Armed Services Medical Waiver Documentation

Applicant Information

Full Name:

Date of Birth:

Branch of Service:

SSN (Last 4 digits):

Medical Condition Information

Medical Condition:

Date of Diagnosis:

Attending Physician Name:

Waiver Justification

Reason for Waiver Request:

Attachments

Medical Reports/Supporting Documents: Choose File No file selected

Applicant Signature

Signature:

Date:

Submit Waiver Request