



Prerequisites for College Program Application

1. Motivated to serve as a commissioned officer in the U.S. Navy or Marine Corp
2. Be a U.S. or naturalized citizen or have submitted naturalization papers
3. Be enrolled full time at University of Idaho or Washington State University
4. Be a high school graduate or possess an equivalent certificate
5. Have no apparent physically disqualifying factors on a review of the Report of Medical History (DD Form 2807-1)
6. Have the ability to meet the height and weight requirements of the U.S. Navy and Marine Corp
7. Have no felony convictions or convictions by court martial
8. Not awaiting criminal trial or sentencing
9. Meet Department of Navy requirements concerning drug or alcohol use in accordance with OPNAVINST 5350/1
10. Have no body piercings or tattoos that violate U.S. Navy or Marine Corp policy
11. Have at least three years of college course work remaining until they receive a college degree

Applicant Checklist:

- High School or College Transcript (Official or Unofficial)
- College Program Application NSTC Form 1533 (2 pages)
- Medical History DD Form 2807-1 (3 pages)
- Personal Data Questionnaire
- Copy of Letter of Acceptance to University of Idaho or Washington State University
- Optional – Letters of Recommendation
- Physical Fitness/Readiness Test Form

Send completed applications to:

College Program Advisor
University of Idaho NROTC
875 Perimeter Drive MS 3236
Moscow, ID 83844-3236

Fed-Ex Address:

College Program Advisor
University of Idaho NROTC
1212 Blake Avenue 2nd Floor
Moscow, ID 83844-3236

ENC 2

PERSONAL DATA QUESTIONNAIRE

Name (Last, First, MI) _____

Date of Birth: _____
 (Example 01JAN2010)

Mailing Address: _____

Phone Number: () _____ Email: _____

Place of Birth (City, State): _____

Service Option (Circle One): NAVY MARINE CORP

Height (inches): _____ Weight (lbs): _____

Background Information:

What is your intended college major and minor: _____

What University will you be attending?

___ University of Idaho ___ Washington State University

Physical Fitness Standards:

Incoming students must meet or exceed the following minimum physical fitness standards to remain in good standing in the NROTC program:

NAVY	Age 17 - 19 years		Age 20 - 24 years	
	Male	Female	Male	Female
Sit Ups (2 min)	72	72	68	68
Push Ups (2 min)	61	34	57	31
1.5 Mile Run	10:30	13:00	11:30	13:45

MARINE CORPS	Male	Female
Sit Ups (2 min)	75	75
Pull Ups / Flexed Arm Hang	15	60 sec
3 Mile Run	22:10	25:10

PRT/PFT Score Verification

I, _____ understand that upon arriving for New Student Orientation, that I must meet the minimum standards outlined in the Personal Data Questionnaire. This document will provide a signed verification that I have reached these minimums prior to arriving to the NROTC unit. If these scores do not reflect my PRT or PFT scores upon arriving to a, I understand that I may be subject to disenrollment from the NROTC College Program. If you are unsure how to correctly perform the PRT or PFT, utilize the appropriate reference cited below; if you still have questions, contact the NROTC Unit at 208-885-6333.

Navy Options:

OPNAV INSTRUCTION 6110.1J

		Score
Push-ups:	reps: _____	_____
Curl-ups:	reps: _____	_____
1.5-mile run:	time: _____	_____
Total Score:	_____	

Marine Corps Options:

MARINE CORPS ORDER 6100.13

		Score
Pull-ups:	reps: _____	_____
Crunches:	reps: _____	_____
3-mile run:	time: _____	_____
Total Score:	_____	

Signature: _____ Date: _____

**NAVAL RESERVE OFFICERS TRAINING CORPS
COLLEGE PROGRAM APPLICATION**

Privacy Act Statement

Authority: The authority to request this information is contained in: 5 USC § 301 (Authorizing Forms and Regulations); Executive Order 9397 (Use of Social Security Numbers).

Principal Purpose(s): To be completed by applicants for the Naval Reserve Officers Training Corps (NROTC) College Program.

Routine Use(s): Information you provide in this application is protected by the Privacy Act and will not be released outside the Department of Defense without your permission unless it comes within an exception to the Act or one of the routine uses in 32 CFR § 701.112, <http://www.privacy.navy.mil> and the routine uses set forth here.

Disclosure: You are not required to provide this information; however, failure to do so will result in an inability to fairly evaluate your application and may result in an inability to process the application.

Personal Information

Name		SSN (last 4)	Date of Birth
Phone Number	Cell Phone Number	Place of Birth	
Current Mailing Address		Name of Parent/Guardian	
		Address of Parent/Guardian	

Are you a US Citizen? Yes No USN USMC

If Naturalized, give date, place, court of jurisdiction, and certificate number:

Military Experience and Training (Past and Present, if any)

Service	Dates of Service	Highest Rank	EAOS	Type of Discharge
Training Programs	Position(s) Held	Awards	Grades of Participation	
JROTC (Service _____)			<input type="checkbox"/> 9	<input type="checkbox"/> 10 <input type="checkbox"/> 11 <input type="checkbox"/> 12
Civil Air Patrol			<input type="checkbox"/> 9	<input type="checkbox"/> 10 <input type="checkbox"/> 11 <input type="checkbox"/> 12
Other (NDCC, etc.)			<input type="checkbox"/> 9	<input type="checkbox"/> 10 <input type="checkbox"/> 11 <input type="checkbox"/> 12

Extracurricular Activities

READ CAREFULLY: Identify only those activities in which you engaged during school grades 9-12. NROTC is particularly interested in identifying activities in which an applicant has participated involving responsibility and leadership.

Organization	Position(s) Held	Hrs/ Wk	Grades of Participation			
			<input type="checkbox"/> 9	<input type="checkbox"/> 10	<input type="checkbox"/> 11	<input type="checkbox"/> 12
			<input type="checkbox"/> 9	<input type="checkbox"/> 10	<input type="checkbox"/> 11	<input type="checkbox"/> 12
			<input type="checkbox"/> 9	<input type="checkbox"/> 10	<input type="checkbox"/> 11	<input type="checkbox"/> 12
			<input type="checkbox"/> 9	<input type="checkbox"/> 10	<input type="checkbox"/> 11	<input type="checkbox"/> 12

Athletic Activities

READ CAREFULLY: Identify only those sports which you participated in during school grades 9-12. Mark the year in which you received a letter and/or you were on varsity. Mark the box if you participated in JV or on a club team during any year. Do not list intramural activity.

Sport	Letter	Varsity	JV/Club	Position(s) Held	Awards/Recognition
	<input type="checkbox"/> 9 <input type="checkbox"/> 10 <input type="checkbox"/> 11 <input type="checkbox"/> 12	<input type="checkbox"/> 9 <input type="checkbox"/> 10 <input type="checkbox"/> 11 <input type="checkbox"/> 12	<input type="checkbox"/>		
	<input type="checkbox"/> 9 <input type="checkbox"/> 10 <input type="checkbox"/> 11 <input type="checkbox"/> 12	<input type="checkbox"/> 9 <input type="checkbox"/> 10 <input type="checkbox"/> 11 <input type="checkbox"/> 12	<input type="checkbox"/>		
	<input type="checkbox"/> 9 <input type="checkbox"/> 10 <input type="checkbox"/> 11 <input type="checkbox"/> 12	<input type="checkbox"/> 9 <input type="checkbox"/> 10 <input type="checkbox"/> 11 <input type="checkbox"/> 12	<input type="checkbox"/>		

Other Activities

Attach additional sheets, if needed, to identify other activities not listed above that involve considerable responsibility and leadership. List positions held and the average number of hours devoted per week to the activity.

Employment

List in chronological order beginning with the most recent, each period of full-time, part-time, or self-employment. List inclusive dates for each period. If discharged for cause from any employment, so state. Include any leadership responsibilities.

Dates		Employer Name and Address	Hrs/Wk	Type of Work Performed
From	To			

Education

List in chronological order beginning with the most recent school attended. Include any/all college work, whether or not a degree was earned. Attach transcripts.

Dates		School Name and Address	Major	Degree
From	To			

Academics

PSAT	Verbal: _____	Math: _____	High School Name: _____
SAT	Verbal: _____	Math: _____	Class Rank: _____ Class Size: _____
ACT	Verbal: _____	Math: _____	GPA: _____ GPA Scale: _____

Answer the following questions. If you answer YES, provide explanations on an additional sheet.	Yes	No
1. Have you ever applied for or signed any agreement concerning any program leading to a commission in any of the Armed Forces of the United States? (If you answer YES, list the date, place of application, program applied for and current status of application.)	<input type="checkbox"/>	<input type="checkbox"/>
2. Have you signed an Enlistment Contract (DD Form 4) with any of the Armed Forces of the United States? (If you answer YES, list the date, place, service and current status of enlistment.)	<input type="checkbox"/>	<input type="checkbox"/>
3. Have you ever been arrested, detained, indicted, summoned into court, or convicted for any violation of civil or military law, including juvenile offenses and moving traffic violations? (If you answer YES, give complete description of incident, name and place of court, nature of offense, date and disposition of case.)	<input type="checkbox"/>	<input type="checkbox"/>
4. Are you currently awaiting trial or sentence, on probation, under suspended sentence or under any other type of military or civilian restraint as a result of violation of law or regulation?	<input type="checkbox"/>	<input type="checkbox"/>
5. Have you ever been known by any other name or names other than that used in this application? (If you answer YES, even if such differences were only differences in spelling, explain in affidavit form and submit with application.)	<input type="checkbox"/>	<input type="checkbox"/>
6. Do you have any moral obligations or personal convictions that will prevent you from conscientiously bearing arms and supporting and defending the Constitution of the United States against all enemies, foreign and domestic?	<input type="checkbox"/>	<input type="checkbox"/>
7. Have you ever taken any narcotic, sedative, or tranquilizer drugs other than as prescribed by a physician or dentist? (If you answer YES, attach a statement with the full circumstances, number of times used, amounts taken, period over which taken, and intent for further use.)	<input type="checkbox"/>	<input type="checkbox"/>
8. Have you ever been arrested or convicted of trafficking illegal drugs?	<input type="checkbox"/>	<input type="checkbox"/>
9. Have you ever used LSD, marijuana, sniffed glue or used any other hallucinogens, hypnotic, stimulants, or other known harmful or habit-forming drugs and/or chemicals? (If you answer YES, attach a statement with the full circumstances, number of times used, amounts taken, period over which taken, and intent for further use.)	<input type="checkbox"/>	<input type="checkbox"/>

I certify that all information given by me is complete and correct to the best of my knowledge.
I understand that this applicant questionnaire does not obligate me in any way, and that I may withdraw my application at any time.

Signature _____	Date _____
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NROTC COLLEGE PROGRAM OATH

"I do solemnly swear (or affirm) that I will support and defend the Constitution of the United States against all enemies, foreign and domestic; that I will bear true faith and allegiance to the same; that I take this obligation freely, without any mental reservation or purpose of evasion; and that I will well and faithfully discharge the duties of office on which I am about to enter: So help me God."

Signature _____	Date _____
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REPORT OF MEDICAL HISTORY

OMB No. 0704-0413
OMB approval expires
Aug 31, 2014

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

The public reporting burden for this collection of information is estimated to average 10 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 the burden, to the Department of Defense, Washington Headquarters Services, Executive Services Directorate, Information Management Division, 1155 Defense Pentagon, Washington, DC 20301-1155 (0704-0413). Respondents should be aware that notwithstanding any other provision of law, no person shall be subject to any penalty for failing to comply with a collection of information if it does not display a currently valid OMB control number.

PLEASE DO NOT RETURN YOUR FORM TO THE ABOVE ORGANIZATION. RETURN COMPLETED FORM AS INDICATED ON PAGE 2.

PRIVACY ACT STATEMENT

AUTHORITY: 10 U.S.C. 136, DoD Instruction 6130.03, and E.O. 9397, as amended (SSN).

PRINCIPAL PURPOSE(S): The primary collection of this information is from individuals seeking to join the Armed Forces. The information collected on this form is used to assist DoD physicians in making determinations as to acceptability of applicants for military service and verifies disqualifying medical condition(s) noted on the prescreening form (DD 2807-2). An additional collection of information using this form occurs when a Medical Evaluation Board is convened to determine the medical fitness of a current member and if separation is warranted. Completed forms are covered by recruiting, medical evaluation board, and official military personnel file SORNs maintained by each of the Services.

ROUTINE USE(S): The Blanket Routine Uses found at http://privacy.defense.gov/blanket_uses.shtml apply to this collection.

DISCLOSURE: Voluntary. However, failure by an applicant to provide the information may result in delay or possible rejection of the individual's application to enter the Armed Forces. An applicant's SSN is used during the recruitment process to keep all records together and when requesting civilian medical records. For an Armed Forces member, failure to provide the information may result in the individual being placed in a non-deployable status. The SSN of an Armed Forces member is to ensure the collected information is filed in the proper individual's record.

WARNING: The information you have given constitutes an official statement. Federal law provides severe penalties (up to 5 years confinement or a \$10,000 fine or both), to anyone making a false statement. If you are selected for enlistment, commission, or entrance into a commissioning program based on a false statement, you can be tried by military courts-martial or meet an administrative board for discharge and could receive a less than honorable discharge that would affect your future.

1. LAST NAME, FIRST NAME, MIDDLE NAME (SUFFIX)	2. SOCIAL SECURITY NUMBER	3. TODAY'S DATE (YYYYMMDD)
4.a. HOME ADDRESS (Street, Apartment No., City, State, and ZIP Code)	5. EXAMINING LOCATION AND ADDRESS (Include ZIP Code)	
b. HOME TELEPHONE (Include Area Code)		

X ALL APPLICABLE BOXES:			7.a. POSITION (Title, Grade, Component)				
<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 33%; padding: 2px;">6.a. SERVICE</td> <td style="width: 33%; padding: 2px;">6.b. COMPONENT</td> <td style="width: 33%; padding: 2px;">6.c. PURPOSE OF EXAMINATION</td> </tr> <tr> <td style="padding: 2px;"> <input type="checkbox"/> Army <input type="checkbox"/> Coast Guard <input type="checkbox"/> Navy <input type="checkbox"/> Marine Corps <input type="checkbox"/> Air Force </td> <td style="padding: 2px;"> <input type="checkbox"/> Regular <input type="checkbox"/> Reserve <input type="checkbox"/> National Guard </td> <td style="padding: 2px;"> <input type="checkbox"/> Enlistment <input type="checkbox"/> Medical Board <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Commission <input type="checkbox"/> Retirement <input type="checkbox"/> Retention <input type="checkbox"/> U.S. Service Academy <input type="checkbox"/> Separation <input type="checkbox"/> ROTC Scholarship Program </td> </tr> </table>	6.a. SERVICE	6.b. COMPONENT	6.c. PURPOSE OF EXAMINATION	<input type="checkbox"/> Army <input type="checkbox"/> Coast Guard <input type="checkbox"/> Navy <input type="checkbox"/> Marine Corps <input type="checkbox"/> Air Force	<input type="checkbox"/> Regular <input type="checkbox"/> Reserve <input type="checkbox"/> National Guard	<input type="checkbox"/> Enlistment <input type="checkbox"/> Medical Board <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Commission <input type="checkbox"/> Retirement <input type="checkbox"/> Retention <input type="checkbox"/> U.S. Service Academy <input type="checkbox"/> Separation <input type="checkbox"/> ROTC Scholarship Program	b. USUAL OCCUPATION
6.a. SERVICE	6.b. COMPONENT	6.c. PURPOSE OF EXAMINATION					
<input type="checkbox"/> Army <input type="checkbox"/> Coast Guard <input type="checkbox"/> Navy <input type="checkbox"/> Marine Corps <input type="checkbox"/> Air Force	<input type="checkbox"/> Regular <input type="checkbox"/> Reserve <input type="checkbox"/> National Guard	<input type="checkbox"/> Enlistment <input type="checkbox"/> Medical Board <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Commission <input type="checkbox"/> Retirement <input type="checkbox"/> Retention <input type="checkbox"/> U.S. Service Academy <input type="checkbox"/> Separation <input type="checkbox"/> ROTC Scholarship Program					

8. CURRENT MEDICATIONS (Prescription and Over-the-counter)	9. ALLERGIES (Including insect bites/stings, foods, medicine or other substance)
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Mark each item "YES" or "NO". Every item marked "YES" must be fully explained in Item 29 on Page 2.

	YES	NO		YES	NO
10.a. Tuberculosis	<input type="radio"/>	<input type="radio"/>	12. (Continued)	<input type="radio"/>	<input type="radio"/>
b. Lived with someone who had tuberculosis	<input type="radio"/>	<input type="radio"/>	f. Foot trouble (e.g., pain, corns, bunions, etc.)	<input type="radio"/>	<input type="radio"/>
c. Coughed up blood	<input type="radio"/>	<input type="radio"/>	g. Impaired use of arms, legs, hands, or feet	<input type="radio"/>	<input type="radio"/>
d. Asthma or any breathing problems related to exercise, weather, pollens, etc.	<input type="radio"/>	<input type="radio"/>	h. Swollen or painful joint(s)	<input type="radio"/>	<input type="radio"/>
e. Shortness of breath	<input type="radio"/>	<input type="radio"/>	i. Knee trouble (e.g., locking, giving out, pain or ligament injury, etc.)	<input type="radio"/>	<input type="radio"/>
f. Bronchitis	<input type="radio"/>	<input type="radio"/>	j. Any knee or foot surgery including arthroscopy or the use of a scope to any bone or joint	<input type="radio"/>	<input type="radio"/>
g. Wheezing or problems with wheezing	<input type="radio"/>	<input type="radio"/>	k. Any need to use corrective devices such as prosthetic devices, knee brace(s), back support(s), lifts or orthotics, etc.	<input type="radio"/>	<input type="radio"/>
h. Been prescribed or used an inhaler	<input type="radio"/>	<input type="radio"/>	l. Bone, joint, or other deformity	<input type="radio"/>	<input type="radio"/>
i. A chronic cough or cough at night	<input type="radio"/>	<input type="radio"/>	m. Plate(s), screw(s), rod(s) or pin(s) in any bone	<input type="radio"/>	<input type="radio"/>
j. Sinusitis	<input type="radio"/>	<input type="radio"/>	n. Broken bone(s) (cracked or fractured)	<input type="radio"/>	<input type="radio"/>
k. Hay fever	<input type="radio"/>	<input type="radio"/>	13.a. Frequent indigestion or heartburn	<input type="radio"/>	<input type="radio"/>
l. Chronic or frequent colds	<input type="radio"/>	<input type="radio"/>	b. Stomach, liver, intestinal trouble, or ulcer	<input type="radio"/>	<input type="radio"/>
11.a. Severe tooth or gum trouble	<input type="radio"/>	<input type="radio"/>	c. Gall bladder trouble or gallstones	<input type="radio"/>	<input type="radio"/>
b. Thyroid trouble or goiter	<input type="radio"/>	<input type="radio"/>	d. Jaundice or hepatitis (liver disease)	<input type="radio"/>	<input type="radio"/>
c. Eye disorder or trouble	<input type="radio"/>	<input type="radio"/>	e. Rupture/hernia	<input type="radio"/>	<input type="radio"/>
d. Ear, nose, or throat trouble	<input type="radio"/>	<input type="radio"/>	f. Rectal disease, hemorrhoids or blood from the rectum	<input type="radio"/>	<input type="radio"/>
e. Loss of vision in either eye	<input type="radio"/>	<input type="radio"/>	g. Skin diseases (e.g. acne, eczema, psoriasis, etc.)	<input type="radio"/>	<input type="radio"/>
f. Worn contact lenses or glasses	<input type="radio"/>	<input type="radio"/>	h. Frequent or painful urination	<input type="radio"/>	<input type="radio"/>
g. A hearing loss or wear a hearing aid	<input type="radio"/>	<input type="radio"/>	i. High or low blood sugar	<input type="radio"/>	<input type="radio"/>
h. Surgery to correct vision (RK, PRK, LASIK, etc.)	<input type="radio"/>	<input type="radio"/>	j. Kidney stone or blood in urine	<input type="radio"/>	<input type="radio"/>
12.a. Painful shoulder, elbow or wrist (e.g. pain, dislocation, etc.)	<input type="radio"/>	<input type="radio"/>	k. Sugar or protein in urine	<input type="radio"/>	<input type="radio"/>
b. Arthritis, rheumatism, or bursitis	<input type="radio"/>	<input type="radio"/>	l. Sexually transmitted disease (syphilis, gonorrhea, chlamydia, genital warts, herpes, etc.)	<input type="radio"/>	<input type="radio"/>
c. Recurrent back pain or any back problem	<input type="radio"/>	<input type="radio"/>	14.a. Adverse reaction to serum, food, insect stings or medicine	<input type="radio"/>	<input type="radio"/>
d. Numbness or tingling	<input type="radio"/>	<input type="radio"/>	b. Recent unexplained gain or loss of weight	<input type="radio"/>	<input type="radio"/>
e. Loss of finger or toe	<input type="radio"/>	<input type="radio"/>	c. Currently in good health (If no, explain in Item 29 on Page 2.)	<input type="radio"/>	<input type="radio"/>
			d. Tumor, growth, cyst, or cancer	<input type="radio"/>	<input type="radio"/>

LAST NAME, FIRST NAME, MIDDLE NAME (SUFFIX)	SOCIAL SECURITY NUMBER
Mark each item "YES" or "NO". Every item marked "YES" must be fully explained in Item 29 below.	
HAVE YOU EVER HAD OR DO YOU NOW HAVE:	YES NO
15.a. Dizziness or fainting spells	<input type="radio"/> <input type="radio"/>
b. Frequent or severe headache	<input type="radio"/> <input type="radio"/>
c. A head injury, memory loss or amnesia	<input type="radio"/> <input type="radio"/>
d. Paralysis	<input type="radio"/> <input type="radio"/>
e. Seizures, convulsions, epilepsy or fits	<input type="radio"/> <input type="radio"/>
f. Car, train, sea, or air sickness	<input type="radio"/> <input type="radio"/>
g. A period of unconsciousness or concussion	<input type="radio"/> <input type="radio"/>
h. Meningitis, encephalitis, or other neurological problems	<input type="radio"/> <input type="radio"/>
16.a. Rheumatic fever	<input type="radio"/> <input type="radio"/>
b. Prolonged bleeding (as after an injury or tooth extraction, etc.)	<input type="radio"/> <input type="radio"/>
c. Pain or pressure in the chest	<input type="radio"/> <input type="radio"/>
d. Palpitation, pounding heart or abnormal heartbeat	<input type="radio"/> <input type="radio"/>
e. Heart trouble or murmur	<input type="radio"/> <input type="radio"/>
f. High or low blood pressure	<input type="radio"/> <input type="radio"/>
17.a. Nervous trouble of any sort (anxiety or panic attacks)	<input type="radio"/> <input type="radio"/>
b. Habitual stammering or stuttering	<input type="radio"/> <input type="radio"/>
c. Loss of memory or amnesia, or neurological symptoms	<input type="radio"/> <input type="radio"/>
d. Frequent trouble sleeping	<input type="radio"/> <input type="radio"/>
e. Received counseling of any type	<input type="radio"/> <input type="radio"/>
f. Depression or excessive worry	<input type="radio"/> <input type="radio"/>
g. Been evaluated or treated for a mental condition	<input type="radio"/> <input type="radio"/>
h. Attempted suicide	<input type="radio"/> <input type="radio"/>
i. Used illegal drugs or abused prescription drugs	<input type="radio"/> <input type="radio"/>
18. FEMALES ONLY. Have you ever had or do you now have:	
a. Treatment for a gynecological (female) disorder	<input type="radio"/> <input type="radio"/>
b. A change of menstrual pattern	<input type="radio"/> <input type="radio"/>
c. Any abnormal PAP smears	<input type="radio"/> <input type="radio"/>
d. First day of last menstrual period (YYYYMMDD)	
e. Date of last PAP smear (YYYYMMDD)	
19. Have you been refused employment or been unable to hold a job or stay in school because of:	
a. Sensitivity to chemicals, dust, sunlight, etc.	<input type="radio"/> <input type="radio"/>
b. Inability to perform certain motions	<input type="radio"/> <input type="radio"/>
c. Inability to stand, sit, kneel, lie down, etc.	<input type="radio"/> <input type="radio"/>
d. Other medical reasons (If yes, give reasons.)	<input type="radio"/> <input type="radio"/>
20. Have you ever been treated in an Emergency Room? (If yes, for what?)	<input type="radio"/> <input type="radio"/>
21. Have you ever been a patient in any type of hospital? (If yes, specify when, where, why, and name of doctor and complete address of hospital.)	<input type="radio"/> <input type="radio"/>
22. Have you ever had, or have you been advised to have any operations or surgery? (If yes, describe and give age at which occurred.)	<input type="radio"/> <input type="radio"/>
23. Have you ever had any illness or injury other than those already noted? (If yes, specify when, where, and give details.)	<input type="radio"/> <input type="radio"/>
24. Have you consulted or been treated by clinics, physicians, healers, or other practitioners within the past 5 years for other than minor illnesses? (If yes, give complete address of doctor, hospital, clinic, and details.)	<input type="radio"/> <input type="radio"/>
25. Have you ever been rejected for military service for any reason? (If yes, give date and reason for rejection.)	<input type="radio"/> <input type="radio"/>
26. Have you ever been discharged from military service for any reason? (If yes, give date, reason, and type of discharge; whether honorable, other than honorable, for unfitness or unsuitability.)	<input type="radio"/> <input type="radio"/>
27. Have you ever received, is there pending, or have you ever applied for pension or compensation for any disability or injury? (If yes, specify what kind, granted by whom, and what amount, when, why.)	<input type="radio"/> <input type="radio"/>
28. Have you ever been denied life insurance?	<input type="radio"/> <input type="radio"/>
29. EXPLANATION OF "YES" ANSWER(S) (Describe answer(s), give date(s) of problem, name of doctor(s) and/or hospital(s), treatment given and current medical status.)	

NOTE: HAND TO THE DOCTOR OR NURSE, OR IF MAILED MARK ENVELOPE "TO BE OPENED BY MEDICAL PERSONNEL ONLY."

LAST NAME, FIRST NAME, MIDDLE NAME (SUFFIX)		SOCIAL SECURITY NUMBER
30. EXAMINER'S SUMMARY AND ELABORATION OF ALL PERTINENT DATA <i>(Physician/practitioner shall comment on all positive answers in questions 10 - 29. Physician/practitioner may develop by interview any additional medical history deemed important, and record any significant findings here.)</i>		
a. COMMENTS		
b. TYPED OR PRINTED NAME OF EXAMINER <i>(Last, First, Middle Initial)</i>		c. SIGNATURE
		d. DATE SIGNED <i>(YYYYMMDD)</i>