



DEPARTMENT OF THE ARMY  
 ARMY ROTC DETACHMENT  
 UNIVERSITY OF NORTH GEORGIA  
 82 COLLEGE CIRCLE  
 DAHLONEGA, GA 30597

REPLY TO  
 ATTENTION OF:

ATCC-AAG-ANG

Date: \_\_\_\_\_

MEMORANDUM FOR Professor of Military Science

SUBJECT: Statement of Acknowledgement for Civilian Dental Records

*Excerpt from CC Pam 145-4:*

2-55. Dental Exam Requirements

b. Dental films for casualty identification purposes are required for all participants in the ROTC program who must use government-owned or government contracted transportation. The PMS is to ensure the Cadet's dental records contain sufficient documentation to aid in forensic identification.

(1) ROTC Cadets must provide name, address, and phone number of his/her dentist and sign a statement acknowledging that his/her civilian dental records contain descriptive profiles, bite wing x-rays, orthodontic profiles or dental x-rays.

(2) ROTC students not pursuing commissioning credit (ineligibles, academic credit only, etc.) are not permitted to participate in other than classroom activities. However, if these students are transported using government owned or government contracted transportation, they must have a dental record for identification purposes. In such circumstances, these students must provide the name, address, and phone number of his/her dentist and sign a statement acknowledging that his/her civilian dental records contain descriptive profiles, bite wing x-rays, orthodontic profiles or dental x-rays.

c. In addition to the above, DNA is obtained as part of the commissioning physical at LDAC.

\_\_\_\_\_ I have verified with my dentist that my dental records **do** contain descriptive profiles, bite wing x-rays, orthodontic profiles or dental x-rays for identification purposes.

**OR**

\_\_\_\_\_ I have verified with my dentist that my dental records **do not** contain descriptive profiles, bite wing x-rays, orthodontic profiles or dental x-rays for identification purposes and have scheduled an appointment.

**\*My appointment is scheduled for (Date) \_\_\_\_\_ (Time): \_\_\_\_\_**

Dentist Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_  
 (CADET PRINT NAME)

\_\_\_\_\_  
 (CADET SIGNATURE)

\_\_\_\_\_  
 (DATE)