

ANNUAL CERTIFICATE OF PHYSICAL CONDITION

1. Have you had any injury, illness or disease within the past 12 months which required hospitalization or caused you to be absent from school, duty or civilian occupation for more than 3 consecutive days?
() NO () YES If yes, explain: _____

2. Are you now, or have you been under a physicians care during the past 12 months?
() NO () YES If yes, explain: _____

3. Have you taken prescription medications in the past 12 months?
() NO () YES If yes, explain: _____

4. Do you have any physical defect(s), family or mental problems which might restrict your performance on active duty or prevent mobilization?
() NO () YES If yes, explain: _____

5. Additional comments: _____
LAST PFT TAKEN: _____
PULL-UPS: _____
CRUNCHES: _____
3 MILE RUN: _____
TOTAL SCORE: _____

Upon completion of indicated action, file completed certificate in the member's Health Record and a copy in member's Dental Record.

I certify that the information contained in this form is true and complete to the best of my knowledge and belief.

MEMBER'S SIGNATURE: _____

MEDICAL DEPT. REP. SIGNATURE: _____

REVIEWING OFFICER'S SIGNATURE: _____

REVIEWING OFFICER'S COMMENTS: _____

