

MOD 15 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 15 and accompanying MOD 15-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:**