OMB No. xxxx-xxxx; OMB approval expires xx/xx/xx

Department of Health and Human Services
Commissioned Corps of the U.S. Public Health Service
Offi ce of Commissioned Corps Operations
ATTN: Medical Evaluations Offi cer
Suite 100, Plaza Level
1101 Wootton Parkway
Rockville, MD 20852

INJURY QUESTIONNAIRE

NAME	SOCIAL SECURITY NUMBER

INSTRUCTIONS: Please complete the following questions regarding history of injury(ies). *Note:* It is intended that this form be completed online as a link to a 'Yes' answer on Item 50, Item 51, or Item 52 of form PHS-7060, Report of Medical History. In the event an applicant to the Commissioned Corps of the U.S. Public Health Service cannot complete this form online, the applicant must complete the form in paper format and mail it to the Offi ce of Commissioned Corps Operations at the above address and mark envelope "To be Opened by Medical Personnel Only." If more space is needed (for versions of this form without expandable fi elds), please use the applicable area on page 2.

PRIVACY ACT STATEMENT

AUTHORITY: 42 U.S.C. 202 et seq. and Executive Order 9397.

RECORDS SYSTEM: 09-40-0002, "PHS Commissioned Corps Medical Records," HHS/PSC/HRS.

PRINCIPAL PURPOSE: To determine medical acceptability or update a medical fi le as part of the application process to the Commissioned Corps of the U.S. Public Health Service.

ROUTINE USES: None.

DISCLOSURE: Voluntary; however, failure to furnish the requested information will impede the selection process and hamper an applicant's candidacy. Use of the Social Security Number is used for positive identifi cation of records.

1. What was/were the specifi c injury(ies)?

2. When did the injury(ies) occur?

3. Please describe how the injury(ies) occurred?

4. How was/were the injury(ies) treated?

5. How long did the treatment last, (e.g., 2 weeks, 6 weeks, 2 months, 6 months, etc.)?

6. Did you or do you now require any external supports, (e.g., knee braces, lifts, ankle taping, etc.)?

☐ Yes ☐ No If yes, please explain:

7. Have you ever been restricted from activities secondary to your injury(ies)?

☐ Yes ☐ No If yes, please explain:

(Continued)

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SPORTS INJURY QUESTIONNAIRE ***(Continued)***

8. Please provide information regarding the extent of your athletic activities during the last 12 months?

9. Please provide any additional pertinent information:

CONTINUED ANSWERS TO PRECEDING QUESTIONS *(If needed when form version does not have expandable fi elds. Please specify question(s))*

CERTIFICATION: By signing below, I hereby certify that all the preceding information is true and accurate to the best of my knowledge.

APPLICANT SIGNATURE	DATE