



DEPARTMENT OF THE NAVY
NAVAL RESERVE OFFICERS TRAINING CORPS
ANYWHERE UNIVERSITY
CALDERON, PENNSYLVANIA 19013-1234

N REPLY REFER TO:
1533
Ser 179
20 Nov 98

From: Commanding Officer, Naval Reserve Officers Training Corps
To: Commanding General, Marine Corps Recruiting Command (ON/E)

Subj: NOMINATION FOR NROTC ADVANCED STANDING (MARINE OPTION)

Ref: (a) CNET P155/3 NAM

Encl: (1) CNET Form 1533/64 (01-96)
(2) Current academic transcript

1. Per reference (a), I nominate the following student for NROTC Advanced Standing (Marine Option):

- a. Name: Amy B. Nobody
- b. University: Anywhere University
- c. Major: Basket Weaving
- d. Estimated date of commissioning: June 2002
- e. Date physical completed: 17 July 1998
- f. Physical status: Qualified
- g. Commanding Officer's recommendation:

Midshipman Nobody has my highest recommendation for advanced standing. She maintains a solid GPA (3.00 accum and 3.03 term) in a difficult major. MIDN Nobody has proven herself as a disciplined and hard working member of the battalion. She is committed to the high ideals required of leadership in the Marine Corps. I am confident that MIDN Nobody will continue to perform academically while maintaining the Corps Values.

R. U. SURE

15 Mar 1999

From: Midshipman 4/C Amy B. Nobody

To: Commanding General Marine Corps Recruiting Command (ON/E)

Via: (1) Commanding Officer, USMC Training Command Somewhere College

Subj: NOMINATION FOR NROTC ADVANCED STANDING (MARINE OPTION)

Ref: (a) CNETINST 1533/3 (NAM)

Encl: (1) Information Sheet (CNET Form 1533/62)

(6) Arms Form (CNET Form 1533/63)

(7) Photograph

(4) Statement of Understanding

1. In accordance with reference (a), application for enrollment in the Marine Corps Naval Science Courses, commencing with the Fall Quarter, Academic Year 1998, is hereby submitted. I desire to be considered as a candidate for a commission in the U.S. Marine Corps.

2. Service as marine officer provides me the opportunity to develop the personal and professional characteristics of an exceptional leader. Readiness is the primary mission. Maintaining the appropriate state of readiness lies first with me who by vigorous study and leadership will ensure the Marine Corps' continued excellence in every assignment. The constraint of limited resources, a continual characteristic of the Marine working environment, will require me to practice active efficiency and provide disciplined guidance so the personnel of my command can exceed any material limitation. Victory goes to those who employ a vigorous pursuit in practice and execution, the only path to success I know. Of the military figures I know, only a Marine can inspire true respect. Always the student, I am eager to receive guidance from those exceptional marine corps officers who came before and continue to serve. Disciplined, loyal and professional a marine officer exceeds the highest standards and I must do the same. No other endeavor will bring the satisfaction of my dedicated service in the world's finest fighting force, the United States Marine Corps.

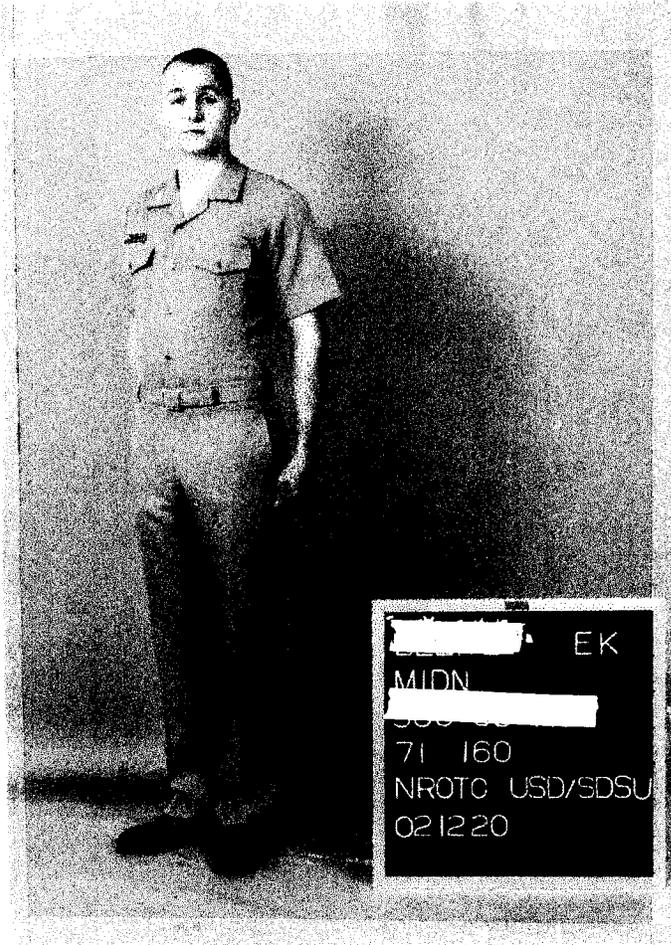
AMY B. NOBODY

INFORMATION SHEET (REQUEST FOR MARINE OPTION)

NRRTC UNIT: AUBURN UNIVERSITY		STATUS: <input type="checkbox"/> SCHOLARSHIP <input type="checkbox"/> FRESHMAN <input type="checkbox"/> JUNIOR <input checked="" type="checkbox"/> COLLEGE PROGRAM <input checked="" type="checkbox"/> SOPHOMORE <input type="checkbox"/> SENIOR	
NAME: (last, first, middle) DOUGLAS, DERRAL		SSN:	RACE/ETHNIC ORIGIN: C/Y
SEX: <input checked="" type="checkbox"/> MALE <input type="checkbox"/> FEMALE	DATE OF BIRTH: (YYMMDD) 78 02 23	SON OR DAUGHTER OF MARINE? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
DATE APPOINTED MIDSHIPMAN: (YYMMDD) (SCHOLARSHIP ONLY)		DATE OF ENROLLMENT: (YYMMDD) 97 09 15 (COLLEGE PROGRAM ONLY)	
ACADEMIC MAJOR: FINANCE	ACADEMIC GPA: (4.0 Scale) 3.09	ESTIMATED GRADUATION DATE: 01 06 10	
NAVAL SCIENCE GPA: 3.33	APTITUDE GRADE: 3.59	CLASS STANDING: 5 OF 33	
CRUISE APTITUDE GRADES: NA	SAI/ACT/EL SCORES: 1330	ESTIMATED BULLDOG YEAR: SUMMER 2000	
MARINE PFT SCORE: 256	HEIGHT: 68" WEIGHT: 157	CLASS SWIMMER: 1ST CLASS	
UNCORRECTED VISUAL ACUITY: 20/25	CORRECTED VISUAL ACUITY: NA	COLOR BLIND? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
EXTRACURRICULAR ACTIVITIES: SEMPER FIDELIS SOCIETY, PISTOL TEAM, FLAG COMPANY, DRILL TEAM, AUBURN UNIVERSITY HONORS			
COLLEGE, COMPANY GUIDE.			
IF DEPENDENT OF MARINE, PROVIDE FOLLOWING: NAME (last first, middle)			
<input type="checkbox"/> ACTIVE <input type="checkbox"/> INACTIVE		GRADE: _____	
ADDRESS:			
<input checked="" type="checkbox"/> REQUIRED ARMS FORM IS PROVIDED AS ENCLOSURE (2) OF REQUEST			
<input checked="" type="checkbox"/> REQUIRED PHOTOGRAPH IS ATTACHED AS ENCLOSURE (3) OF REQUEST			
<input checked="" type="checkbox"/> CUMULATIVE ACADEMIC GPA COMPARES TO AVERAGE OF <u>2.91</u> ATTAINED BY STUDENTS IN COLLEGE/DEGREE PROGRAM			
MARINE OFFICER INSTRUCTOR COMMENTS: Intelligent, bold, and dedicated. Maintains a 3.09 GPA in a finance curriculum in the University Honors College. He earned a 3.53 GPA last quarter. Midn has trained as a Marine Option College Program student for the past year. He has performed well in the field, and demonstrated a high standard of physical fitness and endurance. He is articulate, candid, and has a good sense of humor. He has excelled in the structured Marine environment, and promises to make an excellent Marine Officer. Has an aggressive, stubborn determination which characterizes his performance. An active member of the Auburn Semper Fidelis Society, he contributes greatly to my program. Ranked 3 of 4 competitive candidates. Note that other less competitive candidates were not submitted.			
 VERIFIED: J. C. NEIDIGH Capt. USMC			

(SIGNATURE OF MARINE OFFICER INSTRUCTOR)

ENCLOSURE 2



Midshipman 3 rd Class	<u>PFT</u>	
NROTC USD/SDSU	Pull-ups <u>16</u>	Height <u>71</u>
Scholarship	Crunches <u>100</u>	Weight <u>160</u>
	Run <u>22:59</u>	Photo
	Score <u>250</u>	Date <u>021220</u>

ENCLOSURE(4)

SCHOOL OF ENGINEERING AND APPLIED SCIENCE
 AEROSPACE ENGINEERING (College)
 (Major) 04/30/99
 (Transcript Date)

U (Career/Student Number) (Name) 09/22/97
 (Admit Date)
 554-85-9702 (Res. Status)
 (Soc. Sec. No.) RESIDENT
 SAINT FRANCIS HIGH S DATE GRADUATED
 06/97

OFFICIAL TRANSCRIPT * SEAL REQUIRED

UNIVERSITY REQUIREMENTS - SATISFIED
 AMERICAN HIST & INST SATISFIED

TRANSFER CREDIT ADVANCED PLACEMENT TO 05/97 16.0 UNT
 ----- FALL 1997 -----
 COLLEGE: EN MAJOR: AEROSPACE ENGINEERING 4.0 C 8.0
 CHEM 20A 4.0 P
 ENGR 97 4.0 B- 10.8
 MATH 31A 4.0 B-
 CALC&ANALYTIC GEOM

----- WINTER 1998 -----
 ENERGETICS&CHANGE REPEATED, EXCLUDED FROM GPA 4.0 D RD
 GENRL CHEMISTRY LAB CHEM 20B 4.0 D
 RECENT CHICANO LIT ENGL M105B 2.0 C- 3.4
 CALC&ANALYTIC GEOM MATH 31B 4.0 C+ 14.8
 9.2

----- SPRING 1998 -----
 ENERGETICS&CHANGE CHEM 20B 4.0 C 8.0 G1
 REPEAT OF CRSE PREV TAKEN
 MATH 32A 4.0 C 8.0
 PHYSICS 8AL 1.0 A+ 4.0 G
 PHYSICS 8A 4.0 C+ 9.2

----- FALL 1998 -----
 FORTTRAN PROGRAMMING MECH&AE 20 4.0 C- RD
 REPEATED, EXCLUDED FROM GPA
 MATH 32B 4.0 D RD
 CALC OF SEVRL VAR REPEATED, EXCLUDED FROM GPA
 PHYSICS 8B 4.0 C 8.0
 WAVES&SOUND&HEAT PHYSICS 8BL 1.0 B 3.0 G
 LAB - WAVES&SOUND&HEAT

----- WINTER 1999 -----
 FORTTRAN PROGRAMMING MECH&AE 20 4.0 B+ 13.2 G1
 REPEAT OF CRSE PREV TAKEN
 MATH 32B 4.0 C+ 9.2 G1
 CALC OF SEVRL VAR REPEAT OF CRSE PREV TAKEN
 MATH 33A 4.0 B+ 13.2
 MATRICES&DIFFRNTL EQ PHYSICS 8C 4.0 B+ 13.2
 ELECTRICITY&MAGNETISM PHYSICS 8CL 1.0 B- 2.7 G
 LAB-ELECTRICTY&MAGNETISM

T ATT T PSD G ATT S-G-A G PSD G P BAL GPA
 CUM 57.0 57.0 53.0 53.0 53.0 137.9 31.9 2.602
 TOTAL PASS/NOT PASS ATTM 4.0 PASSED 4.0
 TOTAL NON-UC TRANSFER CREDIT ACCEPTED 16.0
 TOTAL UNITS 73.0
 ----- MEMORANDA -----
 ***** NO ENTRIES BELOW THIS LINE *****

1300
1320

DOD MEDICAL EXAMINATION REVIEW BOARD
8034 EDGERTON DRIVE, SUITE 132
USAF ACADEMY CO 80840-2200

AS OF 05 DEC 96

SERVICE ACADEMY / ROTC MEDICAL QUALIFICATION DETERMINATION

Your medical examination has been reviewed and evaluated. The result of the evaluation is shown. This form is only notification of your current medical status. You must review the reverse side for explanation of terms.

UNIVERSITY OF HEALTH SERVICES:

U S AIR FORCE ACADEMY:

AIR FORCE ROTC:

U S MILITARY ACADEMY:

ARMY ROTC:

U S MERCHANT MARINE ACADEMY:

U S COAST GUARD ACADEMY:

U S NAVAL ACADEMY:

QUALIFIED UNRESTRICTED LINE/SEE ITEM 9 ON BACK

NAVY ROTC:

MARINE CORP ROTC:

DOUGLAS D
4600 LONG BOW RD
JACKSONVILLE FL 32210-0000

DOD MEDICAL EXAMINATION REVIEW BOARD (DODMERB) REPORT OF MEDICAL EXAMINATION
 (This form is affected by the Privacy Act of 1974 - See DD Form 2005)

1. DATE OF EXAMINATION (YYMMDD)
 961011

APPLICANT DATA

2. NAME (Last, First, Middle Initial) Douglas D. 3. SOCIAL SECURITY NUMBER _____ 4a. DATE OF BIRTH (YYMMDD) 79 02 23 b. AGE 18 5. SEX M 6. RACE (Ethnic Group) White

7. HOME ADDRESS (Street, City, State, and Zip Code) 4600 Long Bow Rd. Jacksonville, FL 32210 8. MILITARY STATUS (X one) 9. EXAMINER ADDRESS (Street, City, State, and Zip Code) NAVHOSP BRANCH MEDICAL CLINIC NAVAL AIR STATION JAX 32212-5006

a. ACTIVE DUTY _____
 X b. CIVILIAN _____
 c. RESERVE/GUARD _____

MEASUREMENTS

10. HEIGHT 68 11. BLOOD PRESSURE 134/78 12. EKG _____ 13. AUDIOMETER 14. READING ALOUD TEST

a. STANDING 68 b. SITTING 62 15. PULSE 60 a. NORMAL _____ b. ABNORMAL _____

16. WEIGHT 145 17. DISTANT VISION NO CORRECTION 18. REFRACTION a. CYCLO _____ b. MANIFEST _____ c. LENS _____ 19. NEAR VISION 20 15

a. RIGHT 20' 25 b. CORR TO 20' 20 (1) SPH 0.00 (2) CYL _____ (3) AXIS _____ a. 20' 20 b. CORR TO 20' 20 c. BY 418
 c. LEFT 20' 25 d. CORR TO 20' 20 (4) SPH _____ (5) CYL _____ (6) AXIS _____ d. 20' 20 e. CORR TO 20' 20 f. BY _____

20. METROPHORIA (Far only) 21. COVER TEST 22. COLOR VISION 23. DEPTH PERCEPTION PASS

a. ES' 0.0 b. EX' 2.0 c. RM 0.5 d. LH' 0.0 a. PASS _____ b. FAIL _____

a. TEST USED _____ b. RESULTS _____ a. TEST USED ICAROFF b. SCORE _____
 (1) VTS-Cv No Passed 9 No. Failed 0 (1) VTA-ND (1) 6/8
 (2) FALANT (2) DPA-V (2) _____
 (3) OTHER (Specify) _____ (3) TITMUS/STEREO FLY (3) _____

24. PC 70 25. ACCOMMODATION a. RIGHT DELT b. LEFT DELT 26. RED LENS TEST a. PASS _____ b. FAIL _____

LABORATORY

27. URINALYSIS 1.020 28. BLOOD a. TYPE O c. HEMATOCRIT 43.1 29. OTHER TESTS (Specify type and results) NCT 0D 10 05 13

a. PROTEIN X NEG T 1+ 2+ 3+ 4+ a. TYPE _____ c. HEMATOCRIT _____
 b. SUGAR X NEG T 1+ 2+ 3+ 4+ b. RH FACTOR POS d. HEMOGLOBIN 15.2

c. MICROSCOPIC EXAMINATION (X one) (1) NEGATIVE (2) POSITIVE (List results)

CLINICAL EVALUATION

30. HEAD, FACE, NECK AND SCALP _____
 31. NOSE _____
 32. SINUSES _____
 33. MOUTH AND THROAT _____
 34. EARS - GENERAL (Internal and external canals) (Auditory acuity under item 13) _____
 35. DRUMS (Perforation) _____
 36. VALSALVA _____
 37. EYES-GENERAL (Visual acuity and refraction under items 17, 18, and 19) _____
 38. PUPILS (Equality and reaction) _____
 39. OCULAR MOTILITY (Associated parallel movements, nystagmus) _____
 40. OPHTHALMOSCOPIC _____
 41. LUNGS AND CHEST (Include breasts) _____
 42. HEART (Thrust, size, rhythm, and sounds) _____
 43. VASCULAR SYSTEM (Varicosities, etc.) _____
 44. ABDOMEN AND VISCERA (Include hernia) _____
 45. ENDOCRINE SYSTEM _____
 46. SPINE, OTHER MUSCULOSKELETAL _____
 47. UPPER EXTREMITIES (Strength, range of motion) _____
 48. LOWER EXTREMITIES (Except feet) (Strength, range of motion) _____
 49. FEET _____
 50. IDENTIFYING BODY MARKS, SCARS, TATTOOS _____
 51. SKIN, LYMPHATICS _____
 52. G-U SYSTEM _____
 53. ANUS AND RECTUM (Hemorrhoids, fistulae) (Prostate if indicated) NE
 54. PELVIC EXAMINATION NE
 55. NEUROLOGIC _____
 56. PSYCHIATRIC (Specify any personality deviation) NE

57. NOTES (Describe every abnormality in detail. Enter the item number before each comment. Continue on reverse if necessary.)
#18 Should Read 20-0.25 DS 10/18/96 05-0.25 DS etc.

58. EXAMINER a. TYPED OR PRINTED NAME BERT D. REUER b. SIGNATURE _____
 c. RANK _____ d. CORPS OR DEGREE MC (PS) USN
 e. SIGNATURE _____

59. PHYSICIAN a. TYPED OR PRINTED NAME BERT D. REUER b. RANK _____ c. DEGREE MD

**DOD MEDICAL EXAMINATION REVIEW BOARD (DODMERB)
REPORT OF MEDICAL HISTORY**

(This information is for official and medically confidential use only and will not be released to unauthorized persons.)

Form Approved
OMB No. 0704-0269
Expires Apr 30, 1993

Public reporting burden for this collection of information is estimated to average 15 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to Department of Defense, Washington Headquarters Services, Directorate for Information Operations and Reports, 1215 Jefferson Davis Highway, Suite 1204, Arlington, VA 22202-4302, and to the Office of Management and Budget, Paperwork Reduction Project (0704-0269), Washington, DC 20503. PLEASE DO NOT RETURN YOUR FORM TO EITHER OF THESE ADDRESSES. SEND COMPLETED FORM TO DODMERB/DR, USAF ACADEMY, CO 80340-6318.

PRIVACY ACT STATEMENT

AUTHORITY: Title 10, U.S.C 133, 3012, 5031, 8013, and EO 9397.
PRINCIPAL PURPOSE(S): The medical examination is used to determine medical acceptability for one or more of the five military service academies, the Uniformed Services University of the Health Sciences (USUHS), for the Air Force, Army and Navy Reserve Officer Training Corps (ROTC). This information is used to advise each program manager of initial status and all update actions on the applicant.
ROUTINE USE(S): Medical consultations may be necessary with parents/legal guardians to clarify/explain the applicant's medical status. Examinations may be released to civilian contractors, governmental agencies and private physicians associated with medically certifying applicants for military service.
DISCLOSURE: Voluntary; however, failure to furnish the requested information will impede the selection process and hamper your candidacy. Use of the Social Security Number is necessary to make positive identification of your records.

1. NAME (Last, First, Middle Initial) Douglas Derral	2. SOCIAL SECURITY NUMBER	3. TELEPHONE NO. (Include area code) (904) 384
4. PURPOSE OF EXAMINATION DODMERB	5. EXAMINATION FACILITY OR EXAMINER AND ADDRESS (Include Zip Code) NAVHOSP BRANCH MEDICAL CLINIC NAVAL AIR STATION JAX 32212-5000	6. DATE OF EXAMINATION (YYMMDD) 96 10 11

SECTION I - Mark applicable boxes in items 7 through 10

7. How would you rate your present health? <input checked="" type="checkbox"/> Excellent <input type="checkbox"/> Very Good <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor	8. Are you on any special diet? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	9. Have you ever used any of the following? <table border="1"> <tr> <td><input type="checkbox"/> Amphetamines</td> <td><input type="checkbox"/> Barbiturates</td> </tr> <tr> <td><input type="checkbox"/> Chemical Inhalants</td> <td><input type="checkbox"/> Cocaine</td> </tr> <tr> <td><input type="checkbox"/> Hallucinogens</td> <td><input type="checkbox"/> Narcotic Drugs</td> </tr> </table>	<input type="checkbox"/> Amphetamines	<input type="checkbox"/> Barbiturates	<input type="checkbox"/> Chemical Inhalants	<input type="checkbox"/> Cocaine	<input type="checkbox"/> Hallucinogens	<input type="checkbox"/> Narcotic Drugs	10. If you wear contact lenses, how many days have they been removed prior to this exam? <table border="1"> <tr> <td><input type="checkbox"/> 1-3</td> <td><input type="checkbox"/> 4-20</td> <td><input type="checkbox"/> 21 and over</td> </tr> <tr> <td>Type Lens:</td> <td>Hard</td> <td>Soft</td> </tr> </table>	<input type="checkbox"/> 1-3	<input type="checkbox"/> 4-20	<input type="checkbox"/> 21 and over	Type Lens:	Hard	Soft
<input type="checkbox"/> Amphetamines	<input type="checkbox"/> Barbiturates														
<input type="checkbox"/> Chemical Inhalants	<input type="checkbox"/> Cocaine														
<input type="checkbox"/> Hallucinogens	<input type="checkbox"/> Narcotic Drugs														
<input type="checkbox"/> 1-3	<input type="checkbox"/> 4-20	<input type="checkbox"/> 21 and over													
Type Lens:	Hard	Soft													

SECTION II - Mark each item (11 through 87) "Yes" or "No." If you do not know the answer for a particular item, leave it blank. Every item marked "Yes" must be explained in the REMARKS section on the reverse.

Yes	No	A. Do you or did you ever	Yes	No	B. (Cont'd.) Have you ever had or do you now have	Yes	No	C. (Cont'd.) Have you ever had or do you now have
<input checked="" type="checkbox"/>	<input type="checkbox"/>	11. Wear glasses	<input type="checkbox"/>	<input checked="" type="checkbox"/>	41. Coughed up or vomited blood	<input type="checkbox"/>	<input checked="" type="checkbox"/>	70. Sleepwalking episodes
<input checked="" type="checkbox"/>	<input type="checkbox"/>	12. Wear contact lenses or ocular eye retainers (if "Yes," complete item 10)	<input type="checkbox"/>	<input checked="" type="checkbox"/>	42. Stomach, liver, or intestinal trouble	<input type="checkbox"/>	<input checked="" type="checkbox"/>	71. Easy fatigability
<input checked="" type="checkbox"/>	<input type="checkbox"/>	13. Have any allergies	<input type="checkbox"/>	<input checked="" type="checkbox"/>	43. Gallbladder trouble or gallstones	<input type="checkbox"/>	<input checked="" type="checkbox"/>	72. Car, train, sea, or air sickness
<input checked="" type="checkbox"/>	<input type="checkbox"/>	14. Take any medications regularly	<input type="checkbox"/>	<input checked="" type="checkbox"/>	44. Yellow jaundice or hepatitis	<input type="checkbox"/>	<input checked="" type="checkbox"/>	73. X-ray or other radiation therapy
<input checked="" type="checkbox"/>	<input type="checkbox"/>	15. Stutter or stammer	<input type="checkbox"/>	<input checked="" type="checkbox"/>	45. Hemorrhoids or rectal disease	<input type="checkbox"/>	<input checked="" type="checkbox"/>	74. Sensitivity to chemicals, dust, sunlight, etc.
<input checked="" type="checkbox"/>	<input type="checkbox"/>	16. Wear a bone or joint brace or support	<input type="checkbox"/>	<input checked="" type="checkbox"/>	46. Black or bloody stools	<input type="checkbox"/>	<input checked="" type="checkbox"/>	75. Learning disabilities or speech problems
<input checked="" type="checkbox"/>	<input type="checkbox"/>	17. Frequent, severe, or migraine headaches	<input type="checkbox"/>	<input checked="" type="checkbox"/>	47. Frequent or painful urination	<input type="checkbox"/>	<input checked="" type="checkbox"/>	76. Been treated for a female disorder, painful periods, or cramps
<input checked="" type="checkbox"/>	<input type="checkbox"/>	18. Fainting or dizzy spells	<input type="checkbox"/>	<input checked="" type="checkbox"/>	48. Bed wetting since age 12	<input type="checkbox"/>	<input checked="" type="checkbox"/>	77. Had a change in menstrual pattern
<input checked="" type="checkbox"/>	<input type="checkbox"/>	19. Periods of unconsciousness	<input type="checkbox"/>	<input checked="" type="checkbox"/>	49. Blood, protein, or sugar in urine	<input type="checkbox"/>	<input checked="" type="checkbox"/>	78. Been pregnant or are you now pregnant?
<input checked="" type="checkbox"/>	<input type="checkbox"/>	20. Head injury or skull fracture	<input type="checkbox"/>	<input checked="" type="checkbox"/>	50. History of diabetes or sugar diabetes in family	<input type="checkbox"/>	<input checked="" type="checkbox"/>	79. Taken birth control pills (if yes, give dates and product names)
<input checked="" type="checkbox"/>	<input type="checkbox"/>	21. Epilepsy, seizures, or convulsions	<input type="checkbox"/>	<input checked="" type="checkbox"/>	51. Kidney stone	<input type="checkbox"/>	<input checked="" type="checkbox"/>	80. Date of last menstrual period (YYMMDD)
<input checked="" type="checkbox"/>	<input type="checkbox"/>	22. Loss of memory or amnesia	<input type="checkbox"/>	<input checked="" type="checkbox"/>	52. Hernia or rupture	<input type="checkbox"/>	<input checked="" type="checkbox"/>	D. Have you ever
<input checked="" type="checkbox"/>	<input type="checkbox"/>	23. Depression, excessive worry or nervousness; anxiety	<input type="checkbox"/>	<input checked="" type="checkbox"/>	53. Any bone or joint trouble; bursitis	<input type="checkbox"/>	<input checked="" type="checkbox"/>	81. Been refused employment or been unable to hold a job or stay in school because of:
<input checked="" type="checkbox"/>	<input type="checkbox"/>	24. Any mental condition or illness	<input type="checkbox"/>	<input checked="" type="checkbox"/>	54. Broken bones or amputations	<input type="checkbox"/>	<input checked="" type="checkbox"/>	a. Inability to perform certain movements?
<input checked="" type="checkbox"/>	<input type="checkbox"/>	25. Frequent trouble sleeping	<input type="checkbox"/>	<input checked="" type="checkbox"/>	55. Steel pins, plates, or staples in any bones	<input type="checkbox"/>	<input checked="" type="checkbox"/>	b. Inability to assume certain positions?
<input checked="" type="checkbox"/>	<input type="checkbox"/>	26. Eye trouble (exclude glasses, contact lenses)	<input type="checkbox"/>	<input checked="" type="checkbox"/>	56. Back pain or trouble	<input type="checkbox"/>	<input checked="" type="checkbox"/>	c. Other medical reasons?
<input checked="" type="checkbox"/>	<input type="checkbox"/>	27. Vision change or double vision	<input type="checkbox"/>	<input checked="" type="checkbox"/>	57. Paralysis, lameness, or weakness	<input type="checkbox"/>	<input checked="" type="checkbox"/>	82. Been rejected for or discharged from military service because of physical, mental or other reasons?
<input checked="" type="checkbox"/>	<input type="checkbox"/>	28. Hearing loss	<input type="checkbox"/>	<input checked="" type="checkbox"/>	58. Foot trouble	<input type="checkbox"/>	<input checked="" type="checkbox"/>	83. Been denied or rated up for life insurance?
<input checked="" type="checkbox"/>	<input type="checkbox"/>	29. Ear, nose, or throat trouble	<input type="checkbox"/>	<input checked="" type="checkbox"/>	59. Rheumatic fever	<input type="checkbox"/>	<input checked="" type="checkbox"/>	84. Received, is there pending, or have you applied for pension or compensation for existing disability?
<input checked="" type="checkbox"/>	<input type="checkbox"/>	30. Sinusitis or sinus trouble	<input type="checkbox"/>	<input checked="" type="checkbox"/>	60. Tuberculous or positive TB test	<input type="checkbox"/>	<input checked="" type="checkbox"/>	85. Had, or have you ever been advised to have, any surgical operations?
<input checked="" type="checkbox"/>	<input type="checkbox"/>	31. Hay fever or allergic rhinitis	<input type="checkbox"/>	<input checked="" type="checkbox"/>	61. VD, syphilis, gonorrhea, herpes, etc.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	86. Consulted or been treated by clinics, hospitals, physicians, healers, or other practitioners for other than minor illnesses?
<input checked="" type="checkbox"/>	<input type="checkbox"/>	32. Severe tooth or gum trouble	<input type="checkbox"/>	<input checked="" type="checkbox"/>	62. Skin conditions such as acne, psoriasis, hand or foot rashes, eczema, or dry skin	<input type="checkbox"/>	<input checked="" type="checkbox"/>	87. Had any illness or injury other than those already noted?
<input checked="" type="checkbox"/>	<input type="checkbox"/>	33. Thyroid trouble	<input type="checkbox"/>	<input checked="" type="checkbox"/>	63. Adverse reaction to serum, drugs, medicine, food, or bites or stings	<input type="checkbox"/>	<input checked="" type="checkbox"/>	
<input checked="" type="checkbox"/>	<input type="checkbox"/>	34. Chronic cough or lung disease	<input type="checkbox"/>	<input checked="" type="checkbox"/>	64. A weight problem	<input type="checkbox"/>	<input checked="" type="checkbox"/>	
<input checked="" type="checkbox"/>	<input type="checkbox"/>	35. Asthma or wheezing	<input type="checkbox"/>	<input checked="" type="checkbox"/>	65. Recent gain or loss of weight	<input type="checkbox"/>	<input checked="" type="checkbox"/>	
<input checked="" type="checkbox"/>	<input type="checkbox"/>	36. Unusual shortness of breath	<input type="checkbox"/>	<input checked="" type="checkbox"/>	66. Excessive bleeding or easy bruising	<input type="checkbox"/>	<input checked="" type="checkbox"/>	
<input checked="" type="checkbox"/>	<input type="checkbox"/>	37. Pain or pressure in chest	<input type="checkbox"/>	<input checked="" type="checkbox"/>	67. Tumors, growth, cyst, or cancer	<input type="checkbox"/>	<input checked="" type="checkbox"/>	
<input checked="" type="checkbox"/>	<input type="checkbox"/>	38. Palpitation or pounding heart	<input type="checkbox"/>	<input checked="" type="checkbox"/>	68. Considered or attempted suicide	<input type="checkbox"/>	<input checked="" type="checkbox"/>	
<input checked="" type="checkbox"/>	<input type="checkbox"/>	39. Heart trouble or heart murmur	<input type="checkbox"/>	<input checked="" type="checkbox"/>		<input type="checkbox"/>	<input checked="" type="checkbox"/>	
<input checked="" type="checkbox"/>	<input type="checkbox"/>	40. High blood pressure	<input type="checkbox"/>	<input checked="" type="checkbox"/>		<input type="checkbox"/>	<input checked="" type="checkbox"/>	

68. REMARKS (Every "Yes" response in items 71 through 77 must be explained in the space below. Give dates and complete details, including names of doctors and hospitals or clinics and the current status of the condition. Continue on a separate sheet and attach to this form if additional space is needed.)

Number fifty four, I broke my collar bone when I was 6 years old, There have been absolutely no problems since.

89. CERTIFICATION. I certify that I have reviewed the foregoing information supplied by me and that it is true and complete to the best of my knowledge. I authorize any of the doctors, hospitals, or clinics mentioned above to furnish the Government a complete transcript of my medical record for purposes of processing my application for this employment or service.

a. TYPED OR PRINTED NAME OF EXAMINEE Douglas D. Jr.	b. SIGNATURE <i>Douglas D. Jr.</i>	c. DATE SIGNED (YYMMDD) 96 10 11
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NOTE: HAND TO DOCTOR OR NURSE OR IF MAILED MARK ENVELOPE "TO BE OPENED BY MEDICAL PERSONNEL ONLY"

90. EXAMINER'S SUMMARY AND ELABORATION OF ALL PERTINENT DATA (Examiner shall comment on all "Yes" and blank answers (indicating the item number before each comment), develop by interview any additional medical history deemed important, and record significant findings here. If additional space is needed, continue on a separate sheet and attach to this form.)

54 Rx. clavicle as child, healed w/ sequelae, \emptyset limitations

91. PHYSICIAN OR EXAMINER			92. NUMBER OF ATTACHED SHEETS
a. TYPED OR PRINTED NAME ROBERT D. REUER (CDR MC (S) USNR	b. SIGNATURE <i>[Signature]</i>	c. DATE SIGNED (YYMMDD) 96 10 11	