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COMMISSIONING INFORMATION - FOR ALL HEALTH PROFESSIONS APPLICANTS*(This IMT is subject to the Privacy Act of 1974 - Use blanket PAS - AF IMT 883)*TO HQ AFRS/RSOC
550 D STREET WEST STE 1
RANDOLPH AFB TX 78150-4527

FROM (Recruiting Office and Address)

_____, _____, was commissioned an officer in the United States Air Force,
(Name, Last, First, Middle Initial) (SSN)
on _____ (Date)**SECTION I. PURPOSE**

To obtain updated information to be used in the preparation of EAD orders, completion of commissioning certificates, verify compliance with Air Force height and weight standards, and to determine COT class start dates for HPSP students, It also provides guidance to the applicant on Air Force policy in regard to updating licensure and professional privileges from time of selection to EAD.

SECTION II. AIR FORCE HEIGHT AND WEIGHT STANDARDS

HEIGHT	MAXIMUM WEIGHT	ACTUAL WEIGHT	BODY FAT PERCENTAGE

SECTION III. STATUS STATEMENT

My status (personal, physical, dependency, legal, moral, etc.) has not changed since completing my application and I agree to immediately notify the United States Air Force of any change in my status to include pregnancy, academic standing, etc. which may affect my eligibility to enter on active duty. I understand if I have a change in my medical, legal, personal, moral status that fail to meet the other requirements of my commissioning, the Air Force may withdraw my commission.

INITIALS**SECTION IV. PERSONAL DATA**

HOME OF RECORD (RFD or Box Number, Street, City, State, and Zip Code)	MAIL ORDERS TO (RFD or Box Number, Street, City, State and Zip Code)

DEPART FOR EAD FROM (RFD or Box Number, Street, City, State, and Zip Code)	CURRENT TELEPHONE NUMBER (Include Area Code)

NOTE: If you have a change of address within the next 30-45 days, contact HQ AFPC/DPAMF - Toll Free 1-800-531-5811.

SECTION V. HPSP/FAP INFORMATION ONLY

Immediately after commissioning, contact AFIT/CIMJ, DSN 785-5824, Commercial Number (937)255-5824 or Toll Free 800-543-3490 and obtain the

COT CLASS DATE	AFIT CONTROL NUMBER	AFIT OFFICIAL CONTACTED

SECTION VI. STATEMENT OF UNDERSTANDING - ALL HEALTH CARE PROVIDERS

I, _____, agree to immediately notify the United States Air Force in writing in the event any of my privileges or state licenses are surrendered, suspended, revoked, curtailed or encumbered prior to entry onto active duty with the Air Force. I also agree to notify the Air Force in writing of any malpractice claims brought to my attention prior to my entry on active duty. I understand that this information is vital to any decision to order me to active duty and that a failure on my part to report the events outlined above can be used as a basis

FORWARD WRITTEN CORRESPONDENCE TO:

HQ AFRS/RSOC
550 D STREET WEST STE 1
RANDOLPH AFB TEXAS 78150-4527
Toll free telephone number: 1-800-443-4690

DATE	SIGNATURE OF APPLICANT

SECTION VII. REMARKS

(If address for pickup of household goods is different from block IV, list that address in this block)	FAX NUMBER

SECTION VIII. TO BE COMPLETED BY COMMISSIONING OFFICIAL/OFFICER

DATE	PRINTED NAME, GRADE & TELEPHONE NUMBER OF COMMISSIONING OFFICIAL/OFFICER	SIGNATURE