MILITARY SEALIFT COMMAND  
Medical Department (CODE: N02H)  
Bldg. SP-64, 471 C Street, Norfolk, VA 23511-2419  
E-mail address to submit forms: MSC_Medical@navy.mil  
VOICE: 1-866-827-4955 FAX: 1-866-324-4955  
(757) 443-5760 (757) 443-5767

Mariner Name / Last 4 SSN  
MEDICAL SUMMARY FORM  
(ALTERNATIVELY, A NARRATIVE SUMMARY ADDRESSING THE ELEMENTS BELOW MAY BE PROVIDED)

Note to examining provider: The seafaring environment is arduous and exposes personnel to many environmental and physical hazards. It is essential that crew members be physically fit to perform the duties of their position worldwide. They may work long shifts, be required to engage in strenuous activity, be exposed to temperature extremes for long periods, don emergency gear including respirators, and serve for up to 6-months at sea remote from medical care.

MEDICAL SPECIALTY REQUIRED:

1. MEDICAL PROBLEMS TO BE ADDRESSED:  
   If applicable, minimum MSC acceptable standards are:  
   BP < 140/90  
   HbA1c < 8.0%  
   LDL < 160mg/dl  
   Triglycerides < 400mg/dl  
   OSA – 70% compliance (must provide data)  
   LVEF 40% or higher  
   Stress Test at least 8 METS

2. SIGNIFICANT HISTORY AND PHYSICAL FINDINGS: (HPI, Vital signs, PE results)

3. SIGNIFICANT ANCILLARY TESTING: (Please provide results of labs, imaging, PFT, EKG, audio, etc.)

4. DIAGNOSIS/DIAGNOSES:

CONTINUE ON REVERSE OF FORM
5. TREATMENT: (LIST ALL MEDICATIONS INCLUDING PRESCRIPTION, HERBAL, SUPPLEMENTS AND OTC), PHYSICAL THERAPY, AND OTHER TREATMENTS

Note: For chronic medications, please provide a 6-month supply.

6. WORK RESTRICTIONS/LIMITATIONS AND RECOMMENDATIONS FOR FOLLOW UP:

FOLLOW UP MUST NOT BE LESS THAN EVERY 6 MONTHS DUE TO LENGTH OF SHIPBOARD ASSIGNMENT.

Recommended follow up interval: ___________________________.

7. CHECK ONE OF THE FOLLOWING REGARDING DUTY STATUS:

☐ Fit for sea duty. (Refer to work conditions on top of page one)

☐ Not fit for sea duty ➔ If made not fit for sea duty: Fit to travel? ☐ Yes ☐ No ☐ N/A

Needs escort? ☐ Yes ☐ No ☐ N/A

If Not Fit; Estimated Return to Work date: __________________________

Estimated date of Maximum Medical Improvement (MMI): ______________________

AUTHORITY TO RELEASE PRIVILEGED MEDICAL INFORMATION: I hereby authorize release to the Military Sealift Command Medical Department and the Department of Defense Medical Treatment Facilities, privileged medical correspondence and records in my case.

___________________________________________                                                        _________________________________
Mariner’s signature                                                                                                                    Date

_______________________________________                                                  _______________________________
Mariner’s Phone                                                                                                                         Email Address

**Notice to CIVMARS: MSC Medical Staff must follow all stated guidance in processing and assessing FFD matters, and that pursuant to the QMS instruction (N02H.6000.2-Q), MSC Medical will report for administrative action any mariner that fails to provide medical documentation within 30 days as required.**

Medical/Dental Provider’s Name (Print or Stamp) Medical/Dental Provider’s Signature

Medical Speciality: ____________________________ Date Signed: ____________________________

Address: __________________________________________ Telephone: ____________________________

**MSC Medical has final authority for duty status determination**