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| **New York State Division of Military and Naval Affairs****State Active Duty Line of Duty Statement of Medical Examination and Duty Status**(Form replaces DA Form 2173, Oct. 72 and DA Form 689, Mar. 63) |
| **SECTION I: To be completed by Patient or appropriate designee.** |
| **1.** Name of Individual examined: (Last, First, Middle Initial) | **2.** SSN Last 4: | **3.** GRADE/RANK |
| **4.** Organization and Station: | **5.** Accident/Incident/Illness Occurred: |
| a. DATE | b. PLACE *(city and state)* |
| **SECTION II: To be completed by attending physician or hospital patient administrator.** |
| **6.** INDIVIDUAL WAS: 🞏 Outpatient 🞏 Admitted 🞏 Dead on Arrival | **7.** NAME & ADDRESS OF HOSPITAL/TREATMENT FACILITY:🞏 CIVILIAN 🞏 MILITARY |
| **8.** TIME & DATE TREATED/ADMITTED: | **9.** NATURE OF INCIDENT: 🞏 INJURY 🞏DISEASE 🞏ILLNESS |
| **10.** EXPLANATION OF ACCIDENT, INJURY, ILLNESS OR DISEASE: (how, where, when, what, etc.)**NOTE: Progress Notes, to include diagnosis and prognosis, MUST be provided to patient at time of treatment.** |
| **11.** EXTENT OF ISSIUE: 🞏 TREATABLE/RECOVERABLE 🞏 RESULTED IN DEATH 🞏 POTENTIAL/DEFINITE LONG TERM IMPACT WHERE THE FOLLOWING DISABILITY MAY RESULT: 🞏 TEMPORARY 🞏 PERMANENT PARTIAL 🞏 PERMANENT TOTAL |
| **12.** PROFESSIONAL MEDICAL OPINION (answer where possible/applicable): **INDIVIDUAL:**a. 🞏 WAS 🞏 WAS NOT under the influence of alcohol. (Please specify if “WAS”):b. 🞏 WAS 🞏 WAS NOT under the influence of drugs. (Please specify if “WAS”):c. 🞏 WAS 🞏 WAS NOT mentally sound (Attach Psychiatric evaluation if appropriate). |
| **13.** Blood Alcohol test made: 🞏 YES 🞏 NO | **14.** If tested: Number of MG Alcohol/100 ML Blood |
| **15.** DISPOSITION OF PATIENT: 🞏 RETURN TO DUTY WITHOUT RESTRICTIONS.🞏 MAY NOT RETURN TO DUTY UNTIL \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(list date of return).🞏 OTHER (Specify): | **16.** FOLLOW-UP CARE:🞏 No follow-up care necessary at this time.🞏 Follow-up care required. Explain/When:🞏 Follow-up care recommended. Explain/When: |
| **17.** OTHER REMARKS: |
| **18.** DATE: | **19.** TYPED OR PRINTED NAME OF ATTENDING PHYSICIAN OR PATIENT ADMINISTRATOR | **20.** SIGNATURE: |