DEPARTMENT OF HEALTH AND HUMAN SERVICES
Public Health Service Commissioned Corps

# SUPPLEMENTAL MEDICAL HISTORY RECORD REQUIRED OF APPLICANTS TO OR OFFICERS OF THE PUBLIC HEALTH SERVICE COMMISSIONED CORPS

(This information is for official and medically confidential use only and will not be released to unauthorized persons.)
*(See Privacy Act Statement for Form PHS-6379)*

*(Please Print)*

| Last Name | First Name | Middle Initial | Social Security No. |
|---|---|---|---|
| | | | |

EVERY ITEM CHECKED "YES" MUST BE FULLY EXPLAINED IN THE BLANK SPACE PROVIDED BELOW.

DO YOU NOW OR HAVE YOU EVER:

| *YES* | *NO* | |
|---|---|---|
| ☐ | ☐ | 1. had a high risk exposure to HIV (AIDS virus)? |
| ☐ | ☐ | 2. had a positive test for HIV antibody (test positive for AIDS virus infection)? |
| ☐ | ☐ | 3. used without prescription: marijuana, cocaine, hashish, narcotics, stimulants, depressants, hallucinogenics, steroids, inhalants, or other dangerous or illegal drugs? |
| ☐ | ☐ | 4. felt you ought to cut down on your drinking? |
| ☐ | ☐ | 5. had people criticized your drinking? |
| ☐ | ☐ | 6. felt bad or guilty about your drinking? |
| ☐ | ☐ | 7. had a drink first thing in the morning to steady your nerves or get rid of a hangover? |
| ☐ | ☐ | 8. had alcohol or other substance use ever interfere with your performance or attendance at school or work? |
| ☐ | ☐ | 9. had alcohol or other substance use cause you to have an accident or contribute to your arrest? |
| ☐ | ☐ | 10. had a history of alcohol or drug or substance abuse? |
| ☐ | ☐ | 11. had, or been advised to have, evaluation or treatment for alcohol or drug or substance abuse? |

ANY/ALL OTHER CONDITIONS:

| | | |
|---|---|---|
| ☐ | ☐ | 12. had any illness/injury other than those noted on form DD-2807-1, "Report of Medical History," which may require future evaluation and treatment? If yes, please specify when and where and provide details in the space below. |

*Note: If you are uncertain whether a medical condition will require evaluation or treatment in the future, please list it so that the Medical Evaluation Staff, Division of Commissioned Corps Personnel & Readiness, can determine its significance.*

EXPLAIN IN DETAIL ALL "YES" RESPONSES TO QUESTIONS HERE: *(Use reverse side if necessary)*

I certify that I have reviewed all information supplied on this form and that it is true and complete to the best of my knowledge. (Nondisclosure or falsification can be cause for disqualification or termination of appointment.)

| Applicant Signature | Date |
|---|---|
| | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Public Health Service Commissioned Corps

# Privacy Act Statement
# PHS-6379 "Supplemental Medical History Record Required of Applicants to the Public Health Service Commissioned Corps"

*Authority:*
Our authority to collect this information is 42 U.S.C. 202 et seq and Executive Order 10450.

*Purpose and Use of Information* : The information you provide on this form will be used to determine whether you meet the medical standards that apply to Public Health Service (PHS) Commissioned Corps officers. This is a critical evaluation because you must be physically and mentally fit to perform satisfactorily in national or worldwide health and defense emergencies. In addition, the information will be used to begin monitoring your health and fitness for duty on an ongoing basis if you are appointed. It may be provided to other Federal Agencies that furnish you medical care, when needed to ensure continuity of care or to evaluate your eligibility for benefits from that Agency based on your medical condition. It may also be provided to health care practitioners in the private sector in the event you receive emergency medical care or to ensure continuity of care.

In very rare circumstances this information may be provided to: a congressional office at your request; officials of this Department or the Department of Justice to prepare an effective defense when the Department or any of its employees are the subject of litigation; or your legal guardian if you are found mentally incompetent by a court of law.

More information about how these records are maintained is contained in the Privacy Act System Notice of Records number 09-40-0002, "PHS Commissioned Corps Medical Records," HHS/PSC/HRS, a copy of which may be obtained from the office to which you submit this form.

*Information Regarding Disclosure of Your Social Security Number (SSN)*: Disclosure of the SSN is mandatory under provisions of the Social Security Act, since PHS Commissioned Corps officers are under social security covered employment and taxes must be withheld from their salaries. The SSN is also used as an identifier throughout an officer's career. It is used primarily to identify an officer's personnel, leave, and pay records and to related one to the other. The SSN is also used in connection with lawful requests for information from former employers, educational institutions, and financial or other organizations. The information gathered through the use of the number will be used only as necessary in personnel administration processes carried out in accordance with established regulations and published notices of systems of records. The use of the SSN is made necessary because of the large number of present and former active, inactive, and retired officers and applicants who have identical names and birth dates, and whose identities can only be distinguished by the SSN.

*Effects of Nondisclosure*: Failure to provide the information requested on these forms will eliminate your application from further consideration. If you withhold or falsify information about your medical condition, your appointment will be terminated, you will lose any benefits provided to you based on the false information, and you may be subject to criminal or civil prosecution.