

USAF REFRACTIVE SURGERY APPLICATION - Warfighter

For application IAW USAF-RS Warfighter Program Management

(READ ALL INSTRUCTIONS PRIOR TO COMPLETING FORM)

This form and other USAF-RS Tools are available on AF Knowledge Exchange (DotMil) <https://kx.afms.mil/USAF-RS> or Public Access <http://airforcemedicine.afms.mil/USAF-RS>

Application Date:

APPLICANT INFORMATION

Last Name	First Name	Middle Initial	
SSN (last 4)	DOB	Age	
Grade/Rank	Primary AFSC	Sex	<input type="checkbox"/> Male <input type="checkbox"/> Female
Duty Status	<input type="checkbox"/> AD <input type="checkbox"/> AFRes <input type="checkbox"/> ANG <input type="checkbox"/> AGR <input type="checkbox"/> Other	MAJCOM	
Total # months of remaining AD retainability (eligible for elective surgery benefits)			
NOTE: AF personnel MUST HAVE 6 months retainability AFTER the Date of Surgery.			
Unit/Squadron & Office Symbol		Phone (DSN)	
Street			
Base / State Zip + 4			
Duty E-mail			
Planned RS treatment Location			

This application form is for use by USAF Warfighter personnel seeking RS Treatment at a DOD (military) facility.

Aviation / Aviation Related Special Duty (AASD) personnel or AF members seeking treatment at a civilian RS center, please refer to the USAF-RS website for specific application requirements and forms.

FOR USAF-RS WARFIGHTER PROGRAM MANAGER (WPM) ENDORSEMENT ONLY

Preferred RS Treatment	<input type="checkbox"/> Advanced Surface Ablation (ASA) (PRK, Epi-LASIK, LASEK, WFG-PRK)	<input type="checkbox"/> Intra-Stromal Ablation (ISA) (LASIK, FS-LASIK, WFG-LASIK)	<input type="checkbox"/> Any Approved USAF RS Procedure	
Applicant's Signature		Disposition Date		
		Permission to Proceed? <input type="checkbox"/> Yes <input type="checkbox"/> No		
		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: (DOD Dot.mil) https://kx.afms.mil/USAF-RS or (Public Access) http://airforcemedicine.afms.mil/USAF-RS .
Initials	I understand I am NOT authorized to undergo refractive surgery until I have received "Permission to Proceed" authorization from the USAF RS Warfighter Program Manager. If granted "Permission to Proceed" authorization, the treatment is not guaranteed. Final decision to treat will be made by the treating refractive surgeon.
Initials	I understand my Commander's Authorization expires 6 months from the date of their signature. If I am unable to complete treatment within this authorized period, I obtain a new Commander's Authorization which must be submitted to the Aviation Program Manager. A valid authorization is mandatory for USAF-RS treatment.
Initials	I must inform my primary care manager and eye care provider upon surgery treatment, any required follow-up care, and in the event of any complications. If follow-up examinations as required by policy is not accomplished, I may be restricted from duty until in compliance.
Initials	I understand the final decision whether to perform RS and/or recommended technique 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 RS 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. Furthermore, I understand there is a chance I cannot be fit with contact lenses for vision correction, if desired, after RS.
Initials	I understand RS is a non-reversible, alteration of my vision and, even with optimal outcome, my vision may change over time.
Initials	I understand my vision will require time to fully recover following RS Surgery and there is a risk of not meeting relevant vision standards after RS. Therefore, I may be disqualified from certain careers, duties, or even continued military service.

Submission of application package: If choosing an AF CRS Center, contact and submit completed package to desired RS Center.

If choosing a non-AF RS center, submit completed package for review to: the WPM - Joint Service Refractive Surgery Center, Lackland AFB.

AF RS CENTER	DSN - Voice	COM - Prefix	FAX	Email Address
Lackland AFB	554-2010 / 3495	210-292-xxxx	xxx-2313 / 2813	WHMC-CRS@lackland.af.mil
Air Force Academy	333-5958	719-333-xxxx	xxx-9774	10mdg.lasereveclinic@usafa.af.mil
Andrews AFB	857-8777	240-857-xxxx	xxx-8226	779MDG/wfec/andrewsafb@afncr.af.mil
Keesler AFB	591-0567	228-376-xxxx	xxx-0155	81mdg/refractivesurgery@keesler.af.mil
Travis AFB	799-3146	707-423-xxxx	xxx-3529	60msgs.sgxc.laser.center@travis.af.mil
Wright-Patterson AFB	986-0970 / 1447	937-656-xxxx	xxx-0973	

WARFIGHTER CRS APPLICATION: OCULAR/REFRACTIVE STATUS (TO BE COMPLETED BY THE APPLICANT'S EYE CARE PROVIDER)

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

Evaluation Date	Last Name	First Name	Middle Initial	SSN (last 4)
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Pachymetry (if available locally) OD _____ microns OS _____ microns	Contact Lens Wear History Type Worn <input type="checkbox"/> N/A <input type="checkbox"/> SCL <input type="checkbox"/> RGP How many days since last worn? _____
	Prior to any evaluation/CRS treatment - contact lens use must be discontinued. SCL for minimum 14 days. HCL / RGP for minimum 90 days

Prior Manifest Refraction	Date:
Must be >12 months prior to current exam	
OD _____	X _____
OS _____	X _____

Patient to fill out:	
CONTRAINDICATIONS / WARNINGS	
Age < 21	<input type="checkbox"/> Yes <input type="checkbox"/> No
Pregnant /Nursing during last 6 months	<input type="checkbox"/> Yes <input type="checkbox"/> No
Diabetes Mellitus	<input type="checkbox"/> Yes <input type="checkbox"/> No
Thyroid Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Severe dry eyes / atopic disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Electronic Pacemaker/similar cardiac device	<input type="checkbox"/> Yes <input type="checkbox"/> No
Autoimmune disease / immunodeficiency	
Psoriasis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Dermatitis Herpetiformis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Pemphigus Vulgaris	<input type="checkbox"/> Yes <input type="checkbox"/> No
Vitiligo	<input type="checkbox"/> Yes <input type="checkbox"/> No
Current use of:	
Accutane (Isotretinoin)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Imitrex (Sumatriptan)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cordarone (Amiodarone)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Steroids	<input type="checkbox"/> Yes <input type="checkbox"/> No
INH	<input type="checkbox"/> Yes <input type="checkbox"/> No

MANIFEST REFRACTION TO BEST VISUAL ACUITY			
OD _____	_____	X _____	20/ _____
OS _____	_____	X _____	20/ _____

Eye Care Provider to fill out:	
> 0.50 D change in sph or cyl in past 12 mos.	<input type="checkbox"/> Yes <input type="checkbox"/> No
IOP > 21 / glaucoma (or suspect)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Keratoconus or corneal irregularity	<input type="checkbox"/> Yes <input type="checkbox"/> No
History of HSV / HZV keratitis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Active Ophthalmic disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Corneal scars/ Neovascularization	<input type="checkbox"/> Yes <input type="checkbox"/> No
Corneal NV > 2mm from limbus	<input type="checkbox"/> Yes <input type="checkbox"/> No
Visually significant cataract	<input type="checkbox"/> Yes <input type="checkbox"/> No
Hx of prior refractive surgery	<input type="checkbox"/> Yes <input type="checkbox"/> No
Other pertinent ocular history	<input type="checkbox"/> Yes <input type="checkbox"/> No
I have read and will comply IAW AFI 48-123, Chapter 12 dated 24 September 2009 <input type="checkbox"/> Yes <input type="checkbox"/> No	
I am a USAF Certified RS eyecare provider <input type="checkbox"/> Yes <input type="checkbox"/> No	

CORNEAL TOPOGRAPHY (Explain Abnormal in comments)			
OD		OS	
<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal			

Will a USAF Certified RS eyecare provider be available for post operative care?	<input type="checkbox"/> Yes <input type="checkbox"/> No
In your professional opinion, does the applicant meet USAF RS criteria?	<input type="checkbox"/> Yes <input type="checkbox"/> 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	