

DoD Medical Examination Review Board  
8034 Edgerton Drive, Suite 132  
USAF Academy, Colorado 80840-2200

**THREE DAY BLOOD PRESSURE AND PULSE CHECK**

NAME: \_\_\_\_\_ SOCIAL SECURITY NUMBER: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Please have a medical professional complete all three days of sitting blood pressures and pulses below: Please ensure they sign, indicate title (eg. MD, Nurse, PA, EMT, etc.), and date the form. Please return the completed form to DoDMERB at the above address.

1) Medication currently taken by applicant (if none, so state): \_\_\_\_\_

DAY	DATE	TIME	BLOOD PRESSURE	PULSE
DAY 1				

DAY 1 EXAMINER'S NAME	SIGNATURE	TITLE

DAY	DATE	TIME	BLOOD PRESSURE	PULSE
DAY 2				

DAY 2 EXAMINER'S NAME	SIGNATURE	TITLE

DAY	DATE	TIME	BLOOD PRESSURE	PULSE
DAY 3				

DAY 3 EXAMINER'S NAME	SIGNATURE	TITLE