

USAFRICOM Medical Waiver Request, AC Form 43

Using encrypted email, send this form and all scanned documentation to email address identified in ACI 4200.09
For assistance DSN Contact Phone Number: USAFRICOM HQ 324-591-0705

Patient Name (Last, First):		DOB:	SSN (last 4):
Age:	Sex:	Rank/ Grade:	Service:
Deployment/Travel Date:		Travel Duration (days):	Destination (country):
MOS/AFSC/Skill Identifier/Job Description:		Home Station/Unit:	
Active/Reserve/Civilian/Contractor:			
Requester POC(Medical Personnel)Name/E-mail/Phone:			
Summary of medical condition(s):			

I understand the potential risks associated with this deployment limiting condition. For this individual, I am requesting a waiver of the health requirement for travel to the USAFRICOM Area of Operation.

Commander or

Designee

Signature:

Date:

STAMP / PRINTED NAME AND TITLE

Required documentation for waiver evaluation in addition to this form:

DD Form 2766, Adult Preventive and Chronic Care Flow sheet, with full medical history including all medical conditions, surgeries, medications, and summary of Deployment Limiting Condition(s). DoD Civilians/Contractors who are age 40 and older must have, documented BMI, and a 10-year atherosclerotic cardiovascular disease (ASCVD) risk percentage calculated. (<http://tools.acc.org/ASCVD-Risk-Estimator-Plus/#!/calculate/estimate/>)

Case Summary (To be completed by healthcare provider): Include all clinically relevant information necessary to make a disposition including, but not limited to: Diagnosis (ICD-10), history of the condition, date of onset, prior treatments, current treatments, limitations imposed by the condition and/or medications, prognosis, and required follow-up. *(Use additional sheets, if needed. The more clinical information provided, the better.)*

Supplemental documentation (include information relevant for deployability determination):

- | | |
|---|---|
| a. Specialty consults results establishing diagnosis, treatment, monitoring plan and prognosis. | d. Summaries and past medical documents (e.g. hospital summary). |
| b. Recent and relevant surgery, laboratory, pathology and tissue examination reports. | e. Reports of proceedings (e.g. Tumor Board, Medical Evaluation Boards, etc.) |
| c. Reports of studies (radiographs, pictures, films or procedures). | f. Job requirements (physical condition, exertion level, etc.) |

I have reviewed the case summary and hereby submit this request

Provider's

Signature:

Date:

STAMP / PRINTED NAME AND TITLE

----- **FOR SURGEON'S OFFICE USE ONLY** -----

Waiver Approved: YES NO

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Signature:

Date:

STAMP / PRINTED NAME AND TITLE

Comments:

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