

# West Point Refractive Eye Surgery Program Commander's Authorization

(TO BE SUBMITTED BY ALL ACTIVE DUTY APPLICANTS)

(1) I give my permission for the following active duty soldier to be considered for enrollment in the Warfighter Refractive Eye Surgery Program (WRESP) and for treatment if eligible.

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Patient Name (Print) (Last / First / MI)

Rank

SSN

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Email Address (AKO Preferred)

(2) I certify the following to be true:

The soldier has at least **18 MONTHS** remaining on **ACTIVE DUTY**.

The soldier has no adverse personnel actions pending including medical boards.

The soldier will remain **CONUS** and is **NON-DEPLOYABLE** for at least **90 DAYS** post-surgery.

(3) I realize that after refractive surgery the soldier will be on **CONVALESCENT LEAVE** up to **96 HOURS** and will have the following **PHYSICAL PROFILE** for a minimum of **30 DAYS**, but possibly up to 90 days in a small number of patients (<10%):

No parachuting, diving, night operations or driving military vehicles.

No field, range or other duties involving strenuous activity including AFPT.

No swimming, protective mask use, or use of camouflage face paint.

Needs to wear sun-glasses at all times.

(4) I acknowledge that **NATIONAL GUARD** and **RESERVE** soldiers are **NOT** eligible for treatment unless they have been activated and have at least **18 MONTHS ACTIVE DUTY** remaining at the time of their surgery.

(5) I acknowledge this soldier is required to complete 1, 3, 6 and 12-month **FOLLOW-UP EXAMS** required by the Refractive Eye Surgery Program. Or if deploying before the 6-month exam is due they are required to complete the 1- and 3-month exams and then return to KACH or co-managing optometry clinic for a post-operative exam at the completion of their deployment.

(6) Failure to comply with the post-operative care requirements may affect future enrolments from the soldier's unit.

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Commander's Signature

Commander's Rank and Name (Print)

Date

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Commander's Email Address

Commander's Telephone Number

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Applicant's Signature Date

**FAX THIS COMPLETED FORM TO THE CENTER FOR REFRACTIVE SURGERY AT 845-938-6548  
KEEP A COPY FOR YOUR RECORDS AND BRING IT TO YOUR FIRST APPOINTMENT**