RCMC-M/T Statement of Medical Condition and Treatment Plan

OFFICE SYMBOL DATE

Physician please note: This document will be reviewed by Board Members who are Health Care Providers. This document must be typed or legibly written.

Soldier's Name: _____
Last Four SSN: _____

Provider (Print Name):_____

Current Medical Diagnosis/Diagnoses:_____
ICD-9 codes for each diagnosis or condition:_____

Management Plan:
*Provide a detailed current treatment plan for each diagnosis, including non-invasive care, surgical options, and physical therapy with frequency and length of sessions, estimated duration and end date. The following information **MUST** be completed:*

1. **Date of Surgery (if applicable):** _____
2. **Diagnosis and Prognosis:** _____
3. **Days/Week required for Care:** _____
4. **Number of Weeks required for Care:** _____

Explain necessity for Active Duty order (To include level of disability, home care treatment/physical therapy, medications, and other scheduled medical appointments).
_____
_____
_____
_____
_____

Return to Duty With Physical Limitations: Return to Full Duty:
_____

Attending Physician's Full Name: _____
Grade or Rank, if applicable: _____
Contact information: _____

Signature: _____ **Date**: _____

****This form must be submitted with every initial and amendment RCMC-M/T packet***