WEST POINT REFRACTIVE SURGERY PROGRAM

ADMINISTRATIVE DATA

Patient Name:_____ **Rank:**_____ **SS#:**_____

Branch of Service:_____ **Unit/Company:**_____ **Occupation (MOS):**_____

Are you an aviator / on flight status or receive flight pay?_____

DOB:_____ **Age:**_____ **Sex: M** ☐ **F** ☐

What is your eye color? (circle one) Blue ☐ **Brown** ☐ **Hazel** ☐ **Other:** _____

Phone Numbers: Home: _____ **Work:**_____ **Fax:** _____

Email Address: _____

AKO Email Address: _____

Mailing Address: _____

RELEASE OF INFORMATION

I, the undersigned, give permission for my name/e-mail address to be included in group e-mails for the sole purpose of transmitting information or instructions as pertains to my participation in the Cadet Refractive Eye Surgery Program (CRESP).

_____
SIGNATURE

_____
PRINTED NAME