



DEPARTMENT OF THE AIR FORCE

HEADQUARTERS 66th AIR BASE GROUP
HANSCOM AIR FORCE BASE MASSACHUSETTS

MEMORANDUM FOR CIVILIAN PROVIDER

FROM: 66th Medical Squadron

SUBJECT: Medical Information for Duty Limitations

Patient's Name: _____ Date of Birth: _____

1. The 66th Medical Squadron is requesting documentation for the above mutual patient. Due to their military status, our military providers need additional information to place the patient on official physical/duty limitations or time off of work for recovery. Please be as specific as possible to ensure we can expedite your request.

2. Please check one of the following that apply:

- Duty limitations/restrictions (physical profile)
 - When considering restrictions, please address if member can deploy and travel to remote locations for extended periods of time.
- Time off of work (quarters/convalescent leave)
 - Requests for time off of work must be submitted after the procedure and we can only process up to 30 days at a time. Extensive clinical/surgical notes will be required to process beyond 30 days.

3. Please complete the following information:

a. Diagnosis and Prognosis: _____

b. Treatment Plan: _____

c. Medication (name, dose, frequency, duration): _____

FITNESS: Can the patient perform - ?			Notes:
Push ups	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Sit ups	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Run- 1.5 miles	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Walk- 1 mile	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Does this condition directly apply to a pregnancy or recent abdominal surgery?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	

Duty/Mobility Restrictions: Can the patient perform - ?			Notes:
Run 100 yards with a 40 lb. pack	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Heavy lifting	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Not to exceed (in lbs.): _____
Bending and twisting at waist	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Reaching or lifting above head	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Perform duties for prolonged period of time (12+ hours)	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Travel by air, land, or sea	Yes <input type="checkbox"/>	No <input type="checkbox"/>	

Date restrictions expected to resolve: _____ Next follow-up appointment: _____

Provider Signature: _____ Date: _____

Provider Printed First and Last Name: _____

Address: _____

Phone Number: (_____) _____ - _____ Fax Number: (_____) _____ - _____

4. This completed memorandum and any additional information can be faxed back to the Family Health Clinic at (781) 225-2585.

//SIGNED//
66th Medical Squadron
Family Health Clinic Staff