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| **New York State Division of Military and Naval Affairs**  **State Active Duty Line of Duty Statement of Medical Examination and Duty Status**  (Form replaces DA Form 2173, Oct. 72 and DA Form 689, Mar. 63) | | | | | | |
| **SECTION I: To be completed by Patient or appropriate designee.** | | | | | | |
| **1.** Name of Individual examined: (Last, First, Middle Initial) | | | | **2.** SSN Last 4: | | **3.** GRADE/RANK |
| **4.** Organization and Station: | | | | **5.** Accident/Incident/Illness Occurred: | | |
| a. DATE | | b. PLACE *(city and state)* |
| **SECTION II: To be completed by attending physician or hospital patient administrator.** | | | | | | |
| **6.** INDIVIDUAL WAS:  🞏 Outpatient  🞏 Admitted  🞏 Dead on Arrival | | **7.** NAME & ADDRESS OF HOSPITAL/TREATMENT FACILITY:  🞏 CIVILIAN 🞏 MILITARY | | | | |
| **8.** TIME & DATE TREATED/ADMITTED: | | **9.** NATURE OF INCIDENT:  🞏 INJURY 🞏DISEASE 🞏ILLNESS | | | | |
| **10.** EXPLANATION OF ACCIDENT, INJURY, ILLNESS OR DISEASE: (how, where, when, what, etc.)  **NOTE: Progress Notes, to include diagnosis and prognosis, MUST be provided to patient at time of treatment.** | | | | | | |
| **11.** EXTENT OF ISSIUE: 🞏 TREATABLE/RECOVERABLE 🞏 RESULTED IN DEATH    🞏 POTENTIAL/DEFINITE LONG TERM IMPACT WHERE THE FOLLOWING DISABILITY MAY RESULT:  🞏 TEMPORARY 🞏 PERMANENT PARTIAL 🞏 PERMANENT TOTAL | | | | | | |
| **12.** PROFESSIONAL MEDICAL OPINION (answer where possible/applicable): **INDIVIDUAL:**  a. 🞏 WAS 🞏 WAS NOT under the influence of alcohol. (Please specify if “WAS”):  b. 🞏 WAS 🞏 WAS NOT under the influence of drugs. (Please specify if “WAS”):  c. 🞏 WAS 🞏 WAS NOT mentally sound (Attach Psychiatric evaluation if appropriate). | | | | | | |
| **13.** Blood Alcohol test made: 🞏 YES 🞏 NO | | | **14.** If tested: Number of MG Alcohol/100 ML Blood | | | |
| **15.** DISPOSITION OF PATIENT:  🞏 RETURN TO DUTY WITHOUT RESTRICTIONS.  🞏 MAY NOT RETURN TO DUTY UNTIL \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(list date of return).  🞏 OTHER (Specify): | | | **16.** FOLLOW-UP CARE:  🞏 No follow-up care necessary at this time.  🞏 Follow-up care required. Explain/When:  🞏 Follow-up care recommended. Explain/When: | | | |
| **17.** OTHER REMARKS: | | | | | | |
| **18.** DATE: | **19.** TYPED OR PRINTED NAME OF ATTENDING PHYSICIAN OR PATIENT ADMINISTRATOR | | | | **20.** SIGNATURE: | |