MEDICAL EVALUATION

(Must be completed by Licensed Provider)

AUTHORITY: AFI 36-3026
PRINCIPLE PURPOSE: Used for requesting and issuing Agent Letters due to extreme medical hardship (i.e. member is bedridden or unable to leave home) and no other authorized patron is accessible to the member, not issued for patient convenience.
ROUTINE USES: Letters are issued for a period not to exceed (1) year
DISCLOSURE: Voluntary; however, failure to provide information requested may result in denial.

SECTION I	(COMPLETED BY BENEFICIARY/PATIENT)
FULL NAME:	
SSN:	___ - ___ - ____
DOB	
PHYSICAL ADDRESS	
MAILING ADDRESS	
PHONE:	
EMAIL:	
SECTION II	(COMPLETED BY LICENSED PROVIDER)

	(Initial all that apply)		
BEDRIDDEN	___ Yes ___ No		
LEGALLY BLIND	___ Yes ___ No		
PERMANENT or SEVERELY DISABLED	___ Yes ___ No		
ABILITY TO PERFORM Activities of daily living (A.D.L)	___ Yes ___ No		

By signing this form you hereby authorize the licensed provider to discuss and release any medical information to the selected Agent Coordinators. Information obtained **DOES NOT** guarantee an Agent Letter will be issued.

		EMAIL	PHONE	FAX	
□ Yes □ No	NAVAL BASE GUAM	nbg.vcc@fe.navy.mil	339-1480		
□ Yes □ No	ANDERSEN AFB GUAM	36sfs.vcc@us.af.mil	366-5650	N/A	

PATIENT SIGNATURE

LICENSED PROVIDER SIGNATURE		CONTACT		DATE	