



RESERVE HEALTH READINESS PROGRAM
USAR HISTORICAL UPDATE REQUEST FORM

SERVICE MEMBER INFORMATION (Required): <i>Must be completed by Service member or military authority</i>				
LAST NAME, FIRST NAME, MI:		DATE OF BIRTH:	FULL SSN:	PHONE NUMBER:
Is the Service member a Health Care Worker? <input type="checkbox"/> Yes <input type="checkbox"/> No		Was the Service member born in the United States? <input type="checkbox"/> Yes <input type="checkbox"/> No		
<input type="checkbox"/> Check box if Service member has separated from Service. <i>(Records for separated Service members will be scanned into HRR. Medpros will NOT be updated)</i>				
DENTAL UPDATE: <i>Select the services you would like to update (Check all that apply)</i>				
<input type="checkbox"/> DD2813		<input type="checkbox"/> DENTAL X-RAYS		
DENTAL SUBMIT TO: HistoricalUpdates-Dental@logisticshealth.com Fax: (608) 793-2960 Phone: (800) 666-2833, extension 2030				
MEDICAL UPDATE: <i>Select the services you would like to update (Check all that apply)</i>				
<i>Documentation required to update the following:</i>				
<input type="checkbox"/> IMMUNIZATIONS		<input type="checkbox"/> G6PD	<input type="checkbox"/> SICKLE CELL	
<input type="checkbox"/> VISION SCREENING		<input type="checkbox"/> BLOOD TYPE	<input type="checkbox"/> PREGNANCY - ESTIMATED DUE DATE:	
<input type="checkbox"/> IMMUNIZATION EXCEPTIONS - <i>Documentation required with provider signature</i> Immunization type: _____ Expiration date: _____ <input type="checkbox"/> Medical temporary <input type="checkbox"/> Medical permanent <input type="checkbox"/> Immune <input type="checkbox"/> Assumed				
<input type="checkbox"/> MEDICATIONS Does the Service member have a 180 day supply of prescribed medication(s)? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A, the Service member does not require prescription medication(s)				
<input type="checkbox"/> MEDICAL WARNING TAGS Does the Service member have required medical warning tags in his/her possession? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A, the Service member does not require medical warning tags				
<input type="checkbox"/> HEARING AID BATTERIES Does the Service member have hearing aid batteries in his/her possession? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A, the Service member does not require a hearing aid				
MEDICAL SUBMIT TO: HistoricalUpdates@logisticshealth.com Fax: (888) 888-8476 Phone: (800) 666-2833, extension 3586				
REQUESTOR INFORMATION				
NAME (PLEASE PRINT):		TITLE:		
EMAIL (CONFIRMATION EMAIL WILL BE SENT):		PHONE NUMBER:	RELATIONSHIP TO SERVICE MEMBER:	
SIGNATURE:				DATE:
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