

**IRR ANNUAL SCREENING WORKSHEET**

**PRIVACY ACT STATEMENT**

**AUTHORITY:** Title 10, U.S.C., Sections 275 & 652

**PRINCIPAL PURPOSE:** To maintain essential records of Air Force Reservists, and identify specific personnel capabilities.

**ROUTINE USES:** Disclosure may be made to any Department of Defense component or, upon request, to other Federal, state, or local agencies in pursuit of their official duties and may be used for other lawful purposes including law enforcement and litigation.

**DISCLOSURE: MANDATORY.** Failure to respond could cause incorrect priority for recall in the event of national mobilization and is a violation of Federal law.

**NOTICE:** You must keep the Air Reserve Personnel Center (ARPC), the appointed agent of the Secretary of the Air Force, informed of your current address, physical condition, and availability for military service. To help you meet these responsibilities, information from your computer record maintained by ARPC is shown below on the left. Please verify this information is correct and make any changes on the right.

**SECTION I BASE AND DATE**

PART A - CURRENT INFORMATION		PART B - CHANGED INFORMATION	
1a. E-MAIL ADDRESS		2a. E-MAIL ADDRESS	
1b. NAME		2b. NAME	
1c. MAILING ADDRESS (Include ZIP + 4)		2c. MAILING ADDRESS (Include ZIP + 4)	
1d. RANK	1e. SSN	2d. RANK	2e. SSN
1f. MARITAL STATUS	1g. CITIZENSHIP	2f. MARITAL STATUS	2g. CITIZENSHIP
1h. PRIMARY AFSC		2h. PRIMARY AFSC	
1i. ETO/ETS	1j. SEX	2i. ETO/ETS	2j. SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE
1k. NO. OF DEPENDENTS	1l. NO. OF DEPENDENTS IN HOUSEHOLD	2k. NO. OF DEPENDENTS	2l. NO. OF DEPENDENTS IN HOUSEHOLD
1m. EDUCATION LEVEL		2m. ADDITIONAL EDUCATION ACQUIRED (Send Documentation to ARPC)	
1n. MAJOR FIELD OF STUDY		2n. MAJOR FIELD OF STUDY (Would you volunteer for active service consistent with your skills?)	
1o. HOME PHONE (Include area code)	1p. BUSINESS PHONE	2o. HOME PHONE (Include area code)	2p. BUSINESS PHONE

**SECTION II MEDICAL SCREENING**

1. Do you have a medical condition which you believe may limit your ability to be mobilized?  YES  NO (If yes, please describe.)

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**FOR MEDICAL PERSONNEL ONLY (All blocks must be completed) (To be completed by screening official)**

2. MEMBER IS:  QUALIFIED  QUESTIONABLY QUALIFIED  NOT QUALIFIED FOR WORLDWIDE SERVICE. (Check One)

3. MEMBER IS A VA PENSION/DISABILITY RECIPIENT?  YES  NO If yes, current rating \_\_\_%

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4. HEALTH CARE PROVIDER (Print or stamp)	5. SIGNATURE	6. DATE (YYYYMMDD)
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SECTION III FOR MEMBERS WITH MILITARY SPOUSES			
1. SPOUSE'S SERVICE BRANCH	2. SPOUSE'S COMPONENT	3. SPOUSE'S SERVICE BRANCH <input type="checkbox"/> AF <input type="checkbox"/> NAVY <input type="checkbox"/> USA <input type="checkbox"/> USMC	4. SPOUSE'S COMPONENT <input type="checkbox"/> REG <input type="checkbox"/> RES <input type="checkbox"/> GUARD <input type="checkbox"/> RET
5. SPOUSE'S STATUS	6. SPOUSE'S SSN	7. SPOUSE'S STATUS <input type="checkbox"/> ENLISTED <input type="checkbox"/> OFFICER	8. SPOUSE'S SSN
9. SPOUSE'S LOCATION, I.E., IS SPOUSE ON <input type="checkbox"/> REMOTE <input type="checkbox"/> UNACCOMPANIED ASSIGNMENT			

SECTION IV FOR IRR MEMBERS IN MEDICAL SPECIALTIES ONLY	
1. CREDENTIALLED MEDICAL SPECIALTY (If any)	2. CREDENTIALLED MEDICAL SPECIALTY
3. STATE LICENSED	4. STATE LICENSED
5. LICENSE NUMBER	6. LICENSE NUMBER
NURSE CORP REQUIRES OVER 180 HOURS PER YEAR AND DENTAL CORP REQUIRES OVER 460 HOURS PER YEAR.	
7. LICENSE EXPIRATION DATE	8. LICENSE EXPIRATION DATE

SECTION V ADDITIONAL MOBILIZATION INFORMATION	
1. HAVE YOU BEEN ARRESTED OR HAD ANY CIVIL CONVICTIONS SINCE YOUR LAST SERVICE OTHER THAN MINOR TRAFFIC OFFENSES? <input type="checkbox"/> NO <input type="checkbox"/> YES (If yes, complete the following)	
1a. OFFENSE	1b. PLACE OF ARREST
1c. PLEA	1d. SENTENCE RECEIVED
1e. DATE OF ARREST (YYYYMMDD)	1f. COURT OF JURISDICTION
1g. IF CURRENTLY ON PROBATION, PROVIDE PROBATION OFFICER'S NAME AND COMPLETE MAILING ADDRESS	

SECTION VI MEMBER'S CERTIFICATION	
1. STATEMENT OF UNDERSTANDING - DEPENDENT CARE RESPONSIBILITIES (AFI 36-2908) I UNDERSTAND I AM RESPONSIBLE FOR MAKING ADEQUATE DEPENDENT CARE ARRANGEMENTS IN ADVANCE TO ENSURE THAT I AM AVAILABLE TO MEET MY MILITARY DUTIES AND OBLIGATIONS.  <p style="text-align: right;">MEMBER'S INITIALS _____</p>	
I CERTIFY THAT THE INFORMATION I HAVE PROVIDED IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE. (A knowingly false certification can subject you to a fine of \$5,000.00 or 5 years imprisonment or both.)	
2. MEMBER'S SIGNATURE	3. DATE (YYYYMMDD)