CIVILIAN PROVIDER AF469 REQUEST FORM

SERVICE MEMBER DEMOGRAPHICS: **PRP/FLYER?** ☐ Yes ☐ No

LAST NAME _____ **FIRST NAME** _____ **MI**_____

AFSC_____ **DOB** _____ **SSN/DOD ID#** _____

MEDICAL PROVIDER: **DATE OF VISIT:**_____/_____/_____

DIAGNOSIS:

(1) ICD 10 CODE:_____ **DIAGNOSIS**_____

(2) ICD 10 CODE:_____ **DIAGNOSIS**_____
(IF NEEDED)

(3) ICD 10 CODE:_____ **DIAGNOSIS**_____
(IF NEEDED)

ANTICIPATED RETURN TO FULL DUTY DATE: (Profile end date)

DIAGNOSIS 1:_____/_____/_____ **DIAGNOSIS 2:**_____/_____/_____ **DIAGNOSIS 3:**_____/_____/_____

SELECT THE FOLLOWING AS APPLICABLE:

BODY COMPOSITION AND FITNESS RESTRICTIONS Can member perform:

Yes	No	Item	Expiration:
☐	☐	1.5 Mile Run Assessment	
☐	☐	High Aerobic Multi-shuttle Run	
☐	☐	2k Walk Assessment	
☐	☐	Push-up Assessment	
☐	☐	Hand Release Push-ups	
☐	☐	Sit-Up Assessment	
☐	☐	Cross-leg Reverse Crunch Plank	
☐	☐	Participate in Unit PT	
☐	☐	Waist Measurement	

☐ No running more than _____ yards
☐ No bending/twisting at the waist
☐ No marching/standing in formation
☐ No standing more than _____ minutes
☐ No crawling/kneeling/stooping
☐ May wear/use surgical aftercare device/shoe in uniform
☐ Unable to operate in austere environment
☐ Administrative duties only

MOBILITY RESTRICTIONS:

☐ Needs more than 30 days of supervised care
☐ Do Not Arm

(*Requires additional approval from local Medical Group, send justification documents)

☐ Other:_____

**Please complete and return to your assigned or nearest MTF. When the AF469 is created/completed scan this form in to the service member's medical record.

CLINIC NAME/CONTACT NUMBER:

PROVIDER SIGNATURE/STAMP: