

CENTCOM Medical Waiver Form

[NOTE: This document is ONLY for use by MTFs *without* Waivers Web access . Please email to the appropriate POC listed below.]

WARNING – This document has been opened in a PDF-viewer or web browser which does NOT allow the execution of JavaScript. That means this *fillable form*

CANNOT function *properly*. It **MUST** be completed

using Adobe Acrobat (or other full-featured PDF-editing software). Please SAVE the document locally, navigate

to the file's saved location, 'RIGHT-CLICK' on the

filename and choose 'Open with' to launch Acrobat (or some other *standalone* PDF editor) to fill out the form.

-- Thanks for your understanding and cooperation!

3. Indicate if any items below apply to this member/movement & *attach* any relevant documents.

a) History of Medical Evaluation Board (MEB). Attached results.

b) Profile/LIMDU. List all restrictions in additional pertinent information box below.

4. For Civilians/Contractors, does supporting documentation provided include documentation of medical history (e.g., DD Form 2807-1)?

**Waiver
Prepared
By**

Name:

E-mail:

Ph. Number:

Date:

For all waivers, *regardless* of diagnosis, *supporting medical documentation* must be submitted with the initial waiver request please contact the individual service component prior to contacting CENTCOM with the exception of the DoD personnel and contractors identified in the paragraph 6.b of tab A of the current MOD, using one of the following encrypted methods. DoD SAFE or secure email to the appropriate component listed in the current mod.

CENTCOM. CENTCOM.MACDILL.CENTCOM-HQ.MBX.CCSG-WAIVER@MAIL.MIL; CML: 813.529.0361/0345; DSN: 312.529.0361/0345
 AFCENT. SG.CLINOPS@AFCENT.AF.MIL; CML: 803.717.7101; DSN: 313.717.7101
 ARCENT. USARMY.SHAW.USARCENT.MBX.SURG-WAIVER@ARMY.MIL; CML: 803.885.7946; DSN: 312.889.7946
 MARCENT. MARCENT.WAIVERS@USMC.MIL; CML: 813.827.7175; DSN: 312.651.7175
 NAVCENT. C5FMEDWAIVERS@US.NAVY.MIL; CML: 011.973.1785.4558; DSN: 318.439.4558
 SOCCENT. SOCCENT.SG@SOCOM.MIL; CML: 813.828.7351; DSN: 312.968.7351

Medical Waiver Narrative Summary

This must be completed for ALL medical waiver packages by a provider familiar with the individual's care.

Condition(s) Requiring Waiver

Primary

Diagnosis Date:

Secondary

Diagnosis Date:

Tertiary

Diagnosis Date:

(CENTCOM does require Vitals data for ALL waivers.)	Vitals	Vitals Date	Lipids (<i>IF</i> medically indicated.)	Lipids Date
	Blood Pressure	Heart Rate	Cholesterol	HDL LDL
	Respiratory Rate	Weight (lbs.)	Triglycerides	ASCVD %

IF SM/civilian has ANY specialist referral(s), is specialty care **ongoing?** or **completed?**
(Please **detail** any/ALL specialty care or investigations projected in the next year.)

HPI: All current medical conditions. Include date of onset, treatment modalities, specialty care, frequency of follow-up, etc.

Pertinent PMH: Comorbid conditions & all past medical conditions (behavioral health, profiles, etc., to incl. mo.& yr of DX).

Physical Examination: Pertinent positive & negative findings & date recorded.

Medications (active). **MUST** include *start date, dose, route & freq'cy.* Specify if injectable, refrig'n or special equipment req'd.

Allergies

Additional Pertinent Information: *E.g.*, most recent radiology &/or lab studies; diagnostic & current polysomnogram (PSG); PFTs (**req'd** in last 6 mos for Asthma); EKG; sub-specialist or MEB narratives or comments; any other *relevant* reports.

CENTCOM BEHAVIORAL HEALTH CLEARANCE CHECKLIST

Must be filled out for **all** waivers.

Note: BOLD conditions <i>may</i> be <i>strictly</i> disqualifying for some COCOMs. Also, starred <i>*timeframes</i> may vary between regions (with indicated duration being the maximum required). Check AOR-specific guidance for details.		YES	NO
1	Psychotic or bipolar-spectrum disorders.		
2	Suicidal Ideation, Suicide Attempt, or Self-Mutilation within the last 12* months.		
3	Behavioral health-related hospitalization within the last 12* months.		
4	Referral to or enrollment in substance abuse program (inpatient, outpatient, or service-specific substance abuse program) within the last 12* months.		
5	<u>Use of antipsychotics</u> OR <u>anticonvulsants</u> OR <u>antimanics</u> (bipolar) for stabilization of DSM-IV-TR or DSM-5 diagnoses.		
6	Benzodiazepines: newly prescribed OR chronic use.		
7	CII Stimulants: to include treatment of ADHD/ADD (Ritalin, Concerta, Adderall, Dexedrine, FocalinXR, Vyvanse, etc.)		
8	Insomnia that requires use of sedative hypnotics/amnestics, benzodiazepines, or antipsychotics (include frequency of use).		
9	Use of 3 or more psychotropic medications (antidepressants, anticonvulsants, antipsychotics or benzodiazepines) for stabilization.		
10	History of TBI/mTBI of any severity		
11	Any DSM-5 diagnosed behavioral health disorder which impairs social and/or occupational performance due to personality disorders, residual symptoms, or medication side effects.		
12	Behavioral health condition that requires recurring behavioral health appointments or consultation greater than once per quarter.		
13	Behavioral health disorders with fewer than 3 months of demonstrated stability from the last change in treatment regimen (medication either new, discontinued, or dose changed; OR change in diagnosis/treatment modality).		
14	Indicate the <u>assessed</u> risk of deterioration &/or recurrence of impairing symptoms in the operational environment. Please explain in narrative. (May be from community provider <i>if concurred</i> by MTF mental health.) Minimal risk Low Moderate High		

Behavioral Health Narrative and Recommendation

Support Approval

Recommend Disapproval

Behavioral Health or Treating Provider Signature:

Provider's/ Reviewer's Summation

To be completed for all waivers and electronically signed by the medical reviewer

	YES	NO
Does member's medical history indicate optimal control of condition? (If no , please explain below.)		
	YES	NO
Does the medical provider recommend member for duty in AOR? (Enter reasoning below.)		

Please enter explanation(s) of waiver recommendation selected above.

Medical Provider	Name:	Ph. Number:
	E-mail:	Signature:

WAIVER ADJUDICATION			
Comments:			
Disposition Authority	COCOM	Component	Date:
Is Waiver Approved?	YES	NO	Signature: