USAFRICOM Medical Waiver Request

Using encrypted email, send this form and all scanned documentation to email address identified in ACI 4200.09
For assistance DSN Contact Phone Number: USAFRICOM HQ 324-591-0705

Patient Name (Last, First): **DOB:** **SSN (last 4):**

Age: **Sex:** Male **Rank/ Grade:** **Service:**

Deployment/Travel Date: **Travel Duration (days):** **Destination (country):**

MOS/AFSC/Skill Identifier/Job Description: **Home Station/Unit:**

Active/Reserve/Civilian/Contractor: Active Duty

Requester POC(Medical Personnel)Name/E-mail/Phone:

Summary of medical condition(s):

I understand the potential risks associated with this deployment limiting condition. For this individual, I am requesting a waiver of the health requirement for travel to the USAFRICOM Area of Operation.

Commander or Designee Signature: **Date:** STAMP / PRINTED NAME AND TITLE

Required documentation for waiver evaluation in addition to this form:
DD Form 2766, Adult Preventive and Chronic Care Flow sheet, with full medical history including all medical conditions, surgeries, medications, and summary of Deployment Limiting Condition(s). DoD Civilians/Contractors who are age 40 and older must have, documented BMI, and a 10-year atherosclerotic cardiovascular disease (ASCVD) risk percentage calculated. (http://tools.acc.org/ASCVD-Risk-Estimator-Plus/#!/calculate/estimate/)

Case Summary (To be completed by healthcare provider): Include all clinically relevant information necessary to make a disposition including, but not limited to: Diagnosis (ICD-10), history of the condition, date of onset, prior treatments, current treatments, limitations imposed by the condition and/or medications, prognosis, and required follow-up. *(Use additional sheets, if needed. The more clinical information provided, the better.)*

Supplemental documentation (include information relevant 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: **YES** ◯ **NO** ◯

Waiver Authority Signature: **Date:** STAMP / PRINTED NAME AND TITLE

Comments: