COMMANDER'S CONCURRENCE FORM

Orthodontist: Dr. _____ Phone: _____ Date: _____

Orthodontic Treatment for: _____
(Last, First MI) (Rank / Rate) (SSN)

1. The above active duty member has a dental malocclusion which impairs his/her dental function and may adversely affect the longevity and health of his/her dentition. The malocclusion existed prior to entry into service (EPTS) and treatment can be deferred in most cases.

2. Elective treatment of this problem is complex and will require orthodontics (braces) and possibly surgery of the jaws. The treatment time is lengthy and will require absence from duty for orthodontic appointments every 4-5 weeks. If jaw surgery is required, approximately 1-2 weeks of hospitalization followed by two weeks of convalescent leave will be necessary.

   a. Is surgery anticipated for this patient? **Yes / No** b. Anticipated length of treatment is _____ **months**

3. Current medical regulations do not permit a change of assignment or extension solely for the treatment of an EPTS condition. Orthodontic treatment will be discontinued (the braces removed) when the patient leaves this area if a Navy orthodontist is not available at his/her next duty assignment.

4. We need the following information ***before treatment is initiated***:

   a. Patient's anticipated date of separation: _____.

   b. Patient's anticipated date of PCS: _____.

   c. Is there any action pending or anticipated that might result in an earlier date of separation or PCS? Yes / No

   d. Is this patient's duty performance such that you will recommend approval of his/her absence from duty for treatment? Yes / No

   e. Will the patient have frequent/extended TDY'S that will interfere and/or prolong treatment? Yes / No

   f. Command address: _____

   g. _____
   Supervisor's Printed Name, Signature and Title

   h. _____
   Commander's Printed Name, Signature and Title

5. If you have any further questions, please do not hesitate to call the treating orthodontist,

_____
(Rank / Name) at (Office Phone #).

When completed please return this letter to the Orthodontic Department, Attn: Rank and name of orthodontist, command address for the orthodontic department. ***Treatment will not be initiated until this form is returned!!***
Thank you for your cooperation.

_____
Name of orthodontist
_____ DC, USN _____
Rank,

_____
Name of command