Fillable Form

RECORDS TRANSMITTAL	ADDRESSEE - COMPLETE ITEMS 7, 8 AND 9, AS APPROPRIATE AND RETURN TO SENDER, WHEN THE "RETURN RECEIPT REQUESTED" BOX IS CHECKED.	TRANSMITTAL NUMBER:	SUPPORTING DIRECTIVE MILPERSMAN ARTICLE 1070-120

1. FROM:	2. DATE:

3. TO: *(COMPLETE MAILING ADDRESS)*

☐ RETURN RECEIPT REQUESTED (WHEN BOX IS CHECKED, SIGN BELOW AND RETURN COPY TO SENDER).

4. SENDER: *(NAME & TITLE)*	5. PHONE NUMBER:	6. SIGNATURE:

7. RECORDS TRANSMITTED: ***(SR=SERVICE RECORD, MR=MEDICAL RECORD, DR= DENTAL RECORD)***

NAME: (LAST, FIRST, MI)	RANK/RATE	LAST 4 DIGITS OF SSN ONLY	SR	MR	DR	REMARKS
			☐	☐	☐	
			☐	☐	☐	
			☐	☐	☐	
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			☐	☐	☐	

REPLY RECEIPT

8. RECEIVER: *(NAME, TITLE AND ORGANIZATION)*	9. SIGNATURE:	10. DATE:

11. REMARKS:

12. RETURN RECEIPT TO: *(COMPLETE MAILING ADDRESS)*	**ORIGINATING ACTIVITY, LISTED IN BLOCK 1, WILL ENTER COMPLETE ADDRESS TO WHICH RECEIPT SHOULD BA MAILED**