

**USAF WARFIGHTER CORNEAL REFRACTIVE SURGERY APPLICATION**

Application IAW USAF-CRS Warfighter Program Management (READ ALL INSTRUCTIONS PRIOR TO COMPLETING FORM)

This form and other USAF-RS Tools are available on AF Knowledge Exchange (DotMil) [USAF-CRS website](#)

or Public Access [Public Access](#)

Application Date:

**APPLICANT INFORMATION**

Last Name	First Name	Middle Initial
SSN (last 4)	DOB	Age
Grade/Rank	Primary AFSC	Sex Male Female
Duty Status	AD If not AD, please include a copy of current orders Other	MAJCOM
Total # months of remaining AD retainability (eligible for elective surgery benefits)		
<b>NOTE: AF personnel MUST HAVE 6 months retainability AFTER the Date of Surgery.</b>		
Unit/Squadron & Office Symbol		Phone (DSN)
Street		
Base / State Zip + 4		
Duty E-mail		
Planned RS treatment Location		

**This application form is for use by USAF Warfighter personnel seeking CRS Treatment at a DOD (military) facility.**

*Aviation / Aviation Related Special Duty (AASD) personnel or AF members seeking treatment at a civilian RS center, please refer to the USAF-CRS website for specific application requirements and forms.*

**FOR USAF-CRS WARFIGHTER PROGRAM MANAGER (WPM) ENDORSEMENT ONLY**

Preferred RS Treatment	Advanced Surface Ablation (ASA) (PRK, Epi-LASIK, LASEK, WFG-PRK)	Intra-Stromal Ablation (ISA) (LASIK, FS-LASIK, WFG-LASIK)	Any Approved USAF RS Procedure	Disposition Date	Permission to Proceed? Yes No
Applicant's Signature				Reviewing Officer's Name/Rank	
				Reviewing Officer's Signature	

**MANDATORY QUESTIONS (APPLICANT MUST INITIAL)**

Initials	I am responsible for reading and complying with the policy and guidelines of USAF-CRS Program available at: <a href="https://kx.health.mil/kj/kx1/AFRefractiveSurgery/Pages/home.aspx">https://kx.health.mil/kj/kx1/AFRefractiveSurgery/Pages/home.aspx</a> or (Public Access) <a href="http://www.wpafb.af.mil/Welcome/Fact-Sheets/Display/Article/841456/usafsam-usaf-corneal-refractive-surgery-program/">http://www.wpafb.af.mil/Welcome/Fact-Sheets/Display/Article/841456/usafsam-usaf-corneal-refractive-surgery-program/</a> .
Initials	I understand I am <b>NOT</b> authorized to undergo refractive surgery until I have received "Permission to Proceed" authorization from the USAF-CRS Warfighter Program Manager. If granted "Permission to Proceed" authorization, the treatment is not guaranteed. Final decision to treat will be made by the treating refractive surgeon.
Initials	I understand my Commander's Authorization <b>expires 6 months</b> from the date of their signature. If I am unable to complete treatment within this authorized period, I will obtain a new Commander's Authorization which must be submitted to the Warfighter Program Manager. A valid authorization is mandatory for USAF-CRS treatment.
Initials	I must inform my primary care manager and eye care provider upon surgery treatment, any required follow-up care, and in the event of any complications. If follow-up examinations as required by policy is not accomplished, I may be restricted from duty until in compliance.
Initials	I understand the final decision whether to perform CRS and/or recommended technique will be determined by my treating surgeon. At any time, I may be disqualified for corneal refractive surgery or I may elect not to undergo treatment.
Initials	If I am disqualified as a CRS candidate, I am not eligible for reimbursement of expenses incurred for travel to/from the DoD RS center, including, but not limited to travel, meals, and lodging. (This does not apply if I am unit-funded.)
Initials	I understand I may require or continue to require reading and/or distance prescription correction for best vision after surgery. Furthermore, I understand there is a chance I cannot be fit with contact lenses for vision correction, if desired, after CRS.
Initials	I understand CRS is a non-reversible, alteration of my vision and, even with optimal outcome, my vision may change over time.
Initials	I understand my vision will require time to fully recover following CRS Surgery and there is a risk of not meeting relevant vision standards after CRS. Therefore, I may be disqualified from certain careers, duties, or even continued military service.

**Submission of application package:** If choosing an AF CONUS CRS Center, contact and submit completed package to desired Center. If choosing a non-AF RS center or OCONUS center, submit completed package for review to: the WPM - Joint Service Refractive Surgery Center, Lackland AFB: [usaf.jbsa.59-mdw.mbx.warfighter-refractive-surgery-center@mail.mil](mailto:usaf.jbsa.59-mdw.mbx.warfighter-refractive-surgery-center@mail.mil)

AF RS CENTER	DSN - Voice	COM - Prefix	FAX	Email Address
Lackland AFB	554-2010/3495/4420	210-292-xxxx	xxx-2313/2813	<a href="mailto:usaf.jbsa.59-mdw.mbx.warfighter-refractive-surgery-center@mail.mil">usaf.jbsa.59-mdw.mbx.warfighter-refractive-surgery-center@mail.mil</a>
Air Force Academy	333-0525	719-333-xxxx	xxx-9774	<a href="mailto:usaf.usafa.10-mdg.mbx.10-mdg-sgose@mail.mil">usaf.usafa.10-mdg.mbx.10-mdg-sgose@mail.mil</a>
Andrews AFB	857-1730	240-612-xxxx	xxx-8226	<a href="mailto:usaf.ibanafw.779-mdg.mbx.wfec-andrews@mail.mil">usaf.ibanafw.779-mdg.mbx.wfec-andrews@mail.mil</a>
Keesler AFB	591-0567	228-376-xxxx	xxx-0155	<a href="mailto:usaf.keesler.81-mdg.mbx.refractive-surgery-org@mail.mil">usaf.keesler.81-mdg.mbx.refractive-surgery-org@mail.mil</a>
Travis AFB	799-3146	707-423-xxxx	xxx-3529	<a href="mailto:usaf.travis.60-mdg.mbx.dqmciasercenter@mail.mil">usaf.travis.60-mdg.mbx.dqmciasercenter@mail.mil</a>
Wright-Patterson AFB	986-0970 / 1447	937-656-xxxx	xxx-0973	<a href="mailto:usaf.wright-patt.88-mdg.mbx.laser-center@mail.mil">usaf.wright-patt.88-mdg.mbx.laser-center@mail.mil</a>
JB Elmendorf-Richardson	317-580-2020/5523	907-580-xxxx	xxx-1152	<a href="mailto:usaf.iber.673-mdg.mbx.673-refractive-surgery@mail.mil">usaf.iber.673-mdg.mbx.673-refractive-surgery@mail.mil</a>

**WARFIGHTER CRS APPLICATION: OCULAR/REFRACTIVE STATUS**

(TO BE COMPLETED BY THE APPLICANT'S EYE CARE PROVIDER)

Examination data submitted for Permission-to-Proceed consideration must have been accomplished within 6 months of application date.

Evaluation Date	Last Name	First Name	Middle Initial	SSN (last 4)
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Date contacts last worn	<b>Contact Lens Wear History</b>		
	Type Worn	N/A	How many days since last worn?
	SCL	RGP	

**Pachymetry (if available locally)**

OD	microns
OS	microns

Prior to any evaluation/CRS treatment - contact lens use must be discontinued.

**SCL for minimum 14 days.  
HCL / RGP for minimum 90 days**

**Prior Manifest Refraction Date:**

Must be >12 months prior to current exam

OD	-	X
OS	-	X

**MANIFEST REFRACTION TO BEST VISUAL ACUITY**

OD	-	X	20/
OS	-	X	20/

Cycloplegic Refraction recommended for **OCONUS** patients traveling to **CONUS** CRS centers

OD:	-	X	20/
OS:	-	X	20/

Additional Comments:

**CONTRAINDICATIONS / WARNINGS**

Please review the conditions listed in the USAF-CRS Clinical Guidelines [here](#)

Please make comments in the block below

Age < 21	Yes	No
> 0.50 D change in any meridian in past year	Yes	No
Diabetes Mellitus	Yes	No
Thyroid Disease	Yes	No
Pregnant/Nursing during last 6 months	Yes	No
Electronic Pacemaker/similar cardiac device	Yes	No
Autoimmune disease/immunodeficiency	Yes	No
Current/Recent use of:		
Accutane (Isotretinoin)	Yes	No
Imitrex (Sumatriptan)	Yes	No
Cordarone (Amiodarone)	Yes	No
Steroids	Yes	No
INH	Yes	No
Any Immunosuppressive Drug	Yes	No
Severe dry eyes/atopic disease	Yes	No
IOP > 21 / glaucoma (or suspect)	Yes	No
Keratoconus or corneal irregularity	Yes	No
History of HSV / HZV keratitis	Yes	No
Active Ophthalmic disease	Yes	No
Corneal scars in central 8mm of cornea	Yes	No
Corneal NV > 2mm from limbus	Yes	No
Visually significant cataract	Yes	No
Hx of prior refractive surgery	Yes	No
Other pertinent ocular history	Yes	No

**CORNEAL TOPOGRAPHY (Explain Abnormal in comments)**

OD		OS	
Normal	Abnormal	Normal	Abnormal

I have read and will comply IAW AFI 48-123, para 6.20.5 dated 05 November 2013	Yes	No
I am a USAF Certified RS eyecare provider	Yes	No
Will a USAF Certified RS eyecare provider be available for post operative care?	Yes	No
In your professional opinion, does the applicant meet USAF RS criteria?	Yes	No

**COMMENTS:**

**EYECARE PROVIDER CONTACT INFORMATION**

Eye Care Provider's Name/Rank	Unit/Squadron & Office Symbol	Phone (DSN)
Street	Base / State	Zip + 4
Duty E-mail	Eye Care Provider's Signature	