

USAFRICOM Medical Waiver Request

Email this form and all scanned documentation to africom.stuttgart.acsg.mbx.j004-force-health-protection@mail.mil

DSN Contact Phone Numbers: AFAFRICA: 314-480-7443; CJTF HOA: 311-824-4281; MARFORAF/NAVAF: 314-626-4690; SOCAF: 314-421-3339; USARAF: 314-634-5380; USAFRICOM HQ: 314-421-4741

Patient Name (Last, First):		DOB:	SSN (last 4):
Age:	Sex:	Rank/ Grade:	Service:
Deployment/Travel Date:		Travel Duration (days):	Destination (country):
MOS/AFSC/Skill Identifier/Job Description:		Home Station/Unit:	
Active/Reserve/Civilian/Contractor:			
Supervisor or Requester POC Name/E-mail/Phone:			

This member's position and experience will maximize mission accomplishment; therefore, I request a health requirements waiver to deploy to the USAFRICOM Area of Operations:

Commander/
Supervisor or
Representative's
Signature:

Date:

STAMP / PRINTED NAME AND TITLE

Required documentation for waiver evaluation in addition to this form:

1. DD Form 2795, Pre-Deployment Health Assessment with provisional deployment determination by trained DoD healthcare provider.
2. Periodic Health Assessment and Dental exam dates.
3. DD Form 2766, Adult Preventive and Chronic Care Flow sheet with medical summary of Deployment Limiting Condition(s) [DLC].
4. Proof of current immunizations.

Case Summary (To be completed by healthcare provider): Include all clinically relevant information necessary to make a disposition including, but not limited to: Diagnosis (ICD9), history of the condition, date of onset, applied treatments, current treatments, limitations imposed by the condition and/or medications, prognosis and required follow-up. (Use additional sheets, if needed.)

Supplemental documentation (include relevant information for deployability determination):

- a. Specialty consults results establishing diagnosis, treatment, monitoring plan and prognosis.
- b. Recent and relevant surgery, laboratory, pathology and tissue examination reports.
- c. Reports of studies (radiographs, pictures, films or procedures).
- d. Summaries and past medical documents (e.g. hospital summary).
- e. Reports of proceedings (e.g. Tumor Board, Medical Evaluation Boards, etc.)
- f. Job requirements (physical condition, exertion level, etc.)

I have reviewed the case summary and hereby submit this request

Provider's
Signature:

Date:

STAMP / PRINTED NAME AND TITLE

FOR SURGEON'S OFFICE USE ONLY

Waiver Approved (circle one): YES / NO

Waiver
Authority's
Signature:

Date:

STAMP / PRINTED NAME AND TITLE

Comments: