MAMC WARFIGHTER REFRACTIVE EYE SURGERY PROGRAM
COMMANDER’S AUTHORIZATION
(To Be Submitted By All Applicants)

(1) I give my permission for the following active duty Soldier to be considered for treatment under the Warfighter Refractive Eye Surgery Program (WRESP) and to undergo treatment if eligible.

Applicant Name (Print) (Last / First / MI)       Rank       DOD ID

Email Address (.mil)

(2) I certify the following to be true:

Soldier has at least 6 MONTHS remaining on ACTIVE DUTY before ETS.
Soldier has at least 3 MONTHS remaining on JBLM before PCS.
Soldier has no adverse personnel actions or pending medical boards.
Soldier will not receive any immunizations 30 DAYS pre-surgery and 90 DAYS post-surgery.
Soldier will remain CONUS and is NON-DEPLOYABLE for at least 90 DAYS post-surgery.

(3) I realize that after refractive surgery the Soldier will be on CONVALESCENT LEAVE up to 5 DAYS and will have the following PHYSICAL PROFILE for a minimum of 30 DAYS, but possibly up to 90 DAYS in a small number of patients (<5%):

- No parachuting, night operations, driving military vehicles or operating heavy machinery
- No field, range or other duties involving dirty, dusty, or chemical environments.
- No APFT; No physical training first 2 weeks.
- No swimming, scuba, protective mask use or camouflage face paint.
- Must wear sunglasses at all times when outdoors to prevent corneal scarring; allowable to wear indoors for comfort.

(4) I acknowledge Soldier is required to complete minimum of 1-day, 1-week post-operative exams, 1 and 3-month follow-up exams required by the WRESP; 6 and 12-month exams if Soldier is still at JBLM. If deploying, Soldier is required to return to MAMC for exam at the completion of deployment. If PCS after 3 months, soldier must request a managed care agreement and complete care at next duty station.

(5) I acknowledge Soldier 90-day non-deployable status begins after surgery and not from the date this authorization is signed. I will adhere to provider profile recommendations for the health and safety of the Soldier.

__________________________________________
Commander's Signature

__________________________________________
Commander's Rank and Name (Print)

__________________________________________
Date

__________________________________________
Commander's Email Address

__________________________________________
Commander's Telephone Number

__________________________________________
Applicant's Signature

__________________________________________
Date

This authorization is valid for 90 days from the date signed by the commander and must be turned in at first appointment. A new authorization will be required after 90 days or if the commander changes. Commander may revoke authorization at his/her discretion. Failure to comply with post-operative requirements may affect future enrollments from this unit.