

INDIVIDUAL SICK SLIP		DATE
<input type="checkbox"/> ILLNESS <input type="checkbox"/> INJURY		
LAST NAME - FIRST NAME - MIDDLE INITIAL OF PATIENT		ORGANIZATION AND STATION
SERVICE NUMBER/SSN	GRADE/RATE	
UNIT COMMANDER'S SECTION		MEDICAL OFFICER'S SECTION
IN LINE OF DUTY		IN LINE OF DUTY
REMARKS	DISPOSITION OF PATIENT <input type="checkbox"/> DUTY <input type="checkbox"/> QUARTERS <input type="checkbox"/> SICK BAY <input type="checkbox"/> HOSPITAL <input type="checkbox"/> NOT EXAMINED <input type="checkbox"/> OTHER (<i>Specify</i>):	
	REMARKS	
SIGNATURE OF UNIT COMMANDER		SIGNATURE OF MEDICAL OFFICER

DD FORM 689, MAR 63

PREVIOUS EDITIONS ARE OBSOLETE.