

AUTHORIZATION FOR MEDICAL WARNING TAG

For use of this form, see AR 40-66; the proponent agency is Office of The Surgeon General.

TO: <i>(Include ZIP Code)</i>	FROM: <i>(Medical Treatment Facility (Specify Clinic, Ward, etc.))</i>
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TYPED NAME AND SIGNATURE OF REQUESTING MEDICAL OR DENTAL OFFICER	DATE
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TAG CONTENT

LINE NO.	SPACE NUMBER																	
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18
1																		
2																		
3																		
4																		
5																		

REMARKS

TAG DELIVERED TO PATIENT <i>(Signature of Responsible Officer)</i>	DATE DELIVERED
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PERSON TO CALL IF OTHER THAN PATIENT

NAME AND RELATIONSHIP TO PATIENT	ADDRESS	PHONE NUMBER
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PATIENT IDENTIFICATION

ORGANIZATION, UNIT, LOCATION <i>(Military Pers ONLY)</i>	HOME ADDRESS <i>(Include Zip Code)</i>	PHONE NUMBER
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PATIENT'S NAME <i>(Last, first, middle)</i>	GRADE OR STATUS	IDENTIFICATION NUMBER
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