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:

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

☐ No Running ☐ No Walking ☐ No Push-Ups ☐ No Sit-ups ☐ Abdominal Measurement Exemption*

OTHER RESTRICTIONS: (Check any that apply)

☐ No lifting more than _____ pounds with ☐ Right ☐ Left upper extremity (extremities)

☐ No running more than _____ yards ☐ No standing more than _____ minutes

☐ No bending/twisting at the waist ☐ No crawling/kneeling/stooping

☐ No marching/standing in formation ☐ May wear/use surgical aftercare device/shoe in uniform

☐ Other:_____

(PLEASE BE AS SPECIFIC AS POSSIBLE WHEN USING THE OTHER LINE, MAY USE BACK OF FORM AS NEEDED)

MOBILITY RESTRICTIONS:

☐ Needs more than 30 days of supervised care ☐ Unable to operate in austere environment

☐ Do Not Arm ☐ Administrative duties only

CLINIC NAME/CONTACT NUMBER: **PROVIDER SIGNATURE/STAMP:**

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.