REQUEST FOR	REQUESTING AC		Complete Items 1 through 10 (Except 8b)); also	DATE
MEDICAL/DENTAL RECORDS OR INFORMATION	complete Item 19. ADDRESSEE - Complete Items 8b, 11 to 14 or 15 to 18, as appropriate, final referrer shall return to requester.				
1. PATIENT (Last Name - First Name - Middle Na	ame)		3. STATUS MILITAR	Y \	'A BENEFICIARY
2. ORGANIZATION AND PLACE OF TREATMEN	r		DEPENDENT	FEDERAL EMI	PLOYEE
2. ORGANIZATION AND PLACE OF TREATIVEN	l.		OTHER (Specify) 3a. NAME OF SPONSOR (If de	pendent)	
			(
4. TO (Include ZIP Code)				5. IDENTIFY	/ING INFORMATION
				a. SERVICE NUM	1BER
J				L CDADE (DATE	
				b. GRADE/RATE	
				c. SOCIAL SECU	JRITY ACCOUNT NO.
1		ı			
<u> </u>				d. VA CLAIM NU	JMBER
				o DATE OF BID	TH (If Federal employee)
				e. DATE OF BIK	TTT (II rederal employee)
6. DATES OF TREATMENT (Inclusive)			7. DISEASE OR INJURY		
8. a. RECORDS REQUESTED	b. RECORDS FOR	DWADDED	9. REMARKS		
MIL VA	b. RECORDS FOR	MIL VA	9. REIVIARNS		
CLINICAL OUTPATIENT					
HEALTH RECORD					
DENTAL RECORD					
X-RAY					
MEDICAL REPORT CARDS, EMERGENCY					
MEDICAL TAGS, FIELD MEDICAL CARDS					
ABSTRACT OF RATING SHEET					
REPORT OF PHYSICAL EXAMINATION		Ц Ц			
ALL AVAILABLE RECORDS (Except X-rays unless specifically requested)			10. SIGNATURE		
OTHERS (List under remarks)					
		REPLY/R	EFERRAL		
11. TO:			12. REMARKS		
			RECORDS CHECKED IN NO RECORDS FOUND F		g above period.
			MORE INFORMATION N	EEDED. FURNISH F	OLLOWING:
13. SIGNATURE	14. DATE				
	DED	I V/SECOI	ND REFERRAL		
15. TO:	KEP	L1/3ECO	16. REMARKS		
			RECORDS CHECKED IN	8b FORWARDED.	
			NO RECORDS FOUND F		
	1		MORE INFORMATION N	EEDED. FURNISH F	OLLOWING:
17. SIGNATURE	18. DATE				
19. RETURN TO: (Include ZIP Code)					
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l		l		REQUE	STING ACTIVITY WILL
				ENTER	COMPLETE ADDRESS ICH RECORDS OR FINAL
					SHOULD BE MAILED.
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REQUEST FOR	REQUESTING ACTIVITY -Complete Items 1 through 10 (Except 8b); also DATE				
MEDICAL/DENTAL RECORDS OR INFORMATION	complete Item 19. ADDRESSEE - Complete Items 8b, 11 to 14 or 15 to 18, as appropriate, final referrer shall return to requester.				
1. PATIENT (Last Name - First Name - Middle Na	ame)	3. STATUS MILITARY	_		
2. ORGANIZATION AND PLACE OF TREATMEN	Г	DEPENDENT OTHER (Specify)	DEPENDENT FEDERAL EMPLOYEE		
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4. TO (Include ZIP Code)		1	5. IDENTIFYING INFORMATION		
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<u> </u>			d. VA CLAIM NUMBER		
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6. DATES OF TREATMENT (Inclusive)		7. DISEASE OR INJURY	1		
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MEDICAL REPORT CARDS, EMERGENCY MEDICAL TAGS, FIELD MEDICAL CARDS					
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			ENTER COMPLETE ADDRESS		
			TO WHICH RECORDS OR FINAL REPLY SHOULD BE MAILED.		
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2. ORGANIZATION AND PLACE OF TREATMEN	Г	DEPENDENT OTHER (Specify)	DEPENDENT FEDERAL EMPLOYEE		
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			c. SOCIAL SECURITY ACCOUNT NO.		
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<u> </u>			d. VA CLAIM NUMBER		
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