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 necesary 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? N/A
- O-5/O-6 Commander's Endorsement Letter included? N/A
- Sufficient controls to secure controlled substances and excess medications? N/A
- Medical equipment dual voltage and world-wide capable? N/A
- Refrigeration needs addressed? N/A

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** ◯

Component Waiver Authority Signature:

DATE:

Waiver Approved: **YES** ◯ **NO** ◯ **N/A** ◯

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