

MEDICAL SERVICE AND SUPPLY REQUEST			<input checked="" type="checkbox"/> MLC <input type="checkbox"/> MC <input type="checkbox"/> IHA	1. DATE OF REQUEST	2. REQUEST NUMBER
3. TO: <i>(Name and Address of DFAO)</i> Chief, Yokosuka Defense Facilities Administration Office			4. FROM: <i>(Name of Organization)</i>		
5. NAME OF EMPLOYEE(S)	5a. AGE	5b. JOB TITLE(S)	5c. PASS NUMBER(S)	5d. WORK NUMBER(S)	
See attached list					
6. TYPE(S) OF MEDICAL SERVICES OR SUPPLIES REQUIRED <i>(Specify)</i> Periodic Medical Examination 1. Examination required by MLC, Ch.15 and Industrial Safety and Health Law. 2. Other examination considered necessary by the doctor.					
7. REMARKS In accordance with MLC, Ch.15.					
8. REQUESTED BY <i>(Typed Name & Grade)</i>			9. SIGNATURE		10. PHONE NUMBER
11. COR OR PERSONNEL OFFICER <i>(Typed Name & Grade)</i> FOR HRO USE			12. SIGNATURE		13. DATE
INDORSEMENT BY DFAO					
14. REQUESTED MEDICAL SERVICES OR SUPPLIES FURNISHED BY <i>(Typed Name of Chief DFAO)</i> FOR DFAO USE			15. SIGNATURE		16. DATE

