MEDICAL RECORD - SUPPLEMENTAL MEDICAL DATA

For use of this form, see requiring document. Form is not valid without Requiring Document, Issuance Date, Local Form Number, and Edition Date.

REQUIRING DOCUMENT *(Title and Number)* OPNAVINST 5100.23 SERIES	ISSUANCE DATE CURRENT EDITION
LOCAL FORM TITLE *(Optional)* ASBESTOS TERMINATION FORM	

BRANCH HEALTH CLINIC PSNS

This employee meets the requirements per OPNAVINST 5100.23 series and 29CFR 1910.1001(l)(5) for the termination examination from the Asbestos Medical Surveillance Program. The last physical examination was performed within the last 1 year period.

Physical was completed on:_____.

Signature/Date:_____

(provider name) (date)

PRACTITIONER'S NAME	PRACTITIONER'S SIGNATURE	DATE
PATIENT'S IDENTIFICATION: *(For typed or written entries, give: Name - last, first, middle; SSN; Sex; Date of Birth; Rank/Grade.)*	HOSPITAL OR MEDICAL FACILITY	STATUS
	DEPARTMENT / SERVICE	RECORDS MAINTAINED AT
	SPONSOR'S NAME	SSN
	RELATIONSHIP TO SPONSOR	

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