

FAMILY MEMBER DEPLOYMENT SCREENING SHEET

For use of this form, see AR 608-75; the proponent agency is OACSIM

DATA REQUIRED BY THE PRIVACY ACT OF 1974

AUTHORITY: Title 10, USC Section 3013.
PRINCIPAL PURPOSE: Personnel support.
ROUTINE USES: To validate family member deployment screening, and to provide gaining command with data to assist in making an assignment decision.
DISCLOSURE: The provision of requested information is mandatory. Failure to respond may preclude successful processing of an application for family member travel/command sponsorship and may lead to appropriate administrative or disciplinary action against the soldier.

PART A - SOLDIER/FAMILY MEMBER DATA

1. NAME OF SOLDIER <i>(Last, first, MI)</i>	2. SOCIAL SECURITY NUMBER	3a. RANK	3b. MOS/BRANCH
4a. HOME ADDRESS	5a. DUTY ADDRESS		6. DATE OF EDAS CYCLE OR RFO <i>(OFF)</i> DATE
4b. HOME PHONE NO. <i>(Include Area Code)</i>	5b. DUTY PHONE NO. a. DSN b. COMMERCIAL <i>(Include area code)</i>		

7. FAMILY MEMBERS

a. NAME	b. RELATIONSHIP	c. DOB <i>(YYYYMMDD)</i>	d. HOME ADDRESS

8. AUTHENTICATION

a. MILITARY PERSONNEL DIVISION/PERSONNEL SERVICE COMPANY REPRESENTATIVE'S NAME	c. RANK <i>(Grade)</i>	d. SIGNATURE
b. TITLE	e. DATE <i>(YYYYMMDD)</i>	

PART B - FAMILY MEMBER SCREENING RESULTS

9. NAME	EXCEPTIONAL FAMILY MEMBER PROGRAM(EFMP) ENROLLMENT <i>(Check one)</i>				
	a. NOT WARRANTED	b. CONSIDERATION WARRANTED <i>(Date sent for Coding)</i>	c. SUBSTANTIAL CHANGE SINCE ENROLLMENT		
			NO	YES	DATE SENT FOR CODING
			<input type="checkbox"/>	<input type="checkbox"/>	
			<input type="checkbox"/>	<input type="checkbox"/>	
			<input type="checkbox"/>	<input type="checkbox"/>	
			<input type="checkbox"/>	<input type="checkbox"/>	
			<input type="checkbox"/>	<input type="checkbox"/>	

10. ARMY MEDICAL TREATMENT FACILITY(MTF) EFMP MEDICAL PRACTITIONER COMPLETING THIS FORM

a. PRINTED NAME OF MEDICAL PRACTITIONER	b. SIGNATURE	c. DATE <i>(YYYYMMDD)</i>
d. ADDRESS	e. PHONE NUMBER <i>(Include Commercial and DSN)</i>	

11. ARMY MTF EFMP PHYSICIAN'S AUTHENTICATION *(To be signed when a medical practitioner other than a physician completes this form.)*

a. TYPED OR PRINTED NAME OF PHYSICIAN	b. TITLE	c. RANK
d. SIGNATURE	e. DATE <i>(YYYYMMDD)</i>	