

M	TAB	TAB	TAB	TAB
PERIODIC MEDICAL EXAMINATION (Statement of Exemption) <small>(For use of this form, see AR 40-501; the proponent is the Office of The Surgeon General)</small>				DATE

LAST NAME-FIRST NAME-MIDDLE INITIAL, GRADE & SSN *(Type or print)*

ORGANIZATION

I underwent a medical examination in conjunction with _____

on or about _____ at _____
(date)

(medical treatment facility)

and to the best of my knowledge there has been no significant change in my medical condition since the accomplishment of that medical examination.

(Signature)