AUTHORIZATION FOR MEDICAL WARNING TAG

For use of this form, see AR 40-66; the proponent agency is Office of The Surgeon General.

TO: *(Include ZIP Code)*	**FROM:** *(Medical Treatment Facility (Specify Clinic, Ward, etc.))*

TYPED NAME AND SIGNATURE OF REQUESTING MEDICAL OR DENTAL OFFICER	DATE

TAG CONTENT

LINE NO.	SPACE NUMBER																	
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18
1																		
2																		
3																		
4																		
5																		

REMARKS

TAG DELIVERED TO PATIENT *(Signature of Responsible Officer)*	DATE DELIVERED

PERSON TO CALL IF OTHER THAN PATIENT

NAME AND RELATIONSHIP TO PATIENT	ADDRESS	PHONE NUMBER

PATIENT IDENTIFICATION

ORGANIZATION, UNIT, LOCATION *(Military Pers ONLY)*	HOME ADDRESS *(Include Zip Code)*	PHONE NUMBER

PATIENT'S NAME *(Last, first, middle)*	GRADE OR STATUS	IDENTIFICATION NUMBER

DA FORM 3365, AUG 1968

APD LC v1.02ES