

New York Naval Militia  
Commissioned/Warrant Officer Application Package

**FOR FEDERALLY-RECOGNIZED COMMISSIONED OR WARRANT OFFICERS ONLY  
SEPARATED OR RETIRED**

**In order to become a member of the New York Naval Militia as an officer, an applicant must first be a prior-service member of the United States Coast Guard, Marine Corps, or Navy; AND hold a commission or warrant as an officer in the United States Air Force, Army, Coast Guard, Marine Corps, Public Health Service, Navy, or National Oceanographic and Atmospheric Administration.**

1. This package of forms is designed to be completed by the applicant on a personal computer.  
All forms must be completed and submitted as part of the application package.

The forms include:

- NYNM FORM 101A/B     NOMINATION FOR COMMISSION
- NYNM FORM 1070     CIVILIAN-MILITARY SKILLS QUESTIONNAIRE
- NYNM FORM 93        REPORT OF MEDICAL HISTORY
- NYNM FORM 88        REPORT OF MEDICAL EXAM, to be completed by a medical professional.

2. Additional required documents required along with the application package include:

- Copies of DD FORM 214 (all).
- Copy of CDC COVID-19 Vaccination Record Card, indicating fully vaccinated.
- NY Naval Militia Indoctrination Course completion certificate. Follow this link:  
[dmna.ny.gov/nynm/training/NYNM\\_INDOCTRINATION\\_Link\\_Information.pdf](https://dmna.ny.gov/nynm/training/NYNM_INDOCTRINATION_Link_Information.pdf)
- Copy of valid driver license, or government-issued identification card.

3. Options for package submission:

- a. Applications can be sent electronically via email to: [NG.NY.NYARNG.MBX.NYNavalMilitia@army.Mil](mailto:NG.NY.NYARNG.MBX.NYNavalMilitia@army.Mil)
- b. Via fax to (518)786-4427
- c. Via post to: New York Naval Militia Headquarters, 330 Old Niskayuna Rd Latham, NY 12110

## **PRIVACY ADVISORY STATEMENT**

### **NEW YORK NAVAL MILITIA**

#### **Accession, Program and Separation Personal Information**


**AUTHORITY FOR COLLECTION OF PERSONAL INFORMATION:** Personal Privacy Protection Law of New York State; Privacy Act of 1974, 5 U.S. Code, sections 552-522a.

**WHETHER DISCLOSURE IS MANDATORY OR VOLUNTARY AND EFFECT ON INDIVIDUAL OF NOT PROVIDING INFORMATION:** The requested information is mandatory for New York Naval Militia (NYNM) members to insure that: (1) persons applying to join the New York Naval Militia and/or its specific programs meet all eligibility requirements; (2) required pay and tax information is available for purposes of any orders to state active duty; or (3) eligibility for separation from the New York Naval Militia, if applicable. If the requested information is not furnished, the NYNM member will not be considered for accession, or assignment for routine or emergency state active duty. If a NYNM member currently serving on routine or emergency state active duty declines to provide the requested information, the NYNM member's assignment to routine or emergency state active duty may be terminated.

**ROUTINE USES:** This all inclusive Privacy Act Statement will apply to all requests for personal information made by the New York Naval Militia. It will become part of your New York Naval Militia service record. The intended use is to maintain a rapid recall capability, and to facilitate and document your eligibility for various New York Naval Militia programs.

**PRINCIPAL PURPOSES FOR WHICH INFORMATION IS INTENDED TO BE USED:** The primary use of this information is to identify NYNM members who are eligible to serve in the New York Naval Militia and its specific programs. This form provides you the advice required by the New York State Personal Privacy Act and the federal Privacy Act of 1974.

**THIS FORM IS NOT A CONSENT FORM TO RELEASE PERSONAL INFORMATION PERTAINING TO YOU TO AGENCIES AND ENTITIES OUTSIDE OF THE NEW YORK STATE DIVISION OF MILITARY AND NAVAL AFFAIRS AND THE JOINT FORCES OF THE NEW YORK STATE ORGANIZED MILITIA.**

<b>New York Naval Militia (NYNM)</b> 	<b>NOMINATION FOR COMMISSION</b> (For persons who hold or have held a federal commission as an officer)	FOR OFFICIAL USE ONLY <b>NYNM Form 101A</b>		
<b>NOTICE</b>				
<b>Acknowledgement</b>				
1. Persons receiving a commission in the New York Naval Militia acknowledge the following: <ol style="list-style-type: none"> <li>a. New York Naval Militia members are subject to recall to State Active Duty by the Governor of the State of New York.</li> <li>b. The New York Naval Militia is a state military agency under the Division of Military and Naval Affairs. It is not part of the United States Department of Defense or Department of Homeland Security.</li> <li>c. Persons 68 years of age and older are not eligible for membership in the New York Naval Militia.</li> <li>d. The applicant consents to a background check which may include investigation of my employment history, educational background, criminal history, military records, credit history and department of motor vehicle records.</li> </ol>				
<b>I am a drilling reservist, IRR, separated prior service, or retired from the following federal military component:</b>				
Check One: <b>U.S. Coast Guard</b> <b>U.S. Marine Corps</b> <b>U.S. Navy</b>				
<b>1. APPLICANT INFORMATION</b>				
Complete SSN	Last Name	First Name	MI	Suffix
Designator/MOS	Rank/Paygrade	Date of Rank	Federal Pay Entry Base Date	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female
Home Address (mailing address)		City	County	State
Cell Phone		Home Phone	Work Phone	
Primary Email Address		Secondary Email Address		
Next of Kin (NOK) Name and Relationship			Next of Kin (NOK) Phone	
Marital Status: Single                      Married/Civil Union			Number of Dependent Exemptions Claimed:	
<b>2. FEDERAL RESERVE PROGRAM (USNR, USMCR, USCGR) INFORMATION (If applicable)                      Check box if not applicable</b>				
Reserve Center Name		Reserve Unit Name / UIC		
<b>3. CRIMINAL HISTORY (including DUI, DWAI, BUI)</b>				
Offense, Date, Location (List all criminal history or select N/A if none):				
<b>4. PRIOR SERVICE INFORMATION (List all periods of prior/broken military service)</b>				
Component	Date Start	Date End		
<b>5. REFERRAL INFORMATION</b>				
Recruited or Referred By (Last Name, First Name, Rank, Unit):				



# Oath of Commissioning

I, \_\_\_\_\_  
(First Name) (Middle Name) (Last Name)

A citizen of the United States, do hereby acknowledge to have voluntarily accepted a commission on this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_, as a member of the New York Naval Militia under the conditions prescribed by law, unless sooner discharged by proper authority, and I do also agree to accept from the State of New York such benefits as are or may be established by law, and I do solemnly swear (or affirm) that I will bear true faith and allegiance to the United States of America and the State of New York; that I will serve them honestly and faithfully; and that I will obey the orders of the Governor of the State of New York and the orders of the Officers appointed over me, according to Law. I make this obligation freely, without any mental reservations or purpose of evasion, and that I will well and faithfully discharge the duties of an Officer in the New York Naval Militia of the State of New York on which I am about to enter, so help me God

\_\_\_\_\_  
(Signature of applicant)

HOR: \_\_\_\_\_

\_\_\_\_\_  
(Date of federal reserve enlistment expiration)

Email: \_\_\_\_\_

Phone Number(s): \_\_\_\_\_

Unit name/location: \_\_\_\_\_

# Certificate of Commission

(To be completed by New York Naval Militia Headquarters)

I certify that the above individual was commissioned with the grade of \_\_\_\_\_ and enrolled in the service of the State of New York on this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_. This commission will remain in effect in accordance with the provisions of New York State Military Law.

\_\_\_\_\_  
(Signature of Certifying Officer)

\_\_\_\_\_  
(Name of Officer)

<b>New York Naval Militia</b>		<b>Civilian-Military Skills Questionnaire</b>		FOR OFFICIAL USE ONLY NYNMF0RM 1070	
<b>PERSONAL IDENTIFIER INFORMATION:</b>					
Name:	(LAST)	(FIRST, MI)	DOB:		
Address:	(MAILING)				
Address:	(PHYSICAL)				
Phone:	(MOBILE)		(ALTERNATE)		
E-mail:	(PRIMARY)		(SECONDARY)		
Marital Status:	<input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED/CIVIL UNION		Dependents Claimed:		
<b>MILITARY INFORMATION:</b>					
Component:	<input type="checkbox"/> Coast Guard <input type="checkbox"/> Marine Corps <input type="checkbox"/> Navy				
UIC:		Unit:		Duty Station:	
Grade:		Rank/Rate:		Length in service:	
Status:	<input type="checkbox"/> DRILLING RESERVIST <input type="checkbox"/> RETIRED RESERVIST (Eligible for pay at age 60) <input type="checkbox"/> RETIRED MILITARY (Receiving military retirement pay) <input type="checkbox"/> OTHER (Amplify)				
Date of separation or retirement from federal component:					
<b>CIVILIAN EDUCATION:</b>					
College, and/or Professional/Trade School (Name & Location)	ATTENDED		DEGREE		MAJOR/MINOR/ FIELD OF STUDY
	FROM	TO	TITLE	DATE	
<b>CIVILIAN OCCUPATION:</b>					
Employer:			Job Title:		
Address:			City:		Zip:
Phone:			Contact Name:		
<b>CIVILIAN QUALIFICATIONS:</b>					
Personal Qualifications or Certifications: (Check all that apply)	<input type="checkbox"/> Boat Coxswain <input type="checkbox"/> CDL Class ____ <input type="checkbox"/> Chaplain / Clergy <i>Faith: _____</i> <input type="checkbox"/> Medical Doctor/DO <input type="checkbox"/> Dentist <input type="checkbox"/> EMT/Paramedic		<input type="checkbox"/> Diesel Mechanic <input type="checkbox"/> Firefighter <input type="checkbox"/> Police Officer <input type="checkbox"/> Translator <input type="checkbox"/> Attorney <input type="checkbox"/> Welder MIG/TIG <input type="checkbox"/> Chef/Cook		<input type="checkbox"/> Engine Mechanic <input type="checkbox"/> Physician's Assistant <input type="checkbox"/> Nurse Practitioner <input type="checkbox"/> Nurse RN/LPN <input type="checkbox"/> Other (amplify):

<b>New York Naval Militia</b>	<b>Civilian-Military Skills Questionnaire</b>	FOR OFFICIAL USE ONLY <b>NYNMF FORM 1070</b>							
<b><u>MILITARY QUALIFICATIONS:</u></b>									
List all current military qualifications held: (MOS, NOBC, NEC, Designator, etc.)		Military qualifications (Continued):							
Code:	Title:	Code:	Title:						
<b><u>FOREIGN LANGUAGE FLUENCY:</u></b>									
FOREIGN LANGUAGE	LANGUAGE PROFICIENCY				FOREIGN LANGUAGE (CONTINUED)	LANGUAGE PROFICIENCY			
	SPEAK	WRITE	READ	LISTEN		SPEAK	WRITE	READ	LISTEN
<b><u>DRIVER LICENSE INFORMATION:</u></b>									
ID#:		State:		Class:		Expiration Date:			
<b><u>OTHER RELEVANT INFORMATION:</u></b>									
<b>Signature:</b>						<b>Date:</b>			

1. This form will assist the New York Naval Militia to determine the various skills sets possessed by members of the force. This form asks for comprehensive information on both civilian and military-acquired skills that may prove beneficial to the Naval Militia.
2. Members are to complete this form and return to New York Naval Militia headquarters through their Reserve Unit Point of Contact, or fax directly to 518-786-4427. Enclose copies of certifications, qualifications, diplomas, to support the information provided.
3. Information provided by this form will be maintained in the New York Naval Militia database, and in the member's service record at headquarters.

<b>New York Naval Militia (NYNM)</b>	<b>REPORT OF MEDICAL HISTORY</b> <b>AUTHORIZATION, CONSENT AND RELEASE</b>	FOR OFFICIAL USE ONLY NYNM Form 93																																																																														
<b>NOTICE</b>																																																																																
The information requested below is required to provide the medical examiner an accurate history of illnesses and injuries that may affect the applicant's ability to perform the strenuous physical exercise and exposure to living and working environments that are a part of the New York Naval Militia. Also this information will be provided to medical examiners in case of injury or illness. <b><u>If taking medications at time of application, list in Block 6.</u></b>																																																																																
<b>THE INFORMATION YOU PROVIDE MUST BE ACCURATE AND COMPLETE.</b> You are encouraged to consult your private medical provider regarding past illnesses.																																																																																
<b>1. UNIT INFORMATION</b>																																																																																
<b>1a. Unit Name</b>		<b>1b. NYNM Region</b>																																																																														
<b>2. PERSONAL INFORMATION</b>																																																																																
<b>2a. Last Name</b>		<b>2b. First Name</b>																																																																														
<b>2c. MI</b>		<b>2d. Blank</b>																																																																														
<b>2e. Age</b>	<b>2f. Date of Birth</b>	<b>2g. Sex</b> <input type="checkbox"/> Male <input type="checkbox"/> Female																																																																														
<b>2h. Emergency Person Contact Name and Phone Number</b>																																																																																
<b>2i. Home Address</b>		<b>2j. City</b>																																																																														
<b>2k. State</b>	<b>2l. Zip Code</b>	<b>2m. Home Phone</b>																																																																														
<b>2n. Date of Physical Examination (m/d/yyyy)</b>																																																																																
<b>3. MEDICAL HISTORY</b> (Mark each item "YES" or "NO" Every item marked YES must be fully explained in block 6: explain treatment to return member to medically fit for duty)																																																																																
<table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 40%;">HAVE YOU EVER HAD OR DO YOU NOW HAVE ANY OF THE FOLLOWING CONDITIONS:</th> <th style="width: 10%;">YES</th> <th style="width: 10%;">NO</th> <th style="width: 40%;"></th> <th style="width: 10%;">YES</th> <th style="width: 10%;">NO</th> </tr> </thead> <tbody> <tr> <td><b>3a.</b> Tuberculosis or live with someone with tuberculosis</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><b>3m.</b> Head injury or concussion</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td><b>3b.</b> Chronic or recurrent abdominal or stomach pain</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><b>3n.</b> Seizures, convulsions, epilepsy, or fits</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td><b>3c.</b> Asthma or breathing problems related to exercise, pollen, etc.</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><b>3o.</b> Car, train, sea, and/or air sickness</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td><b>3d.</b> Been prescribed or use an inhaler</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><b>3p.</b> A period of unconsciousness</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td><b>3e.</b> Loss of vision in either eye</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><b>3q.</b> Heart trouble or murmur</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td><b>3f.</b> Loss of hearing or wear a hearing aid</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><b>3r.</b> Received counseling for emotional or behavior disorder</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td><b>3g.</b> Impaired use of arms, legs, hands, feet</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><b>3s.</b> Eating disorder (bulimia, anorexia)</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td><b>3h.</b> Knee problems</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><b>3t.</b> Sleepwalking</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td><b>3i.</b> Broken bones(s) (cracked or fractured)</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><b>3u.</b> Frequent or severe headaches</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td><b>3j.</b> Diabetes</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><b>3v.</b> Been hospitalized (<i>if yes, why, when, where</i>)</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td><b>3k.</b> Anemia (including sickle cell)</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><b>3w.</b> Any illness or injury not mentioned above (<i>if yes, explain</i>)</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td><b>3l.</b> Dizziness or fainting spells (including after exercise)</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><b>3x.</b> Advised to avoid certain physical activities (<i>if yes, explain</i>)</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> </tbody> </table>			HAVE YOU EVER HAD OR DO YOU NOW HAVE ANY OF THE FOLLOWING CONDITIONS:	YES	NO		YES	NO	<b>3a.</b> Tuberculosis or live with someone with tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	<b>3m.</b> Head injury or concussion	<input type="checkbox"/>	<input type="checkbox"/>	<b>3b.</b> Chronic or recurrent abdominal or stomach pain	<input type="checkbox"/>	<input type="checkbox"/>	<b>3n.</b> Seizures, convulsions, epilepsy, or fits	<input type="checkbox"/>	<input type="checkbox"/>	<b>3c.</b> Asthma or breathing problems related to exercise, pollen, etc.	<input type="checkbox"/>	<input type="checkbox"/>	<b>3o.</b> Car, train, sea, and/or air sickness	<input type="checkbox"/>	<input type="checkbox"/>	<b>3d.</b> Been prescribed or use an inhaler	<input type="checkbox"/>	<input type="checkbox"/>	<b>3p.</b> A period of unconsciousness	<input type="checkbox"/>	<input type="checkbox"/>	<b>3e.</b> Loss of vision in either eye	<input type="checkbox"/>	<input type="checkbox"/>	<b>3q.</b> Heart trouble or murmur	<input type="checkbox"/>	<input type="checkbox"/>	<b>3f.</b> Loss of hearing or wear a hearing aid	<input type="checkbox"/>	<input type="checkbox"/>	<b>3r.</b> Received counseling for emotional or behavior disorder	<input type="checkbox"/>	<input type="checkbox"/>	<b>3g.</b> Impaired use of arms, legs, hands, feet	<input type="checkbox"/>	<input type="checkbox"/>	<b>3s.</b> Eating disorder (bulimia, anorexia)	<input type="checkbox"/>	<input type="checkbox"/>	<b>3h.</b> Knee problems	<input type="checkbox"/>	<input type="checkbox"/>	<b>3t.</b> Sleepwalking	<input type="checkbox"/>	<input type="checkbox"/>	<b>3i.</b> Broken bones(s) (cracked or fractured)	<input type="checkbox"/>	<input type="checkbox"/>	<b>3u.</b> Frequent or severe headaches	<input type="checkbox"/>	<input type="checkbox"/>	<b>3j.</b> Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<b>3v.</b> Been hospitalized ( <i>if yes, why, when, where</i> )	<input type="checkbox"/>	<input type="checkbox"/>	<b>3k.</b> Anemia (including sickle cell)	<input type="checkbox"/>	<input type="checkbox"/>	<b>3w.</b> Any illness or injury not mentioned above ( <i>if yes, explain</i> )	<input type="checkbox"/>	<input type="checkbox"/>	<b>3l.</b> Dizziness or fainting spells (including after exercise)	<input type="checkbox"/>	<input type="checkbox"/>	<b>3x.</b> Advised to avoid certain physical activities ( <i>if yes, explain</i> )	<input type="checkbox"/>	<input type="checkbox"/>
HAVE YOU EVER HAD OR DO YOU NOW HAVE ANY OF THE FOLLOWING CONDITIONS:	YES	NO		YES	NO																																																																											
<b>3a.</b> Tuberculosis or live with someone with tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	<b>3m.</b> Head injury or concussion	<input type="checkbox"/>	<input type="checkbox"/>																																																																											
<b>3b.</b> Chronic or recurrent abdominal or stomach pain	<input type="checkbox"/>	<input type="checkbox"/>	<b>3n.</b> Seizures, convulsions, epilepsy, or fits	<input type="checkbox"/>	<input type="checkbox"/>																																																																											
<b>3c.</b> Asthma or breathing problems related to exercise, pollen, etc.	<input type="checkbox"/>	<input type="checkbox"/>	<b>3o.</b> Car, train, sea, and/or air sickness	<input type="checkbox"/>	<input type="checkbox"/>																																																																											
<b>3d.</b> Been prescribed or use an inhaler	<input type="checkbox"/>	<input type="checkbox"/>	<b>3p.</b> A period of unconsciousness	<input type="checkbox"/>	<input type="checkbox"/>																																																																											
<b>3e.</b> Loss of vision in either eye	<input type="checkbox"/>	<input type="checkbox"/>	<b>3q.</b> Heart trouble or murmur	<input type="checkbox"/>	<input type="checkbox"/>																																																																											
<b>3f.</b> Loss of hearing or wear a hearing aid	<input type="checkbox"/>	<input type="checkbox"/>	<b>3r.</b> Received counseling for emotional or behavior disorder	<input type="checkbox"/>	<input type="checkbox"/>																																																																											
<b>3g.</b> Impaired use of arms, legs, hands, feet	<input type="checkbox"/>	<input type="checkbox"/>	<b>3s.</b> Eating disorder (bulimia, anorexia)	<input type="checkbox"/>	<input type="checkbox"/>																																																																											
<b>3h.</b> Knee problems	<input type="checkbox"/>	<input type="checkbox"/>	<b>3t.</b> Sleepwalking	<input type="checkbox"/>	<input type="checkbox"/>																																																																											
<b>3i.</b> Broken bones(s) (cracked or fractured)	<input type="checkbox"/>	<input type="checkbox"/>	<b>3u.</b> Frequent or severe headaches	<input type="checkbox"/>	<input type="checkbox"/>																																																																											
<b>3j.</b> Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<b>3v.</b> Been hospitalized ( <i>if yes, why, when, where</i> )	<input type="checkbox"/>	<input type="checkbox"/>																																																																											
<b>3k.</b> Anemia (including sickle cell)	<input type="checkbox"/>	<input type="checkbox"/>	<b>3w.</b> Any illness or injury not mentioned above ( <i>if yes, explain</i> )	<input type="checkbox"/>	<input type="checkbox"/>																																																																											
<b>3l.</b> Dizziness or fainting spells (including after exercise)	<input type="checkbox"/>	<input type="checkbox"/>	<b>3x.</b> Advised to avoid certain physical activities ( <i>if yes, explain</i> )	<input type="checkbox"/>	<input type="checkbox"/>																																																																											
<b>4. IMMUNIZATION RECORDS</b>																																																																																
<table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 33%;">IMMUNIZATIONS</th> <th style="width: 33%;">Month/Year Given</th> <th style="width: 33%;">Month/Year Given</th> </tr> </thead> <tbody> <tr> <td>Tetanus</td> <td>____/____</td> <td>Mumps</td> </tr> <tr> <td>Diphtheria</td> <td>____/____</td> <td>Rubella</td> <td>____/____</td> </tr> <tr> <td>Pertussis</td> <td>____/____</td> <td>Polio</td> <td>____/____</td> </tr> <tr> <td>Measles</td> <td>____/____</td> <td>Chicken Pox</td> <td>____/____</td> </tr> <tr> <td>Small Pox</td> <td>____/____</td> <td>Influenza</td> <td>____/____</td> </tr> <tr> <td></td> <td></td> <td>Tdap</td> <td>____/____</td> </tr> <tr> <td></td> <td></td> <td>Hepatitis A</td> <td>____/____</td> </tr> <tr> <td></td> <td></td> <td>Hepatitis B</td> <td>____/____</td> </tr> <tr> <td></td> <td></td> <td>TB/PPD</td> <td>____/____</td> </tr> <tr> <td></td> <td></td> <td>Anthrax</td> <td>____/____</td> </tr> </tbody> </table>			IMMUNIZATIONS	Month/Year Given	Month/Year Given	Tetanus	____/____	Mumps	Diphtheria	____/____	Rubella	____/____	Pertussis	____/____	Polio	____/____	Measles	____/____	Chicken Pox	____/____	Small Pox	____/____	Influenza	____/____			Tdap	____/____			Hepatitis A	____/____			Hepatitis B	____/____			TB/PPD	____/____			Anthrax	____/____																																				
IMMUNIZATIONS	Month/Year Given	Month/Year Given																																																																														
Tetanus	____/____	Mumps																																																																														
Diphtheria	____/____	Rubella	____/____																																																																													
Pertussis	____/____	Polio	____/____																																																																													
Measles	____/____	Chicken Pox	____/____																																																																													
Small Pox	____/____	Influenza	____/____																																																																													
		Tdap	____/____																																																																													
		Hepatitis A	____/____																																																																													
		Hepatitis B	____/____																																																																													
		TB/PPD	____/____																																																																													
		Anthrax	____/____																																																																													





<b>New York Naval Militia (NYNM)</b>	<b>REPORT OF MEDICAL EXAM</b>	FOR OFFICIAL USE ONLY <b>NYNM Form 88</b>			
<b>INSTRUCTIONS TO MEDICAL PROFESSIONAL</b>					
<p>The applicant may be participating in strenuous activity, which may include exposure to extreme weather conditions, cold water, fatigue and remote locations. Please, complete the following items and summarize your findings in the section below. By your signature, you have determined that the applicant is fit for full duty in the New York Naval Militia.</p> <p>Medical examinations recorded on another agency or organizational record of medical examination form, with signature of licensed medical practitioner are acceptable in lieu of this completed form. Attach the completed other agency form to this form, and complete sections 1 and 2 below.</p> <p>Acceptance criteria for applicants to the New York Naval Militia include the ability to <u>FULLY</u> participate in militia activities. This includes strenuous physical exercise and activities. Defects that are cause for rejection of an applicant for actual enlistment or appointment into the naval service should be identified. Conditions that will or are likely to require treatment, particularly unresolved injuries and recurrent illness must be listed. The history of immunization should be verified to the satisfaction of the medical examiner. A licensed healthcare provider must complete this examination.</p>					
<b>1. UNIT INFORMATION</b>					
<b>1a.</b> Unit Name		<b>1b.</b> NYNM Region			
<b>2. PERSONNEL INFORMATION</b>					
<b>2a.</b> Last Name		<b>2b.</b> First Name			
<b>2c.</b> MI		<b>2d.</b> Blank			
<b>2e.</b> Age	<b>2f.</b> Date of Birth (m/d/yyyy)	<b>2g.</b> Sex <input type="checkbox"/> Male <input type="checkbox"/> Female			
<b>2h.</b> Emergency Contact Person Name and Phone Number					
<b>2i.</b> Home Address		<b>2j.</b> City			
<b>2k.</b> State		<b>2l.</b> Zip Code + 4			
<b>2m.</b> Home Phone		<b>2n.</b> Date of Physical Examination (DD MMM YY)			
<b>2o.</b> Location of Physical Examination					
<b>3. CLINICAL EVALUATION</b>					
	Normal	Abnormal		Normal	Abnormal
<b>3a.</b> Head, Face, Neck, and Scalp	<input type="checkbox"/>	<input type="checkbox"/>	<b>3q.</b> Mouth and Throat	<input type="checkbox"/>	<input type="checkbox"/>
<b>3b.</b> Nose	<input type="checkbox"/>	<input type="checkbox"/>	<b>3r.</b> Vascular System ( <i>Varicosities, etc.</i> )	<input type="checkbox"/>	<input type="checkbox"/>
<b>3c.</b> Sinuses	<input type="checkbox"/>	<input type="checkbox"/>	<b>3s.</b> Prostate	<input type="checkbox"/>	<input type="checkbox"/>
<b>3d.</b> Ears – General ( <i>Internal and External Canals</i> )	<input type="checkbox"/>	<input type="checkbox"/>	<b>3t.</b> Testicular	<input type="checkbox"/>	<input type="checkbox"/>
<b>3e.</b> Ear Drum ( <i>Perforation</i> )	<input type="checkbox"/>	<input type="checkbox"/>	<b>3u.</b> Anus and Rectum	<input type="checkbox"/>	<input type="checkbox"/>
<b>3f.</b> Eyes- General	<input type="checkbox"/>	<input type="checkbox"/>	<b>3v.</b> Endocrine System	<input type="checkbox"/>	<input type="checkbox"/>
<b>3g.</b> Ophthalmoscopic	<input type="checkbox"/>	<input type="checkbox"/>	<b>3w.</b> G-U System	<input type="checkbox"/>	<input type="checkbox"/>
<b>3h.</b> Pupils ( <i>Equality and Reaction</i> )	<input type="checkbox"/>	<input type="checkbox"/>	<b>3x.</b> Skin, lymphatics	<input type="checkbox"/>	<input type="checkbox"/>
<b>3i.</b> Heart ( <i>Thrust, Size, Rhythm, and Sounds</i> )	<input type="checkbox"/>	<input type="checkbox"/>	<b>3y.</b> Neurologic	<input type="checkbox"/>	<input type="checkbox"/>
<b>3j.</b> Lungs and Chest	<input type="checkbox"/>	<input type="checkbox"/>	Notes: (Describe abnormalities in detail. Continue in Section 6 or additional sheets as necessary.)		
<b>3k.</b> Abdomen and Viscera ( <i>Include Hernia</i> )	<input type="checkbox"/>	<input type="checkbox"/>			
<b>3l.</b> External Genitalia ( <i>Genitourinary</i> )	<input type="checkbox"/>	<input type="checkbox"/>			
<b>3m.</b> Upper Extremities	<input type="checkbox"/>	<input type="checkbox"/>			
<b>3n.</b> Lower Extremities	<input type="checkbox"/>	<input type="checkbox"/>			
<b>3o.</b> Feet	<input type="checkbox"/>	<input type="checkbox"/>			
<b>3p.</b> Spine and other Musculoskeletal	<input type="checkbox"/>	<input type="checkbox"/>			
<b>4. LABORATORY FINDINGS (as clinically indicated)</b>					
<b>4a.</b> Urinalysis (1) Albumin:                      (2) Sugar:			<b>4b.</b> Blood (1) Hemoglobin:                      (2) Hematocrit:		
<b>5. MEASUREMENTS AND OTHER FINDINGS</b>					
<b>5a.</b> Height inches	<b>5b.</b> Weight lbs.	<b>5c.</b> Obese <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>5d.</b> Pulse	<b>5e.</b> Blood Pressure (1) Systolic:                      (2) Diastolic:	
<b>5f.</b> Blank				<b>5g.</b> Wears Glasses <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>5h.</b> Wears Contacts <input type="checkbox"/> Yes <input type="checkbox"/> No
				<b>5j.</b> Best/Corrected Vision (1) Left: 20/                      (2) Right: 20/	
				<b>5k.</b> Or valid NYS Driver License Number/Class	
<b>5l.</b> Other Findings (if more room is needed, continue on reverse)					

Last Name	<b>REPORT OF MEDICAL EXAM</b>	<b>NYNM Form 88</b> (Reverse)
<b>6. NOTES, REMARKS, AND OTHER FINDINGS</b> (Use additional sheets of paper if needed)		
<p style="text-align: center;"><b>ACCEPTANCE CRITERIA FOR APPLICANTS TO, AND CONTINUED SERVICE IN THE NEW YORK NAVAL MILITIA</b></p> <p>A. Acceptance is based upon ability to participate in strenuous physical activity, (which may include exposure to extreme weather conditions, cold water, fatigue and remote locations) and the absence of contagious disease, illness, or history that will or is likely to require medical care or restriction of participation. All members must be able to run/walk one (1) mile in less than 20 minutes and be able to lift or carry up to 40 pounds on a frequent basis.</p> <p>B. Special attention should be given to orthopedic and cardiovascular conditions or complaints.</p> <p>C. There is no specific limit for vision. However, applicants who wear glasses or contact lenses but cannot participate in activities that require the removal of glasses (or contacts) should be reviewed on a case-by-case basis.</p> <p>D. Examining physicians may submit appropriate statements for consideration of acceptance, when the physician is of the opinion that the applicant will not encounter any restriction of participation in the program and that the condition in question does not present an unacceptable risk for aggravation or worsening as the result of participation in the activities of the New York Naval Militia.</p>		
<b>7. ENDORSEMENT</b>		
It is my professional medical opinion in accordance with the above criteria that the examinee is:		
<input type="checkbox"/> <b>PHYSICALLY QUALIFIED:</b> Fit for full duty in the New York Naval Militia		
<input type="checkbox"/> <b>NOT PHYSICALLY QUALIFIED:</b> <b>NOT</b> fit for full duty for reasons stated above in Block 6 (notes)		
<b>7a.</b> Name of Physician (Type or Print) or Physician's Stamp	<b>7b.</b> Signature	<b>7c.</b> Date (m/d/yyyy)

**NYNM 88 (REV 1/22) Reverse**

**New York Naval Militia, 330 Old Niskayuna Road, Latham, New York 12110**