ENROLLMENT WAIVER FOR THE U.S. ARMY HEALTH CLINIC – SOUTHCOM

Date:

Check one of the following:

I am attempting to remain enrolled following retirement from Active Duty military service ☐

I am attempting to enroll a dependent ☐

Name of Patient: Last Name First Name

Sponsor's full benefits # (DOD ID):

Sponsor's email address:

Patient's Work Phone # Patient's Mobile #

Patient's Home Address:

Patient's Date Of Birth:

Reason for Requesting Waiver:

◯ Convenience ◯ Medical Necessity

Please give a brief explanation of the reason check:

Preferred provider's name (if applicable):

Retain current provider (retirees only): ☐

E-mail waiver request to Dr. Wanda Bell at: wanda.f.bell2.civ@mail.mil