| RECOMMENDATION FOR FLYING OR SPECIAL OPERATIONAL DUTY - DENTAL | | | | | | | |
|---|-----------|-----------------------|-----|------------------------|--------------|--|--|
| (THIS FORM IS SUBJECT TO THE PRIVACY ACT OF 1974 - Use blanket PAS - DD Form 2005) | | | | | | | |
| TO: | FROM: | | | DATE/TIME OF TREATMENT | | | |
| NAME (Last, First, Middle Initial) | | GRADE | SSN | | ORGANIZATION | | |
| DIAGNOSIS | | TREATMENT | | | | | |
| MEDICATION ADMINISTERED Local anesthesia: YES NO Other: | | MEDICATION PRESCRIBED | | | | | |
| RECOMMEND NO PARTICIPATION IN FLYING OR SPECIAL OPERATIONA | | | | HOURS OR | DAYS. | | |
| PATIENT TO RETURN TO CLINIC FOR FOLLOW-UP EVALUATION ON | | | | | | | |
| RECOMMEND RETURN TO FLYING OR SPECIAL OPERATIONAL DUTY. FSO NOTIFIED BY PHONE. | | | | | | | |
| TYPED OR PRINTED NAME AND GRADE OF DENTAL OFFICER | SIGNATURE | | | | DATE | | |
| I CERTIFY that i understand the above recommendation. | | | | | | | |
| SIGNATURE OF PATIENT | | | | | DATE | | |
| AF IMT 1418, 20171213, V2 PREVIOUS EDITIONS ARE OBSOLETE. Copy 1 - Flight Medicine via Me | | | | | | | |

| RECOMMENDATION FOR FLYING OR SPECIAL OPERATIONAL DUTY - DENTAL (THIS FORM IS SUBJECT TO THE PRIVACY ACT OF 1974 - Use blanket PAS - DD Form 2005) | | | | | | | | |
|--|-----------|-----------|-----------------------|--------------------------|--------------|--|--|--|
| TO: | FROM: | | | DATE/TIME OF TREATMENT | | | | |
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| NAME (Last, First, Middle Initial) | | GRADE | SSN | | ORGANIZATION | | | |
| | | | | | | | | |
| DIAGNOSIS | | TREATMENT | | | | | | |
| | | | | | | | | |
| | | | | | | | | |
| MEDICATION ADMINISTERED | | | MEDICATION PRESCRIBED | | | | | |
| Local anesthesia: YES NO | | | | | | | | |
| Other: | | | | | | | | |
| | | | | | | | | |
| RECOMMEND NO PARTICIPATION IN FLYING OR SPECIAL OPERATION/ | | | | HOURS OR | DAYS. | | | |
| PATIENT TO RETURN TO CLINIC FOR FOLLOW-UP EVALUATION ON | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |
| TYPED OR PRINTED NAME AND GRADE OF DENTAL OFFICER | SIGNATURE | | | | DATE | | | |
| | | | | | | | | |
| I CERTIFY that i understand the above recommendation. | | | | | | | | |
| SIGNATURE OF PATIENT | | | | | DATE | | | |
| | | | | | | | | |
| AF IMT 1418, 20171213, V2 PREVIOUS EDITIONS ARE OBSOLETE. Copy 2 - Flight Medicine via Me | | | | | | | | |
| AF IM I 1418, 20171213, V2 PREVIOUS EDITIONS ARE OBSOLETE. Copy 2 - Flight Medicine via Membe | | | | | | | | |

| RECOMMENDATION FOR FLYING OR SPECIAL OPERATIONAL DUTY - DENTAL (THIS FORM IS SUBJECT TO THE PRIVACY ACT OF 1974 - Use blanket PAS - DD Form 2005) | | | | | | | |
|--|--------|-----------------------|------------------------|-----|--|--|--|
| | FROM: | | DATE/TIME OF TREATMENT | | | | |
| 10. | FROM: | | | | | | |
| | | | | | | | |
| | | | | | | | |
| NAME (Last, First, Middle Initial) | | GRADE | SSN | | ORGANIZATION | | |
| | | | | | | | |
| DIACNOSIS | | TREATMENT | | | | | |
| DIAGNOSIS | | IREATMENT | | | | | |
| | | | | | | | |
| | | | | | | | |
| MEDICATION ADMINISTERED | | MEDICATION PRESCRIBED | | | | | |
| Local anesthesia: YES NO | | | | | | | |
| Other: | | | | | | | |
| | | | | | | | |
| RECOMMEND NO PARTICIPATION IN FLYING OR SPECIAL OPERATIONAL DUTY FOR HOURS OR DAYS. | | | | | | | |
| PATIENT TO RETURN TO CLINIC FOR FOLLOW-UP EVALUATION ON | | | | | | | |
| RECOMMEND RETURN TO FLYING OR SPECIAL OPERATIONAL DUTY. | | | | | | | |
| TYPED OR PRINTED NAME AND GRADE OF DENTAL OFFICER SIGNATU | | RE | | | DATE | | |
| | | | | | | | |
| | | | | | | | |
| I CERTIFY that i understand the above recommendation. | | | | | | | |
| SIGNATURE OF PATIENT | | | | | DATE | | |
| | | | | | | | |
| AF IMT 1418, 20171213, V2 | PREVIC | US EDITIONS | ARE OBSOLETE | . C | I Copy 3 - Flight Medicine via Member | | |