

NAVAL HEALTH CLINIC CHARLESTON  
SICK IN QUARTERS (SIQ)

NAME:	RANK/RATE:	CHCS DoD Identifier Number:
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DEPARTMENT:	DUTY/PHONE:	HOME PHONE:
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PLACED ON SIQ FOR:    HOME Y OR N    BEQ: Y OR N    MTF: Y OR N  
 \_\_\_\_ 24 HOURS    \_\_\_\_ 48 HOURS    \_\_\_\_ 72 HOURS    \_\_\_\_ OTHER \_\_\_\_\_

RETURN TO:	RETURN DATE/TIME:
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NAME: (PRINT) MEDICAL/DENTAL OFFICER	SIGNATURE:
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INFORMATION DESK:	SIGNATURE:
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MEMBER'S SUPERVISOR:	SIGNATURE:
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REMARKS SECTION


I CERTIFY THAT I FULLY UNDERSTAND THE LIMITATIONS OF MY SIQ, THE RECOMMENDATIONS OF MY MEDICAL PROVIDER, AND THE INSTRUCTIONS FOR AFTER CARE. I FURTHER CERTIFY THAT I HAVE A COMPETENT INDIVIDUAL AVAILABLE TO MONITOR MY STATUS WHILE SIQ. I ALSO UNDERSTAND THAT I MUST CHECK WITH MY SUPERVISOR AND TO PROVIDE THEM WITH A COPY OF THIS CHIT PRIOR TO DEPARTURE.

MEMBER'S SIGNATURE: \_\_\_\_\_

DISTRIBUTION:

ORIGINAL:    INFORMATION DESK  
 COPY:        MEMBER'S SUPERVISOR  
 COPY:        MEMBER