Laser Refractive Surgery Waiver Form
for
United States Army Ranger Training
(Post-PRK or Post-LASIK)

Part I. To be completed by applicant:
Name: ______________________________________   Rank:  ______  Age:_____  DOB:____________
Address: _____________________________________________________________  Zip:___________
Phone: Home (____)__________________   Work (____)_____________________
Unit of Assignment:___________________________________________________
Surgery Date: _____________     Type: PRK or LASIK
(Must be at least 3 months prior to waiver request)
1. I do___do not___have difficulty with glares or haloes at night
2. I do___do not___have difficulty with daily activities such as driving, reading, signs at night, or being exposed to bright sunlight.
3. I do___do not___have double vision.
4. List any topical eye drops/medication you are using or have used in the last month:________________

Part II. (To be completed by Ophthalmologist):
1. Location of Surgery: __________________  Surgeon: ___________________Phone: _____________
2. Flap Size: _________________     Enhancement Date: _____________________
3. Pre-Laser Treatment Refractive Error: _______(sph)_______(cyl)_______(axis) OD
   (Must be documented in pt record) _______(sph)_______(cyl)_______(axis) OS
4. Post-Laser Treatment Refractive Error: _______(sph)_______(cyl)_______(axis) OD  Date:_________
   _______(sph)_______(cyl)_______(axis) OS  Date:_________
5. Best Uncorrected visual acuity:  (sc)  _______ OD     _______ OS    Date: ___________
   Best Corrected visual acuity:      (cc)  _______ OD     _______ OS    Date: ___________
6. Eye Alignment (use Prism Diopters in Primary Position) _____________________________________
   Eye Motility:________________________________________________________________________
7. Red/Green Color Blind  _____ YES  _____ NO     Type of Test: ________________
8. Slit Lamp Exam of Cornea-Interface Haze, rippling/displacement of flap; scarring?
   ___________________________________________________________________________________
9. Dilated Fundus Exam:
   ___________________________________________________________________________________
Any additional observations/other relevant eye diagnosis (eg. Keratoconus): ________________________
   ___________________________________________________________________________________
   ___________________________________________________________________________________
   ___________________________________________________________________________________
   ___________________________________________________________________________________
   ___________________________________________________________________________________
   ___________________________________________________________________________________

___After evaluation, I find no limitations that would inhibit the soldiers successful completion of Ranger Training. (Examiners initials)

Name: _________________________          Rank: ____            Location: ________________
Note:
1. Requirements are in accordance with OTSG’s 04 Feb 2002 memorandum pertaining to medical waivers for individuals with a history of PRK or LASIK surgery. (see attached)

2. All data will be utilized in an on-going study by Ft. Benning EENT clinic on the effects of previous Laser eye surgery with Ranger training.

3. Waiver Data sheet **MUST** accompany soldiers Ranger Physical when presenting to Ft. Benning. Failure of soldier to produce validity of evaluation will result in dismissal from course.

4. Any questions can be e-mailed to bergesone@benning.army.mil, RTB PA or call DSN: 784-6918  COM: (706) 544-6918.