



DEPARTMENT OF THE ARMY
 U.S. ARMY MEDICAL DEPARTMENT ACTIVITY
 1650 COCHRANE CIRCLE
 Fort Carson, Colorado 80913-4604

**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 enrollment in the War fighter Refractive Eye Surgery Program (WRESP) and for treatment if eligible.

 Patient Name (Print) (Last / First / MI) Rank, Last 4 of SSN

 Current Separation Date(ETS)

 Patient AKO Email Address

DO NOT STATE INDEF

(2) I certify the following to be true:

The Soldier has at least **18 MONTHS** remaining on **ACTIVE DUTY (see Separation date above)**.

The Soldier has at least **6 MONTHS** remaining on **FORT CARSON**

The Soldier has no adverse personnel actions pending including medical boards.

The Soldier will remain in the Fort Carson Vicinity for 30 days after the surgery.

The 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 **SEVEN 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 (<10%):

No parachuting, diving, night operations or driving military vehicles.

No field, range or other duties involving strenuous activity including APFT.

No swimming, protective mask use or uses of camouflage face paint.

May wear sunglasses at any time for the first six months at the soldier's discretion.

(4) I acknowledge that **RESERVE** Soldiers are **NOT** eligible for treatment unless they are **AGR** (Active Guard/Reserve) and have at least **18 MONTHS ACTIVE DUTY** remaining at the time of their surgery.

(5) I acknowledge this Soldier is required to complete 1, 3, 6 and 12-month **FOLLOW-UP EXAMS** required by the WRESP, or if deploying they are required to then return to Ft. Carson for a post-operative exam at the completion of their deployment.

(6) Failure to comply with the post-operative care requirements may affect future enrollments from the Soldier's unit.

(7) Soldier pending MEB/MMRB Yes/No (Please Circle)

 Commander's Signature Commander's Rank and Name (Print) Date

 Commander's Email Address Commander's Telephone Number

 Applicant's Signature Date

THIS AUTHORIZATION MUST BE TURNED IN PRIOR TO THE SCHEDULING OF THE SOLDIER'S PREOPERATIVE APPOINTMENT.