

Physical Exam - DA Form 2807, 2808, labs and hearing test required. Must be conducted after 6 June 2025.

-2807 - Make sure you answer 14c correctly

-2808 - Ensure blocks 53-66 are completed and the form is signed by a physician on the last page.

- Include scanned hearing test and official lab results to include **HIV, urinalysis, urine drug screen, Ethanol level and HCG (pregnancy test for females)**. If the provider has documented a date AND result on the 2808 for HIV, that is acceptable, but the other labs require the scanned lab print out.

- If you need a medical waiver, you will have to submit **ALL** medical documentation associated with the diagnosis as well as a specialist provider's clearance for the waiver to be processed. Start collecting these documents now!

Profile

Profile - (If applicable) - submit copy of profile. P3 profiles are not eligible to apply. P2 profiles with a P2 in the P, H, and E category are considered for a waiver by the SP Corps leadership on a case by case basis. P2 profiles with a P2 in the U, L, S category are not eligible for a waiver. Temporary profiles are considered for a waiver on a case by case basis.

REPORT OF MEDICAL HISTORY

OMB No. 0704-0413
OMB approval expires
September, 30 2021

(This information is for official and medically confidential use only and will not be released to unauthorized persons.)

The public reporting burden for this collection of information is estimated to average 10 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding the burden estimate or burden reduction suggestions to the Department of Defense, Washington Headquarters Services, at wha.mc-alex.esd.mbx.d4-dod-information-collections@mail.mil. Respondents should be aware that notwithstanding any other provision of law, no person shall be subject to any penalty for failing to comply with a collection of information if it does not display a currently valid OMB control number. PLEASE DO NOT RETURN YOUR FORM TO THE ABOVE ORGANIZATION. RETURN COMPLETED FORM AS INDICATED ON PAGE 2.

PRIVACY ACT STATEMENT

AUTHORITY: 10 U.S.C. 136, Under Secretary Of Defense For Personnel And Readiness; DoD Directive 1145.2, United States Military Entrance Processing Command; DoD Instruction 6130.03, Medical Standards for Appointment, Enlistment, or Induction in the Military Services; and E.O. 9397 (SSN), as amended.
PRINCIPAL PURPOSE(S): The primary collection of this information is from individuals seeking to join the Armed Forces. The information collected on this form is used to assist DoD physicians in making determinations as to acceptability of applicants for military service and verifies disqualifying medical condition(s) noted on the prescreening form (DD 2807-2). An additional collection of information using this form occurs when a Medical Evaluation Board is convened to determine the medical fitness of a current member and if separation is warranted.
ROUTINE USE(S): The Routine Uses are listed in the applicable system of records notice found at: <http://dpcid.defense.gov/Privacy/SORN/index/DOD-wide-SORN-Article-View/Article/570661/a0601-270-usmepcom-dod/>
DISCLOSURE: Voluntary; however, failure by an applicant to provide the information may result in delay or possible rejection of the individual's application to enter the Armed Forces. An applicant's SSN is used during the recruitment process to keep all records together and when requesting civilian medical records. For an Armed Forces member, failure to provide the information may result in the individual being placed in a non-deployable status. The SSN of an Armed Forces member is to ensure the collected information is filed in the proper individual's record.

WARNING: The information you have given constitutes an official statement. Federal law provides severe penalties (up to 5 years confinement or a \$10,000 fine or both), to anyone making a false statement.

1. LAST NAME, FIRST NAME, MIDDLE NAME (SUFFIX)	2.a. SOCIAL SECURITY NO.	b. DoD ID NO. (If applicable)	3. TODAY'S DATE (YYYYMMDD)
4.a. HOME ADDRESS (Street, Apartment No., City, State, and ZIP Code)	5. EXAMINING LOCATION AND ADDRESS (Include ZIP Code)		
b. HOME TELEPHONE (Include Area Code)			
c. EMAIL ADDRESS			

X ALL APPLICABLE BOXES:			7.a. POSITION (Title, Grade, Component)
6.a. SERVICE <input type="checkbox"/> Army <input type="checkbox"/> Coast Guard <input type="checkbox"/> Navy <input type="checkbox"/> Marine Corps <input type="checkbox"/> Air Force	6.b. COMPONENT <input type="checkbox"/> Regular <input type="checkbox"/> Reserve <input type="checkbox"/> National Guard	6.c. PURPOSE OF EXAMINATION <input type="checkbox"/> Retention <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Separation <input type="checkbox"/> Medical Board <input type="checkbox"/> Retirement	b. USUAL OCCUPATION
8. CURRENT MEDICATIONS (Prescription and Over-the-counter)			9. ALLERGIES (Including insect bites/stings, foods, medicine or other substance)

Mark each item "YES" or "NO". Every item marked "YES" must be fully explained in Item 29 on Page 2.

HAVE YOU EVER HAD OR DO YOU NOW HAVE:	YES	NO	12. (Continued)	YES	NO
10.a. Tuberculosis	<input type="radio"/>	<input type="radio"/>	f. Foot trouble (e.g., pain, corns, bunions, etc.)	<input type="radio"/>	<input type="radio"/>
b. Lived with someone who had tuberculosis	<input type="radio"/>	<input type="radio"/>	g. Impaired use of arms, legs, hands, or feet	<input type="radio"/>	<input type="radio"/>
c. Coughed up blood	<input type="radio"/>	<input type="radio"/>	h. Swollen or painful joint(s)	<input type="radio"/>	<input type="radio"/>
d. Asthma or any breathing problems related to exercise, weather, pollens, etc.	<input type="radio"/>	<input type="radio"/>	i. Knee trouble (e.g., locking, giving out, pain or ligament injury, etc.)	<input type="radio"/>	<input type="radio"/>
e. Shortness of breath	<input type="radio"/>	<input type="radio"/>	j. Any knee or foot surgery including arthroscopy or the use of a scope to any bone or joint	<input type="radio"/>	<input type="radio"/>
f. Bronchitis	<input type="radio"/>	<input type="radio"/>	k. Any need to use corrective devices such as prosthetic devices, knee brace(s), back support(s), lifts or orthotics, etc.	<input type="radio"/>	<input type="radio"/>
g. Wheezing or problems with wheezing	<input type="radio"/>	<input type="radio"/>	l. Bone, joint, or other deformity	<input type="radio"/>	<input type="radio"/>
h. Been prescribed or used an inhaler	<input type="radio"/>	<input type="radio"/>	m. Plate(s), screw(s), rod(s) or pin(s) in any bone	<input type="radio"/>	<input type="radio"/>
i. A chronic cough or cough at night	<input type="radio"/>	<input type="radio"/>	n. Broken bone(s) (cracked or fractured)	<input type="radio"/>	<input type="radio"/>
j. Sinusitis	<input type="radio"/>	<input type="radio"/>	13.a. Frequent indigestion or heartburn	<input type="radio"/>	<input type="radio"/>
k. Hay fever	<input type="radio"/>	<input type="radio"/>	b. Stomach, liver, intestinal trouble, or ulcer	<input type="radio"/>	<input type="radio"/>
l. Chronic or frequent colds	<input type="radio"/>	<input type="radio"/>	c. Gall bladder trouble or gallstones	<input type="radio"/>	<input type="radio"/>
11.a. Severe tooth or gum trouble	<input type="radio"/>	<input type="radio"/>	d. Jaundice or hepatitis (liver disease)	<input type="radio"/>	<input type="radio"/>
b. Thyroid trouble or goiter	<input type="radio"/>	<input type="radio"/>	e. Rupture/hernia	<input type="radio"/>	<input type="radio"/>
c. Eye disorder or trouble	<input type="radio"/>	<input type="radio"/>	f. Rectal disease, hemorrhoids or blood from the rectum	<input type="radio"/>	<input type="radio"/>
d. Ear, nose, or throat trouble	<input type="radio"/>	<input type="radio"/>	g. Skin diseases (e.g. acne, eczema, psoriasis, etc.)	<input type="radio"/>	<input type="radio"/>
e. Loss of vision in either eye	<input type="radio"/>	<input type="radio"/>	h. Frequent or painful urination	<input type="radio"/>	<input type="radio"/>
f. Worn contact lenses or glasses	<input type="radio"/>	<input type="radio"/>	i. High or low blood sugar	<input type="radio"/>	<input type="radio"/>
g. A hearing loss or wear a hearing aid	<input type="radio"/>	<input type="radio"/>	j. Kidney stone or blood in urine	<input type="radio"/>	<input type="radio"/>
h. Surgery to correct vision (RK, PRK, LASIK, etc.)	<input type="radio"/>	<input type="radio"/>	k. Sugar or protein in urine	<input type="radio"/>	<input type="radio"/>
12.a. Painful shoulder, elbow or wrist (e.g. pain, dislocation, etc.)	<input type="radio"/>	<input type="radio"/>	l. Sexually transmitted disease (syphilis, gonorrhea, chlamydia, genital warts, herpes, etc.)	<input type="radio"/>	<input type="radio"/>
b. Arthritis, rheumatism, or bursitis	<input type="radio"/>	<input type="radio"/>	14.a. Adverse reaction to serum, food, insect stings or medicine	<input type="radio"/>	<input type="radio"/>
c. Recurrent back pain or any back problem	<input type="radio"/>	<input type="radio"/>	b. Recent unexplained gain or loss of weight	<input type="radio"/>	<input type="radio"/>
d. Numbness or tingling	<input type="radio"/>	<input type="radio"/>	c. Currently in good health (If no, explain in Item 29 on Page 2.)	<input type="radio"/>	<input type="radio"/>
e. Loss of finger or toe	<input type="radio"/>	<input type="radio"/>	d. Tumor, growth, cyst, or cancer	<input type="radio"/>	<input type="radio"/>

LAST NAME, FIRST NAME, MIDDLE NAME (SUFFIX)	SOCIAL SECURITY NUMBER	DoD ID NUMBER (If applicable)
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Mark each item "YES" or "NO". Every item marked "YES" must be fully explained in Item 29 below.

HAVE YOU EVER HAD OR DO YOU NOW HAVE:	YES	NO	YES	NO
15.a. Dizziness or fainting spells	<input type="radio"/>	<input type="radio"/>		
b. Frequent or severe headache	<input type="radio"/>	<input type="radio"/>		
c. A head injury, memory loss or amnesia	<input type="radio"/>	<input type="radio"/>		
d. Paralysis	<input type="radio"/>	<input type="radio"/>		
e. Seizures, convulsions, epilepsy or fits	<input type="radio"/>	<input type="radio"/>		
f. Car, train, sea, or air sickness	<input type="radio"/>	<input type="radio"/>		
g. A period of unconsciousness or concussion	<input type="radio"/>	<input type="radio"/>		
h. Meningitis, encephalitis, or other neurological problems	<input type="radio"/>	<input type="radio"/>		
16.a. Rheumatic fever	<input type="radio"/>	<input type="radio"/>		
b. Prolonged bleeding (as after an injury or tooth extraction, etc.)	<input type="radio"/>	<input type="radio"/>		
c. Pain or pressure in the chest	<input type="radio"/>	<input type="radio"/>		
d. Palpitation, pounding heart or abnormal heartbeat	<input type="radio"/>	<input type="radio"/>		
e. Heart trouble or murmur	<input type="radio"/>	<input type="radio"/>		
f. High or low blood pressure	<input type="radio"/>	<input type="radio"/>		
17.a. Nervous trouble of any sort (anxiety or panic attacks)	<input type="radio"/>	<input type="radio"/>		
b. Habitual stammering or stuttering	<input type="radio"/>	<input type="radio"/>		
c. Loss of memory or amnesia, or neurological symptoms	<input type="radio"/>	<input type="radio"/>		
d. Frequent trouble sleeping	<input type="radio"/>	<input type="radio"/>		
e. Received counseling of any type	<input type="radio"/>	<input type="radio"/>		
f. Depression or excessive worry	<input type="radio"/>	<input type="radio"/>		
g. Been evaluated or treated for a mental condition	<input type="radio"/>	<input type="radio"/>		
h. Attempted suicide	<input type="radio"/>	<input type="radio"/>		
i. Used illegal drugs or abused prescription drugs	<input type="radio"/>	<input type="radio"/>		
18. FEMALES ONLY. Have you ever had or do you now have:				
a. Treatment for a gynecological (female) disorder	<input type="radio"/>	<input type="radio"/>		
b. A change of menstrual pattern	<input type="radio"/>	<input type="radio"/>		
c. Any abnormal PAP smears	<input type="radio"/>	<input type="radio"/>		
d. First day of last menstrual period (YYYYMMDD)				
e. Date of last PAP smear (YYYYMMDD)				
19. Have you been refused employment or been unable to hold a job or stay in school because of:				
a. Sensitivity to chemicals, dust, sunlight, etc.	<input type="radio"/>	<input type="radio"/>		
b. Inability to perform certain motions	<input type="radio"/>	<input type="radio"/>		
c. Inability to stand, sit, kneel, lie down, etc.	<input type="radio"/>	<input type="radio"/>		
d. Other medical reasons (If yes, give reasons.)	<input type="radio"/>	<input type="radio"/>		
20. Have you ever been treated in an Emergency Room? (If yes, for what?)	<input type="radio"/>	<input type="radio"/>		
21. Have you ever been a patient in any type of hospital? (If yes, specify when, where, why, and name of doctor and complete address of hospital.)	<input type="radio"/>	<input type="radio"/>		
22. Have you ever had, or have you been advised to have any operations or surgery? (If yes, describe and give age at which occurred.)	<input type="radio"/>	<input type="radio"/>		
23. Have you ever had any illness or injury other than those already noted? (If yes, specify when, where, and give details.)	<input type="radio"/>	<input type="radio"/>		
24. Have you consulted or been treated by clinics, physicians, healers, or other practitioners within the past 5 years for other than minor illnesses? (If yes, give complete address of doctor, hospital, clinic, and details.)	<input type="radio"/>	<input type="radio"/>		
25. Have you ever been rejected for military service for any reason? (If yes, give date and reason for rejection.)	<input type="radio"/>	<input type="radio"/>		
26. Have you ever been discharged from military service for any reason? (If yes, give date, reason, and type of discharge; whether honorable, other than honorable, for unfitness or unsuitability.)	<input type="radio"/>	<input type="radio"/>		
27. Have you ever received, is there pending, or have you ever applied for pension or compensation for any disability or injury? (If yes, specify what kind, granted by whom, and what amount, when, why.)	<input type="radio"/>	<input type="radio"/>		
28. Have you ever been denied life insurance?	<input type="radio"/>	<input type="radio"/>		

29. EXPLANATION OF "YES" ANSWER(S) (Describe answer(s), give date(s) of problem, name of doctor(s) and/or hospital(s), treatment given and current medical status.)

NOTE: HAND TO THE DOCTOR OR NURSE, OR IF MAILED MARK ENVELOPE "TO BE OPENED BY MEDICAL PERSONNEL ONLY."

LAST NAME, FIRST NAME, MIDDLE NAME (SUFFIX)	SOCIAL SECURITY NUMBER	DoD ID NUMBER (If applicable)
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30. EXAMINER'S SUMMARY AND ELABORATION OF ALL PERTINENT DATA (Physician/practitioner shall comment on all positive answers in questions 10 - 29. Physician/practitioner may develop by interview any additional medical history deemed important, and record any significant findings here.)

a. COMMENTS

b. TYPED OR PRINTED NAME OF EXAMINER (Last, First, Middle Initial)	c. SIGNATURE	d. DATE SIGNED (YYYYMMDD)
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REPORT OF MEDICAL EXAMINATION			1. DATE OF EXAMINATION (YYYYMMDD)		2a. SOCIAL SECURITY NUMBER		2b. DoD ID NUMBER (if applicable)		
PRIVACY ACT STATEMENT									
<p>AUTHORITY: 10 U.S.C. 504, Persons not qualified; 10 U.S.C. 505, Regular components: qualifications, term, grade; 10 U.S.C. 507, Extension of enlistment for members needing medical care or hospitalization; 10 U.S.C. 532, Qualifications for original appointment as a commissioned officer; 10 U.S.C. 978, Drug and alcohol abuse and dependency; testing of new entrants; 10 U.S.C. 1201, Regulars and members on active duty for more than 30 days: retirement; 10 U.S.C. 1202, Regulars and members on active duty for more than 30 days: temporary disability retired list; 10 U.S.C. 4348, Cadets: requirements for admission; DoD Directive 1145.2, United States Military Entrance Processing Command; E.O. 9397 (SSN) and 10 U.S.C. 1204, Members on Active Duty for 30 Days or Less or on Inactive Duty Training: Retirement, as amended.</p> <p>PRINCIPAL PURPOSE(S): To obtain medical data for determination of medical fitness for enlistment, induction, appointment and retention for applicants and members of the Armed Forces. The information will also be used for medical boards and separation of Service members from the Armed Forces.</p> <p>ROUTINE USE(S): The Routine Uses are listed in the applicable system of records notice found at: http://dpcdd.defense.gov/Privacy/SORNAIndex/DOD-wide-SORN-Article-View/Article/570861/a0601-270-usmepcom-dod/</p> <p>DISCLOSURE: Voluntary; however, failure by an applicant to provide the information may result in delay or possible rejection of the individual's application to enter the Armed Forces. For an Armed Forces member, failure to provide the information may result in the individual being placed in a non-deployable status.</p>									
3. LAST NAME - FIRST NAME - MIDDLE NAME (Suffix)			4. HOME ADDRESS (Street, Apartment Number, City, State and Zip Code)			5a. HOME TELEPHONE NUMBER (Include Area Code)		5b. E-MAIL ADDRESS	
6. GRADE/RANK	7. DATE OF BIRTH (YYYYMMDD)	8. AGE	9a. BIRTH SEX <input type="checkbox"/> Male <input type="checkbox"/> Female	9b. PREFERRED GENDER <input type="checkbox"/> Male <input type="checkbox"/> Female	10a. ETHNIC CATEGORY <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Non Hispanic/Latino		10b. RACIAL CATEGORY (Select one) <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> Asian <input type="checkbox"/> White		
11. TOTAL YEARS GOVERNMENT SERVICE a. MILITARY b. CIVILIAN		12. AGENCY (Non-Service Members Only)			13. ORGANIZATION UNIT AND UIC/CODE				
14a. RATING OR SPECIALTY (Aviators Only)			14b. TOTAL FLYING TIME			14c. LAST SIX MONTHS			
15a. SERVICE <input type="checkbox"/> Army <input type="checkbox"/> Air Force <input type="checkbox"/> Marine Corps <input type="checkbox"/> Navy <input type="checkbox"/> Coast Guard		15b. COMPONENT <input type="checkbox"/> Active Duty <input type="checkbox"/> Reserve <input type="checkbox"/> National Guard		15c. PURPOSE OF EXAMINATION <input type="checkbox"/> Enlistment <input type="checkbox"/> Commission <input type="checkbox"/> Retention <input type="checkbox"/> Separation <input type="checkbox"/> Other		15d. Retirement <input type="checkbox"/> U.S. Service Academy <input type="checkbox"/> ROTC Scholarship Program <input type="checkbox"/> Medical Board		16. NAME OF EXAMINING LOCATION, AND ADDRESS (Include Zip Code)	
MEDICAL EVALUATION (Check each item in appropriate column. Enter "NE" if not evaluated.)						43. DENTAL DEFECTS AND DISEASE (Please explain. Use dental form if completed by dentist. If abnormality noted, explain in item 44.)			
						Acceptable <input type="checkbox"/>			
						Not Acceptable <input type="checkbox"/>			
						Class _____			
						44. NOTES: (Mandatory comment for every abnormality identified in items 17 - 43. Enter pertinent item number before each comment. Continue comments or use drawings in item 89 and use additional sheets if necessary.)			
17. Head, face, neck and scalp						Normal	Abnormal	NE	
18. Nose									
19. Sinuses									
20. Mouth and throat									
21. Ears - General (Int. and ext. canals/Auditory acuity under item 71)									
22. Tympanic Membranes (Perforation)									
23. Eyes - General									
24. Ophthalmoscopic									
25. Pupils (Equality and reaction)									
26. Ocular motility (Associated parallel movements, nystagmus)									
27. Heart (Thrust, size, rhythm, sounds)									
28. Lungs and chest (include breasts)									
29. Vascular system (Varicosities, etc.)									
30. Anus and rectum (Hemorrhoids, Fistulae) (Prostate if indicated)									
31. Abdomen and viscera (include hernia)									
32. External genitalia (Genitourinary)									
33. Upper extremities									
34. Lower extremities (Except feet)									
35. Feet (Check category)									
35a. <input type="checkbox"/> Normal Arch <input type="checkbox"/> Pes Planus <input type="checkbox"/> Pes Cavus									
35b. <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe									
35c. <input type="checkbox"/> Asymptomatic <input type="checkbox"/> Symptomatic <input type="checkbox"/> Rigid									
36. Spine, other musculoskeletal									
37. Body marks, scars, tattoos									
38. Skin, lymphatics									
39. Neurologic									
40. Psychiatric (Specify any personality disorder)									
41. Pelvic (Females only)									
42. Endocrine									

LAST NAME - FIRST NAME - MIDDLE NAME (Suffix)						SOCIAL SECURITY NUMBER				DoD ID NUMBER					
LABORATORY FINDINGS															
45. URINALYSIS			a. Albumin			b. Sugar			46. URINE HCG			47. H/H		48. BLOOD TYPE	
TESTS			RESULTS			HIV SPECIMEN ID LABEL				DRUG TEST SPECIMEN ID LABEL					
49. HIV															
50. DRUGS															
51. ALCOHOL															
52. OTHER															
a. PAP SMEAR															
b. EKG															
c. CXR															
MEASUREMENTS AND OTHER FINDINGS															
53. HEIGHT (in.)		54. WEIGHT (lbs.)		55a. MIN WGT		55b. MAX WGT		55c. MAX BF %		55d. BMI		56. TEMPERATURE		57. HEART RATE	
58. BLOOD PRESSURE								59. RED/GREEN				60. OTHER VISION TEST			
a. 1ST		b. 2ND		c. 3RD											
SYS.		SYS.		SYS.											
DIAS.		DIAS.		DIAS.											
61. DISTANCE VISION				62. REFRACTION <input type="checkbox"/> AUTO <input type="checkbox"/> MANIFEST <input type="checkbox"/> CYCLO				63. NEAR VISION							
Right Uncorr. 20/		Corr. to 20/		Sph:		Cyl:		Axis:		Right Uncorr. 20/		Corr. to 20/		Add:	
Left Uncorr. 20/		Corr. to 20/		Sph:		Cyl:		Axis:		Left Uncorr. 20/		Corr. to 20/		Add:	
64. HETEROPHORIA															
ES		EX		R.H.		L.H.		Prism div.		Prism Conv CT		NPR		PD	
65. ACCOMMODATION				66. COLOR VISION (Pass/Fail and Score)				67. DEPTH PERCEPTION (Pass/Fail and Score)							
Right		Left		PIP		RED/ GREEN		Color Dx		AFVT		RANDOT/ MCST			
68. FIELD OF VISION						69. NIGHT VISION						70. INTRAOCULAR PRESSURE			
												O.D.		O.S.	
71a. AUDIOMETER Unit Serial Number						71b. Unit Serial Number						72a. READING ALOUD TEST:		<input type="checkbox"/> SAT <input type="checkbox"/> UNSAT	
Date Calibrated (YYYYMMDD)						Date Calibrated (YYYYMMDD)						72b. VALSALVA:		<input type="checkbox"/> SAT <input type="checkbox"/> UNSAT	
HZ		500		1000		2000		3000		4000		6000		72c. OTHER TESTING	
Left															
Right															
73. NOTES AND/OR INTERVAL HISTORY															

89. ADDITIONAL REMARKS

Other documents:

The following items are REQUIRED FOR ALL APPLICANTS:

1. **Official Transcripts** - From ALL colleges/universities should be submitted to (UNMC) University of Nebraska Medical Center ONLY!!
(You will no longer be required to mail or electronically send your official transcripts to USARD).
 - If you are using CLEP scores or AP Credit for English, you will have to submit official scores to UNMC.
 - If you completed Basic Medical Terminology on ATIS, you need to submit the completion certificate with your packet to UNMC and USARD.
 - If enlisted, ensure you submit your JST to UNMC.
2. **SAT Scores** - You MUST have official scores within the past 5 years, prior to the board, to be eligible. You MUST score a total of 1000 with at least 450 in math and reading to be eligible. THERE IS NO WAIVER FOR THE SAT REGARDLESS OF PREVIOUS DEGREE OR OTHER TESTING (IE. THE GRE/ACT DO NOT COUNT). The last available testing date to ensure results are sent to USARD in time for the board will be the 14 March 2026 test date. If you do not take the SAT by that date, we cannot ensure a result in time for the board and your packet cannot go forward. *(Please ensure that you have used code "3994" for IPAP and we can download official scores from the College Board website, once scores become available).*
3. **PA-CAT Scores** - You must take the PA-CAT for your packet to be eligible to board. Take the PA-CAT by application deadline of 1 March 2026. Upon registration, select US Army Active Duty, or US Army Reserves for your scores to be submitted to USARD. *(When scores become available, we can download official scores from the website).*