USAFRICOM Medical Waiver Request

Email this form and all scanned documentation to africom.stuttgart.acsg.mbx.j004-force-health-protection@mail.mil
Do not send encrypted emails to this address. Use AMRDEC or contact DSN: 314-421-2263 for assistance
DSN Contact Phone Numbers: AFAFRICA: 314-480-7443; CJTF HOA: 311-824-4281; MARFORAF/NAVAF: 314-626-4690; SOCAF: 314-421-3339; USARAF: 314-634-5380; USAFRICOM HQ: 314-421-4741

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

Age: **Sex:** Female **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 medical summary of Deployment Limiting Condition(s).

Case Summary (To be completed by healthcare provider): Include all clinically relevant information necessary to make a disposition including, but not limited to: Diagnosis (ICD10), 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: