

FAMILY MEMBER DEPLOYMENT SCREENING SHEET

For use of this form, see AR 608-75; the proponent agency is OACSIM

DATA REQUIRED BY THE PRIVACY ACT OF 1974

AUTHORITY: Title 10, USC Section 3013.
PRINCIPAL PURPOSE: Personnel support.
ROUTINE USES: To validate family member deployment screening, and to provide gaining command with data to assist in making an assignment decision.
DISCLOSURE: The provision of requested information is mandatory. Failure to respond may preclude successful processing of an application for family member travel/command sponsorship and may lead to appropriate administrative or disciplinary action against the soldier.

PART A - SOLDIER/FAMILY MEMBER DATA

1. NAME OF SOLDIER <i>(Last, first, MI)</i> DOE, JOHN	2. SOCIAL SECURITY NUMBER 123456789	3a. RANK SGT	3b. MOS/BRANCH 88M
4a. HOME ADDRESS In The Barracks Camp Humphreys	5a. DUTY ADDRESS At the Unit Camp Humphreys		6. DATE OF EDAS CYCLE OR RFO (OFF) DATE
4b. HOME PHONE NO. <i>(Include Area Code)</i> 01023456789	5b. DUTY PHONE NO. a. DSN 757-1234 b. COMMERCIAL <i>(Include area code)</i>		

7. FAMILY MEMBERS

a. NAME	b. RELATIONSHIP	c. DOB (YYYYMMDD)	d. HOME ADDRESS
My Spouse	Spouse	2000101	In the Home, Somewhere USA, 12345
My First Child	Son	20200401	In the Home, Somewhere USA, 12345
My Second Child	Daughter	20240801	In the Home, Somewhere USA, 12345
My Last Child	Daughter	20250201	In the Home, Somewhere USA, 12345

8. AUTHENTICATION

a. MILITARY PERSONNEL DIVISION/PERSONNEL SERVICE COMPANY REPRESENTATIVE'S NAME MPD SIGNATURE WILL AUTO POPULATE	c. RANK <i>(Grade)</i> KN	d. SIGNATURE MPD will sign here
b. TITLE MPD CS Team will receive package, sign, then it will go to MEDCOM		e. DATE (YYYYMMDD) 20260429

PART B - FAMILY MEMBER SCREENING RESULTS

9. NAME	EXCEPTIONAL FAMILY MEMBER PROGRAM(EFMP) ENROLLMENT <i>(Check one)</i>				
	a. NOT WARRANTED	b. CONSIDERATION WARRANTED <i>(Date sent for Coding)</i>	c. SUBSTANTIAL CHANGE SINCE ENROLLMENT		
			NO	YES	DATE SENT FOR CODING
My Spouse	X		<input checked="" type="checkbox"/>	<input type="checkbox"/>	
My First Child	X		<input checked="" type="checkbox"/>	<input type="checkbox"/>	
My Second Child	X		<input checked="" type="checkbox"/>	<input type="checkbox"/>	
My Last Child		X	<input type="checkbox"/>	<input checked="" type="checkbox"/>	
			<input type="checkbox"/>	<input type="checkbox"/>	
			<input type="checkbox"/>	<input type="checkbox"/>	

10. ARMY MEDICAL TREATMENT FACILITY(MTF) EFMP MEDICAL PRACTITIONER COMPLETING THIS FORM

a. PRINTED NAME OF MEDICAL PRACTITIONER The physician will print their name here	b. SIGNATURE The physician will sign here	c. DATE (YYYYMMDD) 20260429
d. ADDRESS The field may or may not be blank	e. PHONE NUMBER <i>(Include Commercial and DSN)</i> This field may or may not be blank	

11. ARMY MTF EFMP PHYSICIAN'S AUTHENTICATION *(To be signed when a medical practitioner other than a physician completes this form.)*

a. TYPED OR PRINTED NAME OF PHYSICIAN This section is often blank and only required if the 10a is NOT a physician	b. TITLE	c. RANK
d. SIGNATURE This section is often blank and only required if the 10a is NOT a physician	e. DATE (YYYYMMDD)	

An EFMP stamp is not required as block 10/11 bears the EFMP provider's info and signature