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 / C	omponent Su	rgeon Respo	nse		
Waiver Approval:	YES	NO			
Signature:			Date:		
CENTCOM Co	mmand Surgeo	n			

Comments:

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