



USEUCOM Medical Waiver Request

This waiver form is used for all tasking into the EUCOM Area of Responsibility > 30 days, excluding PCS (regardless of assigned COCOM).
Submit electronically per routing instructions **at least 30 days prior to departure**.

SECTION 1: MEMBER DEMOGRAPHICS AND ASSIGNMENT SPECIFICS

Patient Name (Last, First): _____ **DOB:** _____ **Age:** _____ **Sex:** _____ **Ht/Wt/BMI:** _____
Status: _____ **Rank/ Grade:** _____ **Service:** _____ **Home Station/Unit:** _____
Home Station Departure Date: _____ **Report Date:** _____ **Tasking Duration (days):** _____ **PHA Date:** _____
EUCOM Destinations (Bases/Cities/Countries): _____ **DoD ID:** _____
MOS/AFSC Skill Identifier AND Job Description: Briefly describe the job the person will be performing while they are deployed with some detail.

**Medical Unit POC Information
For This Waiver (Name/Title/
Position/E-mail/Phone Number):**

DATE:

**Digital
Signature:**

SECTION 2: MEDICAL NARRATIVE / SUMMARY

Healthcare Provider Only: Include all clinically relevant information necessary to make a disposition including, but not limited to:

- 1) Diagnosis (ICD10 and description): _____
- 2) Current treatments and list of all medications currently taking: _____
- 3) List of all current medical problems being treated or followed: _____
- 4) Limitations imposed by the condition(s) and/or medications: _____
- 5) Prognosis/required follow-up: _____
- 6) Provide a case summary that includes **date of onset, condition history, previous treatments, provider recommendation for or against deployment/ tasking** and other relevant information necessary to determine whether the member can perform duties in a deployed environment. The summary must include status updates for SUDCC/ASAP/ADAPT and behavioral/mental health/PTSD/TBI conditions (Additional Comments can be added on page 3).

- Did you include a specialist letter of input/documentation if condition requires/required specialist referral? ☐
- O-5/O-6 Commander's Endorsement Letter included? ☐
- Sufficient controls to secure controlled substances and excess medications? ☐
- Medical equipment dual voltage and world-wide capable? ☐
- Refrigeration needs addressed? ☐

SECTION 3: ADJUDICATION

**Signature of
PCM, SGH,
specialist or
other qualified
medical
provider:**

DATE:

NAME/TITLE/POSITION/E-MAIL/PHONE NUMBER

**Waiver
Approved:** YES ☐ NO ☐ N/A ☐

**Waiver
Approved:** YES ☐ NO ☐ N/A ☐

**Component
Waiver
Authority
Signature:**

DATE:

**EUCOM/SG
Waiver
Authority
Signature:**

DATE:

Comments:

DoD Guidance Documents: [DoDI 6490.07 - Deployment Limiting Medical Conditions for Service Members](#)

[ASD Policy Memo - Clinical Practice Guidelines for Deployment-Limiting Mental Disorders and Psychiatric Medications](#)

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