WRAMC Warfighter Refractive Eye Surgery Program
Commander's Authorization

(TO BE SUBMITTED BY ALL APPLICANTS)

(1) I give my permission for the following active duty soldier to be considered for enrollment in the Warfighter Refractive Eye Surgery Program (WRESP) and for treatment if eligible.

_____ _____ _____

Patient Name (Print) (Last / First / MI) Rank SSN

_____

Email Address (AKO Preferred)

(2) I certify the following to be true:
- The soldier has at least **18 MONTHS** remaining on **ACTIVE DUTY**.
- The soldier has no adverse personnel actions pending including medical boards.
- The soldier will remain **CONUS** and is **NON-DEPLOYABLE** for at least **90 DAYS** post-surgery.

(3) I realize that after refractive surgery the soldier will be on **CONVALESCENT LEAVE** up to **96 HOURS** and will have the following **PHYSICAL PROFILE** for a minimum of **30 DAYS**, but possibly up to 90 days in a small number of patients (<10%):
- No parachuting, diving, night operations or driving military vehicles.
- No field, range or other duties involving strenuous activity including AFPT.
- No swimming, protective mask use, or use of camouflage face paint.
- Needs to wear sun-glasses at all times.

(4) **I** acknowledge that **NATIONAL GUARD** and **RESERVE** soldiers are **NOT** eligible for treatment unless they have been activated and have at least **18 MONTHS ACTIVE DUTY** remaining at the time of their surgery.

(5) I acknowledge this soldier is required to complete 1, 3, 6 and 12-month **FOLLOW-UP EXAMS** required by the Warfighter Refractive Eye Surgery Program. Or if deploying before the 6-month exam is due they are required to complete the 1- and 3-month exams and then return to WRAMC or co-managing optometry clinic for a post-operative exam at the completion of their deployment.

(6) Failure to comply with the post-operative care requirements may affect future enrolments from the soldier's unit.

_____ _____ _____

Commander's Signature Commander's Rank and Name (Print) Date

_____ _____

Commander's Email Address Commander's Telephone Number

_____ _____

Applicant's Signature Date

FAX THIS COMPLETED FORM TO THE CENTER FOR REFRACTIVE SURGERY AT 202-782-4653
KEEP A COPY FOR YOUR RECORDS AND BRING IT TO YOUR FIRST APPOINTMENT