

WRAMC Warfighter Refractive Eye Surgery Program
Enrollment and Post-Operative Care Agreement
(TO BE SUBMITTED BY ALL APPLICANTS)

Enrollment Information (complete all questions)

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

MOS _____ Assigned Unit _____ Military Installation _____ Age _____ Date of Birth _____ ETS Date _____

USA USAR NG Other _____
(Circle One) Deploying? (Yes/ No) If Yes when? (ddmmyyyy) PCS'ing (Yes/ No) If Yes when? (ddmmyyyy)

Contact address _____

Contact Phone (Day) _____ Contact Phone (Evenings) _____ Cell Phone _____

Email Address (AKO Preferred) _____

Eligibility Statement (Complete and initial the statement that applies to you)

_____ I am Active Duty US Army and will not deactivate, ETS or discharge within 18 months of my surgery..

_____ I am a member of the National Guard or Reserves in AGR status or activated status with _____ months remaining on active duty and will not deactivate, ETS or discharge within 18 months of my surgery.

Post-Operative Care Agreement (initial each statement)

_____ I will contact Walter Reed Center for Refractive Surgery or my local Optometry Clinic to schedule my 30-day follow-up appointment as soon as I am notified of my surgery date.

Note that if you are NOT returning to Walter Reed for your post-operative care a Managed Care Agreement must be completed as part of your application package.

_____ I understand that post-operative follow-up appointments are required at 1, 3, 6 and 12 months. If I am deploying before the 6-month exam is due I will complete the 1- and 3-month exams and then return to WRAMC, or to the facility designated in my Managed Care Agreement for a post-operative exam at the completion of my deployment.

Patient 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