

USSOUTHCOM Medical Waiver Request

Patient Name : _____ DOB: _____ SSN(Last 4): _____

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 13 and accompanying PPG-TAB A for required information. Attach supporting medical documentation:

I have reviewed the case summary and hereby submit this request.

Signature: _____ **Commander Approval:** _____

SOUTHCOM Surgeon / Component Surgeon Response

Waiver Approval: **YES** **NO**

Signature: _____ **Date:** _____

**JEFFREY L. ROBERTSON, MD, FAAFP
COL, MC, SFS/USA
Command Surgeon, ARSOUTH**

Comments: