

TEMPORARY DISABILITY RETIRED LIST (TDRL) QUESTIONNAIRE

Completion of this form will provide the information required by the Physical Evaluation Board for evaluation of your Periodic Physical Examination as required by SECNAVINST 1850.4E and DODINST 1332.38. *Please print legibly.*

Full Name

Current Mailing Address

Home Telephone:

Work Telephone:

Where have you been receiving medical care for the condition or conditions in which you were initially placed on the TDRL (please provide name of facility and address)?

Have you been diagnosed with any new medical conditions since you were placed on the TDRL?
__ Yes __ No If yes, list the conditions:

Have you been employed during the last 18 months?
__ Yes __ No If yes, list the kind of employment:

How much work have you missed during the last 18 months due to your medical condition?

How does your medical condition affect your activities of daily living?

Have you been attending school?
__ Yes __ No If yes, is it __ Part time or __ Full time

Are there any dates that you will be unavailable to report for a Periodic Physical Examination?
__ Yes __ No If yes, provide dates:

Dates will be considered when scheduling is performed.

Your signature:

Date:

Please obtain your medical records prior to your examination and bring them with you.

Your Periodic Physical Examination will be scheduled after receipt of this completed form.

Mail it to: **COMMANDING OFFICER
MEDICAL BOARDS (Code 09HI)
NAVAL HEALTH CLINIC CHARLESTON
110 NNPTC CIRCLE
GOOSE CREEK, SC 29445**

This information is protected by the Health Insurance Portability and Accountability Act (PL 104-191)