DEPARTMENT OF THE ARMY
WARFIGHTER REFRACTIVE EYE SURGERY PROGRAM
WOMACK ARMY MEDICAL CENTER
FORT BRAGG, NORTH CAROLINA 28310

MEMORANDUM FOR RECORD

SUBJECT: Refractive Eye Surgery Application

I ____________________________, ____________ , ______ , have reviewed the information
Name DOD ID MOS

available at https://womack.tricare.mil/Health-Services/Vision/-Warfighter-Refractive-Eye-Surgery-Program for the Warfighter Refractive Eye Surgery Program at Womack Army Medical Center. I understand that wearing contact lenses interferes with the preparation and performance of refractive eye surgery. I am aware that *soft* contact lenses must be removed for **2 WEEKS** prior to any preoperative or surgery appointments. Rigid Gas Permeable (*hard*) contact lenses must be removed for **1 MONTH** prior to any preoperative or surgery appointment. I have been informed that I must remove my contact lenses, if applicable, prior to requesting a preoperative appointment for me, therefore, as of____________________, I have removed my contact lenses and agree not to wear them again. Date taken out

Pregnancy and breastfeeding may alter your glasses prescription which could adversely affect outcomes after surgery. To my knowledge, I am not pregnant and have not been breastfeeding within the last 6 months.

I understand that I am required to have a driver on the date of my surgery and all postoperative/ follow up appointments until the doctor has cleared me to drive. If I choose to call my driver after my surgery is completed, I understand I will not be permitted to leave the clinic until my driver arrives. In the event of a schedule conflict, or if I cannot attend my appointment, it is my responsibility to notify the Refractive Eye Clinic prior to the appointment time.

I understand that it is my responsibility to keep all follow-up appointments scheduled with the Refractive Eye Clinic. I am aware that the follow-up period after refractive eye surgery is one year and that I am expected to be evaluated at least: 1 day, 7 days, 30 days, 60 days, 90 days and 6 months following surgery.

My signature acknowledges that I will comply with all rules set forth by the Refractive Eye Clinic. Failure to comply may result in my being deemed ineligible for refractive eye surgery and possible punishment under the Uniformed Code of Justice (UCMJ).

Patient Signature:

Phone number:

Email Address:

DEPARTMENT OF THE ARMY

REPLY TO
ATTENTION OF:

MEMORANDUM FOR Commander Womack Army Medical Center
ATTN: Warfighter Refractive Eye Surgery Clinic, Fort Bragg, NC 28310

SUBJECT: Commander's Endorsement of Refractive Eye Surgery

1. I endorse to be evaluated and considered for enrollment in the Refractive Eye Surgery Program. The service member listed above, as of date of this endorsement, has at least six months retainability in service.

   a) Scheduled ETS/retirement date is _______________
   b) Date of Deployment is _______________

2. I acknowledge that, following surgery, the service member listed above must keep all follow-up appointments.

3. I acknowledge that the service member listed above will have profile for 30 days, with the following limitations:
   a) No Airborne operations
   b) No swimming
   c) No night operations

4. I acknowledge that the service member listed above cannot be deployed for 30 days for LASIK and 90 days for PRKw/MMC, after surgery.

5. This endorsement expires 180 days from date of memorandum.

6. The point of contact for this action is the undersigned at or
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