



Personal data

Surname		Given names			Personal identity code	
Present address		Postal code	Post office	Tel	E-mail	
Next of kin		Tel		E-mail		
Current state of studies						
<input type="checkbox"/> I am not a student		<input type="checkbox"/> I am currently studying, expected graduation date _____		<input type="checkbox"/> I do not have a job <input type="checkbox"/> I have a job, where _____		
Name of school, branch, line of study or faculty (exactly)				Present occupation		
Driving licence	Category of driving licence	If you do not have a driving licence, are you taking driving instruction? Driving licence class and stage of instruction.		Type of sport		Sports branch/series
<input type="checkbox"/> yes <input type="checkbox"/> no	_____	<input type="checkbox"/> yes <input type="checkbox"/> no	_____	<input type="checkbox"/> professional/competitive athlete	<input type="checkbox"/> fitness athlete	
Hobbies						

Wishes concerning the upcoming military service

I will apply for admission to: (If you want to apply for the special forces, you must fill in a separate application.)		My wish regarding the start date of my service in the three years following call-ups: 1)			My wish regarding the military unit or place of service 1)	
<input type="checkbox"/> Paratrooper training	<input type="checkbox"/> Special Border Jaeger	1st year _____	2nd year _____	3rd year _____	1. _____	
<input type="checkbox"/> Sports troops	<input type="checkbox"/> Electronic Warfare Training	<input type="checkbox"/> I Contingent January	<input type="checkbox"/> I Contingent January	<input type="checkbox"/> I Contingent January	2. _____	
<input type="checkbox"/> Air Force conscript course	<input type="checkbox"/> Intl rapid deployment forces	<input type="checkbox"/> II Contingent July	<input type="checkbox"/> II Contingent July	<input type="checkbox"/> II Contingent July	3. _____	
<input type="checkbox"/> Military Musician training	<input type="checkbox"/> Cyber Conscript Training				<input type="checkbox"/> No preference	
<input type="checkbox"/> Diver training						

1) Grounds for why I wish to start my service in one of these units at the specified start date

Surname	Given names
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Health and lifestyle questionnaire

Do you feel healthy? <input type="checkbox"/> yes <input type="checkbox"/> no	Do you believe that you are capable of completing your military service? <input type="checkbox"/> yes <input type="checkbox"/> I cannot say <input type="checkbox"/> no	How do you feel about your upcoming military service? <input type="checkbox"/> I am pleased about it <input type="checkbox"/> I cannot say <input type="checkbox"/> I am not interested <input type="checkbox"/> I'd rather not go	
I can cope with the physical strain of military service <input type="checkbox"/> yes <input type="checkbox"/> almost certainly <input type="checkbox"/> I cannot say <input type="checkbox"/> no		How well do you sleep? <input type="checkbox"/> well <input type="checkbox"/> problems from time to time <input type="checkbox"/> badly	Height _____ cm
Do you use prescription medication? If you do, please specify <input type="checkbox"/> regularly <input type="checkbox"/> some-times _____ <input type="checkbox"/> no		Do you use alcohol? <input type="checkbox"/> no <input type="checkbox"/> Few times a month <input type="checkbox"/> Few times a week <input type="checkbox"/> 4 or more times a week	Do you use tobacco products? Average number of cigarettes/day or snus packets? <input type="checkbox"/> no <input type="checkbox"/> yes _____
		Do you use narcotics? <input type="checkbox"/> no <input type="checkbox"/> some-times <input type="checkbox"/> often	

Diseases or symptoms

<p>Have you ever had any of the disorders or symptoms listed below? (please check either yes or no for each question).</p> <table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 10%; text-align: center;">yes</td> <td style="width: 10%; text-align: center;">no</td> <td style="width: 80%;">1. Musculoskeletal disorder or accident</td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td>a) back</td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td>b) knee</td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td>c) ankle</td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td>d) limited participation in physical education at school</td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td>e) other</td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td>2. Metabolic, endocrine and nutritional disorders (such as hypothyroidism, diabetes)</td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td>3. Cardiovascular disorders (such as a heart condition, elevated blood pressure, recurrent arrhythmia)</td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td>4. Respiratory disorders (such as asthma)</td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td>5. Allergy or skin disorder</td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td>6. Neurological disorder (such as headache, migraine or epilepsy)</td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td>7. Congenital deformities</td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td>8. Eye or ear disorders</td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td>9. Hospital treatments or surgeries</td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td>10. Mental disorders, concentration difficulties, nervousness, depression</td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td>11. Have you visited a professional because of mental disorders or symptoms?</td> </tr> </table>	yes	no	1. Musculoskeletal disorder or accident	<input type="checkbox"/>	<input type="checkbox"/>	a) back	<input type="checkbox"/>	<input type="checkbox"/>	b) knee	<input type="checkbox"/>	<input type="checkbox"/>	c) ankle	<input type="checkbox"/>	<input type="checkbox"/>	d) limited participation in physical education at school	<input type="checkbox"/>	<input type="checkbox"/>	e) other	<input type="checkbox"/>	<input type="checkbox"/>	2. Metabolic, endocrine and nutritional disorders (such as hypothyroidism, diabetes)	<input type="checkbox"/>	<input type="checkbox"/>	3. Cardiovascular disorders (such as a heart condition, elevated blood pressure, recurrent arrhythmia)	<input type="checkbox"/>	<input type="checkbox"/>	4. Respiratory disorders (such as asthma)	<input type="checkbox"/>	<input type="checkbox"/>	5. Allergy or skin disorder	<input type="checkbox"/>	<input type="checkbox"/>	6. Neurological disorder (such as headache, migraine or epilepsy)	<input type="checkbox"/>	<input type="checkbox"/>	7. Congenital deformities	<input type="checkbox"/>	<input type="checkbox"/>	8. Eye or ear disorders	<input type="checkbox"/>	<input type="checkbox"/>	9. Hospital treatments or surgeries	<input type="checkbox"/>	<input type="checkbox"/>	10. Mental disorders, concentration difficulties, nervousness, depression	<input type="checkbox"/>	<input type="checkbox"/>	11. Have you visited a professional because of mental disorders or symptoms?	<p>If your answer to any of the questions was yes, please give additional information about the disorders or symptoms. Where were you treated and when? Please make sure to mention if your treatment is ongoing or if you have any significant disabilities.</p>
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Signatures of the person called up. I affirm that I have answered the above questions without holding anything back or without exaggerating.

The information requested in the form come under the Military Service Register referred to in section 4, subsection 1, paragraph 1 of the Act on the processing of personal data in the Finnish Defence Forces (332/2019). The Defence Command is the register manager of the Military Service Register under subsection 3 of the same provision. Section 5 of the Act on the processing of personal data in the Defence Forces provides for the purpose of use of the Military Service Register. In addition to the Act on the processing of personal data in the Defence Forces, the provisions of the Act on the Processing of Personal Data in Criminal Matters and in Connection with Maintaining National Security (1054/2018) apply to the processing of personal data excluding section 10, subsection 2, section 54, and chapter 7 of the Act.

Advance health examination (Signature at home/health centre) Date and signature	Call-up health examination Information changed <input type="checkbox"/> yes <input type="checkbox"/> no Date and signature	Service entry health examination Information changed <input type="checkbox"/> yes <input type="checkbox"/> no Date and signature
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Please bring along the filled out form to the advance health examination