

How to Apply for Corneal Refractive Surgery at the Warfighter Eye Center , Joint Base Andrews

1. We want you to be well informed about refractive surgery prior to undergoing an evaluation. Please be aware of the following highlighted items from the briefing:
 - a. You must be at least 21 years of age on active duty status to be eligible
 - b. If you are Air Force, you must have at least 6 months remaining on (active duty) from **day of surgery**, not from the time of applying for surgery. We recommend you allow a couple of months additional of (AD status) for processing your CRS packet and to be booked for your pre op. Required time for other branches-(**12 months Navy and Marines/ 18 months Army**)
 - c. **Aviators from other services are NOT eligible for treatment here.** This is available at Walter Reed Medical Center.
 - d. **Local Aviators and Special Duty** career fields must obtain additional approval from the Aero Medical Consult Services prior to proceeding with surgery. This will be accomplished through the Warfighter Eye Center after your pre- op exam.
2. You will need to turn in (5) documents to our center-
INCOMPLETE PACKETS WILL NOT BE PROCESSED.

CLICK ON 779th MDG WARFIGHTER EYE CENTER WEBSITE LINK TO PRINT THE FOLLOWING FORMS:

1. AASD Application
2. **Commander's Authorization**
3. **Managed Care Agreement-** if you will obtain post- surgical care at a location other than Joint Base Andrews, please contact your local optometrist to complete the bottom portion of this form.
4. **Warfighter Refractive Surgery Informational Briefing Form**
5. A copy of an eye glass prescription or exam that is a 1 year or older
(Please include this with all the forms above)

PLEASE SUBMIT PACKET TO OUR ORG BOX:

USAF.JBANAFW.779-MDG.MBX.WFEC-ANDREWS@MAIL.MIL

Once the above forms have been received, you will be scheduled for a pre – operative evaluation at the Warfighter Eye Center at Malcolm Medical Clinic.

- ❖ **You must be out of your contact lenses for at least 30 days (for soft lenses) and 90 days (for hard lenses).**

MOST FREQUENT ASKED QUESTIONS

1. If you are not a flyer you do not need to fill out the left portion of the Application Form. This portion is for aviators only.
2. You need TWO signatures on the Commander's Authorization Form(Commander and either a Mobility or Supervisor Signature, or all THREE signatures.
3. On the Briefing Sheet- the date at the top is the date you viewed the slides on our website it DOE NOT need a doctors signature
4. PSP or PRP only needs to be circled by AF.
5. Aviation AASD CRS Application Form- only needs to be filled out by an optometrist only if you do not have a copy of a 1 year or older eye exam.

*****MOST FREQUENT REASONS YOUR APPLICATION PROCESS WILL BE DELAYED AND NOT PROCESSED*****

- If you are Active Duty Reserve or Active Duty Guard you must provide us a copy of your active duty orders along with your CRS packet submission
- DOS (Date of Separation) does not match on ALL forms
- You must have TWO signatures on the Commanders Authorization Form
- You are missing your 1 year or older eye exam or eyeglass prescription
- You must fill out every portion of ALL the forms- blank spaces are not accepted
- Complete the entire portion of the Application Form which includes initialing and signing at the bottom
- If you are a local you and you are planning on having your post op care here, you only need to fill out the top portion of the Manage Care Form. If you are an out of townner both portions are to be filled out the top by you and the bottom by the doctor that will be doing your post-operative care.
- If you are a flyer- you MUST provide your AFSC and ASC in the portion asked
- You MUST circle the question YES or NO if you are deploying or PCS'n within the next 6 months.

Attendance Date: _____ M.D. Signature: _____

**WARFIGHTER
REFRACTIVE SURGERY INFORMATIONAL BRIEFING**

Personal Information

Last, First, MI, Suffix (Jr., III): _____ Rank: _____
SSN (FMP/xxx-xx-xxxx): _____ Age/DOB (annotate both): _____ Sex: M F

Service: USAF USA USN USMC Other _____
Status: Active duty Reserve Guard Other _____

Occupation/AFSC (please annotate both): _____ PRP: Yes / No PSP: Yes / No
Aviation / Special Duty: Yes No ASC: _____

Date of Separation/Retirement: _____
A date is absolutely required. If Indef, please give anticipated separation or retirement date

Home Address:
Address: _____
City, State, Zip: _____
Phone (H): _____
Phone (C): _____
e-mail: _____

Work Address:
Address: _____
City, State, Zip: _____
Phone (W): _____
e-mail: _____

Commander's Email _____ (used for processing profile)

Medical Information: (please annotate completely. If nothing to annotate, please write "nothing")

Drug Allergies/Sensitivities: _____

Current Medications: _____

Medical History: _____

Surgical History: _____

Do you now or have you ever had any of the following eye conditions?

Corneal diseases	yes / no	Glaucoma	yes / no	Keratoconus	yes / no
Herpes infection	yes / no	Dry eyes	yes / no	Cataract	yes / no
Strabismus/lazy eye	yes / no	Eye surgery	yes / no	Eye injury	yes / no
Ocular allergies	yes / no	Retinal problems	yes / no		

Do you have any of these medical conditions?

Rheumatoid arthritis	yes / no	Diabetes	yes / no	Lupus	yes / no
Autoimmune disease	yes / no	Acne rosacea	yes / no	Heavy scarring	yes / no
Pregnancy	yes / no	Nursing/lactating	yes / no	Pacemaker	yes / no

Have you ever worn contact lenses? Yes / No
If yes, circle the type? Soft daily wear / Soft extended wear / Hard contact lenses
How many years? _____ How many hours per day? _____ What date did you last wear? _____

Females: Are you currently pregnant or planning to become pregnant in the next 6 months? Yes / No
Are you nursing or have you been nursing in the last 6 months? Yes / No

List your hobbies or activities having special visual requirements (Ex: flying, swimming, golf, shooting, sewing)

Describe your expectations from refractive surgery: (Ex: to see the clock in the morning, while swimming)

USAF Corneal Refractive Surgery (USAF-CRS) Program

Commander's Authorization

Applicant's Printed Name/Grade:	
Applicant's Signature	

The above member requests permission to obtain refractive surgery to correct their vision at a DoD Refractive Surgery Center. **AFI 48-123, para 6.20.5 dated 05 November 2013** authorizes this elective treatment and is available online at [USAF-CRS Website](#). The policy letter outlines program guidance, issues to consider before authorizing an individual to enter the program and procedures to be followed. It should be reviewed prior to completion of this authorization. All signatures acknowledge an understanding of the policy and concurrence of the applicant member's request.

LAW *USAF-CRS Policy*, access to DoD laser centers is prioritized by the member's Squadron Commander. The categories are as follows:

- Priority I:** Personnel assigned to USAF Aviation and Aviation-Related Special Duty (AASD) career fields. Not included are permanently disqualified aircrew and/or former aviators who have cross-trained from aviation career duties.
- Priority II:** Personnel whose routine military duties require wear of Night Vision Goggles (NVG), eye protection or respiratory protection. This does not include Nuclear, Biological and Chemical (NBC) masks worn only for deployment/exercises.
- Priority III:** Personnel who do not meet the above criteria in their current military duties.

LAW *USAF-CRS Policy, para 4.3*, Air Force personnel must have 6 months of active duty (AD) retainability (time until separation, retirement or loss of AD status) from date of surgery.

Participation in this program requires a considerable investment of time by the individual, resulting in an impact upon mission requirements.

Typical Time Requirements	Initial evaluation (local MTF) – ½ day
	Surgery – 1 week (pre-surgery evaluation, treatment, and initial recovery)
	Post-operative evaluations (local MTF) – 5 visits up to ½ day each in the first year

Recovery from surgery will impact the member's activities. The wear of sunglasses outdoors for the first year is authorized and strongly recommended to prevent complications. Depending upon individual healing and applicable AFSC vision standards, the individual **WILL NOT be World-Wide Qualified (WWQ) while on steroid eye drops (minimum of one month, typically 3-4 months)**. PCS during the post-operative period is strongly discouraged in order to maintain continuity of care. The member will be non-deployable during this timeframe, and a Duty Limiting Condition (DLC) report will be issued. Duties may be assigned relative to the member's recovery. For aircrew, non-deployable Return-to-Flight Status (RTFS) is typically within the first 1-2 months, with return to WWQ status typically within the first 4 months. Flight Surgeons (FS) will manage the appropriate grounding actions and DLC for AASD personnel. Primary Care Managers (PCM) in conjunction with local optometry clinics will manage the DLC for Warfighter personnel.

The member must bring this letter to the initial corneal refractive surgery evaluation in order for the evaluation to proceed. LAW *USAF-CRS Policy, para 4.2*, the **Commander's Authorization is only valid 6 months from the date of signature**. Individuals will be required to re-accomplish the authorization letter if surgery is scheduled beyond 6 months from the date it is signed.

Member's Job Title _____ AFSC: Primary/Duty _____ AASD ONLY: ASC _____

Date of separation, retirement or loss of AD status (Do not put "indefinite"): _____

To best of your knowledge, is the member scheduled to deploy or PCS during the next 6 months? Yes No

This member is eligible as (circle appropriate): Priority I II III

Supervisor	Printed Name/Grade Stamp, if applicable		Date
	Signature		Phone
Unit Mobility Officer	Printed Name/Grade Stamp, if applicable		Date
	Signature		Phone
Squadron Commander	Printed Name/Grade Stamp recommended		Date
	Signature		Phone

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	<input type="checkbox"/> Yes <input type="checkbox"/> No	Current Aircraft of Assignment
SSN (last 4)	DOB	Age	Crew/Duty Position	Aviation Service Code (ASC)
Grade/Rank	Primary AFSC	Gender	<input type="checkbox"/> Male <input type="checkbox"/> Female	Total # of Military Flying Hours
		Total # of Flying Hours in Last 6 Month		

Duty Status	<input type="checkbox"/> AD <input type="checkbox"/> Other	If not AD, please include a copy of current orders	MAJCOM	FLIGHT SURGEON CONTACT INFORMATION
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Total # months of remaining AD retainability (ADSCD from DVB located on vMPPF - do not put indefinite)	Unit/Squadron & Office Symbol	Phone (DSN)
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NOTE: AF personnel MUST HAVE 6 months retainability AFTER the Date of Surgery.

Unit/Squadron & Office Symbol	Phone (DSN)	Street
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Street	Flight Surgeon's Name/Rank
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Base / State Zip + 4	Duty email
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Duty E-mail	<i>I have read and will comply with AF guidance on CRS for AASD Personnel</i>
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Planned RS treatment Location	Flight Surgeon's Signature
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Preferred RS Treatment	<input type="checkbox"/> Advanced Surface Ablation (ASA) (PRK, WFG-PRK, LASEK, Epi-LASIK)	<input type="checkbox"/> Intra-Stromal Ablation (ISA) (LASIK, WFG-LASIK, FS-LASIK)	<input type="checkbox"/> Any Approved USAF CRS Procedure	FOR USAF-RS AASD PROGRAM MANAGER (APM) ENDORSEMENT ONLY	
			Disposition Date	Permission to Proceed? <input type="checkbox"/> Yes <input type="checkbox"/> No	

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-CRS Program available at: https://cx.afms.mil/kj/kx1/AFRefractiveSurgery/Pages/home.aspx or (Public Access) http://www.wpafb.af.mil/library/factsheets/factsheet.asp?id=20427
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 expires 6 months 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 mandatory 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 DNIF 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 DNIF 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 USAFSAM/FECO Wright-Patterson AFB, OH (click to email completed form) USAFSAM.AP.Mgr@us.af.mil Voice: Commercial (937) 938-2684 / 2677 == DSN 798-2684 / 2677
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USAF Corneal Refractive Surgery (USAF-CRS) Program Managed Care Agreement

Patient Name _____ Rank _____ USAF USA USN USMC
 USCG USPHS NOAA
 Military Installation _____ Phone _____ E-mail _____

In the next 6 months, are you: PCSing Separating Retiring Deploying N/A

Refractive Surgery Center: Joint Warfighter, Lackland AFB USAF Academy Wright-Patterson AFB
 Keesler AFB Travis AFB Joint Base Elmendorf/Richardson Andrews AFB Other DoD _____

PATIENT AGREEMENT (after reading and understanding, initial each statement)

_____ I request to be returned to my local eye clinic for post-operative care following refractive surgery at the DoD Refractive Surgery Center listed above. The Refractive Surgery Center staff will be available for additional consultation as needed.

_____ I will contact my local Optometry Clinic to schedule my first follow-up appointment as soon as I am notified of my surgery date.

_____ I understand that I must comply with and accomplish all required referral and follow-up evaluations as required by USAF policy. Non-compliance may result in duty restrictions or disqualification.

_____ I will contact my local Optometry Clinic or Primary Care Manager within 3 days of receiving treatment. I am aware that I will be placed on Duty Limiting Condition status after surgery and can not deploy or PCS for up to 4 months after surgery. I understand that I must be evaluated by the base optometry clinic prior to being cleared to resume unrestricted duties.

_____ I understand that I must bring the package of all pre-operative evaluations, surgical reports, and follow-up exams provided by the Refractive Surgery Center to my local optometry clinic for inclusion in my military medical records.

Patient Signature

Date

Post-Operative Appointment Schedule:

AASD: 1, 3, 6, 12, and as required for waiver renewal.

Warfighter: 1, 3, 6, 12 months

Note: ASA (PRK, LASEK, Epi-LASIK, WFG-PRK) requires a 2 month pressure check

REFERRING DOCTOR'S AGREEMENT

I certify that I have attended the USAF-CRS Co-Management Course. I will manage this patient and accept responsibility for his/her post-operative care. I agree to refer this patient promptly if a condition arises post-operatively that will require further treatment by the Refractive Surgery Center. I will assure that I am able to provide post-operative care until expiration date provided below.

Referring Optometrist Stamp/Signature

Co-management expiration Date
(not to exceed one year from exam date)

Military Installation

Phone

Fax

E-mail

AVIATION (AASD) 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	Date contacts last worn	Last Name	First Name, MI	SSN (last 4)	
Uncorrected Visual Acuity		Pachymetry (if available locally)		Contact Lens Wear History	
OD 20 /	OS 20 /	OD	OS	Type Worn <input checked="" type="checkbox"/> N/A	How many days since last worn?
				<input type="checkbox"/> SCL	<input type="checkbox"/> RGP
KERATOMETRY				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	@	/	@	<input type="checkbox"/>	
PRIOR MANIFEST REFRACTION			Date:		
Must be >12 months prior to current exam					
OD			X		
OS			X		
MANIFEST REFRACTION TO <u>BEST</u> VISUAL ACUITY					
OD			X	20/	
OS			X	20/	
CORRECTED VISUAL ACUITY					
Visual Acuity is calculated from the total number of letters correctly identified. Encourage patient to identify as many letters as possible.					
OD		OS			
PV (High Contrast)					
# letters	20/xx	# letters	20/xx		
	20/		20/		
PV (5% Contrast)					
# letters	20/xx	# letters	20/xx		
	20/		20/		
Precision Vision charts should be used IAW USAF CRS guidance. Information to obtain PV charts available online: AF Knowledge Exchange					
The standard "Chart to Patient Distance" used for testing is 4 meters (13.1 ft).					
CYCLOPLEGIC REFRACTION TO <u>BEST</u> VISUAL ACUITY					
1st drop	2nd drop			Times	
OD			X	20/	
OS			X	20/	
CORNEAL TOPOGRAPHY			Explain Abnormal		
OD	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal			
OS	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal			
SLIT LAMP EXAM			Explain Abnormal in comment box		
OD	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal	IOP		mmHg
OS	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal	IOP		mmHg
DILATED FUNDUS EXAM			Explain Abnormal		
OD	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal			
OS	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal			
CONTRAINDICATIONS / WARNINGS					
Please review the conditions listed in the USAF-CRS Clinical Guidelines here					
Please make comments in the block below					
Age < 21	<input type="checkbox"/> Yes	<input type="checkbox"/> No			
> 0.50 D change in sph or cyl in past 12 mos.	<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			
Pregnant/Nursing during last 6 months	<input type="checkbox"/> Yes	<input type="checkbox"/> No			
Electronic Pacemaker/similar cardiac device	<input type="checkbox"/> Yes	<input type="checkbox"/> No			
Autoimmune disease/immunodeficiency	<input type="checkbox"/> Yes	<input type="checkbox"/> No			
Current/Recent use of:					
Accutane (Isotretinoin)	<input type="checkbox"/> Yes	<input type="checkbox"/> No			
Imitrex (Sumatriptan)	<input type="checkbox"/> Yes	<input type="checkbox"/> No			
Cordarone (Amlodarone)	<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			
Any Immunosuppressive Drug	<input type="checkbox"/> Yes	<input type="checkbox"/> No			
Severe dry eyes/atopic disease	<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 in central 8mm of cornea	<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, para 6.20.5 dated 05 November 2013					
<input type="checkbox"/> Yes <input type="checkbox"/> No					
I am a USAF Certified CRS eyecare provider					
<input type="checkbox"/> Yes <input type="checkbox"/> No					
Will a USAF Certified CRS 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 CRS 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		