ARMY RESERVE MEDICAL PROFILE REQUEST PACKET INSTRUCTIONS

1. Completely fill out POC information - top of the AR Medical Profile Request Form.
2. Soldier completes **Standard Form 507 (FCC),** see pages 3 & 4, by electronically filling in (enable all features) PDF fields completely.
3. Soldier obtains the **Personal Physician Letter,** typed on physician's letterhead with signature and date **(NO prescription pad notes)**. Physician portion of FCC 507(bottom of page 4) is not required to be filled out by physician, if physician letter obtained. In most cases, this is easiest to accomplish by working through the Physician's office staff. They can prepare the Physician Letter for signature prior to the patient's arrival.

   The requirements are:
   - **Diagnosis**, the process of determining by examination the nature and circumstances of a diseased condition/the decision reached from such an examination. If no diagnoses provided, on page 3 describe the limiting conditions in question 22 in the space next to 'Diagnosis' on the FCC 507.
   - **Treatments**, the administration or application of remedies to a patient or for a disease or an injury; medicinal or surgical management; therapy.
   - **Prognosis**, the act or art of predicting the course of a disease/the prospect of survival and recovery from a disease as anticipated from the usual course of that disease or indicated by special features of the case.
   - **Any specific physical restrictions**
   - **Time limits**
   - **Note**: The Personal Physician Letter is referenced in the FCC 507 note (section to be completed by the examining provider) and must be submitted with the profile request packet (substitutes for provider completing that section of the FCC 507, if FCC 507 is not available during the exam).
4. Determine if your **PHA** is current (updated on AKO 'my medical'). If your PHA is not current, it is often more expedient to submit supporting medical documentation during the PHA process with LHI. The information submitted with the PHA will generate a new profile.
5. Assemble all the documents and the AR Medical Profile Request Form.
6. Scan any hard-copy document and e-mail with FCC 507 to the Army Reserve Medical Management Center.

   usarmy.usarc.usarc-hq.mbx.armmc@mail.mil

SUBJECT Line your e-mail message as "Profile Request:", Last Name, First Name, and last 4 SSN.

Example - **Profile Request: Snuffy, Joe, 6424**

7. Check your AKO account for the updated medical profile in 7-14 days.
   - **Log onto your AKO and click on My Medical Readiness Status**
   - **Click on DLC "View Detailed Information" in on right side of page**
   - **Click on 'Download My Profiles (DA 3349) under the Forms section**
   - **Find current profile and click on 'View PDF' and open**
   - **Print if necessary**

RSC

ARMY RESERVE MEDICAL PROFILE REQUEST FORM

** MANDATORY Information Fields are ***BOLD*****

NAME: Last, First , MI _____ Rank: _____
SSN: _____ MOS/AOC:_____ TPU:☐ AGR:☐ Other:☐
PHONE: Day: _____ Evening: _____
EMAIL: _____
UNITNAME: _____ UIC: _____
UNIT POC: _____ ***Unit POC Phone:*** _____
UNIT CDR NAME: _____ ***Rank:*** _____ ***Phone:*** _____

Request Profile Type (select one): Initial☐ Extension☐ Change☐ Pregnancy☐
(select one): Temporary ☐ (30-90 days) Permanent ☐

Is the profiled condition service connected/occurred while on duty? NO☐ YES☐
If yes, has an LOD been initiated by the unit? NO☐ YES☐

REQUIRED DOCUMENTATION:

• SF 507, Functional Capacity Certificate

☐ **Soldier** completes questions 1-24, date and sign form
☐ **Personal Physician** completes bottom of second page of SF 507 numbers 1-3. If this section is left blank, this information needs to be included in the physician notes and enclosed in this packet.

• Personal Physician Letter

- **Current** (*dated within last 2 months*), on physician's **official letterhead**. *(Prescription pad notes NOT accepted),* and **signed by the physician**.
- **Letter must include**: (1) Diagnosis, (2) Treatments, (3) Prognosis, (4) any specific physical restrictions, and (5) time limitations.
- **Include** X-ray reports, MRI/CT reports, and/or Lab results if related to the diagnosis.
- **Chiropractor** letter/diagnosis **ONLY** used for **musculoskeletal injuries/issues.**
- **Pregnant Soldiers** must include their expected due date (EDC) and Pregnancy Test date in the letter.

Previous Profiles: NO☐ YES☐ (Include copies of all past profiles in packet)

PHA (Periodic Health Assessment) current and on file? **NO☐ YES☐**

WE DO NOT NEED YOUR ENTIRE MEDICAL RECORD WITH THIS REQUEST. IF ADDITIONAL RECORDS ARE REQUIRED, WE WILL CONTACT YOUR UNIT FOR THEM.

To avoid delays in processing your profile request, please ensure information in this Medical Profile Request packet is accurate, complete, and submitted in accordance with instructions provided.

Today's Date:_____Signature:_____

I represent that the signature above is my own or that I have been legally authorized to affix the signature. I recognize that signing the name of another person to this document without legal authorization may be subject to prosecution. Signature requirements are intended to protect member privacy.

PROFILE REQUEST FORM SUBMISSION INSTRUCTIONS

for AR Operational, Functional, Training & Supporting Commands/Units

- Completely fill-out Functional Capacity Certificate Form 507 (FCC 507)
  - Is number 18 filled out completely?

- Include All Supporting Medical Documentation Regarding the Condition
  - Include Imaging Reports (X-Ray, MRI, CT, etc…)
  - For Behavioral Health Issues, include encounter documentation or statement from counselor /therapist or psychiatrist.

- Supporting Documentation 'MUST' Include:
  - PROVIDER NAME/TITLE, ADDRESS, PHONE NUMBER and DATE.

- If there is a CHANGE (improvement/worsening/intervention)
  - Submit NEW FCC 507 and current medical documentation to the AR-MMC.

*For all medical profile requests, **encrypt**, and e-mail this completed request form and the scanned medical documents supporting the request to:

The Army Reserve Medical Management Center (AR-MMC):
usarmy.usarc.usarc-hq.mbx.armmc@mail.mil

E-mail **Subject Line** will state: **"Profile Request": [Last Name, First Name, and last 4 of SSN]"** for example:

Profile Request: Snuffy, Joe, 4321

For questions or to speak to your case management team, call:

AR-MMC Toll-free Phone: 1-877-891-3281, 'main menu' option 4.

FUNCTIONAL CAPACITY CERTIFICATE FORM 507 (FCC 507)

NSN 7540-00-634-4120

NOTE: TO BE COMPLETED BY SERVICE MEMBER. PLEASE READ QUESTIONS CAREFULLY.
Answer all questions by placing an X in the appropriate block. This information constitutes an Official Statement. Certain medical conditions and/or limitations may indicate need for further evaluation and/or additional information and/or change in Profile and/or referral to Medical Evaluation Board (MEB), Non-Duty Related Physical Evaluation Board(NDR-PEB) and/or Military Occupational Specialty Medical Board (Military Occupational Specialty Administrative Retention Review).

1.	Are you able to carry and fire an individual assigned weapon?	☐ YES	☐ NO
	If NO, what is the medical condition that prevents you from doing so?		
2.	Are you able to evade direct and indirect fire if the enemy is shooting at you?	☐ YES	☐ NO
	If NO, what is the medical condition that prevents you from doing so?		
3.	Are you able to ride in a military vehicle for at least 12 hours per day?	☐ YES	☐ NO
	If NO, what is the medical condition that prevents you from doing so?		
4.	Are you able to wear a helmet for at least 12 hours per day?	☐ YES	☐ NO
	If NO, what is the medical condition that prevents you from doing so?		
5.	Are you able to wear body armor for at least 12 hours per day?	☐ YES	☐ NO
	If NO, what is the medical condition that prevents you from doing so?		
6.	Are you able to wear load bearing equipment?	☐ YES	☐ NO
	If NO, what is the medical condition that prevents you from doing so?		
7.	Are you able to wear military boots and uniform for at least 12 hours per day?	☐ YES	☐ NO
	If NO, what is the medical condition that prevents you from doing so?		
8.	Are you able to wear protective mask and MOPP 4 for at least 2 continuous hours per day?	☐ YES	☐ NO
	If NO, what is the medical condition that prevents you from doing so?		
9.	Are you able to move 40 lbs (e.g., duffle bag) while wearing usual protective gear (helmet, weapon, body armor, and LBE) at least 100 yds?	☐ YES	☐ NO
	If limited, what is the maximum distance you can lift and carry?		
	If NO, what is the medical condition that prevents you from doing so?		
10.	Are you able to live in an austere environment without worsening your medical condition(s) or behavioral health problem(s)? There may be environmental hazards (heat, cold, altitude, aerosol particles), limited access to electricity, and prolonged use of body armor and/or chemical protection equipment may be required.	☐ YES	☐ NO
	If NO, what is the medical condition that prevents you from doing so?		
11.	The following 4 questions are related to the Army Physical Fitness Test (APFT).	☐ YES	☐ NO
	Are you able to run or jog 2 miles?		
	If NO, what is the medical condition that prevents you from doing so?		
	If you cannot perform the APFT 2 mile run, you must perform an aerobic alternate APFT.		
	Indicate all aerobic alternate APFT events you can perform: ☐ Walk [2] ☐ Swim [2] ☐ Bicycle [2]		
	I cannot perform the APFT 2 mile run or any alternate aerobic APFT events (walk, swim, bike).	☐ YES	
12.	Are you able to do APFT sit-ups?	☐ YES	☐ NO
	If NO, what is the medical condition that prevents you from doing so?		
13.	Are you able to do APFT push-ups?	☐ YES	☐ NO
	If NO, what is the medical condition that prevents you from doing so?		
14.	Have you been diagnosed with asthma? If YES, answer all questions below. If NO, go to #15.	☐ YES	☐ NO
	a. Have you been admitted to a hospital, visited an emergency department, or lost time from work due to asthma and/or asthma related conditions? ☐ Yes ☐ No If YES, how many? _____ Admissions _____ Emergency Department Visits _____ Lost Work Days		
	b. Have you taken oral and/or inhaler steroid medications for your asthma in the past 12 months? ☐ Yes ☐ No If YES, how many times? _____ x daily _____ x weekly _____ x monthly		
	c. If you can use your inhaler beforehand, would your asthma still prevent you from taking and passing the APFT 2 mile run event? ☐ Yes ☐ No		
	d. Does your asthma prevent you from wearing a protective mask? ☐ Yes ☐ No		

Name: _____ SSN: _____ Unit: _____

Address: _____

Email: _____

Medical Record
STANDARD FORM 507 (7-91)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-9.202-1
**U.S. GOVERNMENT PRINTING OFFICE: 2000-560-042/20030*

FUNCTIONAL CAPACITY CERTIFICATE FORM 507 (FCC 507)

15.	Do you have a medical condition that requires any breathing assistive device and/or supplemental oxygen?	☐ YES	☐ NO
	If YES, what is the medical condition and length of time device used (e.g., 12 months)?		
16.	Have you been treated for any behavioral health condition in the past 12 months?	☐ YES	☐ NO
	If YES, what is the condition?		
17.	Do you take any medication to control your blood sugar?	☐ YES	☐ NO
	If YES, indicate type: ☐ Pills ☐ Shots List Medication Names:		
18.	Do you currently take any prescription and/or non prescription medications?	☐ YES	☐ NO
	If YES, specify medications and medical conditions:		
19.	Have you ever had a medical board? ☐ MEB ☐ PEB ☐ MMRB	☐ YES	☐ NO
	If YES, date: _____ PULHES? _____		
	If YES, what is (are) the medical conditions evaluated?		
	What is (are) the recommended limitation(s) stated by the Board?		
	Please attach a copy of your board results and the board profile including any DA Form 199, DA Form 3349.		
20.	Do you currently have a permanent profile?	☐ YES	☐ NO
	If YES, what is the date of issue (month/day/year)?		
	What is (are) the medical conditions? _____		
	What is (are) the recommended limitations?		
21.	Do you currently have a temporary profile?	☐ YES	☐ NO
	If YES, what is the date of issue (month/day/year)?		
	What is (are) the medical conditions? _____		
	What is (are) the recommended limitations?		
22.	Have you been evaluated by a medical provider for the limitations reported?	☐ YES	☐ NO
	If YES, date of evaluation: _____ Diagnosis:		
23.	Are the reported limitations due to a duty related condition?	☐ YES	☐ NO
	If YES, do you have a copy of your Line of Duty DA Form 2173? ☐ Yes ☐ No		
24.	Do you have health insurance?	☐ YES	☐ NO

Service Member Signature: _____ Date (month/day/year): _____

NOTE: THE FOLLOWING SECTION MAY BE COMPLETED AND SIGNED BY THE EXAMINING PROVIDER. ALL INFORMATION MUST BE LEGIBLE, INCLUDING THE SIGNATURE.

1. **Provider's Findings:** List all current diagnoses with respective current physical limitations. If no current physical limitations, indicate "none."

_____

_____

2. **Provider's Statement:** I have reviewed this Service Member's Functional Capacity Certificate (FCC 507) and ☐ CONCUR ☐ DO-NOT-CONCUR with Service Member's Self Assessment. Check one and explain any DO-NOT-CONCUR.

_____

_____

3. Limitations are: ☐ Permanent ☐ Temporary If Temporary, expected duration of limitation is _____ days.

NOTE: IF ABOVE SECTION IS NOT COMPLETED AND SIGNED BY EXAMINING PROVIDER, A PERSONAL PHYSICIAN LETTER (WITH PHYSICIAN LETTER HEAD - NO PRESCRIPTION PAD NOTES) MUST ACCOMPANY PROFILE REQUEST PACKET WHEN SUBMITTED.

Provider Full Name (Print or Type): _____ Date (month/day/year): _____

Provider Full Signature: _____ Provider Degree (MD, PA-C, etc.) _____

Provider Medical Speciality or Specialties: _____

Telephone No. with Area Code: _____ Fax No. with Area Code: _____

Name: _____ SSN: _____ Unit: _____

Address: _____

Email: _____

Medical Record
STANDARD FORM 507 (7-91)
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**U.S. GOVERNMENT PRINTING OFFICE: 2000-560-042/20030*