

MOD 17 TAB C

CENTCOM Medical Waiver Request

Patient Name (Last, First): _____ DOB: _____ SSN(Last 4): _____

Previous Deployments: _____ Destination (country): _____ Diagnosis (Lay term): _____

Age: _____ Sex: _____ Grade: _____ Service: _____ Home Station: _____

Years of Service: _____ Active/Reserve/Guard/Civilian: _____ MOS/Job Description: _____

Deployment Length: _____ Previous Waivers (Y/N): _____ Currently Deployed (Y/N): _____

Waiver POC Name/E-mail/Phone: _____

Case Summary (To be completed by provider, including clinical information necessary to make a disposition. See most recent updated MOD 17 and accompanying MOD 17-TAB A for required information. Attach supporting medical documentation (Lack of necessary supporting documentation will result in disapproval):

I have reviewed the case summary and hereby submit this request.

Signature: _____ **Commander Approval:** _____

CENTCOM Surgeon / Component Surgeon Response

Waiver Approval: **YES** **NO**

Signature: _____ **Date:** _____

CENTCOM Command Surgeon

Comments: