AUTHORIZATION FOR MEDICAL WARNING TAG

For use of this form, see AR 40-15; the proponent agency is Office of The Surgeon General.

TO: *(Include ZIP Code)*

FROM: *(Medical Treatment Facility (Specify Clinic, Ward, etc.))*

TYPED NAME AND SIGNATURE OF REQUESTING MEDICAL OR DENTAL OFFICER

DATE

TAG CONTENT

LINE NO.	SPACE NUMBER																	
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18
1																		
2																		
3																		
4																		
5																		

REMARKS

TAG DELIVERED TO PATIENT *(Signature of Responsible Officer)*

DATE DELIVERED

PERSON TO CALL IF OTHER THAN PATIENT

NAME AND RELATIONSHIP TO PATIENT

ADDRESS

PHONE NUMBER

PATIENT IDENTIFICATION

ORGANIZATION, UNIT, LOCATION *(Military Pers ONLY)*

HOME ADDRESS *(Include Zip Code)*

PHONE NUMBER

PATIENT'S NAME *(Last, first, middle)*

GRADE OR STATUS

IDENTIFICATION NUMBER