

PHYSICAL FITNESS ASSESSMENT MEDICAL CLEARANCE/WAIVER

SECTION 1 Completed by member

A. Command	B. UIC/RUIC	C. CFL/POC	D. CFL Telephone No.
E. Reason for Referral			
Positive PARFQ Screening <input type="checkbox"/> Yes <input type="checkbox"/> No	Expired PHA <input type="checkbox"/> Yes <input type="checkbox"/> No	Age >= 50 years <input type="checkbox"/> Yes <input type="checkbox"/> No	No PRT in last year <input type="checkbox"/> Yes <input type="checkbox"/> No
			Injury/Illness <input type="checkbox"/> Yes <input type="checkbox"/> No

SECTION 2 Completed by AMDR/Treating Provider

A. PRT Waiver			
Curl-Ups <input type="checkbox"/> Yes <input type="checkbox"/> No	Push-Ups <input type="checkbox"/> Yes <input type="checkbox"/> No	Cardio Event <input type="checkbox"/> Yes <input type="checkbox"/> No	Waiver Expiration Date
B. PRT Modifications			
CLEARED TO PARTICIPATE <input type="checkbox"/> Yes <input type="checkbox"/> No	PRT ACTIVITY	COMMENTS	
<input type="checkbox"/> Yes <input type="checkbox"/> No	Treadmill		
<input type="checkbox"/> Yes <input type="checkbox"/> No	Elliptical Trainer		
<input type="checkbox"/> Yes <input type="checkbox"/> No	Stationary Bike		
<input type="checkbox"/> Yes <input type="checkbox"/> No	Swim		
CLEARED TO PARTICIPATE <input type="checkbox"/> Yes <input type="checkbox"/> No	PHYSICAL TRAINING	COMMENTS	
<input type="checkbox"/> Yes <input type="checkbox"/> No	Command Physical Training/Fitness Enhancement Program		
<input type="checkbox"/> Yes <input type="checkbox"/> No	Individual Physical Training		
C. AMDR/Treating Provider Name		D. AMDR/Treating Provider Signature	E. Date

SECTION 3 Completed by Treating Physician and AMDR/AMDR Supervisor

A. BCA Waiver (Requires two signatures if granted)		
Waiver <input type="checkbox"/> Yes <input type="checkbox"/> No	AMDR/Treating Physician Signature	AMDR/AMDR Supervisor Signature
B. Reason IAW OPNAVINST 6110.1 (series) <input type="checkbox"/> Inability to obtain BCA measurement <input type="checkbox"/> Medical Treatment/Therapy		C. BCA Waiver Expiration Date

SECTION 4 Completed by AMDR

A. Member Cleared <input type="checkbox"/> Yes <input type="checkbox"/> No	B. PRT Waiver Recommended <input type="checkbox"/> Yes <input type="checkbox"/> No	C. BCA Waiver Recommended <input type="checkbox"/> Yes <input type="checkbox"/> No	D. Is member in LIMDU <input type="checkbox"/> Yes <input type="checkbox"/> No	E. LIMDU Expiration Date
F. AMDR Name		G. AMDR Signature	H. Date	

SECTION 5 CO Endorsement Required Prior to Input into PRIMs

A. Waiver Status		
Waivers in Most Recent 4 Years	CFL Signature	Date
B. PRT Waiver Approved <input type="checkbox"/> Yes <input type="checkbox"/> No	C. BCA Waiver Approved <input type="checkbox"/> Yes <input type="checkbox"/> No	D. Member CO/OIC Signature
		E. Date

PATIENT'S IDENTIFICATION (Use this space for mechanical imprint)

PATIENT'S NAME (Last, First, Middle Initial)		SEX
SSN / IDENTIFICATION NO.	STATUS	RANK/GRADE
RECORDS MAINTAINED AT		DATE OF BIRTH