MEDICAL RECOMMENDATION FOR FLYING DUTY

For use of this form, see AR 40–501; the proponent agency is the Office of the Surgeon General

TO: *(Include ZIP Code)*

FROM: *(Include ZIP Code)*

AVIATION HEALTH CLINIC, TMC #5
FT SILL, OK 73503

1. NAME *(Last, First, MI)*	2. SSN	3. GRADE	4. BRANCH	5. TYPE FLYING DUTY PERFORMED

6. ORGANIZATION

CERTIFICATION

(Minimum of three blocks must be checked)

- [x] I certify that I am on flying status according to current orders.
- [ ] I certify that I have an official waiver of medical disqualification for flying duties.
- [x] I certify that I have been notified of the recommendations below and understand the action taken this date.
  - [ ] I have a medical disqualification for flying duty.
  - [x] I am medically qualified to perform flying duties.

(Signature of Airman)

7. MEDICAL CLEARANCE IS GRANTED FOR THE FOLLOWING REQUIREMENT

[X] REPORTING TO NEW STATION [X] MEDICAL EXAMINATION [ ] AFTER AIRCRAFT ACCIDENT

[ ] OTHER *(Give full explanation under REMARKS)*

8. DATE MEDICAL CLEARANCE EXPIRES *(Year, Month, Day)*

9. WAIVERS OF MEDICAL DISQUALIFICATION FOR FLYING DUTY

DIAGNOSIS CODES		
PREFIX	WAIVER CODE	SUFFIX

ACTION RECOMMENDED

DISQUALIFYING ACTIONS	QUALIFYING ACTIONS
10. ESTIMATED DURATION OF INCAPACITY TO FLY *(Give duration in days or months as applicable)*	14. TERMINATION OF MEDICAL RESTRICTION EFFECTIVE *(Year, Month, Day)*
11. MEDICAL RESTRICTION FOLLOWING AIRCRAFT ACCIDENT EFFECTIVE *(Year, Month, Day)*	15. DA TERMINATION OF SUSPENSION EFFECTIVE *(Year, Month, Day)*
12. MEDICAL RESTRICTION EFFECTIVE *(Year, Month, Day)*	16. AIRCREWMAN WAS HOSPITALIZED [ ] YES [ ] NO
13. DA SUSPENSION EFFECTIVE *(Year, Month, Day)*	17. PROFILE [ ] CHANGE *(Check only if changed from last profile)* P U L H E S

REMARKS

TYPED NAME AND GRADE OF FLIGHT SURGEON	SIGNATURE	DATE
DR KEITH RUSSELL CPT, MC, FS [redacted]		

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