

**FLYING/SPECIAL OPERATIONS DUTY
CORNEAL REFRACTIVE SURGERY WAIVER CHECKLIST (PRK/LASEK/Epi-LASIK)
(BASED ON HQ USAF/SGOP Corneal Refractive Surgery Policy Letter dated 5 Sep 2006)
MUST BE COMPLETED BY AN EYE CARE PROFESSIONAL
THIS SUPERCEDES ALL PREVIOUS FLY/SPECIAL OPERATIONS PRK CHECKLISTS**

APPLICANTS NAME: _____ SSAN: _____

1. Pre-Operative refractive error, Cycloplegic Refraction: **Date of Surgery:** _____
Any cycloplegic cannot be > - 5.50 for FC1 or > -8.00 (no hyperopia allowed) for FC1A/II/III duties in any meridian to be acceptable. (No exceptions).
 OD: _____
 OS: _____
2. Post-operative refractive error, Cycloplegic Refraction: **Date:** _____
(30 days post-operative)
 OD: _____
 OS: _____
 Best Uncorrected Distant visual acuity: OD 20/ _____ OS 20/ _____
 Best Uncorrected Near Visual Acuity: OD 20/ _____ OS 20/ _____
3. Two Month Post-operative refractive error, Cycloplegic Refraction: **Date:** _____
 OD: _____
 OS: _____
 Best Uncorrected Distant visual acuity: OD 20/ _____ OS 20/ _____
 Best Uncorrected Near Visual Acuity: OD 20/ _____ OS 20/ _____
4. Three Month Post-operative refractive error, Cycloplegic Refraction: **Date:** _____
 OD: _____
 OS: _____
 Best Uncorrected Distant visual acuity: OD 20/ _____ OS 20/ _____
 Best Uncorrected Near Visual Acuity: OD 20/ _____ OS 20/ _____
5. Six Month Post-operative refractive error, Cycloplegic Refraction: **Date:** _____
Must be no less than six months post eye surgery.
 OD: _____
 OS: _____
 Best Uncorrected Distant visual acuity: OD 20/ _____ OS 20/ _____
 Best Uncorrected Near Visual Acuity: OD 20/ _____ OS 20/ _____
6. * One year post Cycloplegic Refraction: **Date:** _____
Must be no less than one year post eye surgery.
 OD: _____
 OS: _____
 Best Uncorrected Distant visual acuity: OD 20/ _____ OS 20/ _____
 Best Uncorrected Near Visual Acuity: OD 20/ _____ OS 20/ _____

Evaluate / explain any side effects secondary to the surgery (Y/N) glare: ____, haze: ____, halos: ____, diplopia: ____, difficulty seeing at night: ____, lattice degeneration: ____, retinal detachment / holes: ____, other eye pathology: ____.

Explain any (Y) findings: _____

A stable refraction equals two cycloplegic refractions at least 6 months apart with no more than 0.50 change in either eye.

* UPT (Pilot) follow-up evaluation will be in conjunction with MFS at Brooks AFB prior to Pilot training.

Note 1: All evaluations noted above are mandatory and must be completed by the eye care professional.

Note 2: All pre/post evaluations must be submitted with the waiver package, or case will be returned.

**Printed Name and Stamp
(Eye Care Professional)**

Signature

Date

Corneal Refractive Error Checklist revised October 2006

**NON-FLYING APPLICANT
CORNEAL REFRACTIVE SURGERY WAIVER CHECKLIST (PRK/LASEK/Epi-LASIK /LASIK)**

(BASED ON HQ USAF/SGOP Corneal Refractive Surgery Policy Letter dated 5 Sep 2006)

MUST BE COMPLETED BY AN EYE CARE PROFESSIONAL.
(THIS CHECKLIST SUPERCEDES ALL PREVIOUS NON-FLYING PRK CHECKLISTS)

APPLICANTS NAME: _____ SSAN: _____

1. **Pre-Operative refractive error**, Cycloplegic Refraction: Date of Surgery: _____
Any cycloplegic cannot be over + / - 8.00 in any meridian to be acceptable for **initial** military accession (No exceptions).

OD: _____

OS: _____

2. **Three Month Post-operative refractive error**, Cycloplegic Refraction: Date: _____

OD: _____

OS: _____

Best Uncorrected Distant visual acuity: OD 20/ OS 20/

Best Uncorrected Near Visual Acuity: OD 20/ OS 20/

3. **Six Month Post-operative refractive error**, Cycloplegic Refraction: Date: _____
Must be no less six months post eye surgery.

OD: _____

OS: _____

Best Uncorrected Distant visual acuity: OD 20/ OS 20/

Best Uncorrected Near Visual Acuity: OD 20/ OS 20/

Evaluate / explain any side effects secondary to the surgery (Y/N) glare: ____, haze: ____, halos: ____, diplopia: ____,
difficulty seeing at night: ____, lattice degeneration: ____, retinal detachment / holes: ____, other eye pathology: ____,
Explain any (Y) findings:

* A stable refraction equals no more than 0.50 change in either eye as compared from the 3 month and 6 month post-operative cycloplegic evaluations.

Note 1: All evaluations noted above are mandatory and must be completed by the eye care professional.

Note 2: All pre/post evaluations must be submitted with the package, or case will be returned.

Printed Name and Stamp
(Eye Care Professional)

Signature

Date