

# USAF REFRACTIVE SURGERY APPLICATION - Aviation & Aviation-Related Special Duty

For application IAW USAF-RS AASD Program Management (READ ALL INSTRUCTIONS PRIOR TO COMPLETING FORM)

This form and other USAF-CRS Tools are available on AF Knowledge Exchange (DotMil) [USAF-CRS Website](#)

Application Date:

or Public Access [\(Public Access\)](#)

## APPLICANT INFORMATION

Last Name: \_\_\_\_\_ First Name, MI: \_\_\_\_\_

Actively Flying: Yes  No  Current Aircraft of Assignment: \_\_\_\_\_

SSN (last 4): \_\_\_\_\_ DOB: \_\_\_\_\_ Age: \_\_\_\_\_

Crew/Duty Position: \_\_\_\_\_ Aviation Service Code (ASC): \_\_\_\_\_

Grade/Rank: \_\_\_\_\_ Primary AFSC: \_\_\_\_\_ Gender: Male  Female

Total # of Military Flying Hours: \_\_\_\_\_ Total # of Flying Hours in Last 6 Month: \_\_\_\_\_

Duty Status: AD  If not AD, please include a copy of current orders  Other  MAJCOM: \_\_\_\_\_

## FLIGHT SURGEON CONTACT INFORMATION

Total # months of remaining AD retainability (ADSCD from DVB located on vMPF - do not put indefinite): \_\_\_\_\_

Unit/Squadron & Office Symbol: \_\_\_\_\_ Phone (DSN): \_\_\_\_\_

**NOTE: AF personnel MUST HAVE 6 months retainability AFTER the Date of Surgery.**

Street: \_\_\_\_\_

Unit/Squadron & Office Symbol: \_\_\_\_\_ Phone (DSN): \_\_\_\_\_

Base / State: \_\_\_\_\_ Zip + 4: \_\_\_\_\_

Street: \_\_\_\_\_

Flight Surgeon's Name/Rank: \_\_\_\_\_

Base / State: \_\_\_\_\_ Zip + 4: \_\_\_\_\_

Duty email: \_\_\_\_\_

Duty E-mail: \_\_\_\_\_

*I have read and will comply with AF guidance on CRS for AASD Personnel*

Planned RS treatment Location: \_\_\_\_\_

Flight Surgeon's Signature: \_\_\_\_\_

|                        |   |  |  |
|------------------------|---|--|--|
| Preferred RS Treatment | Advanced Surface Ablation (ASA)<br>(PRK, WFG-PRK, LASEK, Epi-LASIK) | Intra-Stromal Ablation (ISA)<br>(LASIK, WFG-LASIK, FS-LASIK) | Any Approved USAF CRS Procedure <input type="checkbox"/> |
|------------------------|---|--|--|

## FOR USAF-RS AASD PROGRAM MANAGER (APM) ENDORSEMENT ONLY

|                         |  |
|-------------------------|--|
| Disposition Date: _____ | Permission to Proceed?<br>Yes <input type="checkbox"/> No <input type="checkbox"/> |
|-------------------------|--|

Applicant's Signature: \_\_\_\_\_

Reviewing Officer's Name/Rank: \_\_\_\_\_

Reviewing Officer's Signature: \_\_\_\_\_

## MANDATORY QUESTIONS (APPLICANT MUST INITIAL)

- |          |   |
|----------|---|
| Initials | I am responsible for reading and complying with the policy and guidelines of USAF-RS Program available at: <a href="https://kx.afms.mil/kj/kx1/AFRefractiveSurgery/Pages/home.aspx">https://kx.afms.mil/kj/kx1/AFRefractiveSurgery/Pages/home.aspx</a> or (Public Access) <a href="http://www.wpafb.af.mil/librar/factsheets/factsheet.asp?id=20427">http://www.wpafb.af.mil/librar/factsheets/factsheet.asp?id=20427</a> |
| Initials | I understand I am NOT authorized to undergo corneal refractive surgery until I have received "Permission to Proceed" authorization from the USAF-CRS Aviation Program Manager. If granted "Permission to Proceed" authorization, treatment is still not guaranteed. The final decision to treat will be made by the treating refractive surgeon.  |
| Initials | I understand my Commander's Authorization <b>expires 6 months</b> from the date of their signature. If I am unable to complete treatment within this authorized time period, I will obtain a new Commander's Authorization which must be submitted to the Aviation Program Manager. A valid authorization is <b>mandatory</b> for USAF-CRS treatment.   |
| Initials | I must inform my flight surgeon and eye care provider after surgical treatment, any required follow-up care, and in the event of any complications. I will be placed on a profile and be non-WWQ while on steroids. If follow-up examinations, as required by policy, are not accomplished, I may be restricted from duty or be placed on <b>DNIF</b> status until in compliance.   |
| Initials | I understand the final decision whether to perform CRS and/or the recommended procedure will be determined by my treating refractive surgeon. At any time, I may be disqualified for refractive surgery or I may elect not to undergo treatment.  |
| Initials | If I am disqualified as a CRS candidate, I am not eligible for reimbursement of expenses incurred for travel to/from the DoD RS center, including, but not limited to travel, meals, and lodging. (This does not apply if I am unit-funded.)  |
| Initials | I understand I may require or continue to require reading and/or distance prescription correction for best vision after surgery, especially after I am 40 years old. Furthermore, I understand there is a chance I cannot be fit with contact lenses for vision correction, if desired, after CRS.  |
| Initials | I understand CRS is a non-reversible, alteration of my vision and, even with an initial optimal outcome, my vision may change over time.  |
| Initials | I understand my vision will require time to fully recover from CRS treatment. I will be <b>DNIF</b> until I recover and meet requirements for a waiver. There is a risk that after surgery I may not meet applicable AF vision standards. If I am unable to meet relevant standards, I may be disqualified from certain careers, duties, or even continued military service.  |
| Initials | I understand that if I have my follow-up evaluations completed at a clinic other than an AF facility, I will contact my AF flight surgeon within 3 days to be put on a profile. I must be evaluated by an AF optometrist prior to being cleared to resume unrestricted duties, and I will bring copies of all my pre-operative, surgical, and follow-up exams for inclusion in my medical records.                        |

|   |  |
|---|--|
| E-mail application and all supporting documents to: | Aviation Program Manager<br>USAFSAM/FECO<br>Wright-Patterson AFB, OH<br><a href="mailto:USAFSAM.AP.Mgr@us.af.mil">USAFSAM.AP.Mgr@us.af.mil</a><br>Voice: Commercial (937) 938-2684 / 2677 == DSN 798-2684 / 2677 |
|---|--|

Examination data submitted for Permission-to-Proceed consideration must have been accomplished within 6 months of application date.

|  |                         |  |                |  |
|--|-------------------------|--|----------------|--|
| Evaluation Date  | Date contacts last worn | Last Name                                | First Name, MI | SSN (last 4)   |
| <b>Uncorrected Visual Acuity</b>   |                         | <b>Pachymetry</b> (if available locally) |                | <b>Contact Lens Wear History</b>   |
| OD 20 /  | OS 20 /                 | OD                                       | OS             | Type Worn SCL N/A RGP How many days since last worn?   |
| <b>KERATOMETRY</b>   |                         |  |                | Prior to any evaluation/CRS treatment - contact lens use must be discontinued: SCL for minimum 30 days. HCL / RGP for minimum 90 days  |
| OD   | @                       | /  | @              |  |
| OS   | @                       | /  | @              |  |
| <b>PRIOR MANIFEST REFRACTION</b>   |                         | <b>Date:</b>                             |                | <b>CONTRAINDICATIONS / WARNINGS</b><br>Please review the conditions listed in the USAF-CRS Clinical Guidelines <a href="#">here</a><br>Please make comments in the block below |
| Must be >12 months prior to current exam   |                         |  |                |  |
| OD   | -                       | X  |                |  |
| OS   | -                       | X  |                |  |
| <b>MANIFEST REFRACTION TO BEST VISUAL ACUITY</b>                                   |                         |  |                |  |
| OD   | -                       | X  | 20/            |  |
| OS   | -                       | X  | 20/            |  |
| <b>CORRECTED VISUAL ACUITY</b>   |                         |  |                |  |
| Visual Acuity is calculated from the total number of letters correctly identified. |                         |  |                |  |
| OD   |                         | OS                                       |                |  |
| PV (High Contrast)   |                         |  |                |  |
| # letters  | 20/xx                   | # letters                                | 20/xx          |  |
| 20/  |                         | 20/                                      |                |  |
| PV (5% Contrast)   |                         |  |                |  |
| # letters  | 20/xx                   | # letters                                | 20/xx          |  |
| 20/  |                         | 20/                                      |                |  |
| The standard "Chart to Patient Distance" used for testing is 4 meters (13.1 ft).   |                         |  |                |  |
| <b>CYCLOPLEGIC REFRACTION TO BEST VISUAL ACUITY</b>                                |                         |  |                |  |
| 1st drop   | 2nd drop                | Times                                    |                |  |
| OD   | -                       | X  | 20/            |  |
| OS   | -                       | X  | 20/            |  |
| <b>CORNEAL TOPOGRAPHY</b>  |                         | Explain Abnormal                         |                |  |
| OD   | Normal                  | Abnormal                                 |                |  |
| OS   | Normal                  | Abnormal                                 |                |  |
| <b>SLIT LAMP EXAM</b>  |                         | Explain Abnormal in comment box          |                |  |
| OD   | Normal                  | Abnormal                                 | IOP mmHg       |  |
| OS   | Normal                  | Abnormal                                 | IOP mmHg       |  |
| <b>DILATED FUNDUS EXAM</b>   |                         | Explain Abnormal                         |                |  |
| OD   | Normal                  | Abnormal                                 |                |  |
| OS   | Normal                  | Abnormal                                 |                |  |

|   |     |    |
|---|-----|----|
| Age < 21                                      | Yes | No |
| > 0.50 D change in sph or cyl in past 12 mos. | Yes | No |
| Diabetes Mellitus                             | Yes | No |
| Thyroid Disease                               | Yes | No |
| Pregnant/Nursing during last 6 months         | Yes | No |
| Electronic Pacemaker/similar cardiac device   | Yes | No |
| Autoimmune disease/immunodeficiency           | Yes | No |
| Current/Recent use of:                        |     |    |
| Accutane (Isotretinoin)                       | Yes | No |
| Imitrex (Sumatriptan)                         | Yes | No |
| Cordarone (Amiodarone)                        | Yes | No |
| Steroids                                      | Yes | No |
| INH   | Yes | No |
| Any Immunosuppressive Drug                    | Yes | No |
| Severe dry eyes/atopic disease                | Yes | No |
| IOP > 21 / glaucoma (or suspect)              | Yes | No |
| Keratoconus or corneal irregularity           | Yes | No |
| History of HSV / HZV keratitis                | Yes | No |
| Active Ophthalmic disease                     | Yes | No |
| Corneal scars in central 8mm of cornea        | Yes | No |
| Corneal NV > 2mm from limbus                  | Yes | No |
| Visually significant cataract                 | Yes | No |
| Hx of prior refractive surgery                | Yes | No |
| Other pertinent ocular history                | Yes | No |

I have read and will comply IAW AFI 48-123, para 6.20.5 dated 05 November 2013 Yes No

I am a USAF Certified CRS eyecare provider Yes No

Will a USAF Certified CRS eyecare provider be available for post operative care? Yes No

In your professional opinion, does the applicant meet USAF CRS criteria? Yes No

**COMMENTS:**

**EYECARE PROVIDER CONTACT INFORMATION**

|                               |                               |             |
|-------------------------------|-------------------------------|-------------|
| Eye Care Provider's Name/Rank | Unit/Squadron & Office Symbol | Phone (DSN) |
| Street                        | Base / State                  |             |
| Duty E-mail                   | Zip + 4                       |             |
|                               | Eye Care Provider's Signature |             |