

**USAFRICOM Medical Waiver Request, AC Form 43**

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**

<b>Patient Name (Last, First):</b>		<b>DOB:</b>	<b>SSN (last 4):</b>
<b>Age:</b>	<b>Sex:</b>	<b>Rank/ Grade:</b>	<b>Service:</b>
<b>Deployment/Travel Date:</b>		<b>Travel Duration (days):</b>	<b>Destination (country):</b>
<b>MOS/AFSC/Skill Identifier/Job Description:</b>		<b>Home Station/Unit:</b>	
<b>Active/Reserve/Civilian/Contractor:</b>			
<b>Requester POC(Medical Personnel)Name/E-mail/Phone:</b>			
<b>Summary of medical condition(s):</b>			

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. | d. Summaries and past medical documents (e.g. hospital summary).              |
| b. Recent and relevant surgery, laboratory, pathology and tissue examination reports.           | e. Reports of proceedings (e.g. Tumor Board, Medical Evaluation Boards, etc.) |
| c. Reports of studies (radiographs, pictures, films or procedures).                             | 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**

**K Uj Yf**

**5 i R cf]m**

**Signature:**

**Date:**

STAMP / PRINTED NAME AND TITLE

**Comments:**

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