

Applicant Instructions for Completing Standard Forms 88 and 93 (v19-06 WSG)

PLEASE PRINT USING UPPERCASE LETTERS ONLY while completing these forms—do not use cursive or lowercase. Complete this form by first printing it out (if you do not already have a hard copy) and then fill it out by hand using the following instructions.

Note: Depending on how these forms are printed, there may be additional questions for you on the back a given sheet. Please check and complete as necessary.

Standard Form 88 (SF 88):

Note 1: Parts 2 and 3 are intentionally missing.

Note 2: Parts 12a and 12b are already filled in for you.

- On Page 1 fill out Parts 1-13 ONLY. Leave “DATE OF EXAM” and the rest of the page blank.
- On Page 2 fill out “NAME” exactly as you filled in Part 1 on Page 1. Leave the rest of the page blank.

Standard Form 93 (SF 93):

Note 1: Parts 2 and 3 are intentionally missing.

Note 2: Part 6 is already filled in for you.

- Fill out Parts 1-24 ONLY. Leave the rest of the form blank. Be sure to sign and date Part 24.

After you have completed your portion of both forms:

- Give these two completed forms (SF 88 and SF 93) along with the following Physician Instructions to your physician for him/her to complete.

After your physician has completed their portions of both forms:

- Upon receipt of the completed Standard Form 88 from your physician, please check that they checked the appropriate box in Part 46 and has signed and dated Part 48 of the form.
- Also check that on the completed Standard Form 93 that your physician signed and dated Part 26 of the form. If either form is not done correctly, your application will be rejected.
- Make a copy of these forms (not the instructions) and give/send it to your WSG Recruiter. DO NOT send/give your original forms to your Recruiter. Instead keep those for your records.

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Physician Instructions for Completing Standard Forms 88 and 93 (v19-06 WSG)

PLEASE PRINT USING UPPERCASE LETTERS ONLY while completing these forms—do not use cursive or lowercase. Complete this form by first printing it out (if you do not already have a hard copy) and then fill it out by hand using the following instructions.

Note: Depending on how these forms are printed, there may be additional questions for you on the back a given sheet. Please check and complete as necessary.

Standard Form 88 (SF 88):

Note 1: Parts 2-3, 18-19, 24-41, and 45 are intentionally missing.

Note 2: Parts 1-13 should already be filled out by your patient.

- Fill out the “DATE OF EXAM” in the upper right corner of Page 1.
- Complete Parts 14-48 as applicable. Be sure to check the appropriate box in Part 46 and sign at Part 48.
- If additional documentation is included, note the number of pages for such at “NO. OF SHEETS ATTACHED” located at the top right side of the second page.

Standard Form 93 (SF 93):

Note 1: Parts 2 and 3 are intentionally missing.

Note 2: Parts 1-24 should already be filled out by your patient.

- After reviewing your patient’s answers to Parts 1-23, note any appropriate comments you may have in Part 25. Be sure to sign and date Part 26.

After you have completed your portion of both forms:

- Return both completed forms (four pages) to your patient.

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1. LAST NAME - FIRST NAME - MIDDLE			
4. HOME ADDRESS (Number, street or RFD, city or town, state and ZIP Code)		5. EMERGENCY CONTACT (Name and address of contact)	
6. DATE OF BIRTH	7. AGE	8. SEX <input type="checkbox"/> FEMALE <input type="checkbox"/> MALE	9. RELATIONSHIP OF CONTACT
10. PLACE OF BIRTH		11. RACE <input type="checkbox"/> WHITE <input type="checkbox"/> BLACK <input type="checkbox"/> AMERICAN INDIAN/ ALASKA NATIVE <input type="checkbox"/> HISPANIC WHITE <input type="checkbox"/> HISPANIC BLACK <input type="checkbox"/> ASIAN/PACIFIC ISLANDER	
12a. AGENCY WASHINGTON MILITARY DEPARTMENT		12b. ORGANIZATION UNIT WASHINGTON STATE GUARD (WSG/VSG)	
		13. TOTAL YEARS GOVERNMENT SERVICE a. MILITARY b. CIVILIAN	
14. NAME OF EXAMINING FACILITY OR EXAMINER, AND ADDRESS		15. RATING OR SPECIALTY OF EXAMINER	
		16. PURPOSE OF EXAMINATION ENLISTMENT	

17. CLINICAL EVALUATION

NOR-MAL	(Check each item in appropriate column, enter "NE" if not evaluated)	ABNOR-MAL	NOR-MAL	(Check each item in appropriate column, enter "NE" if not evaluated)	ABNOR-MAL
	A. HEAD, FACE, NECK AND SCALP			O. PROSTATE (Over 40 or clinically indicated)	
	B. EARS - GENERAL (INTERNAL CANALS) <i>(Auditory acuity under items 39 and 40)</i>			P. TESTICULAR	
	C. DRUMS (<i>Perforation</i>)			Q. ANUS AND RECTUM (<i>Hemorrhoids, Fistulae</i>) (<i>Hemocult Results</i>)	
	D. NOSE			R. ENDOCRINE SYSTEM	
	E. SINUSES			S. G-U SYSTEM	
	F. MOUTH AND THROAT			T. UPPER EXTREMITIES (<i>Except feet</i>) (<i>Strength, range of motion</i>)	
	G. EYES - GENERAL (<i>Visual acuity and refraction under items 28, 29, and 36</i>)			U. FEET	
	H. OPHTHALMOSCOPIC			V. LOWER EXTREMITIES (<i>Except feet</i>) (<i>Strength, range of motion</i>)	
	I. PUPILS (<i>Equality and reaction</i>)			W. SPINE, OTHER MUSCULOSKELETAL	
	J. OCULAR MOTILITY (<i>Associated parallel movements nystagmus</i>)			X. IDENTIFYING BODY MARKS, SCARS, TATTOOS	
	K. LUNGS AND CHEST			Y. SKIN, LYMPHATICS	
	L. HEART (<i>Thrust, size, rhythm, sounds</i>)			Z. NEUROLOGIC (<i>Equilibrium tests under item 41</i>)	
	M. VASCULAR SYSTEM (<i>Varicosities, etc.</i>)			AA. PSYCHIATRIC (<i>Specify any personality deviation</i>)	
	N. ABDOMEN AND VISCERA (<i>Include hernia</i>)			BB. BREASTS	
				CC. PELVIC (<i>Females only</i>)	

NOTES: (Describe every abnormality in detail. Enter pertinent item number before each comment. Continue in item 42 and use additional sheets if necessary)

NAME

NO. OF SHEETS ATTACHED

MEASUREMENTS AND OTHER FINDINGS

20. HEIGHT	21. WEIGHT	22. COLOR HAIR	23. COLOR EYES
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42. NOTES (Continued) AND SIGNIFICANT OR INTERVAL HISTORY

(Use additional sheets if necessary)

43. SUMMARY OF DEFECTS AND DIAGNOSES (List diagnoses with item numbers)

44. RECOMMENDATIONS - FURTHER SPECIALIST EXAMINATIONS INDICATED (Specify)

46. EXAMINEE (Check)

A IS QUALIFIED FOR

ADMINISTRATIVE DUTIES

B IS NOT QUALIFIED FOR

47. IF NOT QUALIFIED, LIST DISQUALIFYING DEFECTS BY ITEM NUMBER

48. TYPED OR PRINTED NAME OF PHYSICIAN

SIGNATURE



MEDICAL RECORD	REPORT OF MEDICAL HISTORY	DATE OF EXAM
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NOTE: This information is for official and medically-confidential use only and will not be released to unauthorized persons

1. NAME OF PATIENT (Last , first, middle)				
4a. HOME STREET ADDRESS (Street or RFD; City or Town; State; and ZIP Code)		5. EXAMINING FACILITY		
4b. CITY	4 c. STATE	4 d. ZIP CODE		
6. PURPOSE OF EXAMINATION				

ENLISTMENT

7. STATEMENT OF PATIENT'S PRESENT HEALTH AND MEDICATIONS CURRENTLY USED (Use additional pages if necessary)

a. PRESENT HEALTH	b. CURRENT MEDICATION	REGULAR OR INTERM.
c. ALLERGIES (Include insect bites/stings and common foods)		
	d. HEIGHT	e. WEIGHT
8. PATIENT'S OCCUPATION	9. ARE YOU (Check one)	
	<input type="checkbox"/> RIGHT HANDED <input type="checkbox"/> LEFT HANDED	

10. PAST/CURRENT MEDICAL HISTORY

CHECK EACH ITEM	YES	NO	DON'T KNOW	CHECK EACH ITEM	YES	NO	DON'T KNOW	CHECK EACH ITEM	YES	NO	DON'T KNOW
Household contact with anyone with tuberculosis				Shortness of breath				Bone, joint or other deformity			
Tuberculosis or positive TB test				Pain or pressure in chest				Loss of finger or toe			
Blood in sputum or when coughing				Chronic cough				Painful or "trick" shoulder or elbow			
Excessive bleeding after injury or dental work				Palpitation or pounding heart				Recurrent back pain or any back injury			
Suicide attempt or plans				Heart trouble				"Trick" or locked knee			
Sleepwalking				High or low blood pressure				Foot trouble			
Wear corrective lenses				Cramps in your legs				Nerve Injury			
Eye surgery to correct vision				Frequent indigestion				Paralysis (including infantile)			
Lack vision in either eye				Stomach, liver or intestinal trouble				Epilepsy or seizure			
Wear a hearing aid				Gall bladder trouble or gallstones				Car, train, sea or air sickness			
Stutter or stammer				Jaundice or hepatitis				Frequent trouble sleeping			
Wear a brace or back support				Broken bones				Depression or excessive worry			
Scarlet fever				Adverse reaction to medication				Loss of memory or amnesia			
Rheumatic fever				Skin diseases				Nervous trouble of any sort			
Swollen or painful joints				Tumor, growth, cyst, cancer				Periods of unconsciousness			
Frequent or severe headaches				Hernia				Parent/sibling with diabetes, cancer, stroke or heart disease			
Dizziness or fainting spells				Hemorrhoids or rectal disease				X-ray or other radiation therapy			
Eye trouble				Frequent or painful urination				Chemotherapy			
Hearing loss				Bed wetting since age 12				Asbestos or toxic chemical exposure			
Recurrent ear infections				Kidney stone or blood in urine				Plate, pin or rod in any bone			
Chronic or frequent colds				Sugar or albumin in urine				Easy fatigability			
Severe tooth or gum trouble				Sexually transmitted diseases				Been told to cut down or criticized for alcohol use			
Sinusitis				Recent gain or loss of weight				Used illegal substances			
Hay fever or allergic rhinitis				Eating disorder (anorexia bulimia, etc.)				Used tobacco			
Head injury				Arthritis, Rheumatism, or Bursitis							
Asthma				Thyroid trouble or goiter							

11. FEMALES ONLY

CHECK EACH ITEM	YES	NO	DON'T KNOW	DATE OF LAST MENSTRUAL PERIOD	DATE OF LAST PAP SMEAR	DATE OF LAST MAMMOGRAM
Treated for a female disorder						
Change in menstrual pattern						

CHECK EACH ITEM. IF "YES" EXPLAIN IN BLANK SPACE TO RIGHT. LIST EXPLANATION BY ITEM NUMBER.

ITEM	YES	NO
12. Have you been refused employment or been unable to hold a job or stay in school because of:		
a. Sensitivity to chemicals, dust, sunlight, etc.		
b. Inability to perform certain motions.		
c. Inability to assume certain positions.		
d. Other medical reasons (If yes, give reasons.)		
13. Have you ever been treated for a mental condition? (If yes, specify when, where, and give details.)		
14. Have you ever been denied life insurance? (If yes, state reason and give details.)		
15. Have you had, or have you been advised to have, any operation. (If yes, describe and give age at which occurred.)		
16. Have you ever been a patient in any type of hospital? (If yes, specify when, where, why, and name of doctor and complete address of hospital.)		
17. Have you consulted or been treated by clinics, physicians, healers, or other practitioners within the past 5 years for other than minor illnesses? (If yes, give complete address of doctor, hospital, clinic, and details.)		
18. Have you ever been rejected for military service because of physical, mental, or other reasons? (If yes, give date and reason for rejection.)		
19. Have you ever been discharged from military service because of physical, mental, or other reasons? (If yes, give date, reason, and type of discharge; whether honorable, other than honorable, for unfitness or unsuitability.)		
20. Have you ever received, is there pending, or have you ever applied for pension or compensation for existing disability? (If yes, specify what kind, granted by whom, and what amount, when, why.)		
21. Have you ever been arrested or convicted of a crime, other than minor traffic violations. (If yes, provide details.)		
22. Have you ever been diagnosed with a learning disability? (If yes, give type, where, and how diagnosed.)		

23. LIST ALL IMMUNIZATIONS RECEIVED

I certify that I have reviewed the foregoing information supplied by me and that it is true and complete to the best of my knowledge. I authorize any of the doctors, hospitals, or clinics mentioned above to furnish the Government a complete transcript of my medical record for purposes of processing my application for this employment or service. I understand that falsification of information on Government forms is punishable by fine and/or imprisonment.

24a. TYPED OR PRINTED NAME OF EXAMINEE	24b. SIGNATURE X	24 c. DATE
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25. PHYSICIAN'S SUMMARY AND ELABORATION OF ALL PERTINENT DATA (Physician shall comment on all positive answers in Items 7 through 11. Physician may develop by interview any additional medical history deemed important, and record any significant findings here.)

26a. TYPED OR PRINTED NAME OF PHYSICIAN OR EXAMINER	26b. SIGNATURE X	26 c. DATE
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