DEPARTMENT OF DEFENSE

ACTIVE DUTY RETURN TO DUTY CLEARANCE

COMMAND / MEDICAL AUTHORITY DIRECTIVE

Date: _____ **Control Number:** _____

PART I - MEMBER IDENTIFICATION

Full Name (Last, First, Middle)	
Rank / Grade	
SSN / DoD ID Number	
Branch of Service	
Unit / Command of Assignment	

PART II - MEDICAL / ADMINISTRATIVE DISPOSITION

Following comprehensive evaluation of the service member, the following status has been determined:

☐

Fit for Full Duty: Member is cleared for immediate return to full, unrestricted active duty, including deployment, physical fitness testing, and field operations globally.

☐

Fit for Duty with Restrictions: Member is cleared to return to duty subject to the limitations specified below.

☐

Unfit for Duty: Member remains incapacitated for active service and is not cleared to return to duty. Timeline for reassessment is noted below.

PART III - SPECIFIC RESTRICTIONS AND REMARKS

PART IV - CLEARING AUTHORITY & SIGNATURE

_____ _____

Printed Name of Clearing Official | Title / Organization / Command

_____ _____

Signature of Clearing Official | Date Signed

PART V - MEMBER ACKNOWLEDGMENT

I acknowledge receipt of this clearance determination and understand any duty restrictions placed upon me.

Signature of Service Member	Date

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CONTROLLED UNCLASSIFIED INFORMATION (CUI) WHEN FILLED IN.