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

We want you to be well informed about refractive surgery prior to undergoing an evaluation. Please be aware of the following:

1. You must be at least 21 years of age on active duty status to be eligible
2. If you are Air Force, you must have at least 6 months remaining on active duty status from the date of surgery, not from the date of applying for surgery. It takes several months to process your application and schedule your evaluation and surgery.

<table>
<thead>
<tr>
<th>Service Branch</th>
<th>Time Remaining</th>
</tr>
</thead>
<tbody>
<tr>
<td>Air Force</td>
<td>6 months</td>
</tr>
<tr>
<td>Allied Forces</td>
<td>Follows US military branches</td>
</tr>
<tr>
<td>Army</td>
<td>6 months</td>
</tr>
<tr>
<td>Coast Guard</td>
<td>12 months</td>
</tr>
<tr>
<td>Marines</td>
<td>12 months</td>
</tr>
<tr>
<td>Navy</td>
<td>12 months</td>
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<tr>
<td>NOAA</td>
<td>12 months</td>
</tr>
<tr>
<td>USPHS</td>
<td>12 months</td>
</tr>
</tbody>
</table>

3. Non-Air Force Aviators are NOT eligible for treatment here, this is available at other military treatment facilities.
4. Out of Towner Aviators and Aviation-Related Special Duty must submit application to Wright-Patterson AFB to obtain Letter to Proceed, please follow directions on AASD Application. Members who are overseas must submit application to Lackland AFB to obtain Letter to Proceed. Needs to be included with your packet.

You will need to complete and submit five documents to our center to apply:

INCOMPLETE PACKETS WILL NOT BE PROCESSED

1. AASD Application/Warfighter Application
2. Commander’s Authorization
3. Managed Care Agreement - If you will obtain post-operative 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 - Air Force must provide an AFSC and an ASC
5. A copy of an eye glass prescription or exam that is a one year or older.

PLEASE SUBMIT PACKET TO OUR ORG BOX:
USAF.JBANAFW.779-MDG.MBX.WFEC-ANDREWS@MAIL.MIL

Once the above forms have been received and processed, you will be contacted to schedule a pre-operative evaluation. Processing times may vary depending if you are a local or out of towner.
Important things you need to know:

1. You need TWO signatures on the Commander’s Authorization form (Squadron Commander and either a Mobility or Supervisor, or all three). **Aviators must have all three signatures.**
2. Must provide a commander’s email on briefing sheet.
3. PSP or PRP only needs to be circled by Air Force.
4. If you are Active Duty Reserve or Active Duty Guard, you must provide us with a copy of your active duty orders along with your CRS packet.
5. You need to have a date of separation and it needs to match on all forms.
6. You must fill out every portion of ALL the forms, blank spaces are not acceptable.
7. You must circle the questions YES or NO if you are deploying or PCSing within the next six months.
WARFIGHTER REFRACTIVE SURGERY INFORMATIONAL BRIEFING SHEET

Personal Information
Last, First, MI, Suffix (Jr., III): __________________________

DoD ID: __________________ Age/DOB (annotate both): ________________ Sex: M  F

Branch of Service: USAF  USA  USN  USMC  Other ________

Status: Active Duty
Status: Guard – On Active Duty Orders / Reserve- On Active Duty Orders

** Active Duty Orders are required with ALL applicants that are Guard or Reserve *Please Note* You must be on active duty status at time of surgery also, the retainability requirement begins on day of surgery, not day of application.

** PLEASE REVIEW APPLICATION PROCESS TIME FRAMES ON OUR WEBSITE**

Occupation (“in layman’s terms”) ___________ AFSC ___________
PRP: Yes / No  PSP: Yes / No

Aviation / Special Duty: Yes  No  ASC: ____________

Date of Separation/Retirement: __________

***A separation 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 (REQUIRED) ______________________________

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?

<table>
<thead>
<tr>
<th>Condition</th>
<th>Yes / No</th>
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</thead>
<tbody>
<tr>
<td>Corneal diseases</td>
<td>yes / no</td>
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<tr>
<td>Glaucoma</td>
<td>yes / no</td>
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<tr>
<td>Keratoconus</td>
<td>yes / no</td>
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<tr>
<td>Herpes infection</td>
<td>yes / no</td>
</tr>
<tr>
<td>Dry eyes</td>
<td>yes / no</td>
</tr>
<tr>
<td>Cataract</td>
<td>yes / no</td>
</tr>
<tr>
<td>Strabismus/lazy eye</td>
<td>yes / no</td>
</tr>
<tr>
<td>Eye surgery</td>
<td>yes / no</td>
</tr>
<tr>
<td>Eye injury</td>
<td>yes / no</td>
</tr>
<tr>
<td>Ocular allergies</td>
<td>yes / no</td>
</tr>
<tr>
<td>Retinal problems</td>
<td>yes / no</td>
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</tbody>
</table>

Do you have any of these medical conditions?

<table>
<thead>
<tr>
<th>Condition</th>
<th>Yes / No</th>
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</thead>
<tbody>
<tr>
<td>Rheumatoid arthritis</td>
<td>yes / no</td>
</tr>
<tr>
<td>Diabetes</td>
<td>yes / no</td>
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<tr>
<td>Lupus</td>
<td>yes / no</td>
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<tr>
<td>Autoimmune disease</td>
<td>yes / no</td>
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<tr>
<td>Acne rosacea</td>
<td>yes / no</td>
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<tr>
<td>Heavy scarring</td>
<td>yes / no</td>
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<tr>
<td>Pregnancy</td>
<td>yes / no</td>
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<tr>
<td>Nursing/lactating</td>
<td>yes / no</td>
</tr>
<tr>
<td>Pacemaker</td>
<td>yes / no</td>
</tr>
</tbody>
</table>

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)

Rev 02-03-2010

The privacy Act 1974, 5 U.S.C. 552(a), and/ or the Health Insurance Portability and Accountability Act ( PL 104-191), 10 U.S.C . Section 1102, and its various implementing regulations protect the information in this package. Unauthorized release, use or failure to maintain confidentiality subjects you to appropriate sanctions.
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.

IAW 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.

IAW 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.

<table>
<thead>
<tr>
<th>Typical Time Requirements</th>
<th>Initial evaluation (local MTF) – ½ day</th>
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<tr>
<td></td>
<td>Surgery – 1 week (pre-surgery evaluation, treatment, and initial recovery)</td>
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<tr>
<td></td>
<td>Post-operative evaluations (local MTF) – 5 visits up to ½ day each in the first year</td>
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</tbody>
</table>

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. IAW 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

<table>
<thead>
<tr>
<th>Supervisor</th>
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<tr>
<td>Printed Name/Grade</td>
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<td>Stamp, if applicable</td>
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<tr>
<td>Date</td>
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<tr>
<td>Signature</td>
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<td>Phone</td>
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<th>Unit Mobility Officer</th>
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<tr>
<td>Printed Name/Grade</td>
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<td>Stamp, if applicable</td>
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<tr>
<td>Date</td>
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<tr>
<td>Signature</td>
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<td>Phone</td>
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<tr>
<th>Squadron Commander</th>
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<tr>
<td>Printed Name/Grade</td>
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<tr>
<td>Stamp recommended</td>
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<tr>
<td>Date</td>
</tr>
<tr>
<td>Signature</td>
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<tr>
<td>Phone</td>
</tr>
</tbody>
</table>
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.

### MANDATORY QUESTIONS (APPLICANT MUST INITIAL)

**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.
- 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.
- 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.
- 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.
- 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.)
- I understand I cannot be fit with contact lenses for vision correction, if desired, after RS.
- I understand RS is a non-reversible, alteration of my vision and, even with optimal outcome, my vision may change over time.
- 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.

**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.

### 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 Name**
- **DOB**
- **Age**
- **SSN** (last 4)
- **Grade/AFSC**
- **Primary Sex**
- **Sex**
- **Unit/Squadron & Office Symbol**
- **Street**
- **Base / State**
- **Zip + 4**

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

- **Total # months of remaining AD retainability**
  - (eligible for elective surgery benefits)

### Preferred RS Treatment

- **Advanced Surface Ablation (ASA)**
- **Intra-Stromal Ablation (ISA)**
- **Any Approved USAF RS Procedure**

### Disposition

- **Permission to Proceed?**
  - **Yes**
  - **No**

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

- **Reviewing Officer's Name/Rank**
- **Reviewing Officer's Signature**

### MANDATORY QUESTIONS (APPLICANT MUST INITIAL)

- **Initials**

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- **Any Approved USAF RS Procedure**

### Disposition

- **Permission to Proceed?**
  - **Yes**
  - **No**

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### 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.

<table>
<thead>
<tr>
<th>Evaluation Date</th>
<th>Last Name</th>
<th>First Name</th>
<th>Middle Initial</th>
<th>SSN (last 4)</th>
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<tbody>
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</table>

**Contact Lens Wear History**

- Type Worn: ___ SCL ___ RGP ___ N/A
- 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

**Pachymetry (if available locally)**

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<thead>
<tr>
<th>OD</th>
<th>microns</th>
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<table>
<thead>
<tr>
<th>OS</th>
<th>microns</th>
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**Prior Manifest Refraction**

- **Date:**
- **Must be >12 months prior to current exam**

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**MANIFEST REFRACTION TO BEST VISUAL ACUITY**

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</tbody>
</table>

**Contraindications / Warnings**

- Age < 21 ______ Yes ______ No
- Pregnant / Nursing during last 6 months ______ Yes ______ No
- Diabetes Mellitus ______ Yes ______ No
- Thyroid Disease ______ Yes ______ No
- Severe dry eyes / atopic disease ______ Yes ______ No
- Electronic Pacemaker/similar cardiac device ______ Yes ______ No
- Autoimmune Disease / Immunodeficiency
  - Psoriasis ______ Yes ______ No
  - Dermatitis Herpetiformis ______ Yes ______ No
  - Pemphigus Vularis ______ Yes ______ No
  - Vitiligo ______ Yes ______ No
- Current use of:
  - Accutane (Isotretinoin) ______ Yes ______ No
  - Imitrex (Sumatriptan) ______ Yes ______ No
  - Cordarone (Amiodarone) ______ Yes ______ No
  - Steroids ______ Yes ______ No
  - INH ______ Yes ______ No
- > 0.50 D change in sph or cyl in past 12 mos ______ 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 / Neovascularization ______ 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

**Eye Care Provider to fill out:**

- I have read and will comply IAW AFI 48-123, Chapter 12 dated 24 September 2009 ______ Yes ______ No
- I am a USAF Certified RS eyecare provider ______ Yes ______ No

**Other pertinent ocular history**

<table>
<thead>
<tr>
<th>Patient to fill out:</th>
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</table>

**Corneal Topography (Explain Abnormal in comments)**

- OD: ______ Normal ______ Abnormal
- OS: ______ Normal ______ Abnormal

**Comments:**

**Eye Care Provider Contact Information**

<table>
<thead>
<tr>
<th>Eye Care Provider’s Name/Rank</th>
<th>Unit/Squadron &amp; Office Symbol</th>
<th>Phone (DSN)</th>
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<th>Base / State</th>
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<tr>
<th>Duty</th>
<th>E-mail</th>
<th>Eye Care Provider’s Signature</th>
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USAF-RS Application IAW Warfighter Program Management (Page 2), revised: 2011/FEB/11

unlock: usaf-rs
USAF Corneal Refractive Surgery (USAF-CRS) Program
Managed Care Agreement

Patient Name ___________________________ Rank ______________

Military Installation ___________________ Phone _______________ E-mail ______________

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

□ USAF □ USA □ USN □ USMC
□ USCG □ USPHS □ NOAA

□ Keester 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.

Post-Operative Appointment Schedule:
AASD: 1, 3, 6, 12, and as required for waiver renewal.
Warfighter: 1, 3, 6, 12 months
Note: ASA (PRK, LASIK, 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 ____________

USAF-CRS Managed Care Agreement, 28 May 14
<table>
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<th>STEP</th>
<th>DATE</th>
<th>Initials / ☐ COMPLETED</th>
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| 1    |      | Member obtains appropriate documents from USAF-RS website:  
  ☐ Commander’s Authorization Form  
  ☐ USAF-RS Application  
  ☐ Patient Information Booklet (FDA Required) |
| 2    |      | Member completes and obtains appropriate signatures:  
  ☐ USAF-RS Application (completes demographic and initials mandatory statements)  
  ☐ USAF-RS Application (FSO signature) --- AASD ONLY  
  ☐ Commander’s Authorization Form (signatures) |
| 3    |      | For members who wear contact lenses:  
  ☐ No soft contact lens wear for 30 days. Date last worn_________________.  
  ☐ No rigid gas permeable contact lens wear for 90 days. Date last worn_________________. |
| 4    |      | Only after completion of steps 1-3 member schedules pre-operative evaluation with base optometry. Base Optometry completes evaluation and provides member with:  
  ☐ USAF-RS Application (Clinical Evaluation)  
  ☐ Color copy of Corneal Topography (req’d) and color copy of ORBSCAN or PENTACAM (if available)  
  ☐ Co-Management Agreement Form |
| 5    |      | Member submits package to appropriate Program Manager or laser center:  
  ☐ APM (Aviation and Aviation Related Special Duty)  
    Aviation Program Manager  
    USAFSAM/FECO  
    USAFSAMAircrewProgramManager@wpafb.af.mil  
    Voice: Commercial (937) 938-2684/2676 / DSN 798-2684/2676  
  ☐ WPM (Warfighter)  
    Please submit your application package as instructed on the bottom of page 1 of the Warfighter RS Application Form. Reminder: All OCONUS applications must be submitted to the WPM-Joint Service Refractive Surgery Center, Lackland AFB.  
  ☐ Member retains hard copy of completed application package |
| 6    |      | ☐ “Permission to Proceed” determination received by member from Program Manager.  
  ☐ Member verifies Base Optometry receipt of “Permission to Proceed”  
  ☐ Member verifies FSO receipt of “Permission to Proceed” --- AASD ONLY |
| 7    |      | ☐ If “Approved”, member and DoD RS Center coordinate surgery date  
  ☐ Member notifies Base Optometry of surgery date  
  ☐ Member FSO of surgery date --- AASD ONLY  
  ☐ If “Denied”, process is terminated. Contact FSO (AASD only) or Base Optometry with questions |
| 8    |      | Prior to departure to surgery center, member initiates convalescent leave with:  
  ☐ FSO --- AASD  
  ☐ PCM --- Warfighter  
  ☐ Commander  
  ☐ Prior to departure, member reports to FSO for initiation of AF Form 1042 --- AASD ONLY |
| 9    |      | ☐ Surgery and initial post-op evaluations completed  
  ☐ AF Form 469 initiated in PIMR at RS Center  
  ☐ AF Form 1042 initiated in PIMR at Refractive Surgery Center --- AASD ONLY |
| 10   |      | Within one week of surgery/return to homebase member reports for completion of AF Form 469 and AF Form 1042 (AASD ONLY)  
  ☐ FSO --- AASD  
  ☐ PCM/Base Optometry --- Warfighter |
| 11   |      | Member completes follow-up evaluations with co-manager.  
  *If co-manager is not at USAF medical treatment facility, member must obtain copies at each visit. Member must contact FSO (AASD) or Base Optometry (Warfighter) following each post-operative visit to submit documentation.  
  ☐ 1 month post-op completed  
  ☐ 2 month post-op completed  
  ☐ 3 month post-op completed  
  ☐ 6 month post-op completed  
  ☐ 12 month post-op completed  
  ☐ 1 month post-op copy submitted  
  ☐ 2 month post-op copy submitted  
  ☐ 3 month post-op copy submitted  
  ☐ 6 month post-op copy submitted  
  ☐ 12 month post-op copy submitted |