MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA

For use of this form, see AR 40-66; the proponent agency is the Office of The Surgeon General.

REPORT TITLE	OTSG APPROVED *(Date)* *(YYYYMMDD)*
COMMANDER'S AUTHORIZATION FOR REFRACTIVE EYE SURGERY	20200817

Irwin Army Community Hospital (IACH) Warrior Refractive Eye Surgery Program
Phone: (785) 240-7335

The following Soldier is interested in refractive eye surgery to reduce his/her need for corrective lenses:

Rank_____Name_____Last Four SSN_____MOS Type _____[ ] Combat Arms
[ ] Non-Combat Arms

1. Soldier's earliest potential deployment date is_____(DD MMM YY, or N/A)

2. Soldier meets the following criteria:
a. At least 21 years old by the date of surgery (exceptions handled on a case by case basis)
b. At least 6 months remaining on active duty from the date of surgery. End of obligated service date:_____(MMM YY or Indefinite)
c. At least 6 months remaining at Fort Riley (in the same or similar unit) from the date of surgery
d. No adverse personnel actions (e.g., FLAG, UCMJ) pending
e. No Medical Evaluation Board pending

3. After refractive surgery, the Soldier will receive a temporary profile to which the undersigned will adhere:
a. Convalescent leave following surgery: 5 days for LASIK, 7 days for PRK, 10 days for ICL surgery
b. No field training, firing of weapons, driving of military vehicles, sea duty, swimming, or airborne jumps for 1 month
c. No organized PT for 1 month; Soldier may conduct PT at their own pace beginning 2 weeks after surgery
d. No gas chamber or OC spray training for 3 months
e. No wearing of CBRN mask or face paint for 1 month
f. Sunglasses may need to be worn outdoors & in bright lights for a minimum of 3 months
g. No deployments or TDY for at least 1 month after LASIK and ICL; 3 months after PRK

4. Soldier will appear at all follow-up appointments to ensure proper healing at IACH Eye Clinic. Minimum appointments required:
a. PRK: 1 week / 1 month / 3 months
b. LASIK: 1 day / 1 week / 1 month / 3 months
c. ICL: 1 day / 1 week / 1 month / 3 months

5. This authorization is valid for 6 months from the date below.
a. A new authorization must be completed if the Soldier transfers to another unit, another officer assumes command, or if surgery cannot be performed within 6 months of the date below.
b. An Assumption of Command memorandum must accompany this authorization form if it is signed by someone other than the Commander.
c. The undersigned will notify IACH Eye Clinic immediately if the Soldier's circumstances change and they no longer meet the above criteria.

6. By signing below, the Soldier and Commander agree with all the above statements.

Soldier's Signature _____

Commander's Signature _____

Commander's Name (print) _____

Commander's Phone Number _____

Commander's Email address _____

Date of Signature _____

(Continue on reverse)

PREPARED BY *(Signature & Title)*	DEPARTMENT/SERVICE/CLINIC	*DATE (YYYYMMDD)*
	IACH Eye Clinics	

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name –last, first, middle; grade; date; hospital or medical facility)*

- ☐ HISTORY/PHYSICAL
- ☐ FLOW CHART
- ☐ OTHER EXAMINATION OR EVALUATION
- ☐ OTHER *(Specify)*
- ☐ DIAGNOSTIC STUDIES
- ☐ TREATMENT

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