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*)	ISSUANCE DATE
DODI 6055.12 / NMCPHC TM-OEM-6260.99-1	03DEC 2010 /15 Sept 2008

LOCAL FORM TITLE *(Optional)*
RECALL FOR HEARING

HEARING RECALLS
"The DD 2216 monitoring sequence should be completed within two weeks,
and cannot exceed 30 days to be considered valid."

Date of original hearing test---(STS):_____

Follow-up No. 1_____

Kept_____

N/S_____

Sent request to C/ 902.3_____

Follow-up No. 2_____

Kept_____

N/S_____

Sent request to C/902.3_____

Not Qualified for 503--Failed to complete sequence.

Qualified for 503_____

Rikki Deblois
Lead Health Technician

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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