

**Airborne Physical**  
**Coyote Creek Clinic 520-533-9034**  
**Apache Ridge Clinic 520-533-9033**  
**Physical Exams**

Name: \_\_\_\_\_ DoD ID: \_\_\_\_\_ Gender:  Male  Female

Date of Birth: \_\_\_\_\_

Over 40:  Yes  No

Pregnant? (Female)  Yes  No

**Packet Checklist**

\_\_\_\_\_ DD Form 2807-1 w/ attached SF 600

\_\_\_\_\_ DD Form 2808

\_\_\_\_\_ Audiology (Page 2 of DD Form 2808)

\_\_\_\_\_ Optometry (Color Vision Required, Page 2 of DD Form 2808)

\_\_\_\_\_ Dental (Block 84 on DD Form 2808 or DD Form 2813 for civilian dentist)

\_\_\_\_\_ Labs (UA, FBS)

All items must be completed and turned into ***your assigned Soldier/Family Member Clinic***  
prior to booking appointment.

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