REQUEST FOR MEDICAL CARE IN A FEDERAL MEDICAL TREATMENT FACILITY OUTSIDE DEPARTMENT OF DEFENSE

(For use of this form, see AR 40-400; the proponent agency is the Office of the Surgeon General)

DATE

PREPARE IN TRIPLICATE

TO: *(Include ZIP Code)*

FROM: *(Include ZIP Code)*

If this person is admitted as an inpatient, immediately notify the closest Army Medical Treatment facility for assumption of administrative responsibility. Please furnish information regarding diagnosis, treatment, etc., necessary to complete Army medical records and reports, upon request of the commander of the designated Army facility.

1. PATIENT'S NAME *(Last, first, MI)*

2. GRADE

3. ORGANIZATION

4. STATION TO WHICH ASSIGNED

5. LOCATION OF TRAINING SITE WHERE DISEASE OR INJURY OCCURRED

PATIENT'S STATUS

6. PATIENT'S STATUS AS DUTY, PASS, LEAVE, ABSENT WITHOUT LEAVE, DELAY IN ROUTE *(Specify)*

7. PATIENT IS A MEMBER OF

☐ USAR ☐ ANG ☐ AROTC

☐ OTHER *(Specify)*

8. PATIENT'S STATUS *(*Inclusive dates of training)*

☐ ACTIVE DUTY FOR TRAINING* ☐ INACTIVE DUTY FOR TRAINING*

☐ OTHER *(Specify)*

9. IF KNOWN, STATE NATURE OF TREATMENT OR SERVICE REQUIRED WITH DIAGNOSIS

10. REASON FOR REQUESTING MEDICAL CARE IN A FEDERAL MEDICAL TREATMENT FACILITY OUTSIDE THE DEPARTMENT OF DEFENSE *(For USAR, ANG, AROTC on inactive duty training, and ANG on active duty training, date of occurrence of disease or injury and brief description of events leading up to and surrounding the occurrence).*

11. DISPOSITION INSTRUCTIONS UPON COMPLETION OF TREATMENT

TYPED NAME AND GRADE

SIGNATURE