

Attachment A: USSOUTHCOM Medical Waiver Request Form (2022-2024)

General Instructions: Please complete, sign form and attach any supporting medical documentation necessary to make a disposition.

Patient Name: Last, F MI: _____ DOB: _____ DODID#: _____

USA/USN/USAF/USMC/USCG: _____ Deployment Destination: _____ Diagnosis (Lay term): _____

Grade: _____ Age: _____ Gender: _____ Job/MOS: _____ Home Station: _____

Currently Deployed? _____ Expected Deployment Date: _____ Deployment Length: _____

Previous waivers on file? _____ AD/NG/Reserve/Civilian/CTR: _____ Unit: _____

Waiver POC Name/E-mail/Phone: _____

Instructions for Medical Provider (MD/DO, PA/NP, PsyD/LCSW): Include clinical summary and a thorough risk mitigation plan. Refer to Attachment B "Amplification of Minimal Standards of Fitness", Attachment C "Waiver Process" and Attachment D "Force Health Protection Guidance" for required information. Once signed, submit ENCRYPTED waiver packet to corresponding component surgeon found in Attachment C . Allow up to 15 days for processing.

Medical Provider Recommendation: ____ YES ____ NO

Unit Commander

Signature: _____

Signature: _____

USSOUTHCOM Section ONLY

Waiver Approval: YES NO

Signature: _____ Date: _____

Comments:

DISCLAIMER: This document may contain confidential information exempt from mandatory disclosure under the Freedom of Information Act (FOIA) of 1986 {Public Law 99-570, 5 USC 552(B)} and is legally privileged under the Privacy Act, 5 USC 552(a), and/or the Health Insurance Portability and Accountability Act (PL 104-191) and its various implementing regulations. You are obligated to maintain it in a safe, secure and confidential manner. Unauthorized redisclosure or failure to maintain confidentiality subjects you to application of appropriate civil and federal criminal sanctions. If you have received this correspondence in error, destroy any copies you have made and notify the sender.