ANNUAL CERTIFICATE OF PHYSICAL CONDITION

Privacy Act Statement

Authority: 10 U.S.C. 136, DoD Instruction 6130.03, and E.O. 9397.

Principal Purpose(s): This form is intended to inform Marine Corps Recruiting Command and all subordinate commands of any changes to the member'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 in loss of disability benefits and be the basis for administrative action, including disenrollment from the program.

Section I: Personnel Information

Last	First	Full DODID or Last 4 SSN	Date

Unit	Rank	Telephone Number	Birthdate
VMI NROTC	MIDN/Class of: 2027		

Section II: Medical History

Type of last physical exam ☐ DoDMERB ☐ MEPS ☐ Special Duty/ MTF | Date of Last DoD Physical

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,LASEK, SmILE, intraocular lens implant, cross linking)?	☐	☐
3. Color vision deficiency?	☐	☐
4. Ear trouble (to include perforated ear drum, tubes in ears, or other ENT surgery)?	☐	☐
5. Diagnosed with or tested positive for COVID-19 or other infectious disease?	☐	☐
6. Hearing loss, tinnitus, 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, pneumothorax or 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, bloody stool, ulcer, reflux, esophagitis, gallstones, hernia, or hepatitis)?	☐	☐
13. Inflammatory bowel disease (to include ulcerative colitis or Crohn's disease)?	☐	☐
14a. Gynecologic trouble (to include 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 neck, spine, hip, or pelvis?	☐	☐
17. Orthopedic problems of the upper extremities (to include fracture, dislocation, sprain, surgery, compartment syndrome)?	☐	☐
18. Orthopedic problems of the lower extremities (to include fracture, dislocation, sprain, surgery, compartment syndrome)?	☐	☐
19. Vascular trouble (to include Raynaud's, deep venous thrombosis or embolus, high blood pressure)?	☐	☐
20. Skin trouble (to include pilonidal cyst, psoriasis, eczema, atopic dermatitis, hives, severe acne)?	☐	☐
21. Prescribed systemic retinoid medications (e.g., Accutane)? (List date completed or projected completion date in Section III).	☐	☐
22. Blood disorders (to include anemia, thrombocytopenia, bleeding disorders, disorder of the spleen)?	☐	☐
23. Allergic reaction to food, medications, insects, latex?	☐	☐

24. A positive ppd skin test, tuberculosis lab test, or been treated for tuberculosis?	☐	☐
25. Car, train, sea, or air sickness that required prescription medication or avoidance of travel?	☐	☐
26. Endocrine disorders (to include diabetes, thyroid disease, osteoporosis)?	☐	☐
27. Head injury, memory loss, amnesia?	☐	☐
28. Neurologic trouble (to include dizziness, vertigo, fainting spell, seizure, paralysis)?	☐	☐
29. Frequent or severe headache that resulted in missed school, work, fitness?	☐	☐
30. Sleeping trouble (to include narcolepsy, sleepwalking, chronic insomnia, sleep apnea)?	☐	☐
31. Evaluation or treatment for self-harm, depression, gender dysphoria, substance abuse, or bipolar 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. Rhabdomyolysis or heat-related injury?	☐	☐
37. Autoimmune disorder (to include lupus, rheumatoid arthritis, reactive arthritis, ankylosing spondylitis)?	☐	☐
38. A medical waiver for the PFT or CFT?	☐	☐
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 been hospitalized (including psychiatric) since your last physical/ annual certification?	☐	☐
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?	☐	☐
43. Are you currently in good health?	☐	☐

Section III: Applicant Comments

Explain all "Yes" answers to questions 1-42 above. Begin with the Item Number. Describe condition(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	*

Section IV: Review

Reviewing Officer Comments

☐ No change in physical condition since last physical or annual certification.

☐ Change in physical condition since last physical or annual certification.

*Any change in physical condition requires review by district Corpsman.

Reviewing Officer Signature		Date	

Reviewing Corpsman Comments

Reviewing Corpsman Signature		Date	