DEPARTMENT OF THE AIR FORCE
AIR FORCE RESERVE COMMAND

1/10/2017

FROM: David Trowbridge, Lt Col, USAFR, MD
Chief of Flight Medicine
477 AMDF JBER, AK,

Dear Treating Physician,

Your patient is an Airman in the U.S Air Force Reserves and has been found to have a condition that requires specific documentation to assess this member for medical qualification and readiness for military duty, and to determine the level of participation the member may be able to safely sustain in the service of our country.

1) Please briefly address the items below on your medical letterhead:

1. Symptoms, Physical Findings, and Comorbidities pertaining to the diagnosis.
2. Test Results (Labs, X-Rays, Surgical/Operative/Hospital Report etc.), if applicable
3. Consultations and Results, if applicable
4. Diagnosis
5. Medications and/or any other Treatment Regiments, and Projected Duration
6. Specific Physical/Duty Limitations and Restrictions, and Projected Duration
7. Prognosis
8. Treatment plan
9. Other:

2) Please complete the "Restrictions Checklist" on the reverse side or second page of this memo.

Once completed, **PLEASE PROVIDE THE DOCUMENTATION AND ORIGINAL MEDCIAL NOTES TO THE MEMEBR**, who is responsible for delivering it to our squadron for medical review. These items will become a part of the member's military medical record.

Your patient is a vital member of our Armed Forces. I respect your busy schedule, and truly appreciate your prompt attention and cooperation concerning this request.

\\SIGNED\\
David Trowbridge, Lt Col, USAFR, MC, FS
Chief of Aerospace Medicine
(907) 552-3430

Restrictions Checklist

Patient's Name: ____

Condition: ____

ICD10 Code: __________

Please answer the following questions below about the patient:

(A) Mobility Restrictions (requirements for Military Deployment):

Free of medical conditions requiring special appliances? YES / NO

Able to wear or use all required items of uniform or personal protective Equipment, including protective mask, ballistic helmet, body armor and Chemical/biological protective garments? YES / NO

Able to lift, carry, and push **up to** 40 lbs.? YES / NO

Able to run **at least** 100 yards **<u>in an emergency</u>**? YES / NO

Able to function with minimal risk of sudden incapacitation? YES / NO

What is the **<u>estimated duration</u>** of the Mobility restrictions noted above? ____________

(B) Fitness Restrictions:

Medically cleared for the maximal effort 1.5 mile run? YES / NO

Medically cleared for the maximal effort 2.0-kilometer walk? YES / NO

Medically cleared for push-ups? YES / NO

Medically cleared for sit-ups? YES / NO

Medically cleared for participation in all unit physical conditioning programs? YES / NO

What is the **<u>ESTIMATED DURATION</u>** of the Fitness restrictions noted above? ____________

(C) Duty Restrictions:

____
____
____
____

What is the **<u>ESTIMATED DURATION</u>** of the Duty restriction noted above? ____________

______________________ ______________________ ____________

Physician's Printed Name **Signature** **Date**