis, gallstones, hernia, or hepatitis)?	☐	☐
13. Inflammatory bowel disease (to include Ulcerative colitis, Ulcerative proctitis, or Crohn's disease)?	☐	☐

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	Yes	No
14a. Gynecologic trouble (including endometriosis, polycystic ovarian disease, abnormal pap smear)?	☐	☐
14b. Date of last menstrual period:		
14c. Date of Last PAP smear:		
15.Testicular or prostate trouble?	☐	☐
16. Orthopedic problems of the back/spine, neck, or pelvis?	☐	☐
17. Orthopedic problems of the upper extremities (fracture, dislocation, sprain, surgery)?	☐	☐
18. Orthopedic problems of the lower extremities (fracture, dislocation, sprain, surgery)?	☐	☐
19. Vascular trouble (Raynaud's disease, blood clot or deep venous thrombosis, high blood pressure)?	☐	☐
20. Skin trouble (to include psoriasis, eczema, atopic dermatitis, severe acne)?	☐	☐
21. Prescribed systemic retinoid medications (ie: Accutane)? (List date completed or projected completion date in Section III.)	☐	☐
22. Blood disorders (anemia, thrombocytopenia, bleeding disorders, disorder of the spleen)?	☐	☐
23. Allergic reaction to food, medications, insects?	☐	☐
24. A positive PPD or been treated for tuberculosis?	☐	☐
25. Car, train, sea, or air sickness that required prescription medication or avoidance of travel?	☐	☐
26. Endocrine disorders (including diabetes, thyroid, osteoporosis)?	☐	☐
27. Head injury, memory loss, amnesia?	☐	☐
28. Neurologic trouble (including dizziness, vertigo, fainting, tic disorder, tremor, seizure, or paralysis)?	☐	☐
29. Frequent or severe headaches in the past 2 years?	☐	☐
30. Sleeping trouble (narcolepsy, sleepwalking, chronic insomnia, sleep apnea)?	☐	☐
31. Evaluation or treatment for depressive, other mood, substance use, bipolar, or psychotic disorder?	☐	☐
32. Evaluation or treatment for anxiety disorder or panic attacks?	☐	☐
33. Evaluation or treatment for eating disorders (anorexia or bulimia)?	☐	☐
34. Evaluation or treatment for attention deficit hyperactivity disorder, attention deficit disorder, or learning disability?	☐	☐
35. Tumor or cancer?	☐	☐
36. Cold or heat injury?	☐	☐
37. Rhabdomyolysis?	☐	☐
38. A medical waiver for the PFA or PFT?	☐	☐
39. Have you been prescribed medications in the last 12 months? (if "yes" list names, reason, and approximate dates used in Section III)?	☐	☐
40. Have you EVER been hospitalized (including psychiatric)?	☐	☐
41. Have you EVER been rejected or discharged for military service for any reason?	☐	☐
42. Have you had any significant medical diagnoses or treatments not previously reported on a military physical?	☐	☐

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Section III: Midshipman Comments

Explain all "Yes" answers to questions 1-42 above. Begin with the Item Number. Describe answer(s): provide date(s) of problem(s) / condition(s); provide names of Health Care Providers (HCPs), Clinic(s) and/or Hospital(s) along with the City and State; explain what was done (e.g., evaluation and/or treatment); and describe your current medical status (ongoing/resolved). Attach additional sheet(s) if necessary and sign and date each additional page. Obtain and attach copies of applicable medical evaluation and treatment records if requested.

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

Date Signed

Section IV: Review

Unit Medical Representative Comments

Unit Medical Representative Signature

Date Signed

Reviewing Officer Comments (if indicated)

Review Officer Signature (if indicated)

Date Signed

If additional records requested from midshipman, provide date of request.

If referred for further medical examination, provide date of referral.

If referred to BUMED for review, provide date of referral.

Section V: Outcome

- ☐ No further action required
- ☐ MLOA
- ☐ Waiver
- ☐ PQ

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