U.S. PUBLIC HEALTH SERVICE COMMISSIONED CORPS

COMMISSIONED CORPS HEADQUARTERS Rockville, MD 20852

Active Duty/Ready Reserve Corps Medical Waiver Recommendation

Officer Name_____ SERNO_____

Officer phone number:_____ Officer email:_____

Provider: I recommend waiving the officer from the following requirements (select all that apply):

Limit Item: **Waiver Expiration date**: ____/____/_____
(maximum of 6 months)

- ☐ Deployment
- ☐ Cardiorespiratory endurance exercise of PFT
- ☐ Upper body endurance exercise of PFT
- ☐ Core endurance exercise of PFT
- ☐ Weight standards
- ☐ Basic Life Support (BLS) Training
- ☐ Immunization, identify the vaccine(s)_____
- ☐ Uniform: Shoe
- ☐ Shaving facial hair

Other considerations

- ☐ Officer is pregnant Estimated due date ____/____/_____
- ☐ Officer is breastfeeding
- ☐ Other_____

Please complete this bottom section **OR** provide medical documentation (e.g. clinic note) that addresses the following information.

(1) Diagnosis and/or Symptoms_____

Treatment/Plan:_____

(2) Diagnosis and/or Symptoms_____

Treatment/Plan:_____

Additional notes (if needed):

_____

_____

_____

Provider and credentials/specialty:_____

Provider signature: _____Date: _____