MFS-N Personal Data Form

Date Scheduled:

Last Name, First Name, FULL Middle Name:	SSN:	Sex: ☐ Male ☐ Female
DoD ID Number:	☐ AFROTC CADET ☐ RESERVE ☐ GUARD ☐ ACTIVE DUTY	
Home of Record (Address)	Emergency contact: (Name, Relation, Address, and Phone Number)	
Current Address	Date of Birth Day: Month: Year:	Place of Birth
Home Phone (include area code)	☐ White ☐ Black ☐ American Indian/Alaska Native ☐ Asian ☐ Hispanic ☐ Pacific Islander/Hawaiian	
Cell Phone (include area code)	Duty Phone: DSN:	Email Address:
ACTIVE DUTY, GUARD, AND RESERVE How long have you been in the military? Years: Months: Rank: Major Command: Base: Squadron and Unit:	**AFROTC CADETS** Det #: College: Det NCO & Phone #:	**Please specify duty you are applying for:** ☐ Pilot ☐ GBO/RPA Pilot **What airframe will you be flying?**

1	**Have you had corneal refractive surgery (CRS) (IF YES, CLICK LINK FOR WORKSHEET)? Example: PRK, LASEK, or LASIK eye surgery** ☐ No ► Continue to next question ☐ Yes ► You must send all pre & post-surgery reports and 6 mo eval along with the surgical LASER REPORT.

2	**A) Are you currently a trained asset? (i.e. Navigator or other aircrew member)** ☐ Yes ☐ No	**B) Were you ever given an Aeromedical Waiver?** ☐ Yes ☐ No	**C) Flight Hours (Military ONLY)** **Total Flight Hours:** **Total Last 6 Months:**

3	**A) When is your IFT Date?**	**B) When is your UPT/URT Date?**

4	**GBO/RPA Pilot Only: Have you had an FAA exam within the past 36 months? (FAA CLASS III – CIVILIAN STUDENT PILOT CERT'S NOW VALID FOR 5 YEARS – THIS ALLOWS FOR TIME PERIOD BETWEEN FCI EXAM DATE AND FIRST IFS TRAINING DATE)** ☐ Yes ☐ No ► **If no, CLICK HERE to register for your FAA Class 3 exam and enter your FAA MedXpress confirmation number here:**
5	**Do you have a DOD/Military ID card?** ☐ Yes ☐ No ► Please provide Driver's License information below

Driver's License State:	Driver's License #:

Updated 05 Feb 2025

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Have you had any significant illness, injury, or surgery since your Initial Flying Class Physical?

☐ YES ☐ NO

If YES, please explain:

Ophthalmology Questionnaire

Please check YES or NO to the following questions and explain in the space provided.

	YES	NO
1. Have you ever had any type of eye surgery to include: refractive eye surgery (PRK or LASIK), eye muscle surgery, eye lid surgery, cataract surgery, etc.?	☐	☐
If yes, please list type and when:		
2. Have you ever been diagnosed with lazy eye or amblyopia? Did you have to wear an eye patch as a child or glasses in childhood?	☐	☐
If yes, please list when:		
3. Have you ever had any trauma to or around your eye? Have you ever broken a bone in your facial area?	☐	☐
If yes, list where and when:		
4. Have you ever worn contact lenses to include soft and hard contacts, or the one's you sleep in at night and take them out in the morning? **(Soft contact lenses must be removed for 30 days and hard contacts must be removed for 90 days prior to date of appointment or your Flying physical will not be completed and will be deferred)**	☐	☐
If yes, please indicate what type and list the last time you wore them, even for an hour:		
5. Have you ever failed depth perception or had any known issues with depth perception?	☐	☐
If yes, please explain:		
6. Have you ever failed color vision or had any known issues with color vision?	☐	☐
If yes, please explain:		

Privacy Act-1974 as Amended applies. This form contains information which must be protected IAW DoD 5400.11 and it is Official Use Only (FOUO). In addition, this transmission may contain information covered under the Privacy Act, 5 USC 552(a), Health Insurance Portability and Accountability Act Public Law 104-191, and DoD Directive 6025.18, DoD Health Information Privacy Regulation. It must be protected in accordance with those provisions.

AUTHORIZATION FOR DISCLOSURE OF MEDICAL OR DENTAL INFORMATION

PRIVACY ACT STATEMENT

In accordance with the Privacy Act of 1974 (Public Law 93-579), the notice informs you of the purpose of the form and how it will be used. Please read it carefully.
AUTHORITY: Public Law 104-191; E.O. 9397 (SSAN); DoD 6025.18-R.
PRINCIPAL PURPOSE(S): This form is to provide the Military Treatment Facility/Dental Treatment Facility/TRICARE Health Plan with a means to request the use and/or disclosure of an individual's protected health information.
ROUTINE USE(S): To any third party or the individual upon authorization for the disclosure from the individual for: personal use; insurance; continued medical care; school; legal; retirement/separation; or other reasons.
DISCLOSURE: Voluntary. Failure to sign the authorization form will result in the non-release of the protected health information.
This form will not be used for the authorization to disclose alcohol or drug abuse patient information from medical records or for authorization to disclose information from records of an alcohol or drug abuse treatment program. In addition, any use as an authorization to use or disclose psychotherapy notes may not be combined with another authorization except one to use or disclose psychotherapy notes.

SECTION I - PATIENT DATA

1. NAME *(Last, First, Middle Initial)*	2. DATE OF BIRTH *(YYYYMMDD)*	3. SOCIAL SECURITY NUMBER

4. PERIOD OF TREATMENT: FROM - TO *(YYYYMMDD)*	5. TYPE OF TREATMENT *(X one)*
from birth to present	☐ OUTPATIENT ☐ INPATIENT ☒ BOTH

SECTION II - DISCLOSURE

6. I AUTHORIZE Any medical facility or physician that has provided services to me TO RELEASE MY PATIENT INFORMATION TO:
(Name of Facility/TRICARE Health Plan)

a. NAME OF PERSON OR ORGANIZATION TO RECEIVE MY MEDICAL INFORMATION	b. ADDRESS *(Street, City, State and ZIP Code)*
USAFSAM/FCI/MFS Medical Staff	2510 Fifth St Wright Patterson AFB, OH 45433
c. TELEPHONE *(Include Area Code)* (937) 938-2867	d. FAX *(Include Area Code)* (937) 656-4006

7. REASON FOR REQUEST/USE OF MEDICAL INFORMATION *(X as applicable)*

☐ PERSONAL USE ☐ CONTINUED MEDICAL CARE ☐ SCHOOL ☒ OTHER *(Specify)* US Air Force/AFR accession & duty qualifications
☐ INSURANCE ☐ RETIREMENT/SEPARATION ☐ LEGAL

8. INFORMATION TO BE RELEASED
My entire medical record, including any and all mental health records. This includes but is not limited to AHLTA, CHCS, and MHS Genesis.
AUTHORIZATION START DATE: Date of flight physical administrative review.
Authorization complete upon final disposition and certification of exam by HQ AFAC/AM, IAW DAFMAN 48-123 08 December 2020.

9. AUTHORIZATION START DATE *(YYYYMMDD)*	10. AUTHORIZATION EXPIRATION DATE *(YYYYMMDD)*	
	☐	☒ ACTION COMPLETED

SECTION III - RELEASE AUTHORIZATION

I understand that:
a. I have the right to revoke this authorization at any time. My revocation must be in writing and provided to the facility where my medical records are kept or to the TMA Privacy Officer if this is an authorization for information possessed by the TRICARE Health Plan rather than an MTF or DTF. I am aware that if I later revoke this authorization, the person(s) I herein name will have used and/or disclosed my protected information on the basis of this authorization.
b. If I authorize my protected health information to be disclosed to someone who is not required to comply with federal privacy protection regulations, then such information may be re-disclosed and would no longer be protected.
c. I have a right to inspect and receive a copy of my own protected health information to be used or disclosed, in accordance with the requirements of the federal privacy protection regulations found in the Privacy Act and 45 CFR §164.524.
d. The Military Health System (which includes the TRICARE Health Plan) may not condition treatment in MTFs/DTFs, payment by the TRICARE Health Plan, enrollment in the TRICARE Health Plan or eligibility for TRICARE Health Plan benefits on failure to obtain this authorization.
I request and authorize the named provider/treatment facility/TRICARE Health Plan to release the information described above to the named individual/organization indicated.

11. SIGNATURE OF PATIENT/PARENT/LEGAL REPRESENTATIVE	12. RELATIONSHIP TO PATIENT *(If applicable)*	13. DATE *(YYYYMMDD)*
	self	

SECTION IV - FOR STAFF USE ONLY *(To be completed only upon receipt of written revocation)*

14. X IF APPLICABLE:	15. REVOCATION COMPLETED BY	16. DATE *(YYYYMMDD)*
☐ AUTHORIZATION REVOKED		

17. IMPRINT OF PATIENT IDENTIFICATION PLATE WHEN AVAILABLE	
	SPONSOR NAME: SPONSOR RANK: FMP/SPONSOR SSN: BRANCH OF SERVICE: PHONE NUMBER:

Reset

Adobe Professional 8.0

PRIVACY ACT STATEMENT - HEALTH CARE RECORDS

This form is not an authorization or consent to use or disclose your health information.

1. AUTHORITY FOR COLLECTION OF INFORMATION INCLUDING SOCIAL SECURITY NUMBER (SSN):

10 U.S.C. 136, Under Secretary of Defense for Personnel and Readiness; 10 U.S.C. Chapter 55, Medical and Dental Care; 42 U.S.C. Chapter 32, Third Party Liability for Hospital and Medical Care; 32 CFR Part 199, Civilian Health and Medical Program of the Uniformed Services (CHAMPUS); DoDI 6055.05, Occupational and Environmental Health (OEH); and E.O. 9397 (SSN), as amended.

2. PRINCIPAL PURPOSES FOR WHICH INFORMATION IS INTENDED TO BE USED:

Information may be collected from you to provide and document your medical care; determine your eligibility for benefits and entitlements; adjudicate claims; determine whether a third party is responsible for the cost of Military Health System (MHS) provided healthcare and recover that cost; evaluate your fitness for duty and medical concerns which may have resulted from an occupational or environmental hazard; evaluate the MHS and its programs; and perform administrative tasks related to MHS operations and personnel readiness.

3. ROUTINE USES:

Information in your records may be disclosed to:

- Private physicians and Federal agencies, including the Department of Veterans Affairs, Health and Human Services, and Homeland Security (with regard to members of the Coast Guard), in connection with your medical care;
- Government agencies to determine your eligibility for benefits and entitlements;
- Government and nongovernment third parties to recover the cost of MHS provided care;
- Public health authorities to document and review occupational and environmental exposure data; and
- Government and nongovernment organizations to perform DoD-approved research.

Information in your records may be used for other lawful reasons which may include teaching, compiling statistical data, and evaluating the care rendered. Use and disclosure of your records outside of DoD may also occur in accordance with 5 U.S.C. 552a(b) of the Privacy Act of 1974, as amended, which incorporates the DoD Blanket Routine Uses published at: http://dpcld.defense.gov/privacy/SORNsIndex/BlanketRoutineUses.aspx.

Any protected health information (PHI) in your records may be used and disclosed generally as permitted by the HIPAA Privacy Rule (45 CFR Parts 160 and 164), as implemented within DoD by DoD 6025.18-R. Permitted uses and disclosures of PHI include, but are not limited to, treatment, payment, and healthcare operations.

4. WHETHER DISCLOSURE IS MANDATORY OR VOLUNTARY AND EFFECT ON INDIVIDUAL OF NOT PROVIDING INFORMATION:

Voluntary. If you choose not to provide the requested information, comprehensive health care services may not be possible, you may experience administrative delays, and you may be rejected for service or an assignment. However, care will not be denied.

This all inclusive Privacy Act Statement will apply to all requests for personal information made by MHS health care treatment personnel or for medical/dental treatment purposes and is intended to become a permanent part of your health care record.

Your signature merely acknowledges that you have been advised of the foregoing. If requested, a copy of this form will be furnished to you.

5. SIGNATURE OF PATIENT OR SPONSOR	6. SOCIAL SECURITY NUMBER OR DOD IDENTIFICATION NUMBER OF MEMBER OR SPONSOR	7. DATE *(YYYYMMDD)*

CORNEAL REFRACTIVE SURGERY (CRS) CHECKLIST

Must Be Completed By Your Eye Care Professional

NAME:	LAST 4 SSAN	Scheduled Date of AF Physical Exam:

Notes for Eye Care Professional: This patient is applying for a United States Air Force medical clearance which has very specific requirements. The purpose of this form is two-fold: to document the individual's pre-operative cycloplegic refraction so that Air Force medical personnel can verify pre-operative suitability for specific duties AND to document post-operative refractive error at the times indicated below to determine post-operative suitability for specific duties. Your assistance in treating/assessing this patient and providing this documentation is greatly appreciated.

Applicants must be at least **6 months post-CRS** prior to an accession medical examination or initial flight physical (**one year** for **hyperopic** CRS treatments prior to initial flight physical).

Approved CRS procedures include: photorefractive keratectomy (PRK), epithelial-laser in-situ keratomileusis (epi-LASIK), laser in-situ epithelial keratomileusis (LASEK), and laser in-situ keratomileusis (LASIK) with flap formation either by microkeratome or femtosecond laser (Intralase). Although it is expected that most, if not all, procedures will be accomplished using wavefront-guided technique, this is not a requirement.

Non-Approved CRS procedures include radial keratotomy, limbal relaxation incisions, thermokeratoplasty, intra-corneal rings, clear lens extraction and any phakic lens implantation. These procedures are **disqualifying and NOT waiverable** for ALL flying positions without exception.

The current use of punctual plugs is **disqualifying** for an initial physical. If you had punctual plugs inserted pre or post operatively, they **must be removed at least 30 days prior** to your evaluation. Failure to do so will **delay the processing** of your physical.

General Military Service or Commissioning:

Pre-Operative cycloplegic refraction **cannot exceed a spherical equivalent of +8.00 to -8.00** and **cannot exceed 3.00 diopters of astigmatism** with a good outcome to be **non-disqualifying** for accession.

Initial Flying Class (IFC I/IA/II/III/RPA Pilot) or Special Operational Duty:

Pre-Operative cycloplegic refraction **cannot exceed +3.00 to -8.00 in ANY meridian** and **cannot exceed 3.00 diopters of astigmatism** with a good outcome to be **non-disqualifying** for all flying classes.

Pre-Operative cycloplegic refraction **greater than +3.00 and less than or equal to +5.00** or **greater than -8.00 and less than or equal to -10.00** in **ANY meridian** or **greater than 3.00 and less than or equal to 6.00 diopters of astigmatism** is **DISQUALIFYING** for all flying classes and **may** be considered for a waiver on a **case-by-case basis.** Astigmatism greater than 5.00 diopters will **not** be waived for accession/commissioning.

1. PRE-OPERATIVE exam with cycloplegic refraction:

Date: _____

OD: Sph: _____ Cyl: _____ Axis: _____ 20/

OS: Sph: _____ Cyl: _____ Axis: _____ 20/

2. OPERATIVE REPORTS, must provide copy of LASER REPORT: Surgery Date:_____

3. Two post-op manifest refractions with no more than 0.50 diopter shift in sphere or cylinder power (initial post-op refraction must be at least 90 days post-CRS and second refraction at least 1 month apart) WE WILL NOT ACCEPT AUTO-REFRACTIONS AS A MANIFEST REFRACTION:

Date : _____

OD: Sph: _____ Cyl: _____ Axis: _____ BCVA 20/
OS: Sph: _____ Cyl: _____ Axis: _____ BCVA 20/

Date: _____

OD: Sph: _____ Cyl: _____ Axis: _____ BCVA 20/
OS: Sph: Cyl: Axis: BCVA 20/

List any surgical or post-operative complications (e.g. corneal haze, flap striae, ocular hypertension, etc.):

List any current eye medications used (including over-the-counter) and frequency of use:

List any side effects secondary to the surgery.

	YES	NO		YES	NO
Glare/ghosting/halos	☐	☐	Double Vision:	☐	☐
Dry Eye:	☐	☐	Difficulty seeing at night:	☐	☐

Please explain all YES responses:

Notes:

- **Send us ALL of your pre & post-operative exams (as well as any other eye surgeries) with this sheet.** Please DO NOT FORGET to ask for the actual "*LASER REPORT*", this item must be sent to us.
- The laser report is the actual form printed from the machine/laser (NOT THE TREATMENT PLAN) that was use to complete your surgery--without this form, your IFC physical may be canceled or delayed.

This sheet and accompanying documents must be submitted at least 30 days prior to your appointment.

_____ _____

Printed name & stamp (Eye care professional) Signature and date