

USAF REFRACTIVE SURGERY APPLICATION - Aviation & Aviation-Related Special Duty For

application IAW USAF-RS AASD Program Management (READ ALL INSTRUCTIONS PRIOR TO COMPLETING FORM)

This form and other USAF-RS Tools are available on AF Knowledge Exchange (DotMil) <https://kx.afms.mil/USAF-RS>

or Public Access <http://airforcemedicine.afms.mil/USAF-RS>

Application Date:

APPLICANT INFORMATION **AASD PERSONNEL ONLY**

Last Name	First Name	Middle Initial	Actively Flying <input type="checkbox"/> Yes <input type="checkbox"/> No	Current Aircraft of Assignment
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SSN (last 4)	DOB	Age	Crew/Duty Position	Aviation Service Code (ASC)
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Grade/Rank	Primary AFSC	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Total # of Military Flying Hours	Total # of Flying Hours in Last 6 Month
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Duty Status AD AGR AFRes ANG Other MAJCOM

FLIGHT SURGEON CONTACT INFORMATION

Total # months of remaining AD retainability (eligible for elective surgery benefits)	Unit/Squadron & Office Symbol	Phone (DSN)
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NOTE: AF personnel MUST HAVE 6 months retainability AFTER the Date of Surgery.

Street

Unit/Squadron & Office Symbol	Phone (DSN)
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Base / State
Zip + 4

Street

Duty E-mail

Base / State
Zip + 4

Flight Surgeon's Name/Rank

Duty E-mail

I have read and will comply with AF guidance on CRS for AASD Personnel

Planned RS treatment Location

Flight Surgeon's Signature

Preferred RS Treatment Advanced Surface Ablation (ASA) (PRK, WFG-PRK, LASEK, Epi-LASIK) Intra-Stromal Ablation (ISA) (LASIK, WFG-LASIK, FS-LASIK) Any Approved USAF RS Procedure

FOR USAF-RS AASD PROGRAM MANAGER (APM) ENDORSEMENT ONLY

Disposition Date	Permission to Proceed? <input type="checkbox"/> Yes <input type="checkbox"/> No
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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-RS Program available at: (DOD Dot.mil) <https://kx.afms.mil/USAF-RS> or (Public Access) <http://airforcemedicine.afms.mil/USAF-RS>.

Initials I understand I am NOT authorized to undergo refractive surgery until I have received "Permission to Proceed" authorization from the USAF-RS Aviation 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 expires 6 months from the date of their signature. If I am unable to complete treatment within this authorized period, I obtain a new Commander's Authorization which must be submitted to the Aviation Program Manager. A valid authorization is mandatory for USAF-RS treatment.

Initials I must inform my flight surgeon 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 or be placed on DNIF status until in compliance.

Initials I understand the final decision whether to perform RS and/or recommended technique will be determined by my treating refractive surgeon. At any time, I may be disqualified for refractive surgery or I may elect not to undergo treatment.

Initials If I am disqualified as a RS 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 RS.

Initials I understand RS 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 from RS treatment and there is a risk that I may not meet applicable AF vision standards. If unable to meet relevant standards, I may be disqualified from certain careers, duties, or even continued military service.

E-mail application and all supporting documents to: USAFSAMAircrewProgramManager@wpafb.af.mil
Aviation Program Manager
USAFSAM/FECO
Wright-Patterson AFB, OH

Voice: Commercial (937) 938-2684 / 2676 == DSN 798-2684 / 2676

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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Uncorrected Visual Acuity	Pupil Size (indicate method used)	Contact Lens Wear History
OD 20 / <u> </u> OS 20 / <u> </u> OD OS OD OS microns OD OS microns	OD OS Imm Imm <input type="checkbox"/> Infrared Pupilometry (lights off) <input type="checkbox"/> Humphrey Visual Field (lights off) <input type="checkbox"/> PD Ruler (min light to see pupils) <input type="checkbox"/> Other	Type Worn <input type="checkbox"/> N/A <input type="checkbox"/> SCL <input type="checkbox"/> RGP How many days since last worn? Prior to any evaluation/CRS treatment - contact lens use must be discontinued. SCL for minimum 30 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 / <u> </u>
OS	-	X	20 / <u> </u>

Visual Acuity is calculated from the total number of letters correctly identified. Encourage patient to identify as many letters as possible. Precision Vision charts should be used IAW USAF CRS guidance. Information to obtain PV charts available online: AF Knowledge Exchange

CORRECTED VISUAL ACUITY (AASD ONLY)

OD	OS
PV (High Contrast)	PV (5% Contrast)
# letters 20/xx	# letters 20/xx
20 / <u> </u>	20 / <u> </u>
# letters 20/xx	# letters 20/xx
20 / <u> </u>	20 / <u> </u>

Chart to Patient Distance used for testing as measured in meters. Standard is 4 meters (13.1 ft)

CYCLOPLEGIC REFRACTION TO BEST VISUAL ACUITY

OD	-	X	20 / <u> </u>
OS	-	X	20 / <u> </u>

KERATOMETRY Check box if Irregular Mires

OD	@	/	@	<input type="checkbox"/>
OS	@	/	@	<input type="checkbox"/>

CORNEAL TOPOGRAPHY Explain Abnormal

OD	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal
OS	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal

SLIT LAMP EXAM Explain Abnormal in comment box

OD	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	IOP	mmHg
OS	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	IOP	mmHg

DILATED FUNDUS EXAM Explain Abnormal

OD	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal
OS	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal

Patient to fill out:

CONTRAINDICATIONS / WARNINGS

Age < 21	<input type="checkbox"/> Yes <input type="checkbox"/> No
Pregnant /Nursing during last 6 months	<input type="checkbox"/> Yes <input type="checkbox"/> No
Diabetes Mellitus	<input type="checkbox"/> Yes <input type="checkbox"/> No
Thyroid Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Severe dry eyes / atopic disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Electronic Pacemaker/similar cardiac device	<input type="checkbox"/> Yes <input type="checkbox"/> No
Autoimmune disease / immunodeficiency	<input type="checkbox"/> Yes <input type="checkbox"/> No
Psoriasis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Dermatitis Herpetiformis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Pemphigus Vulgaris	<input type="checkbox"/> Yes <input type="checkbox"/> No
Vitiligo	<input type="checkbox"/> Yes <input type="checkbox"/> No

Current/ Recent use of:

Accutane (Isotretinoin)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Imitrex (Sumatriptan)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cordarone (Amiodarone)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Steroids	<input type="checkbox"/> Yes <input type="checkbox"/> No
INH	<input type="checkbox"/> Yes <input type="checkbox"/> No

Eye Care Provider to fill out:

> 0.50 D change in sph or cyl in past 12 mos.	<input type="checkbox"/> Yes <input type="checkbox"/> No
IOP > 21 / glaucoma (or suspect)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Keratoconus or corneal irregularity	<input type="checkbox"/> Yes <input type="checkbox"/> No
History of HSV / HZV keratitis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Active Ophthalmic disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Corneal scars/ Neovascularization	<input type="checkbox"/> Yes <input type="checkbox"/> No
Corneal NV > 2mm from limbus	<input type="checkbox"/> Yes <input type="checkbox"/> No
Visually significant cataract	<input type="checkbox"/> Yes <input type="checkbox"/> No
Hx of prior refractive surgery	<input type="checkbox"/> Yes <input type="checkbox"/> No
Other pertinent ocular history	<input type="checkbox"/> Yes <input type="checkbox"/> No

I have read and will comply IAW AFI 48-123, Chapter 12 dated 24 September 2009 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	