(Office Symbol)_____ (Date)_____

MEMORANDUM TO OIC, Center for Refractive Surgery Center, WRAMC

SUBJECT: Commander's Endorsement of Refractive Eye Surgery

1. I hereby give my endorsement/permission for the below listed active duty soldier to be evaluated and considered for enrollment in the warfighter refractive eye surgery program (WRESP) and for their treatment if eligible.

Name: _____
Last **First** **MI**
SSN: _____ **ETS DATE:** _____
RANK: _____ **SERVICE:** _____
DUTY TITLE: _____ **MOS:** _____
ASSIGNED UNIT: _____
CONTACT ADDRESS: _____
CONTACT PHONE: (DAY)_____**(EVES)**_____
E-MAIL ADDRESS: _____

2. I realize that after the surgery, the soldier will have the following profile for a minimum of 30 days (100%), but possibly up to 90 days in a small number of patients (<10%).
   a. No parachuting
   b. No diving
   c. No night operations
   d. No duty requiring strenuous activities to include APFT

3. Must keep all follow-up appointments with refractive eye surgery clinic to avoid potential complications.

4. I further realize that the soldier must remain CONUS for at least 30 days following the surgery.

5. The soldier will be on unit convalescent leave for up to 96 hours following surgery.

6. The soldier has a minimum of 18 months active duty service commitment remaining.

7. National Guard and Reserves are not eligible for treatment under the WRESP

_____ _____ _____
Applicants Signature Commander's signature Date

_____
Commander's Name and Rank

_____
Unit

_____
Commander's Telephone number and e-mail