PRIVACY ACT STATEMENT - HEALTH CARE RECORDS

THIS FORM IS NOT A CONSENT FORM TO RELEASE OR USE HEALTH CARE INFORMATION PERTAINING TO YOU.

1. AUTHORITY FOR COLLECTION OF INFORMATION INCLUDING SOCIAL SECURITY NUMBER *(SSN)*

Sections 133, 1071-87, 3012, 5031 and 8012, title 10, United States Code and Executive Order 9397.

2. PRINCIPAL PURPOSES FOR WHICH INFORMATION IS INTENDED TO BE USED

This form provides you the advice required by The Privacy Act of 1974. The personal information will facilitate and document your health care. The Social Security Number (SSN) of member or sponsor is required to identify and retrieve health care records.

3. ROUTINE USES

The primary use of this information is to provide, plan and coordinate health care. As prior to enactment of the Privacy Act, other possible uses are to: Aid in preventive health and communicable disease control programs and report medical conditions required by law to federal, state and local agencies; compile statistical data; conduct research; teach; determine suitability of persons for service or assignments; adjudicate claims and determine benefits; other lawful purposes, including law enforcement and litigation; conduct authorized investigations; evaluate care rendered; determine professional certification and hospital accreditation; provide physical qualifications of patients to agencies of federal, state, or local government upon request in the pursuit of their official duties.

4. WHETHER DISCLOSURE IS MANDATORY OR VOLUNTARY AND EFFECT ON INDIVIDUAL OF NOT PROVIDING INFORMATION

In the case of military personnel, the requested information is mandatory because of the need to document all active duty medical incidents in view of future rights and benefits. In the case of all other personnel/ beneficiaries, the requested information is voluntary. If the requested information is not furnished, comprehensive health care may not be possible, but CARE WILL NOT BE DENIED.

This all inclusive Privacy Act Statement will apply to all requests for personal information made by health care treatment personnel or for medical/dental treatment purposes and will become a permanent part of your health care record.

Your signature merely acknowledges that you have been advised of the foregoing. If requested, a copy of this form will be furnished to you.

SIGNATURE OF PATIENT OR SPONSOR	SSN OF MEMBER OR SPONSOR	DATE

DD FORM 2005, FEB 76 PREVIOUS EDITION IS OBSOLETE.

MEDICAL FITNESS STATEMENT FOR ENROLLMENT IN BASIC COURSE, SENIOR ROTC For use of this form, see AR 145-1; the proponent agency is ODSCPER	DATE

I have examined ______________________________ and find no medical
(First Name - Middle Initial - Last Name)
condition or physical impairment that precludes his participation in the basic course, Army ROTC, a program not more physically strenuous than a normal college physical education program.

SIGNATURE OF PHYSICIAN

DA FORM 3425-R, 1 SEP 68

USAPPC V1.00

MEDICAL HISTORY STATEMENT FOR ADMISSION TO ROTC BASIC COURSE

Title	Last Name	First Name	M Initial	SSN

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PRIVACY ACT STATEMENT

AUTHORITY: 10 U.S.C. 103 (Sec 2103, 2104)
PRINCIPAL PURPOSE: To inform personnel about RFD Program
ROUTINE USES: To determine or verify medical fitness for participation in the Army ROTC Basic Course.
MANDATORY OR VOLUNTARY DISCLOSURE AND EFFECTS ON INDIVIDUALS NOT PROVIDING INFORMATION: Disclosure of information is voluntary; however, failure to furnish any or all of the requested information may delay processing or result in denial of participation.

****

The medical history requested below is required for admission to the ROTC Basic Course. This course is no more strenuous than a college physical education course.

1.	**Do you know of any medical reason why you should not take Army ROTC?** **If Yes, Cause:**
2.	**Do you require: Insulin, Desensitization Epilepsy treatments, Other;** ***Underline or annotate "N/A" if not applicable**
3.	**Have you had counseling for mental health reasons?** **If YES, Cause:**
4.	**What serious accidents have you had?**
5.	**What surgical operations have you undergone?**
6.	**Cause of other hospitalization?**
7.	**Do you have a disability?** **If YES, What?**
8.	**What broken bones have you had?**
9.	**Check the diseases you have or have had:** ___ **Asthma** ___ **Diabetes** ___ **Epilepsy** ___ **Scarlet Fever** ___ **Heart Trouble** ___ **Rheumatic Fever** ___ **Nervous Breakdown** ___ **Other Disease**
10.	**Do you have any other condition that we need to be aware of? _____ If so, what?**

"I hereby affirm that to the best of my knowledge ALL INFORMATION FURNISHED ON THIS FORM IS COMPLETE AND ACCURATE. I understand that withholding information may make me ineligible for admission or may result in dismissal.

DATE ____________ SIGNATURE OF APPLICANT ____________

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U.S. ARMY ROTC DENTAL EXAM REQUIREMENTS STATEMENT

(Cadet Command PAM 145-4)

DATA REQUIRED BY THE PRIVACY ACT 07 1974

1. AUTHORITY: CC PAM 145-4.

2. PRINCIPAL PURPOSE(S): To be used for forensic identification of remains when appropriate.

3. ROUTINE USES: To ensure specific dental information is provided to aid in the forensic identification process for all cadets enrolled in the Army ROTC program at the University of Puerto Rico, Rio Piedras, PR who must use government-owned or government contracted transportation when deemed necessary. Information will be used by ROTC Cadet Command, the ROTC Regions and PMS.

4. MANDATORY OR VOLUNTARY DISCLOSURE AND EFFECT ON INDIVIDUAL NOT PROVIDING INFORMATION: All data is mandatory. Individuals who do not provide this data will not be allowed to be transported on any government-owned or government contracted transportation, no exception(s) to this rule is allowed.

1. NAME OF INSTITUTION: ______	2. SCHOOL CODE: ______
3. NAME OF CADET: (Please. Print)	4. SOCIAL SECURITY NUMBER:

5. ACCEPTABLE DENTAL DOCUMENT(3):

(Initial all that have been completed)

____ Bite Wing X-Rays

____ Orthodontic Profiles

____ Dental X-Rays

*** Scheduled date of outstanding dental requirements: (Please input scheduled apt date)

** Bite Wing X-Rays

____

** Orthodontic Profiles

____

**Dental X-Rays

____

6. CADET STATUS:

____a. Contracted Scholarship Cadet

____b. Contracted Non-Scholarship Cadet

____c. Non-Contracted Cadet

____d. Alien Student

____e. Other (Please Explain):

____

____

____

7. DENTIST INFORMATION DESIGNEE (PLEASE PRINT CLEARLY)

1. Dentist Name: ______________________

____

(Include the practice name)

2. Dentist Address: ______________________

____

____

____

3. Dentist Phone Number: (_____) ______-________

I, THE UNDERSIGNED, DO HEREBY ACKNOWLEDGE THAT THE ABOVE STATEMENT/INFORMATION IS CORRECT AND TRUE.

8. SIGNATURE:	9. DATE:

UPR FORM 145-4-R, 17 Jan 06