RECOMMENDATION FOR FLYING OR SPECIAL OPERATIONAL DUTY - DENTAL

(THIS FORM IS SUBJECT TO THE PRIVACY ACT OF 1974 - Use blanket PAS - DD Form 2005)

TO:	FROM:	DATE/TIME OF TREATMENT

NAME *(Last, First, Middle Initial)*	GRADE	SSN	ORGANIZATION

DIAGNOSIS	TREATMENT
MEDICATION ADMINISTERED *Local anesthesia:* ☐ *YES* ☐ *NO* *Other:*	MEDICATION PRESCRIBED

☐ RECOMMEND NO PARTICIPATION IN FLYING OR SPECIAL OPERATIONAL DUTY FOR ______ HOURS OR ______ DAYS.

☐ PATIENT TO RETURN TO CLINIC FOR FOLLOW-UP EVALUATION ON ____________ .

☐ RECOMMEND RETURN TO FLYING OR SPECIAL OPERATIONAL DUTY. ☐ FSO NOTIFIED BY PHONE.

TYPED OR PRINTED NAME AND GRADE OF DENTAL OFFICER	SIGNATURE	DATE

I CERTIFY that i understand the above recommendation.

SIGNATURE OF PATIENT	DATE

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