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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **HEALTH RECORD** | | **CHRONOLOGICAL RECORD OF MEDICAL CARE** | | | | | | | | | |
| **DATE** | | **SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*** | | | | | | | | | | | |
|  | |  | | | | | | | | | | | |
| **Background**. The MA rating provides commands with force protection and antiterrorism specialists who perform base defense, law enforcement, and physical security duties. MAs enforce appropriate orders and regulations, make apprehensions, conduct investigations, and prepare required records and reports. Due to the unique functions and trust inherent in the MA rating, the quality of personnel selected is of paramount importance and requires strict adherence to eligibility criteria. MAs are world-wide assignable to the continental U.S. (CONUS), outside continental the U.S. (OCONUS), sea, shore, and hostile-fire duty assignments. | | **MA CONVERSION MEMO** | | | | | | | | | | | |
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|  | | **STANDARDS IAW MILPERSMAN 1440-010** | | | | | | | | | | | |
|  | | **DVA:** Uncorrected OD: 20/ OS: 20/ Corrected: OD: 20/ OS: 20/ | | | | | | | | | | | |
|  | | **NVA:** Uncorrected OD: 20/ OS: 20/ Corrected: OD: 20/ OS: 20/ | | | | | | | | | | | |
|  | |  | | | | | | | | | | | |
|  | | **COLOR VISION**: (TEST: FALANT /PIP) PASS/FAIL | | | | | | | | | | | |
|  | | **AUDIOGRAM COMPLETION DATE:** | | | | | | | | | | | |
|  | |  | | | | | | | | | | | |
|  | | DOES PATIENT HAVE A HISTORY OF MENTAL IMPAIRMENT OR DISORDER: **YES NO** | | | | | | | | | | | |
|  | | DOES PATIENT HAVE A HISTORY OF EMOTIONAL INSTABILITY: **YES NO** | | | | | | | | | | | |
|  | | DOES PATIENT HAVE A CONDITION THAT IMPAIRS THE PERFORMANCE OF | | | | | | | | | | | |
|  | | LAW ENFORCEMENT DUTIES: **YES NO** | | | | | | | | | | | |
|  | | IS PATIENT MEDICALLY QUALIFIED AND WORLD WIDE ASSIGNABLE: **YES NO** | | | | | | | | | | | |
| PCM/IDC SIGNATURE | |  | | | | | | | | | | | |
|  | | | | **RECORDS**  **MAINTAINED**  **AT:** |  |  | | | | | | | | |
|  | | | | **PATIENT'S NAME *(Last, First, Middle initial)*** | | | | | | | **SEX** | | | |
|  | | | | **RELATIONSHIP TO SPONSOR** SELF | | | | **STATUS** ACTIVE DUTY | | **RANK/GRADE** | | | | |
|  | | | | **SPONSOR'S NAME** | | | | | **ORGANIZATION** | | | | | |
|  | | | | **DEPART./SERVICE**  DOD / USN | | | **SSN/IDENTIFICATION NO.**  **20/** | | | | | **DATE OF BIRTH** | | | |

**SF 600**

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| **CHRONOLOGICAL RECORD OF MEDICAL CARE STANDARD FORM 600** |