USAF REFRACTIVE SURGERY APPLICATION - Aviation & Aviation-Related Special Duty

For application IAW USAF-RS AASD Program Management (READ ALL INSTRUCTIONS PRIOR TO COMPLETING FORM)

This form and other USAF-CRS Tools are available on AF Knowledge Exchange (DotMil) USAF-CRS Website

Application Date:

APPLICANT INFORMATION

Last Name	First Name, MI		Actively Flying ☐ Yes ☐ No	Current Aircraft of Assignment
SSN (last 4)	DOB	Age	Crew/Duty Position	Aviation Service Code (ASC)
Grade/ Rank	Primary AFSC	Gender ☐ Male ☐ Female	Total # of Military Flying Hours	Total # of Flying Hours in Last 6 Month
Duty Status ☐ AD ☐ Other	If not AD, please include a copy of current orders	MAJCOM		
Total # months of remaining AD retainability (ADSCD from DVB located on vMPF - do not put indefinite)				

NOTE: AF personnel MUST HAVE 6 months retainability AFTER the Date of Surgery.

Unit/Squadron & Office Symbol	Phone (DSN)
Street	
Base / State Zip + 4	
Duty E-mail	
Planned RS treatment Location	

Preferred RS Treatment	☐ Advanced Surface Ablation (ASA) (PRK, WFG-PRK, LASEK, Epi-LASIK)	☐ Intra-Stromal Ablation (ISA) (LASIK, WFG-LASIK, FS-LASIK)	☐ Any Approved USAF CRS Procedure

Applicant's Signature

FLIGHT SURGEON CONTACT INFORMATION

Unit/Squadron & Office Symbol	Phone (DSN)
Street	
Base / State Zip + 4	
Flight Surgeon's Name/Rank	
Duty email	
I have read and will comply with AF guidance on CRS for AASD Personnel	
Flight Surgeon's Signature	

FOR USAF-RS AASD PROGRAM MANAGER (APM) ENDORSEMENT ONLY

Disposition Date	Permission to Proceed? ☐ Yes ☐ No
Reviewing Officer's Name/Rank	
Reviewing Officer's Signature	

MANDATORY QUESTIONS (APPLICANT MUST INITIAL)

Initials	I am responsible for reading and complying with the policy and guidelines of USAF-CRS Program available at: https://kx.health.mil/kj/kx1/AFRefractiveSurgery/Pages/home.aspx
Initials	I understand I am NOT authorized to undergo corneal refractive surgery until I have received "Permission to Proceed" authorization from the USAF-CRS Aviation Program Manager. If granted "Permission to Proceed" authorization, treatment is still not guaranteed. The final decision to treat will be made by the treating refractive surgeon.
Initials	I understand my Commander's Authorization **expires 6 months** from the date of their signature. If I am unable to complete treatment within this authorized time period, I will obtain a new Commander's Authorization which must be submitted to the Aviation Program Manager. A valid authorization is **mandatory** for USAF-CRS treatment.
Initials	I must inform my flight surgeon and eye care provider after surgical treatment, any required follow-up care, and in the event of any complications. I will be placed on a profile and be non-WWQ while on steroids. If follow-up examinations, as required by policy, are not accomplished, I may be restricted from duty or be placed on **DNIF** status until in compliance.
Initials	I understand the final decision whether to perform CRS and/or the recommended procedure will be determined by my treating refractive surgeon. At any time, I may be disqualified for refractive surgery or I may elect not to undergo treatment.
Initials	If I am disqualified as a CRS candidate, I am not eligible for reimbursement of expenses incurred for travel to/from the DoD RS center, including, but not limited to travel, meals, and lodging. (This does not apply if I am unit-funded.)
Initials	I understand I may require or continue to require reading and/or distance prescription correction for best vision after surgery, especially after I am 40 years old. Furthermore, I understand there is a chance I cannot be fit with contact lenses for vision correction, if desired, after CRS.
Initials	I understand CRS is a non-reversible, alteration of my vision and, even with an initial optimal outcome, my vision may change over time.
Initials	I understand my vision will require time to fully recover from CRS treatment. I will be **DNIF** until I recover and meet requirements for a waiver. There is a risk that after surgery I may not meet applicable AF vision standards. If I am unable to meet relevant standards, I may be disqualified from certain careers, duties, or even continued military service.
Initials	I understand that if I have my follow-up evaluations completed at a clinic other than an AF facility, I will contact my AF flight surgeon within 3 days to be put on a profile. I must be evaluated by an AF optometrist prior to being cleared to resume unrestricted duties, and I will bring copies of all my pre-operative, surgical, and follow-up exams for inclusion in my medical records.

E-mail application and all supporting documents to:

Aviation Program Manager
USAFSAM/FECO
Wright-Patterson AFB, OH
(**click to email completed form**) shirley.vance.1.ctr@us.af.mil
Voice: Commercial (937) 938-2684 / 2682 == DSN 798-2684 / 2682

AVIATION (AASD) CRS APPLICATION: OCULAR/REFRACTIVE STATUS (TO BE COMPLETED BY THE APPLICANT'S EYE CARE PROVIDER)

Examination data submitted for Permission-to-Proceed consideration must have been accomplished within 6 months of application date.

Evaluation Date	Date contacts last worn	Last Name	First Name, MI	SSN (last 4)

Uncorrected Visual Acuity		Pachymetry (if available locally)		Contact Lens Wear History
OD 20 /	OS 20 /	OD	OS microns / microns	Type Worn ☐ SCL ☐ N/A ☐ RGP How many days since last worn?

KERATOMETRY Check Box if Irregular Mires

OD	@	/	@	☐
OS	@	/	@	☐

Prior to any evaluation/CRS treatment - contact lens use must be discontinued: SCL for minimum 30 days. HCL / RGP for minimum 90 days

PRIOR MANIFEST REFRACTION Date:

Must be >12 months prior to current exam

OD	-	x	
OS	-	x	

MANIFEST REFRACTION TO *BEST* VISUAL ACUITY

OD	-	x	20/	
OS	-	x	20/	

CORRECTED VISUAL ACUITY

Visual Acuity is calculated from the total number of letters correctly identified.

Encourage patient to identify as many letters as possible.

Precision Vision charts should be used IAW USAF CRS guidance.

Information to obtain PV charts available online: AF Knowledge Exchange

	OD	OS
PV (High Contrast)	# letters / 20/xx	# letters / 20/xx
PV (5% Contrast)	# letters / 20/xx	# letters / 20/xx

The standard "Chart to Patient Distance" used for testing is 4 meters (13.1 ft).

CYCLOPLEGIC REFRACTION TO *BEST* VISUAL ACUITY

	1st drop	2nd drop	Refraction Time	
OD	-	x	20/	
OS	-	x	20/	

CORNEAL TOPOGRAPHY Explain Abnormal

OD ☐ Normal ☐ Abnormal

OS ☐ Normal ☐ Abnormal

SLIT LAMP EXAM Explain Abnormal in comment box

OD ☐ Normal ☐ Abnormal IOP mmHg

OS ☐ Normal ☐ Abnormal IOP mmHg

DILATED FUNDUS EXAM Explain Abnormal

OD ☐ Normal ☐ Abnormal

OS ☐ Normal ☐ Abnormal

CONTRAINDICATIONS / WARNINGS

Please review the conditions listed in the USAF-CRS Clinical Guidelines here

Please make comments in the block below

Age < 21	☐ Yes	☐ No
> 0.50 D change in sph or cyl in past 12 mos.	☐ Yes	☐ No
Diabetes Mellitus	☐ Yes	☐ No
Thyroid Disease	☐ Yes	☐ No
Pregnant/Nursing during last 6 months	☐ Yes	☐ No
Electronic Pacemaker/similar cardiac device	☐ Yes	☐ No
Autoimmune disease/immunodeficiency	☐ Yes	☐ No
Current/Recent use of:		
Accutane (Isotretinoin)	☐ Yes	☐ No
Imitrex (Sumatriptan)	☐ Yes	☐ No
Cordarone (Amiodarone)	☐ Yes	☐ No
Steroids	☐ Yes	☐ No
INH	☐ Yes	☐ No
Any Immunosuppressive Drug	☐ Yes	☐ No
Severe dry eyes/atopic disease	☐ Yes	☐ No
IOP > 21 / glaucoma (or suspect)	☐ Yes	☐ No
Keratoconus or corneal irregularity	☐ Yes	☐ No
History of HSV / HZV keratitis	☐ Yes	☐ No
Active Ophthalmic disease	☐ Yes	☐ No
Corneal scars in central 8mm of cornea	☐ Yes	☐ No
Corneal NV > 2mm from limbus	☐ Yes	☐ No
Visually significant cataract	☐ Yes	☐ No
Hx of prior refractive surgery	☐ Yes	☐ No
Other pertinent ocular history	☐ Yes	☐ No
I have read and will comply IAW DAFMAN 48-123, para 5.7.3. dated 08 December 2020	☐ Yes	☐ No
I am a USAF Certified CRS eyecare provider	☐ Yes	☐ No
Will a USAF Certified CRS eyecare provider be available for post operative care?	☐ Yes	☐ No
In your professional opinion, does the applicant meet USAF CRS criteria?	☐ Yes	☐ No
Was cycloplegic refraction completed using 2 drops of 1% cyclopentolate separated by 5-15 mins	☐ Yes	☐ No

COMMENTS:

EYECARE PROVIDER CONTACT INFORMATION

Eye Care Provider's Name/Rank	Unit/Squadron & Office Symbol	Phone (DSN)
Street	Base / State Zip + 4	
Duty E-mail	Eye Care Provider's Signature	