

**ANNUAL MEDICAL CERTIFICATE (AMC)**

*(This form is subject to the privacy Act of 1974 - Use Blanket PAS - DD Form 2005)*

NAME/RANK		SSN	UNIT	
HOME STREET ADDRESS		CITY	STATE	ZIP CODE
WORK PHONE	HOME PHONE	YEAR LAST MILITARY PHYSICAL EXAM	YEAR LAST MILITARY DENTAL EXAM	

**INSTRUCTIONS**

Mark the appropriate response to each numbered question and sign the form after reading it carefully. If the answer to a question is "YES", answer the additional questions. Continue on reverse side or attach comments or documentation if necessary. Positive responses which are not fully explained or which may effect your medical qualifications for continued military duty will require an interview and further documentation. You may also be required to provide supporting civilian medical and dental documentation for inclusion in your medical records.

1. DO YOU CURRENTLY HAVE ANY MEDICAL OR DENTAL PROBLEMS, OR HAVE YOU HAD ANY MEDICAL OR DENTAL PROBLEMS SINCE YOUR LAST AF FORM 895? (Use a diagnosis if known. Do you currently have any physical restrictions or limitation? If yes, explain).	YES	NO
	<input type="checkbox"/>	<input type="checkbox"/>

2. HAVE YOU BEEN SEEN OR TREATED BY A PHYSICIAN, DENTIST, OR OTHER HEALTH PROVIDER OR HAVE YOU BEEN HOSPITALIZED OR HAD SURGERY SINCE YOUR LAST AF FORM 895?(Explain each instance separately. What was the diagnosis? If hospitalized, where and when? Type of surgery, if any? What was the treatment and are you still receiving treatment? What are your physical restrictions? Have you been released to unrestricted physical duty?)	YES	NO
	<input type="checkbox"/>	<input type="checkbox"/>

3. ARE YOU CURRENTLY OR HAVE YOU TAKEN ANY MEDICATION PRESCRIBED BY A PHYSICIAN, DENTIST, OR OTHER HEALTH CARE PROVIDER SINCE YOUR LAST AF FORM 895?(What condition was the medication prescribed to treat? Name of the medication? How often do you take it? How long will you be on the medication?)	YES	NO
	<input type="checkbox"/>	<input type="checkbox"/>

4. ARE YOU CURRENTLY OR HAVE YOU IN THE PAST RECEIVED A VA DISABILITY, WORKMAN'S COMPENSATION, OR OTHER TYPE COMPENSATION FOR HEALTH OR PHYSICAL REASONS NOT PREVIOUSLY DOCUMENTED?(Include % of disability and condition for which it was granted.)	YES	NO
	<input type="checkbox"/>	<input type="checkbox"/>

Disclosure of this information is required by title 10, chap 51, section 1004 of the United States Code. I swear under penalty of perjury that this information is true and accurate. I understand that giving false information is punishable under Article 107 of the Uniform Code of Military Justice and Title 18, Section 1001 of the United States Code. Giving false information concerning my current health status could lead to my conviction of a felony, confinement in a federal prison for 5 years, a fine of \$10,000, and discharge from the Reserve.

SIGNATURE OF MEMBER

**MEDICAL USE ONLY**

*(File in medical records. All "YES" answers must be reviewed by appropriate medical authority (physicians, PA, Nurse, or Senior Medical Technician))*

YES	<input type="checkbox"/>	INDICATE IF ADDITIONAL INFORMATION, PROFILE CHANGE, OR WAIVER IS NEEDED. (If YES, continue on SF 600)	DATE OF REVIEW	REVIEWER SIGNATURE
NO	<input type="checkbox"/>			

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### **About the ITAOP/savePDF Method**

The traditional Field-by-Field creation process is extremely ineffective and slow.

The only realistic option to create high-quality forms is the Insert-Text-Anywhere-on-Page (ITAOP) method.

The field creation process is about 10,000 times faster than the traditional method; the list of ITAOP features is not even available for the traditional method.

ITAOP savePDF method proved to be very simple and completely reliable for millions of users all over the world (incl. individuals, companies, organizations, government employees).

