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!

Last Name: _____ First: _____ MI: __ DoD ID: _____ Age: ____ DOB: _____

- select - Component: - select - Home Station: _____ MOS/Rating: _____

Select Branch: Army Air Force Submitting MTF: _____ Other MTF: _____

Is member currently Deployed: Yes: ○ No: ○ Prior Waiver for Condition: Yes: ○ No: ○

1a) Tasking CCCOM: - select - Gaining AOR: - select - Assignment Type: - select -

* Estimated Departure Date - when member will leave permanent station (for training en route or directly to AOR)

	YES	NO	N/A
	○	○	☐
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: _____ Ph. Number: _____ E-mail: _____ Date: _____ Reset Checklist

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	- Please Select -		Diagnosis Date: _____
Secondary	- Please Select -		Diagnosis Date: _____
Tertiary	- Please Select -		Diagnosis Date: _____

(CENTCOM *does* require Vitals data for ALL waivers.)

Vitals	Vitals Date _____	**Lipids** (***IF*** 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.

DSN (313) or Comm (803) 717- 7097 / 6410
(Osbia Watson, MEDXS Waiver Supt. Coord.)

CENTCOM BEHAVIORAL HEALTH CLEARANCE CHECKLIST

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

Note: **BOLD** conditions ***may*** be *strictly* disqualifying for some COCOMs. Also, starred **timeframes* 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	Use of antipsychotics OR anticonvulsants OR antimanics (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 assessed risk of deterioration &/or recurrence of impairing symptoms in the operational environment. Please explain in narrative. (May be from community provider *if* **concurred** by MTF mental health.) ○ Minimal risk ○ Low ○ Moderate ○ High		

Behavioral Health Narrative and Recommendation

Reset BH Checklist

○ Support Approval ○ Recommend Disapproval

Behavioral Health or Treating Provider Signature: _____

DSN (313) or Comm (803) 717- 7097 / 6410
(Osbia Watson, MEDXS Waiver Supt. Coord.)

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: _____

Validate Form

WAIVER ADJUDICATION

Comments:

Disposition Authority ○ COCOM ○ Component **Date:** _____

Is Waiver Approved? ○ YES ○ NO **Signature:** _____

DSN (313) or Comm (803) 717- 7097 / 6410
(Osbia Watson, MEDXS Waiver Supt. Coord.)