

MEDICAL RECORD SUPPLEMENTAL MEDICAL DATA

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

REPORT TITLE:

COMMANDER'S PERMISSION FOR REFRACTIVE SURGERY

OTSG APPROVED (Date)

11 Jun 10

CRDAMC Refractive Eye Surgery Center, Phone 254-286-7952

This soldier is interested in eye surgery to reduce his/her need for corrective lenses.

Rank Name Last Four SSN MOS Type [] Combat Arms [] NonCombat Arms

- 1. This soldier's earliest potential deployment date is (DDMMYY).
2. Required Army obligation:
a. Soldier has at least 18 months remaining on active duty.
b. Soldier is not scheduled to PCS in the next 6 months.
c. Soldier has no adverse personnel actions pending.
d. Soldier will not deploy for at least 90 days after PRK.
e. Soldier will not deploy for at least 30 days after LASIK.
f. Soldier will not deploy for at least 30 days after ICL surgery.
3. After refractive surgery this soldier will get a temporary profile to which the undersigned will adhere:
a. No organized PT for 30 days.
b. No living in tents or working in windy, dusty or sunny environs for 30 days.
c. No wearing of protective NBC mask or face paint for 30 days.
d. No swimming, firing weapons or driving military vehicles for 30 days.
e. Sunglasses should be worn outdoors & in bright lights for one year after PRK.
f. No deployments for 3 months after PRK, 4 weeks after LASIK & 30 days after ICL surgery.
4. This soldier will make all follow-up appointments while on profile to ensure proper healing.
5. The undersigned will notify the Refractive Surgery Center immediately if the soldier's circumstances change & he/she no longer meets the above criteria.
6. This endorsement is valid for 3 months. If surgery cannot be performed within the next 3 months, a new endorsement must be completed by the soldier & his commander(s).
7. By signing below, you have agreed to comply with all the above statements. See our website for more information concerning PRK & LASIK at Fort Hood, http://www.crdamc.amedd.army.mil/default.asp?page=lasik#HowTo.

Soldier's Signature

Company CDR's Signature Block

Battalion CDR's Signature Block

Name & Signature

Name & Signature

Phone #

Phone #

E-mail Address

E-mail Address

Date of Signature

Date of Signature

(Continue on reverse)

PREPARED BY (Signature & Title)

DEPARTMENT/SERVICE/CLINIC

DATE (YYYYMMDD)

PATIENT'S IDENTIFICATION (For typed or written entries give: Name,-last, first, middle; grade; date; hospital or medical facility)

- HISTORY/PHYSICAL
OTHER EXAMINATION OR EVALUATION
DIAGNOSTIC STUDIES
TREATMENT
FLOW CHART
OTHER (Specify)