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MEDICAL EXAMINATIONS AND STANDARDS

COMPLIANCE WITH THIS PUBLICATION IS MANDATORY

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This instruction implements AFPD 48-1, *Aerospace Medical Program* and Department of Defense Directive (DoDD) 1332.18, *Separation or Retirement for Physical Disability*, and DoDD 6130.3, *Physical Standards for Appointment, Enlistment and Induction*, May 1994, DoDD 5154.24, *Armed Forces Institute of Pathology (AFIP)*, regarding mandatory requirements for all military personnel to provide a deoxyribonucleic acid (DNA) specimen sample for the repository, and implements the DoD Form 2697, *Report of Medical Assessment*, for separating and retiring members. It establishes procedures, requirements, recording, and medical standards for medical examinations given by the Air Force. It prescribes procedures and references the authority for retiring, discharging, or retaining members who, because of physical disability, are unfit to perform their duties. This instruction applies to all applicants for military service, scholarship programs, and the Air Force Reserve. It also applies to the Air National Guard (ANG) when published in the NGR (AF) 0-2. Active duty flight medicine offices will use the AFRC supplement to this instruction when managing unit assigned Reserve Members and will maintain a copy of the AFRC Supplement when Reserve units are located on the same base. This instruction is affected by the Privacy Act of 1974. Authority to collect and maintain records is outlined in Section 8013, Title 10, United States Code, and Executive Order, 9397. Privacy Act System Notice F044 AFSG G, Aircrew Standards Case File, applies. Each form affected by the Privacy Act which is required by this instruction either contains a Privacy Act Statement incorporated in the body of the document or is covered by DD Form 2005, *Privacy Act Statement-Health Care Records*. Send comments and suggested improvements on AF Form 847, *Recommendation for Change of Publication*, through channels, to AFMOA/SGOA, 110 Luke Avenue, Room 405, Bolling AFB, DC 20332-7050. **Attachment 1** is a list of references and supporting information. Maintain and dispose of all records created as a result of processes prescribed in this publication in accordance with AFMAN 37-139, *Records Disposition Schedule*.

(AFMC) This supplement outlines the established medical examination standards for Preventive Health Assessment and Individual Medical Readiness Guidelines (PIMR) at Air Force Medical Treatment Facilities.

AFI 48-123, 22 May 2001, is supplemented as follows:

SUMMARY OF REVISIONS

This revision incorporates Interim Change IC 2001-3. This change incorporates new weight for ejection system standards. A bar (|) indicates revision from the previous edition.

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Chapter 1

GENERAL INFORMATION AND ADMINISTRATIVE PROCEDURES

1.1. Medical Standards. Medical standards and medical examination requirements ensure acquisition and retention of members who are medically acceptable for military life.

1.1.1. These standards apply to:

1.1.1.1. Applicants for enlistment, commission, training in the Air Force and Air Reserve Component (ARC), United States Air Force Academy (USAFA), ROTC Scholarship, and the Uniformed Services University of Health Sciences (USUHS).

1.1.1.2. Air Reserve Component (ARC) and Health Professions Scholarship Program (HPSP) personnel entering active duty with the Regular Air Force, unless otherwise specified in other directives.

1.1.1.3. Military members and civilians ordered by proper Air Force authority to participate in frequent and regular aerial flights.

1.1.1.4. Members of all components on extended active duty (EAD) not excluded by other directives.

1.1.1.5. Members not on EAD, but eligible under applicable instructions.

1.2. Medical Examinations. There are various types of medical examinations: Accession, Department of Defense Medical Examination Review Board (DODMERB), Initial Flying, Periodic Flying (long and short), Periodic Non-flying, Operational Support Flying (**long and short**), Retirement, Separation, Report of Medical Assessment (DD Form 2697) and **Preventive Health Assessment** (**PHA**). Each is conducted and recorded according to the format and procedures prescribed in AFPAM 48-133, *Medical Examination Techniques*. As long as all requirements are met, a medical examination may serve more than one purpose.

1.2.1. A Medical Examination Is Required Before:

1.2.1.1. Entrance into active military service, ARC, AFROTC, USAFA, and Officer Training School (OTS).

1.2.1.2. Entry into Flying or other special duty training.

NOTE:

Documents forwarded to certification/waiver authority will be typewritten and submitted in 3 copies (4 copies if referral to ACS is required) unless an electronic version is authorized by the certification/waiver authority.

1.2.1.3. Termination of service when specified by this instruction.

1.2.1.4. Annually or periodically, as required by this instruction.

1.2.2. Examiners:

1.2.2.1. A credentialed flight surgeon of any Service or government agency may perform medical examinations on Air Force flying personnel. When this occurs, forward the documents (physical assessment, etc.) to the examinee's MAJCOM/SG for review and certification. All aircrew members examined by a U.S. military flight surgeon and found qualified to perform flight duties will be returned to flying status upon completion of their examination.

1.2.2.2. A credentialed medical officer or physician employed by the armed services (regardless of active duty status, to include TRICARE providers), as well as designated Air Force physician assistants, (Air Force specialty code 42G4X) or primary care nurse practitioners (AFSC 46NXC), under the supervision of, and subject to review by a physician give all other medical examinations.

1.2.3. Locations:

1.2.3.1. Physical examinations are normally accomplished at the following locations:

1.2.3.2. Medical facilities of the uniformed services, including TRICARE Facilities.

1.2.3.3. Military Entrance Processing Stations (MEPS) Examinations.

1.2.3.4. DODMERB contract sites.

1.2.3.5. AFMOA/SGOA must authorize exceptions to the above. Exceptions to the above for TDRL examinations, require HQ AFPC /DPMADS approval.

1.2.3.6. Hospitalization of civilian applicants in military or government hospitals is authorized only when medical qualification for military service or flying training cannot be determined without hospital study.

1.2.4. Required Baseline Tests:

1.2.4.1. Blood type and Rh factor.

1.2.4.2. Glucose-6-Phosphate Dehydrogenase (G6PD).

1.2.4.3. Hemoglobin-S. Confirm positive results with electrophoresis.

1.2.4.4. Human Immunodeficiency Virus (HIV) Antibody. Confirm repeatedly positive enzyme immunoassay by Western Blot.

1.2.4.4. (Added-AFMC) HIV test is reaccomplished every five years.

1.2.4.5. Pseudoisochromatic Plate (PIP) testing to determine color vision perception.

1.2.4.6. DNA Specimen Collection, for Genetic Deoxyribonucleic Acid Analysis testing.

1.2.4.6. (Added-AFMC) Footprints must be accomplished on all flying personnel.

NOTE: (Insert after "Flowsheet...") IAW AFPAM 44-155, *Implementing Put Prevention Into Practice*.

1.2.5. Locations: The above tests should be accomplished at the MEPS. If tests are not completed at MEPS, accomplish at the following locations:

1.2.5.1. Air Force enlisted personnel at Lackland AFB, Texas, during basic training.

1.2.5.2. OTS personnel at Maxwell AFB, Alabama, during OTS training.

1.2.5.3. Combined Officer Training School (COTS) students at their first permanent duty station.

1.2.5.4. All other entrants at their entry point or first permanent duty station.

NOTE:

Examiners record the results of these tests on DD Form 2766, Adult Preventive and Chronic Care Flowsheet.

1.2.6. Records Transmittal. Transmit reports of medical examination and supporting documents that contain sensitive medical data in sealed envelopes labeled "Sensitive Medical Information" and "To be opened by Medical Personnel only."

1.3. (Added-AFMC) Preventive Health Assessment and Individual Medical Readiness (PIMR).

The Preventive Health Assessment (PHA) and Individual Medical Readiness (IMR) is an upgrade to the existing PHA program instituted in November 1997. Over the last several years, there have been numerous changes in the Air Force Medical Service (AFMS) and Military Healthcare Services (MHS) which are reflected in this program. The outcome of PIMR should be a medically fit and ready force. Responsibility for ensuring a fit and healthy force is shared between commanders, primary care management (PCM) teams and the individual service members. All have a role ensuring the success of this program.

1.3.1. (AFMC) The primary purpose of PIMR is to provide a “real-time” medical readiness assessment of IMR requirements for commanders, individuals, and PCMs so they can manage the readiness status of their assigned or enrolled Air Force personnel.

1.3.2. (AFMC) Secondly, PIMR provides a year-round systematic process to optimize the health and reliability of the human weapon system through prevention at every encounter. Use of the PHA as the “safety net” ensures preventive health requirements are met and feedback is provided to all stakeholders.

1.3.3. (AFMC) PIMR is strictly a database management tool used to monitor the readiness status of an individual. It does not take the place of the DD Form 2766, **Adult Preventive and Chronic Care Flowsheet,** which provides the detailed information of the individual’s physical health.

Chapter 2

RESPONSIBILITIES

2.1. Air Force Surgeon General (HQ USAF/SG). Establishes medical standards and examination policy.

2.2. Medical Treatment Facility (MTF) Commander.

2.2.1. Ensures timely scheduling and appropriate completion of required examinations and consultations.

2.2.2. Ensures medical documents are filed in the health record.

2.2.3. Appoints members of the Medical Evaluation Board. Consult AFI 44-113 for further guidance.

2.2.4. (Added-AFMC) Appoints the PIMR Program Manager and ensures that adequate personnel and resources are allocated for daily operations. Commanders should monitor PIMR rates as part of the P2R2 metric system and track performance by PCM teams to ensure optimal force readiness. This information can be viewed at https://www.afchips.brooks.af.mil/pimr/Stats_PIMR.htm.

2.3. Aerospace Medicine Squadron/Flight Commander/ ANG State Air Sur geon:

2.3.1. Ensures quality of medical examination process.

2.3.2. Ensures commanders are aware of the fitness of the force

2.4. Health Care Provider . Identifies individuals for Medical Evaluation Board (MEB), if qualification for continued military service is questionable. If the examinee is within 60 calendar days of Estimated Termination of Service (ETS), Date of Separation (officer), or Date of Retirement, the health care provider requests medical hold from AFPC/DPAMM.

NOTE:

This does not apply to ARC personnel not on extended active duty or AGR tour of duty. Contact appropriate ARC/SG for appropriate guidance. (See **Attachment 10**, note 8).

2.4.1. **(Added-AFMC)** PCM Teams: These teams are extensions of the health care providers and are responsible for the delivery of preventive health services on a daily basis. They ensure PHA (including final review) are accomplished in a timely manner and documented appropriately. They continuously monitor IMR status for their enrollees as well as their occupational health, fitness, clinical preventive service requirements and any necessary medical follow-up.

2.4.1.1. (Added-AFMC) Properly record results of examinations.

2.4.1.2. (Added-AFMC) Perform appropriate ancillary examinations.

2.4.1.3. (Added-AFMC) Update PIMR at a minimum during the following: Visits requiring profiling actions; clinical (acute or routine) visits (when time and resources permit); occupational health

exams and/or PHAs; during records reviews (i.e., retraining, mobility, or attendance at PME); Pre- and post-deployment processing.

2.5. Physical Examinations and Standards Section:

2.5.1. Advises all health care providers on physical standards. Periodically briefs the professional staff on related issues.

2.5.2. Schedules individuals for required medical examinations.

2.5.3. Properly records results of examinations.

2.5.4. Performs appropriate ancillary examinations.

2.5.5. (Added-AFMC) PIMR Program Manager: The MDG/CC will appoint a PIMR program manager to:

2.5.5.1. (Added-AFMC) Monitor PIMR and coordinate with the Health Care Integrator (HCI) and Group Practice Manager (GPM) to run products and track metrics and reports.

2.5.5.2. (Added-AFMC) Monitor, track, and report show rates for PHA/OHME.

2.5.5.3. (Added- AFMC) Monitor and track AF Forms 422 (Profile Serial Report) actions.

2.5.5.4. (Added-AFMC) Oversee and/or initiate updates on PIMR program.

2.5.5.5. (Added-AFMC) Monitor and run other reports as directed in the *Preventive Health Assessment and Individual Medical Readiness, Program Manager Guide, April 2001.*

2.5.6. (Added-AFMC) Maintains responsibility for mnoitoring PIMR functions.

2.5.7. (Added-AFMC) Generates PIMR reports for metrics.

2.5.8. (Added-AFMC) Runs unit rosters of individuals to be scheduled and forwards those rosters to the appropriate unit health monitor (UHM).

2.5.9. (Added-AFMC) Maintains quality control of PIMR products.

2.5.10. (Added-AFMC) Integrates with IS to accomplish PIMR system software upgrades.

2.5.11. (Added-AFMC) Gathers/monitors/reports no-show data and is liaison between the UHMs and PCMs.

2.5.12. (Added-AFMC) Consultant to PCM teams on questions regarding application of medical standards.

2.5.13. (Added-AFMC) Ensures PHAs are being completed and results are entered into the database in a timely manner.

2.5.14. (Added-AFMC) Ensures 4T profiles are initiated on military members found to be questionable for continued active duty IAW chapter 10 of this Air Force Instruction.

2.6. Member's Commander. Ensures the member is available for examination until processing is complete.

2.6. (Added-AFMC) Unit Commanders. Responsible for ensuring personnel assigned to their unit complete their appropriate medical appointments to ensure a force that is fit and deployment ready.

2.7. Member. Meets scheduled medical appointments as directed. Reports all medical/dental treatment obtained through civilian sources or any medical condition that hinders duty performance to the appropriate military medical authority. See **Chapter 14** for additional guidance regarding ARC members.

2.8. (Added-AFMC) Population Health Working Group. Review/analyze PIMR data on a routine basis as part of the outcomes management function.

2.8.1. (Added-AFMC) Resolve issues with process completion, staff interactions, scheduling problems, etc., and ensure line commanders are receiving adequate support.

2.8.2. (Added-AFMC) Ensure that all enrollees are assigned to a PCM by name and that they are generally seen by their assigned PCM for their routine care and PHA.

2.8.3 (Added-AFMC) Ensure that the PCM teams roles and responsibilities are well defined and training needs are met.

2.9. (Added-AFMC) Group Practice Manager (GPM). Responsible for clinical practice administration, long and short term strategic planning, monitoring/improving quality of clinical/administrative data, resource management, and general administration.

2.9.1. Utilizes demand forecasting to ensure sufficient open appointments to complete PHA and other additional services, e.g., CPS, counseling, immunizations, etc.

2.10. (Added-AFMC) Health Care Integrator (HCI). In concert with assigned teams, utilizes population-based health principles to build healthy people, communities, and a fit and ready force.

2.10.1. (Added-AFMC) Leads the MTF in population health program development, integrates all aspects of care along the health continuum.

2.10.2. (Added-AFMC) Develops educational programs for staff concerning integrated health care processes and data management.

2.10.3. (Added-AFMC) Establishes links with utilization managers, case managers, and discharge planners, including contractors, to provide all aspects of services for patients who experience barriers to appropriate care.

2.11. (Added-AFMC) Information Systems (IS).

2.11.1. (Added-AFMC) Responsible for network management, software installation and overall system support.

2.11.2. (Added AFMC) A program manager is appointed by the MDG/CC (or his/her designee) to maintain responsibility for the daily management of the PIMR software system. At least three individuals are identified locally (primary, secondary and alternate) and trained on the use and application of the PIMR software.

Chapter 3

TERM OF VALIDITY OF INITIAL MEDICAL EXAMINATION

3.1. Term of Validity of Reports of Medical Examination:

3.1.1. Reports. Reports of medical examination are considered administratively valid as follows:

3.1.1.1. Enlistment. Within 24 months of date of entry on active or ARC duty.

3.1.1.2. Commission:

3.1.1.3. Civilian Applicants. Within 24 months of date of entry on active or ARC duty.

3.1.1.4. Military and AFROTC Applicants:

3.1.1.5. Entry into Professional Officers Course (POC) and for AFROTC scholarship. Validity same as above.

3.1.1.6. Entry into active duty in a non-rated status. Validity same as above.

3.1.1.7. Air Force Academy. Validity same as above.

3.1.1.8. Officer Applicants for Conditional Reserve Status (CRS). When required, within 23 months from the date of application.

3.1.1.9. ARC members. Validity, within 24 months of taking oath of office. Applicants accessed into the ARC from any service component may use a current DD Form 2697 **and** their last physical examination (SF Form 88 and SF Form 93, dated within 24 months or completed PHA, completed within the last 12 months) prior to entry into the ARC.

3.1.2. Flying Training. Examination (SF Form 88) must be current within 36 months prior to starting Undergraduate Flying Training (UFT). Medical history (SF Form 93) must be verified as current within 12 months prior to start of training.

3.1.2.1. Undergraduate Pilot Training (UPT) applicants must meet flying class I standards for entry into the Enhanced Flight Screening (EFS) program.

3.1.2.2. A long flying class II physical is conducted prior to beginning active flying Undergraduate Flying Training (UFT). Pilot candidates must have a current, certified flying class I examination on record, pass EFS-Medical and meet flying class II standards to begin UPT. Navigator candidates must have a current, certified flying class 1A examination on record and meet flying class II standards to begin UNT.

3.1.2.3. This physical is valid for two years or until the end of the first birth month following graduation from Introduction to Fighter Fundamentals and initial upgrade training.

3.1.2.4. The medical examination establishes the individual's evaluation cycle and is followed by two short flying physicals (applies to ARC only).

3.1.3. Banked Status. UFT graduates awaiting upgrade training are required to maintain Flying Class II qualification and are followed the same as any active flyer. They are inactive, but still require flying qualification. Inactive flyers who do not receive flying pay and hold aviation service codes

(ASCs) of 6J, 7J, 8J, 9J, etc. (see paragraph. **9.1.4.**, Inactive Flyers) do not require Flying Class II qualification.

3.1.4. Pre-Banked Status ("re-cats"). Individuals selected to attend UFT and currently assigned to a non-rated position pending UFT report date. If the start of the UFT will be more than 36 months from the date of the original flying class I physical, a new flying class I exam will be required with certification by HQ AETC/SGPS.

3.1.5. Entry Into Initial Flying Class III and Flying Class II (Flight Surgeon Duties). Medical examinations for Flying Class III and Flying Class II (flight surgeon) duties are valid within 24 months of entry into training.

NOTE:

If the certified physical expires during the training period, the training base accomplishes an examination (PHA for active duty and Short FCII for ARC) valid until the end of the next birth month, not to exceed 18 months.

3.1.6. General Officers, Aircrew, Special Operational Duty, and ARC Personnel**.** Medical examinations are valid as specified in **Attachment 9**.

3.1.7. Active Duty (AD) non-flying Personnel. Preventive Health Assessments (PHA) as

specified in **Attachment 19**.

3.1.8. Missile Launch Crew, Ground Based Controllers, Air Vehicle Operators, and Space Operations Duty. Initial medical examinations are valid as per paragraph **3.1.5.**.

3.1.9. Physiological Training/Operational Support Duty Clearance**.** Physiological Training/Operational Support (ASC 9C) clearance examinations. These examinations are valid until the end of the birth month of the next year from the date accomplished.

3.1.10. ARC Members Entering EAD/AGR. The regular Air Force Medical examination (SF Form 88/93 completed within 24 months or PHA within 12 months) prior to voluntary or involuntary entry is valid.

NOTE:

ARC members involuntarily ordered to EAD with the regular AF cannot be forced to have a physical before entry on AD. Members are scheduled for physicals according to applicable guidance.

Chapter 4

PERIODIC MEDICAL EXAMINATIONS

4.1. Periodic Medical Examinations:

4.1.1. Frequency. Accomplish examinations at the frequency listed in **Attachment 9**. Examinations are usually scheduled in the three months prior to expiration but may be scheduled as early as 6 months prior. AFMOA/SGOA grants operational commands specific exceptions to prescribed examination frequency requirements.

4.1.1.1. Air Force Reserve members with an expired periodic medical exam will be restricted from Reserve participation for pay or points IAW AFM 36-8001. An AF Form 422 will be accomplished without changing the member's numerical profile. Reference the Air Force Reserve supplement to AF PAM 48-133 for appropriate AF Form 422 format. **For ANG members, an AF Form 422 will be accomplished changing the member's profile to P4T.**

4.1.2. Validity. Active duty (flying and non-flying), consult PHA guidelines in AFPAM 48-133. ARC flying examinations expire on the last day of the birth month. ARC periodic non-flying examinations expire on the last day of the month in which the previous examination was accomplished**.** See **Attachment 9**.

4.1.2. (Added-AFMC) Reference Air Force Reserve supplement to AFPAM 48-133, *Physical Examination Techniques*, and HQ USAF/SG Guidelines for the Implementation of Preventive Health Assessment and Individual Medical Readiness (PIMR) at Air Force Medical Treatment Facilities.

4.1.3. Preventive Health Assessment (PHA). Consult PHA implementation instructions and **Attachment 19** of this AFI.

Chapter 5

MEDICAL EXAMINATIONS FOR SEPARATION & RETIREMENT

5.1. Policy. Do not delay separation or retirement past scheduled date of separation or retirement to complete a medical examination unless medical hold is approved (See **Chapter 6**).

5.2. Purpose. To identify medical conditions requiring attention and to document current medical status (not to determine eligibility for physical disability separation or retirement).

5.3. Presumption of Fitness. If performance of duty in the 12 months before scheduled separation or retirement is satisfactory, the member is presumed to be physically fit for continued active duty, separation or retirement, unless there is clear and convincing evidence to the contrary.

5.4. Disability Information:

5.4.1. Title 10, United States Code, Chapter 61 provides for disability retirement and separation.

5.4.2. Title 38, United States Code administered by the Department of Veterans Affairs governs disability compensation for ratable service-connected defects which have not precluded active service.

5.5. Mandatory Examinations:

5.5.1. A medical examination **(SF 88**) for separation or retirement is mandatory when:

5.5.1.1. The member has not had a Preventive Health Assessment (PHA) or complete medical examination **(SF 88**) within 5 years of scheduled separation or 3 years of scheduled retirement date Otherwise, the member will complete a medical assessment using DD Form 2697 as outlined in paragraph **5.5.2.**, and AF Form 422, *Physical Profile Serial Report***,** to document the member's World Wide Qualification status.

5.5.1.2. Medical authority requires an examination to be done for either clinical or administrative reasons.

5.5.1.3. Separation is involuntary, or is voluntary in lieu of trial by court martial, or retirement in lieu of involuntary administrative separation.

Exception: Member is separated or retired in absentia.

NOTE:

A medical assessment as outlined in paragraph **5.5.2.** is acceptable if the member has had a medical examination (PHA or SF Form 88) within 5 years of scheduled separation or 3 years of scheduled retirement date.

5.5.1.4. The member is tentatively approved by HQ AFPC for early separation from active duty and assignment into an ARC under PALACE CHASE, and the member's most recent medical examination is more than 3 years old (SF Form 88) or more than 12 months (PHA) at the time of application.

5.5.1.5. The member is entering an ARC from active duty Air Force under the PALACE FRONT program and the member's most recent medical examination is more than 4 years old (SF Form 88) or more than 12 months (PHA) at the time of application.

5.5.1.6. The member's medical record has been lost.

NOTE:

A Preventive Health Assessment with SF Form 93 is required along with the DD Form 2697.

5.5.1.7. The member is a Repatriated Prisoner of War (PDS assignment limitation code 5, or 7). The evaluation will include a MEB review unless waived by HQ AFPC/DPAMM. Forward a copy of the examination to the addresses in paragraph **8.2.4.** See paragraph **5.5.2.**, Note 2.

5.5.2. Medical Assessment (DD Form 2697). Members who are not required to have a medical examination in accordance with paragraph **5.5.1.** will complete, as a minimum, a medical assessment prior to separating or retiring from Service or defederalization--includes ARC members called/ ordered to initial active duty for training (IADT), active duty or federal service during times of contingency, conflict, or war.

5.5.2.1. The evaluation should include:

5.5.2.1.1. A completed DD Form 2697 (see **Chapter 15**).

5.5.2.1.2. Clear documentation of any significant medical history and/or new signs or symptoms of medical problems since the member's last medical assessment/medical examination. See the last two sentences in section II (DD Form 2697) for additional guidance.

5.5.2.1.3. An examination by a credentialed/privileged health care provider. When appropriate/ required, examinations will be done and results documented in section II, item 20 of DD Form 2697. The examination will only be as extensive as the provider considers necessary to determine the examinee's continued qualification for worldwide service, evaluate significant items of medical history, or evaluate new signs and/or symptoms of injury or illness.

5.5.2.2. Notes:

5.5.2.2.1. File the completed DD Form 2697 in the medical record. If the medical record is not available, forward DD Form 2697 sealed, to the Separation and Retirements Section of the member's servicing MPF. File a copy of the form in the dental record if a dental problem was identified during the assessment. File all consultation reports with the DD Form 2697.

5.5.2.2.2. Forward copies of medical examinations/medical assessments accomplished on ANG (full-time) members to HQ ARPC/DSFRA for retention as required by Title 10, United States Code, Chapter 8502.

5.5.2.2.3. Forward a copy of DD Form 2697 to the In-Service recruiter for all members entering an ARC through the PALACE CHASE/FRONT Programs.

5.5.2.2.4. HIV testing is not required for separation or retirement, unless deemed appropriate by the primary care manager. (Consult AFI 48-135, Human Immunodeficiency Virus Program).

5.5.3. Termination Occupational Examinations. If required, accomplish during the separation or retirement examination/assessment.

5.5.4. Elective surgery. Ensure elective surgery on procedures, excluding those that are emergent, a threat to life, limb, vision, or prevent undo suffering, are not performed within six months of retirement or separation without prior approval by HQ AFPC/DPAMM. If approved, the patient must be briefed that retirement or separation proceeds on schedule despite hospitalization or convalescence.

Chapter 6

MEDICAL HOLD

6.1. Purpose. Administrative action retaining a member on active duty beyond an established date of separation or retirement.

6.1.1. Medical hold is not appropriate for members who are being involuntarily separated, unless normal separation is imminent or HQ AFPC has approved an involuntary separation date.

6.1.2. Separation or retirement processing continues until medical hold is approved.

6.2. Requests. Requests for medical hold may be coordinated by telephone with the attending physician contacting HQ AFPC/DPAMM directly for active duty personnel. Medical hold requests on ARC personnel will be coordinated with the appropriate ARC/SG. (See **Attachment 10**, note 8). The requesting physician should have the following information readily available:

6.2.1. Date of projected separation or retirement

6.2.2. Whether MEB processing is initiated

6.2.3. Whether administrative or punitive discharge is pending

6.2.4. Servicing Military Personnel Flight (MPF) implementing separation or retirement

6.2.5. A projected medical hold release date

6.3. Approvals . The completed MEB must be received by HQ AFPC/DPAMM or the appropriate ARC/SG no later than 30 days from the date of approval of the medical hold action.

6.4. Disapprovals. Medical hold is not approved for the purpose of evaluating or treating chronic conditions, performing diagnostic studies, elective surgery or its convalescence, other elective treatment of remedial defects, or for conditions that do not warrant termination of active duty through the Disability Evaluation System.

6.4.1. Enlisted members cannot be forced to remain in service beyond their Expiration of Term of Service (ETS). They must agree in writing to a medical hold. For officers, medical hold does not require their consent.

6.5. Separation Dates. Medical hold cannot be imposed after the date of separation or retirement has elapsed. If an individual requires an MEB, medical hold should be requested at least 60 calendar days prior to retirement or separation date.

6.6. Judicial Proceedings. Members sentenced to dismissal or punitive discharge by a court martial, or who are under charges which may result in such sentences, are not eligible for MEB processing. Medical hold is not authorized unless court martial sentences are suspended, or court martial charges are dropped to permit separation or retirement in lieu of court martial, or charges are held in abeyance pending a sanity determination. Refer to AFI 36-3212, paragraphs 1.3. and 1.4.

6.7. Separation or Retirement. Members having orders for separation or retirement due to disability, who experience a significant clinical change before actual release from active duty, require revocation of orders and reprocessing of MEB. The servicing MTF contacts HQ AFPC/**DPPDS** (Disability Processing Division).

Chapter 7

MEDICAL STANDARDS

7.1. Medical Evaluation for Continued Military Service:

7.1.1. Scope. **Attachment 2** establishes medical conditions and defects which may preclude continued military service and require MEB processing. It incorporates guidelines in DoD Directive 1332.18, *Separation or Retirement for Physical Disability*.

7.1.2. Applicability. The standards in **Attachment 2** apply to:

7.1.2.1. Regular Air Force members on active duty, unless excluded from disability evaluation by appropriate directives.

7.1.2.2. All individuals who have separated from active duty with any of the regular Armed Services, but who are reenlisting in the regular Air Force or ARC when no more than 6 months have elapsed between separation and reenlistment.

7.1.2.3. ARC and retired regular members if mobilized.

7.1.2.4. ARC members who are:

7.1.2.4.1. On EAD unless excluded from disability evaluation by applicable directives.

7.1.2.4.2. Involuntarily ordered to EAD with the regular Air Force and who are eligible for fitness evaluation under applicable directives.

7.1.2.4.3. Reenlisting in the regular Air Force when no more than 93 calendar days have elapsed between release from EAD with any regular Armed Service and reenlistment or entry. If more than 93 days have elapsed, **Attachment 3** applies.

7.1.2.4.4. Not on EAD but eligible for MEB under applicable directives.

7.1.2.4.5. ARC members voluntarily entering EAD statutory tours (i.e., 265, 678, AGR tours) with the Air Force Reserve or Air National Guard.

7.1.2.5. USAFA, AFROTC cadets and HPSP after successful completion of two years of training.

7.1.3. Air Reserve Components. The appropriate ARC surgeon (see **Attachment 10**, note 8) uses the standards in **Attachment 2** either alone or in combination with other criteria to determine:

7.1.3.1. The medical qualification for continued military duty in the ARC for members not on

EAD and not eligible for disability processing.

7.1.3.2. The medical qualification of officers and enlisted members from any service component requesting entrance into an ARC provided no more than 6 months have elapsed between separation from the service component and entry into the ARC. If more than 6 months have elapsed, applicants must meet standards in **Attachment 3**.

7.2. Medical Standards for Appointment, Enlistment, and Induction:

7.2.1. Scope. **Attachment 3** establishes basic medical standards for enlistment, appointment, and induction into the Armed Forces of the United States according to the authority contained in Title 10,

United States Code, Section 113. It implements DoD Directive 6130.3, *Physical Standards for Appointment, Enlistment and Induction.*

7.2.2. Applicability. These standards apply to:

7.2.2.1. Applicants for appointment as commissioned officers in the Active and Reserve components who have not held a prior commission for a least 6 months, or it has been more than 6 months since separation.

7.2.2.2. Applicants for enlistment in the regular Air Force. Medical conditions or physical defects predating original enlistment, for the first six months of active duty in the regular Air Force.

7.2.2.3. Applicants for enlistment in the Reserve or Air National Guard. For medical conditions or physical defects predating original enlistment, these standards apply during the enlistee's initial period of active duty for training until their return to their Reserve Component Units.

7.2.2.4. Applicants for reenlistment in Regular and Reserve components and Air National Guard after a period of more than 6 months has elapsed since separation.

7.2.2.5. Applicants for the Scholarship or Advanced Course ROTC, and all other Armed Forces special officer personnel procurement programs.

7.2.2.6. Retention of cadets and midshipmen at the United States Air Force Academy and students enrolled in the ROTC scholarship programs, who have not completed 2 years of the program.

7.2.2.7. AFROTC graduates whose active duty is delayed under applicable directives.

7.2.2.8. All individuals being inducted into the Armed Forces.

7.2.2.9. Individuals on Temporary Disability Retirement Listing (TDRL) who have been found fit upon reevaluation and wish to return to active duty. The prior disabling defect or defects, and any other physical defects identified before placement on the TDRL that would not have prevented reenlistment, are exempt from this directive.

7.2.3. Rejection. **Attachment 3** sets forth the medical conditions and physical defects which are causes for rejection for military service.

7.3. Medical Standards for Ground Based Controller Duty:

7.3.1. Applicability. The standards in **Attachment 4** apply to all ground based aircraft controllers including *air traffic controllers, weapons controllers, combat controllers and weapons directors (AFSC 1C5X1D).* Individuals required to perform frequent and regular aerial flights must meet Flying Class III standards in **Attachment 7**.

7.3.2. Rejection. The medical conditions listed in **Attachment 2** and **Attachment 4** are cause to reject an examinee for initial controller duty or continued duty unless a waiver is granted. Acute medical problems, injuries, or their appropriate therapy are cause for withholding certification of initial training or temporarily restricting the individual from controller duties until the problem is resolved. These standards are not all inclusive and other diseases or defects can be cause for rejection based upon the medical judgment of the examining flight surgeon.

7.3.3. Acute Conditions. Acute conditions which impair safe and effective performance of duty are cause for temporary removal from controlling duties using AF Form 1042.

7.4. Space and Missile Operations Crew Duty:

7.4.1. Applicability. The medical conditions listed in **Attachment 2** and **Attachment 5** are cause to reject an examinee for initial Space and Missile Operations Crew (SMOC) duty (AFSCs 13SXX and 1C6XX) and any individual of another AFSC assigned to operational crew duty maintaining mission ready or equivalent status and for continued duty unless a waiver is granted.

7.4.2. Rejection. Acute medical problems, injuries, or their appropriate therapy can be cause for withholding certification for initial training or temporarily restricting the individual from crew duty until the problem is resolved. These standards are not all inclusive and other diseases or defects are cause for rejection based upon the medical judgment of the examining flight surgeon.

7.4.3. Acute Conditions. Acute conditions which impair safe and effective performance of duty are cause for temporary removal from Space and Missile Operations Crew (SMOC) duties using AF Form 1042*, Medical Recommendation for Flying or Special Operational Duty.*

7.5. Medical Standards for Flying Duty:

7.5.1. General Waiver Information. The medical conditions listed in **Attachment 2**, **Attachment 3**, and **Attachment 7** are cause to reject an examinee for flying training (all classes), or continued flying duty (classes II or III) unless a waiver is granted. Acute medical problems, injuries, or their appropriate therapy are cause for withholding certification for flying training or temporarily restricting the individual from flying until the problem is resolved. These standards are not all inclusive and other diseases or defects can be cause for rejection based upon the judgment of the examining flight surgeon. Any condition that in the opinion of the flight surgeon presents a hazard to flying safety, the individual's health, or mission completion is cause for temporary disqualification for flying duties. To be considered waiverable, any disqualifying condition should meet the following criteria:

7.5.1.1. Not pose a risk of sudden incapacitation.

7.5.1.2. Pose minimal potential for subtle performance decrement, particularly with regard to the higher senses.

7.5.1.3. Be resolved or be stable and be expected to remain so under the stresses of the aviation environment.

7.5.1.4. If the possibility of progression or recurrence exists, the first symptoms or signs must be easily detectable and not pose a risk to the individual or the safety of others.

7.5.1.5. Cannot require exotic tests, regular invasive procedures, or frequent absences to monitor for stability or progression.

7.5.1.6. Must be compatible with the performance of sustained flying operations in austere environments.

7.5.2. Medical Examination for Flying:

7.5.2.1. There are seven medical classes that qualify an individual for flying duty:

7.5.2.1.1. Flying Class I qualifies for selection into Enhanced Flight Screening and commencement of undergraduate pilot training (UPT).

7.5.2.1.2. Flying Class IA qualifies for selection and commencement of undergraduate navigator training.

7.5.2.1.3. Flying Class II qualifies undergraduate flight training students, rated officers, and physician applicants for Aerospace Medicine Primary training.

7.5.2.1.4. Flying Class III qualifies individuals for non-rated duties in ASC 9D, 9E and 9W.

7.5.2.1.5. Physiologic training standards (**Attachment 8**) qualifies individuals for non-rated duties in ASC 9C.

7.5.2.1.6. Categorical Flying Class II qualifies rated officers for duty in certain restricted aircraft categories.

7.5.2.1.6.1. Flying Class IIA qualifies rated officers for duty in low-G aircraft (tanker, transport, bomber, T-43 and T-1).

7.5.2.1.6.2. Flying Class IIB qualifies rated officers for duty in non-ejection seat aircraft.

7.5.2.1.6.3. Flying Class IIC qualifies rated officers for aviation duty as specified in the remarks section of AF Form 1042, and as annotated on the AMS, SF 88, *Report of Medical Examination*, or AF Form 1446, *Medical Examination -- Flying Personnel*. These waivers are coordinated with HQ USAF/XOOT.

7.5.2.2. Medical examinations are required when:

7.5.2.2.1. Individual applies for initial flying duty (all classes). (Initial rated flying or Initial non-rated flying.).

7.5.2.2.2. Officers holding comparable status in other US military services apply for Air Force aeronautical ratings (FC II, SF 88/SF 93, etc.).

7.5.2.2.3. Personnel, including personnel of the ARC, are ordered to participate in frequent and regular aerial flight (Periodic Flying, Long).

7.5.2.2.4. Flying personnel, including personnel of the ARC, are suspended from flying status for 12 months or more for medical reasons, applying for return to flying duties (Periodic Flying, long for ARC and PHA with AMS for AD/AF).

7.5.2.2.5. Flying personnel are ordered to appear before a Flying Evaluation Board (FEB). (See AFI 11-401, *Flight Management*). (Periodic flying (long) for ARC and PHA with AMS for AD/AF).

7.5.2.2.6. All members on flying status, annually, within 3 months preceding the last day of the birth month or 6 months for special circumstances, such as permanent change of station (PCS), temporary duty (TDY), retirement or waiver renewal, etc.

7.5.2.2.7. Return to flying status after a break in flying duties.

NOTE:

If the break is less than 24 months, the local flight surgeon clears the member for flying duty. If the break has been greater than 24 months, forward to the gaining MAJCOM/SG for review and certification. All waivers must go to the gaining MAJCOM/SG.

7.5.2.3. Medical evaluations with scope to be determined by the examining flight surgeon are required when:

7.5.2.3.1. Flying personnel have been involved in an aircraft accident.

7.5.2.3.2. A commander or flight surgeon determines a member's medical qualifications for flying duty have changed.

7.5.2.3.3. Flying personnel report to a new base.

7.5.2.3.4. The examining flight surgeon handles disqualifying defects in the following manner:

7.5.2.3.4.1. Completes all Flying Class I and IA (UFT) examinations regardless of the nature of disqualifying defect. Send completed SFs 88 and 93, Report of Medical History, to the appropriate certifying authority or requesting agency, such as MPF, Air Force Recruiting, ROTC Detachment, etc. The examining flight surgeon completely identifies, describes, or documents the disqualifying defects.

7.5.2.3.4.2. Completes initial Flying Class II or III, controller, air vehicle operator, or space operations crew duty examinations when a disqualifying defect is likely to receive favorable waiver consideration. Sends complete waiver package (see paragraph **8.2.**) to the appropriate waiver authority.

7.5.2.3.4.3. Discontinues initial flying class II or III, controller, air vehicle operator, or space operations crew duty examinations on applicants with medically disqualifying conditions unlikely to receive a medical waiver from the opinion of the local flight surgeon utilizing current Air Force policies and guidelines. Annotates on the SF 88 (See example) that the individual is medically disqualified. Forwards copy to appropriate waiver authority. Forwards medical disqualification's for ARC flying positions to appropriate ARC/SG.

Example: 89 AMDS/SGP, 1 Apr 96

Medically disqualified from Flying Duty, Class III, by reason of thoracic levoscoliosis

in excess of 30 degrees by Cobb method.

JOHN Z. DOE, Col, USAF, MC, SFS

AFSC: 48A4

89. AMDS/CC

7.5.2.3.4.4. Medical facilities will forward aeromedical disqualifications to the MAJCOM/SG for review and disposition. Local medical facilities do not have **disqualification certification authority.** MAJCOM/SG will forward a copy of disqualified cases to AFMOA/SGOA (rated members only). MAJCOM/SG will provide information to the WAVR file (Brooks AFB, TX) for rated members medically disqualified. AFMOA/

SGOA will forward a copy of medically disqualified cases to the FAA for rated members only.

7.6. Medical Standards for Miscellaneous Categories. The medical standards for the following categories are contained in **Attachment 8**:

7.6.1. Attendance at service schools.

7.6.2. Parachute duty.

7.6.3. Marine diving duty and hyperbaric chamber duty (Includes SCUBA for pararescue and combat control duty).

7.6.4. Physiological training and Physiological Training Personnel/Operational Support Flying duty (including ASC 9C).

7.6.5. Survival training instructor duty, Selection and Retention.

7.6.6. Military Training Instructor (MTI) duty.

7.6.7. Duty requiring use of Night Vision Goggles (NVG).

7.6.8. Remote or isolated duty.

7.6.9. Hyperbaric Chamber Training and duty.

7.6.10. Medical Certification and Waiver Requirements for Combat Control (1C2X1) and Pararescue (1T2X1) duty.

7.6.11. Incentive and Orientation Flights.

7.7. Medical Standards for Air Vehicle Operators (AVO). The following categories are contained in **Attachment 6** under Air Vehicle Operator Duty:

7.7.1. Applicability. All AVOs must meet worldwide qualifications as outlined in **Attachment 2**.

7.7.2. All rated personnel performing as AVOs will maintain Flying Class II standards as outlined in **Attachment 7**, and must also meet AVO standards as outlined in this AFI for continued AVO duties. When required, AVOs must comply with FAA Class III Medical Standards.

7.7.3. Non-rated AVOs (to include Sensor Operators) and medically disqualified rated personnel will require AVO standards for physical examination and for continued AVO duties. Non-rated personnel required to perform frequent and regular aerial flights will maintain Flying Class III standards for physical examination as outlined in **Attachment 7**. When required AVOs must comply with FAA Class III Medical Standards.

7.7.4. Rejection: Acute medical problems, injuries or their appropriate therapy can be cause for withholding certification for initial training or temporary restriction of the individual from AVO duties until the problem is resolved. These standards are not inclusive of all conditions for restriction and other diseases or defects may be cause for restriction if this is the medical opinion and judgment of the examining flight surgeon.

7.7.5. Acute conditions: Acute conditions which impair safe and effective performance of duty are cause for temporary removal from AVO duties. After such action is accomplished a AF Form 1042,

Medical Recommendation for Flying or Special Operational Duty, or telephonic notification to the operational unit will be made by responsible medical personnel.

Chapter 8

WAIVERS

8.1. Waiver of Medical Conditions. The authority to grant a waiver for medically disqualifying defects is listed in **Attachment 10**, Certification & Waiver Authority. Controversial or questionable cases may be referred to AFMOA/SGOA at the discretion of the MAJCOMs. **Members who do not meet medical standards for continued military service must be presented to MEB/PEB prior to aeromedical waiver consideration.**.

8.1.1. Initiating Waivers. Forward all relevant medical information through proper channels to the waiver authority. Special requirements for flying waivers are contained in paragraph **7.5.1.**, General Waiver Information.

8.1.2. Term of Validity of Waivers:

8.1.2.1. The waiver authority establishes the term of validity of waivers.

8.1.2.2. An expiration date is placed on waivers for conditions that may progress or require periodic reevaluation.

8.1.2.3. Waivers are valid for the specified condition. Any exacerbation of the condition or other changes in the patient's medical status automatically invalidates the waiver and a new one must be requested.

8.1.2.4. If a condition resolves and the member is qualified by appropriate medical standards, forward an aeromedical summary to the MAJCOM/SG.

8.1.3. Flying Duty. Waiver Authority for Rated Officers. AFMOA/SGOA retains waiver authority as listed below.

8.1.3.1. All initial categorical flying waivers; changes from one category to another; removal of a categorical restriction and previously medically disqualified rated members.

NOTE:

Consult **Attachment 10**, Certification & Waiver Authority for delegation of waiver authority to MAJCOM/SG.

8.1.3.1.1. All initial waivers in cases previously certified medically disqualified by AFMOA/SGOA or MAJCOM/SG (rated).

8.1.3.2. All initial waivers for conditions listed in **Attachment 2**, Medical Standards for Continued Military Service.

8.1.3.3. All initial waivers for conditions referred to the Aeromedical Consultation Service (ACS), except for those as listed in Note 3., in **Attachment 10**, Certification & Waiver Authority. MAJCOM/SG may grant initial and renewal waivers for all routine ACS clinical management group evaluations. Controversial cases will be forwarded to AFMOA/SGOA.

8.1.3.4. All cases where the ACS recommends medical disqualification or a change in waiver status.

Exception: "Change of Waiver Status" is defined as active clinical management members who are on a waiver who have new findings during ACS re-evaluation. If a new finding involves the same body system, the MAJCOM/SG retains waiver authority. If the new condition involves a different body system, MAJCOM/SG retains waiver authority if the condition is currently under the authority of the MAJCOM/SG. Additionally, new disqualifying diagnosis found during an ACS re-evaluation may be waived by MAJCOM/SG if the new diagnosis does not change the previous waiver recommendations made by the ACS.

8.1.3.5. All initial waivers for maintenance medication except those listed in Attachment **A7.32.**., Medication.

8.1.3.6. All flying waivers and disqualifications for general officers, regardless of diagnosis.

8.1.3.7. All categorical IIC waivers except as delegated to MAJCOM/SG, see **Attachment 10**, Certification & Waiver Authority (Notes).

8.1.3.7.1. Renewal of IIC waivers originally granted by AFMOA/SGOA, except as delegated to MAJCOM/SG, see **Attachment 10**, Certification & Waiver Authority (Notes).

8.1.3.8. Any controversial condition that in the opinion of the MAJCOM/SG warrants a AFMOA/SGOA decision.

8.1.4. Delegation of Waiver Authority for Flying Personnel:

8.1.4.1. MAJCOM/SGs will not grant/renew waivers for members of active ACS study groups without concurrence from the Aeromedical Consultation Service (ACS).

8.1.4.2. Command surgeons may delegate waiver authority to another command surgeon. Provide AFMOA/SGOA a copy of the policy.

8.1.4.3. Command surgeons may delegate their certification or waiver authority to the senior flight surgeon at local bases. Provide copy of the policy to AFMOA/SGOA.

NOTE:

Authority to grant flying class III waivers to rated personnel who have been medically disqualified for flying class II is delegated to the members MAJCOM/SG of assignment.

8.1.4.4. Certification and waiver authority for assignment into ARC flying positions may not be delegated lower than MAJCOM/SG level unless authorized by ARC/SG

8.1.4.4.1. Certification/Waiver Stamp Information. Place the certification information in a visible location on SF Form 502 (AMS), SF Form 88 (for ARC members if authorized by ARC/SG).

8.1.4.4.2. Certification and waiver authority for 9C aircrew is listed in **Attachment 10**, Certification & Waiver Authority.

8.1.5. Centralized Flying Waiver Repository (WAVR File):

8.1.5.1. All MAJCOM waiver authorities assure the WAVR File is properly updated.

8.1.5.2. Send this data every 2 weeks to WAVR File, USAFSAM/AFC, Brooks AFB TX 77235-5301.

8.1.5.3. ACS sends suspense rosters to all waiver authorities quarterly.

8.1.5.4. Update and correct the suspense roster and return it to ACS within 1 month of receipt.

8.1.6. Waivers for Enlisted Occupations:

8.1.6.1. The medical service does not make recommendations for medical waivers for entry or retention for those who fall below qualification standards imposed by personnel authorities. Air Force resource managers determine if a waiver request is appropriate.

8.1.6.2. When requested, the medical service provides professional opinion to line or personnel authorities.

8.1.7. Waiver Case Files. All waiver authorities maintain copies of their waiver actions. Transfer active cases (with copy of PCS orders) to the gaining waiver authority within 30 calendar days of assignment.

8.2. Submission of Reports of Medical Examination to Certification or Waiver Authority:

8.2.1. Waiver for Flying or Special Operational Duty. When sending medical reports for review, send the following TYPEWRITTEN documents with the original and 3 copies in the order listed to the reviewing authority, unless other arrangements have been coordinated with the waiver authority, such as use of electronic media. Send an original and 4 copies when an ACS evaluation is required, or when the examination is forwarded to AFMOA/SGOA, unless other arrangements have been coordinated.

NOTE:

SF Form 88 or AF Form 1446 must be accomplished according to the frequency in **Attachment 9** (or PHA per **Attachment 19**) and is irrespective of waiver action. However, these documents are not required for waiver submission unless specifically requested by the waiver authority. Utilize the aeromedical summary format when requesting waivers for trained aircrew or for aircrew in training. Do not accomplish SF Form 88 or AF Form 1446 (or PHA) solely for the purpose of a waiver submission.

8.2.1.1. All waiver requests referred to AFMOA/SGOA must be submitted to the MAJCOM/SG. MAJCOM/SG must provide a recommendation on the case to AFMOA/SGOA.

8.2.1.2. Cover letter outlining the basis of the appeal (include demographics, and any other information pertinent to the case such as pending TDY, PCS, etc.).

8.2.1.3. Aeromedical Summary with other supporting documents pertinent to the case.

8.2.1.4. AF Form 618, *Medical Board Report*, if appropriate, indicating the member has been returned to duty.

NOTE:

Ensure the final determination made by the MEB/PEB authorities is included with the waiver request, to include Assignment Limitation Code C status, if imposed.

8.2.1.5. AF Form 1139, *Request for Tumor Board Appraisal and Recommendation***.** Document the frequency and nature of required follow-up studies. A new tumor board is not required for waiver renewal if adequate documentation of follow-up, 5-year survival rate, and future follow-up requirements are included in the aeromedical summary

8.2.1.6. SF Form 515, *Medical Record-Tissue Examination*, in cases of malignancy. (Initial waiver request.).

8.2.1.7. Armed Forces Institute of Pathology (AFIP) opinion, in cases of malignancy. (Initial waiver request.).

8.2.1.8. Documents may be mailed or sent electronically as directed by the appropriate certification and waiver authority. Initial certification physicals require the original documents be made available. Consult the appropriate certification and waiver authority if in question.

8.2.1.9. AFIP, 6825 16th St NW, Building 54, Washington DC 20306-6000. DSN 662-2100.

8.2.2. The following are required for Air Reserve Component (ARC):

8.2.2.1. Cover letter.

8.2.2.2. Aeromedical Summary.

8.2.2.3. Armed Forces Institute of Pathology (AFIP) opinion, in cases of malignancy (initial waiver request), consult ANG/SG and AFRC/SG for current policy regarding AFIP

8.2.2.4. Any other relevant documentation.

8.2.2.5. Civilian medical documentation. Medical documentation from the member's civilian health care provider will be included in all waiver cases submitted on ARC members. The examining flight surgeon will review this information and reference it in the aeromedical summary.

8.2.3. Other Waivers. Waiver requests should include all pertinent medical information and operational justification for granting a medical waiver. Include extent to which the condition interferes with performance of military duty.

8.2.4. Flying Waiver Renewal. The examiner prepares relevant documents and copies as listed above.

8.2.5. Repatriated Prisoners of War (RPW). PES sends a copy of each medical examination (SFs 88, 93, or DD Form 2697 and attachments) to USAFSAM/AFC, 2507 Kennedy Circle, Brooks AFB, TX 78235-5117, and to the Office of Special Studies, NOMI, Code 25, NAS Pensacola, FL 32508-5600.

NOTE:

Include "RPW" on SF Form 88, item 5, as an additional purpose for examination.

8.2.6. Routing of Dispositions:

8.2.6.1. The certifying authority certifies the SF Form 88 or AMS.

8.2.6.1.1. PES files the certified document in the health record.

8.2.6.1.2. Give initial medical examinations (three copies) for Undergraduate Pilot Training (UPT), Undergraduate Navigator Training (UNT), and Aerospace Medicine Primary (AMP) course training to the applicant to include with the training request.

8.2.6.1.3. Send a copy of disqualifications on rated officers to AFMOA/SGOA.

Chapter 9

MEDICAL RECOMMENDATION FOR FLYING OR SPECIAL OPERATIONAL DUTY

9.1. General. Use AF Form 1042, *Medical Recommendation for Flying or Special Operational Duty*, to convey medical qualification for flying or special operational duty.

9.1.1. Applicability. Applies to each Air Force MTF or ARC medical squadron providing support for flying or special operational duty personnel, missile launch crew personnel, controllers, and air vehicle operators. Only flight surgeons can perform aeromedical dispositions.

9.1.2. A new AF Form 1042 is required when an individual is:

9.1.2.1. Found temporarily medically unfit.

9.1.2.2. Fit to return to duty, flying or special operational duty.

9.1.2.3. Medically qualified by appropriate review authority following disqualification.

9.1.2.4. For duty following medical examinations.

9.1.2.5. Incoming clearance to a new base (maintain until reassigned).

9.1.2.6. After an aircraft mishap.

9.1.3. Form Completion:

9.1.3.1. Must contain the date the individual is actually found qualified.

9.1.3.2. If the examination cannot be completed for reasons beyond the member's control, the appropriate waiver authority extends certification to cover administrative processing.

9.1.4. Inactive Flyers. Do not complete an AF Form 1042 for individuals in inactive aviation service categories who are not involved in flying duties, if the medical condition is minor and does not require a medical waiver. Inactive flyers with ASCs of 6J, 7J, 8J, or 9J do not require aeromedical disposition (i.e., DNIF, waiver processing, ACS evaluation, etc.). Aeromedical issues will be addressed when and if the member requests return to active flying status at a later date. **Attachment 2**, Medical Standards for Continued Military Service apply to these members. Care should be taken to ensure the members Aviation Service Code is correct prior to applying **Attachment 2** standards.

9.1.5. Form Distribution:

9.1.5.1. Original to patient's health record. (For transient personnel, send the original and 2 copies to the individual's home MTF for distribution).

9.1.5.2. One copy to the local Host Operations System Management (HOSM) office (within 10 workdays) for flying personnel or to the unit commander or supervisor for other personnel.

9.1.5.3. One copy to the member's unit.

9.1.5.4. One handwritten, legible, abbreviated copy to the individual.

9.1.6. Expired AF Form 1042: Dispose of this form upon expiration:

9.1.6.1. Grounding actions such as Duty Not Involving Flying (DNIF), Duty Not Involving Controlling (DNIC), Duty Not Involving Alert (DNIA).

9.1.6.2. Periodic clearances when superseded or expired.

9.1.6.3. Incoming clearances from previous assignments.

9.1.7. Record of Action. The flight surgeon maintains a monthly log of restrictions and requalifications on AF Form 1041, *Medical Recommendation for Flying or Special Operational Duty Log***,** and disposes of AF Form 1041 as specified by AFI 37-138, *Records Disposition--Procedures Responsibilities.* Use the AF Form 1041 log to track personnel who are in DNIF, DNIC, or DNIA status.

9.1.8. Flight medicine section personnel will notify the individual squadron operations sections daily by telephone, or by some other form of expeditious communication, on changes in the DNIF status of aircrew and special operational duty personnel.

NOTE:

The remarks section can be used for local special purpose determinations, i.e., "May perform Supervisor of Flying (SOF) duties," with the determination based upon the flight surgeon's assessment of the member's mental alertness and physical capabilities.

9.1.9. The Chief and NCOIC, Flight Medicine, will conduct weekly reviews of the AF Form 1041 log with all assigned flight surgeons and the waiver file monitor. This review is to identify those personnel who are on an unwarranted extended grounding, and to update the diagnosis and duration of DNIF on those flyers or special operational duty personnel whose medical status has changed. Document administrative updates on the reverse side of the AF Form 1041. The Chief and NCOIC, Flight Medicine will sign the AF Form 1041 to verify the weekly review. (this review will occur monthly for ARC flight medicine sections).

9.1.10. The flight medicine section will notify their MAJCOM/SG by telephone during duty hours when a general officer or wing commander is grounded or when an aircrew or special operational duty member dies. Reports will include: date of DNIF (as applicable), aeronautical rating, Aviation Service Code (ASC) with AFSC, duty title and organization, diagnosis(es), estimated duration of DNIF (as applicable), and name and duty phone of attending flight surgeon.

Chapter 10

PROFILES & DUTY LIMITATIONS

10.1. Purpose of This Chapter. This chapter, with **Attachment 10** and **Attachment 12**, establishes documentation and administrative management of members with duty limitations.

10.2. Physical Profile System. The physical profile system classifies individuals according to physical functional abilities. It applies to the following categories of personnel:

10.2.1. Applicants for appointment, enlistment, and induction into military service.

10.2.2. Active and ARC (throughout their military service).

10.3. Purpose of AF Form 422, *Physical Profile Serial Report*. Communicates information in layman's terms to non-medical authorities on the general physical condition or specific duty limitations of military members. For detailed instruction for completing AF Form 422, see AFPAM 48-133, *Medical Examination Techniques*.

10.3.1. (Added-AFMC) Physical profiles will be accomplished and tracked utilizing the PIMR software.

10.4. Establishing the Initial Physical Profile. Verify the initial profile serial of all individuals entering active duty and establish a baseline AF Form 422.

10.4.1. Airmen. Physical Examination and Standards (PES) section personnel review the physical profile entered on the SF 88 during basic training. Make any necessary revision using AF Form 422.

10.4.2. Officers. PES personnel screen new officer's health records at their first permanent duty station. Enter appropriate profile on AF Form 422.

10.5. Episodic Review of Physical Profile Serials

10.5.1. Revalidate or Revise the Profile Serial:

10.5.1.1. At all standard, special purpose medical examinations, or Preventive Health Assessments. If a member fails to comply with required medical assessments, and because of the member's failure to comply, the Air Force Medical Service is unaware of member's current medical status, a 4T profile will be processed.

10.5.1.1. (AFMC) When individual is placed on prophylactic medication or when permanently affected by disease or injury under PULHES, but does not warrant medical retraining or MEB.

10.5.1.2. On return to normal duty after any illness or injury that significantly affected duty performance or qualification for worldwide duty.

10.5.1.3. On selection for overseas, geographically separated unit (GSU), or combat zone assignment. Ensure members selected for overseas who have been placed on a Assignment Limitation Code-C (ALC-C) are identified to AFPC/DPAMM to prevent reassignment of members to locations where specialty care is not available. See paragraph **A7.8.**, Remote or Isolated Duty.

10.5.1.4. Every 30 calendar days when a member possesses a 4T profile.

10.5.1.5. When the results of a MEB or PEB are returned from HQ AFPC, see paragraph **10.5.2.** below.

10.5.2. Other:

10.5.2.1. Pregnancy profiles may be reviewed by the clinic providing primary care to the patient. Any changes in restrictions must be referred to PES. Refer to AFRC 48-101 for profiling guidance on pregnant reserve members.

10.5.2.2. The MPF provides Assignment Availability Code 31, 37, and 81 roster to the PES on a monthly basis.

10.5.2.3. PES personnel notify the health care provider to initiate MEB action (or fitness for worldwide duty evaluation - ARC members) as soon as the provider determines that the member will not be expected to return to duty within 1 year of the 4T start date (or within 1 year of the date a 4T profile should have been initiated).

10.5.2.4. ARC members placed on Assignment Limitation Code-C or Deployment Availability Code-42 will be appropriately profiled and reevaluated IAW guidance from the appropriate ARC Surgeon.

10.5.2.5. A 4T profile temporarily disqualifies ARC members from military duty and precludes them from military participation in unit training assemblies (UTA), annual tours, or any other type active duty tour until the profile is removed. Only HQ AFRC/SG or HQ ARPC/SG as appropriate may remove a 4 profile assigned because a member currently has or has a history of a disqualifying medical condition. For NAG members, the State Air Surgeon may grant an interim waiver for IDT only in the likelihood the member will be returned to duty.

10.5.3. Profile after MEB/PEB action: All active duty members returned to duty by MEB/PEB and those given an assignment limitation code-C (ALC-C) by AFPC/DPAMM should be profiled by the local profiling officer. Document the ALC-C restriction in the remarks section of the AF Form 422 for easy identification by the MPF when updating the PDS system or when considering medical retraining (if warranted). When required for medical retraining, document in the remarks section the final revised profile (PULHES) of the medical condition(s) along with any restrictions, even though the member is on a 4T due to the ALC-C action. This new revised PULHES listing in the remarks section will allow the MPF personnel the ability to determine which career fields the member can be considered for, if medical retraining is warranted. Additionally, the profile should indicate when the next in-lieu-MEB review is due at HQ AFPC/DPAMM (if required). Note: If a member is returned to unrestricted worldwide service by MEB/PEB (without ALC-C action), do not assume that the member's condition is compatible with mobility, deployment or overseas assignments. If TDY or PCS is pending, address the member's qualification for mobility and deployment as a separate issue, see **Attachment 18**, Deployment Criteria, and coordinate questionable conditions with the gaining MAJCOM/SG if PCS is pending. Profiles for members returned to duty following MEB/PEB with ALC-C require semi-annual review.

10.5.3.1. ARC members are placed on Assignment Limitation Code-C or Deployment Availability Code-42 by the appropriate ARC/SG and will be appropriately profiled and reevaluated IAW guidance from the appropriate ARC Surgeon.

10.6. Duty Limitations:

10.6.1. Temporary Assignment and Deployability Limitation:

10.6.1.1. A 4T profile precludes reassignment until the MEB or PEB processing is completed or the condition is resolved.

10.6.1.2. A 4T profile precludes worldwide assignment and deployment (mobility).

10.6.1.3. A 4 under any profile heading temporarily disqualifies Reserve members from military duty and precludes them from performing active or inactive military duty until the profile is removed. Only HQ AFRC/SG or HQ ARPC/SG, as appropriate, may remove a 4 profile assigned because a member currently has or has a history, of a disqualifying medical condition. For ANG members, the State Air Surgeon may grant an interim waiver for IDT only in the likelihood the member will be returned to duty within one year.

10.6.1.4. When an assignment is pending (confirmed by MPF), the health care provider provides the medical facts and circumstances to HQ AFPC/DPAMM, Randolph AFB TX via narrative summary or telephone.

10.6.2. Temporary Occupational Restriction. Use AF Form 422, AF Form 1042 or DD Form 689, Individual Sick Slip, to inform the member's unit commander or supervisor that member has an injury or illness which limits job performance, or deployability, for a specified duration. Type and submit to the MPF those 4T profiles issued for injuries or illnesses not compatible with worldwide assignment or mobility (deployability) and are not expected to resolve within 60 calendar days. 4T profiles issued for periods of 60 days or less are not forwarded to the MPF and can be handwritten. . For ARC members, forward a copy of all "4" profiles to the member's supporting ARC MPF and immediate commander regardless of expected date of resolution. In all cases where standards for continued military service, deployment or mobility are not met, the AF Form 422 shall be annotated “not qualified for mobility or deployment” and the worldwide assignment block shall be checked “no.”

10.6.3. Permanent Assignment or Deployment Restriction. Assignment Limitation Code C justifies use of the 4T profile and precludes deployment and unrestricted assignment until removed. For **Reserve** members a 3C profile will be used instead of the 4T profile to identify ALC-C status. No **Reserve** member assigned an ALC-C may perform military duty OCONUS unless approval is specifically granted by **AFRC/SG.** ANG members will be assigned a P3 profile. **ANG members may deploy to non-remote locations in CONUS, Hawaii, Puerto Rico and Alaska while in DAC-42 status as long as restrictions annotated in the remarks section of the AF Form 422 are not violated.**

NOTE:

For active duty members it does not necessarily preclude retraining.

10.7. Additional Uses of AF Form 422.

10.7.1. Notification to the MPF of the member’s qualification for retirement or separation.

10.7.2. Drug Abuse Reporting to commanders, social actions officers, and other responsible parties of active duty personnel identified as drug experimenters, users, or addicts.

10.7.3. AFSC Medical Retraining:

10.7.3.1. When a medical defect permanently precludes further employment within a member's AFSC, a medical recommendation for retraining is sent to the servicing MPF on an AF Form 422 according to AFI 34-1087, *Military Personnel Classification Policy (Officers and Airmen).* The AF Form 422 must accompany a Narrative Summary (SF Form 502), which includes comments clearly defining the individual's limitations, recommendation by the member's squadron commander, and approval by the MTF Commander or senior profile officer.

10.7.3.2. The MPF determines the retraining AFSC and notifies the PES. Approval authority certifies the member medically qualified, or not qualified, for each selected or requested AFSC. Approval authority for retraining is the personnel system.

10.7.3.3. Recommendations are disapproved and MEB is indicated when the defect:

10.7.3.3.1. Is permanent and precludes worldwide assignment

10.7.3.3.2. Existed prior to service (EPTS).

10.7.3.3.3. Precludes cross-training to alternate AFSC occupations commensurate with the member's grade and office.

10.7.3.3.4. For members who have had MEB processing and returned to duty, see paragraph **10.5.2.**

10.7.4. Validating the member's profile for placement into the Personnel Reliabil ity Program (See AFI 36-2104, *Nuclear Weapons Personnel Reliability Program*).

Notification to unit commander of member's refusal to submit DNA sample. The AF Form 422 may be used to notify the unit commander when a DNA sample is not on file, or when a member refuses to provide a sample.

Physical Restrictions/Fitness Exemptions: AF Form 422 will be utilized to communicate the fitness condition of members to the unit commander.. Utilize the remarks section to communicate fitness status. The following guidelines should be used:

10.7.4.1. A member who has a chronic and stable condition which imposes physical restrictions but does not preclude worldwide duty assignment, deployability, mobility, or fitness testing a AF Form 422 can be processed without an expiration date, referred to as a permanent profile of 1, 2, or 3 (see AFPAM 48-133 for further guidance).

10.7.4.2. Excusal of fitness testing requires a AF Form 422. This profile must be reviewed annually (1 year expiration) to ensure the provider determines the condition does not require Medical Evaluation Board (MEB) processing.

NOTE:

Ensure the Fitness Medical Liaison Officer receives a copy of the AF Form 422.

10.7.4.3. Members undergoing alcohol rehabilitation (those diagnosed with DSM IV criteria for alcohol abuse or dependence), in the Alcohol & Drug Abuse Prevention & Treatment (ADAPT) program will require a 4T in order to allow completion of treatment. The 4T profile will not extend beyond 18 months. This should allow sufficient time for program completion and will not require Medical Evaluation Board (MEB) unless there is secondary disease process requiring MEB per **Attachment 2**.

10.8. Use of the Department of the Army (DA) Form 3349. DA Form 3349, *Physical Profile Serial,* is acceptable in lieu of AF Form 422. Review any entry in DA Form 3349 which recommends temporary or permanent geographic or climate assignment restrictions. An Army “3” profile is not compatible with worldwide assignment in the Air Force and must be converted to a “4” profile.

10.9. Strength Aptitude Test (SAT):

10.9.1. General Information:

10.9.1.1. AF Pamphlet 36-2108, *Airman Classification,* establishes a SAT standard for each AFSC.

10.9.1.2. When MPF requests a SAT evaluation in writing, PES personnel review the accession MEPS physical and complete the appropriate endorsement.

10.9.1.2.1. If the profile "X" factor equals or exceeds the SAT standard for the retraining AFSC do not retest unless a medical condition is discovered changing the SAT. If a medical condition is discovered, refer the individual to a health care provider for evaluation prior to SAT testing.

10.9.1.2.2. If the profile "X" factor is blank, contains a numeric character 1, 2, or 3, or is an alpha character less than the SAT standard, the SAT results are unsatisfactory. Refer member to the Fitness Center (gym) for administration of the SAT.

NOTE:

AFI 36-2626, Airman Retraining Program, outlines additional MPF responsibilities and contains a copy of the SAT requesting letter mentioned above.

10.10. Medical Evaluation Board General Information. Guidance for processing MEBs is contained in AFI 44-157, *Medical Evaluation Boards (MEB) and Continued Military Service.*

10.10.1. HQ AFPC/DPAMM:

10.10.1.1. Reviews all local MEB actions and In-Lieu-of-MEB case submissions.

10.10.1.2. Authorizes medical hold and informs servicing MPF, the member's MAJCOM/SG, and HQ AFPC/DPMARR/DPMARS/DPPDS/DPMRAS2.

10.10.1.3. If member is qualified for continued active duty, HQ AFPC/DPAMM returns the approved medical evaluation report to the medical facility with instructions for disposition of the examinee.

10.10.1.4. Refers to Physical Evaluation Board (PEB) all cases in which qualifications for world-wide duty are questionable.

10.10.1.5. Enters Assignment Limitation Code-C (ALC-C) for individuals returned to duty by PEB who are not medically suitable for worldwide assignability or global deployment.

10.10.1.6. Establishes requirements for periodic reevaluation of all individuals with ALC-C.

NOTE:

For all overseas cases, coordinate any assignment action with AFPC/DPAMM on members with an Assignment Limitation Code C, or if a medical condition will require specialty care follow-up not available at the gaining overseas assignment.

10.10.2. ARC Surgeon. Reviews all MEBs on ARC members eligible for disability processing prior to forwarding to HQ AFPC. Determines medical qualification for continued military duty on ARC members with questionable or disqualifying medical conditions who are not eligible for disability processing. Assigns ALC-C code to Reserve members or assigns DAC-42 code to ANG members with coordination with ANG/MP as appropriate. (See paragraph **7.1.3.**).

10.10.3. HQ AFPC/DPPDS. Reviews all appeal cases of ARC members who are pending separation for a non-duty related impairment or condition. Members will enter the DES for a determination of fitness only. Notifies all appropriate agencies of the PEB decision and provides disposition instructions. (See AFI 36-3212 for further guidance).

10.10.4. MTF Profile Officer. When notified of MEB/PEB decision completes appropriate profile action to include permanent changes if required. The primary care manager with approval of the profile officer is responsible for proper profiling and restrictions. If the member is processed through the MEB/PEB system, and returned to full duty, without Assignment Limitation Code-C, the member may not be suitable for deployment due to restrictions imposed by the profile officer, see **Attachment 18**, Deployment Criteria.

10.10.5. Temporary Disability Retirement List (TDRL) Process: The AFI 36-3212, *Physical Evaluation For Retention, Retirement, and Separation*, Section 7.10, Processing at the Examining Facility, states that the commander of the examining facility or designated representative makes sure the medical facility completes the examination as quickly as possible so the member may return to his or her home without delay. The commander may utilize his/her resources and personnel to best meet a quality and expeditious TDRL process. Utilizing the PEBLO clerk to ensure the administrative duty of scheduling TDRL appointments is properly conducted is recommended, however this decision is at the discretion of the commander.

10.10.6. Notify MAJCOM/SG when a general officer receives a 4T profile.

Chapter 11

MEDICAL CLEARANCE FOR JOINT OPERATIONS OR EXCHANGE TOURS

11.1. Medical Clearance for Joint Operations:

11.1.1. Air Force personnel must meet Air Force standards while in joint assignments, or inter-Service exchange tours.

11.1.2. Waiver authority is the Air Component Surgeon (i.e., ACC/SG for CENTCOM and SOUTHCOM; AFSOC/SG for SOCOM and USSOCOM; STRATCOM/SG for STRATCOM and AMC/SG for TRANSCOM) or the MAJCOM/SG responsible for administrative management of the member.

11.1.3. In cases where no qualified Air Force flight surgeon is assigned to the Air Component Surgeon's office, or the waiver authority is uncertain, waiver authority is AFMOA/SGOA.

11.1.4. Medical examinations performed by other services are acceptable but must be reviewed and approved by the appropriate Air Force waiver authority.

11.1.5. Waivers for flying or other special duty positions granted by another service or nation may not necessarily be continued upon return to Air Force command and control.

11.2. Joint Training:

11.2.1. The Air Force accepts waivers granted by the parent service prior to the start of training unless there is a serious safety concern or information is available which was not considered by

the waiver authority.

11.2.2. After students in-process at the host base, the administrative requirements and medical management policies of the host base apply.

11.2.3. Students must meet the physical standards of the parent service.

11.2.4. Individuals who develop medical problems while in training should not be continued unless both host and parent service concur.

11.2.5. In cases of irreconcilable conflict, host service decision takes precedence.

Chapter 12

NORTH AMERICAN TREATY ORGANIZATION (NATO) AND OTHER FOREIGN MILITARY PERSONNEL

12.1. North American Treaty Organization (NATO) Personnel:

12.1.1. This chapter implements STANAG 3526, *Interchangeability of NATO Aircrew Medical Categories.*

12.2. Evidence of Clearance. Definition: The host nation is the nation where TDY flying duties take place or the nation with primary aeromedical responsibility. The parent nation is the nation of armed services in which the individual is a member.

12.2.1. Local MTF flight surgeons prepare AF Form 1042 based on the statement of medical fitness for flying duties issued by the parent country.

12.2.1.1. Aircrew on TDY for greater than 30 days are to have a copy of their latest flight physical report with pertinent information and documentation helpful for post-accident identification purposes (fingerprints, dental charts, DNA profile, etc.).

12.2.2. If the aircrew member does not have documentary evidence of a parent nation physical within 12 months, the flight surgeon will complete an aircrew physical.

12.2.2.1. Pre-existing conditions, waived by the parent NATO nation will be accepted by the USAF out health or safety as a result Pre-existing conditions waivered by non-NATO parent nations will be accepted IAW the agreement between USAF and parent nation.

12.2.3. In the case of progress of an existing condition, development or discovery of a new medical condition, the host nation medical standards apply and remain in effect for that individual aircrew member whenever in that host nation.

12.2.4. Periodic examinations for flying are conducted according to the host nation's regulations. A copy of the examination is sent to the aeromedical authority of the parent nation.

12.2.5. Groundings exceeding 30-days and permanent medical disqualification must be discussed with AFMOA/SGOA and the appropriate parent nation liaison.

12.3. Medical Qualification of NATO Aircrew Members:

12.3.1. NATO Aircrew will have the same medical benefits and requirements as USAF aircrew (See AFI 41-115, *Authorized Health Care and Health Care Benefits in the Military Health Services System (MHSS)).*

12.3.2. Assure Air Force aircrew proceeding for NATO duty of more than 30 days have copies of all pertinent medical information to include as a minimum footprints or similar identification documentation, the most current flight physical, and AF Form 1480, *Summary of Care*.

NOTE:

Members should have documentation in the medical record that a DNA sample has been obtained and on record at AFIP.

12.3.3. Waivers for flying or other special operational duty positions granted by another nation may not necessarily be continued upon return to the USAF.

12.4. Medical Qualification for Security Assistance Training Program (SATP) Flying (Non-NATO Students):

12.4.1. The flight surgeon conducts appropriate medical examinations of foreign students enrolled in flying training courses under the SATP. Apply USAF Standards to physicals done at USAF bases.

12.4.2. Forward reports to HQ Air Education and Training Command (HQ AETC)/SG for certification or waiver consideration.

12.4.3. Disqualification decisions should be discussed with AFMOA/SGOA and appropriate parent nation liaison.

12.5. Non-NATO Aircrew. For non-NATO aircrew, specific memorandums of agreement between the United States and parent nation take precedence over this chapter if in conflict.

Chapter 13

MEDICAL EXAMINATION FOR FEDERAL AVIATION ADMINISTRATION (FAA) CERTIFICATION

13.1. Medical Examination for Federal Aviation Administration (FAA) Certifi cation.

13.1.1. Availability. MAJCOM/SGs and ANG/SG determine whether FAA examinations are available in their facilities. Reserve medical squadrons will not perform FAA examinations.

13.1.2. Personnel Authorized to Perform FAA Examinations and Issue Certificates. Air Force flight surgeons designated as Aviation Medical Examiners (AME) by the FAA.

13.1.3. Eligibility for Examination. The following personnel are eligible for FAA examinations at Air Force facilities:

13.1.3.1. Active duty of the United States Armed Forces.

13.1.3.2. DoD ROTC personnel.

13.1.3.3. Members of foreign military services assigned to duties within the CONUS.

13.1.3.4. Military retirees or dependents of active duty who are members of a military aeroclub.

13.1.4. Standards. FAA medical standards are in Federal Aviation Regulation (FAR), Part 67, and in the Guide for Aviation Medical Examiners published by the FAA Office of Aviation Medicine.

13.1.4.1. FAA second or third class examinations may be performed in Air Force facilities.

13.1.4.2. Air Force facilities are required to meet all FAA requirements if FAA examinations are performed.

13.1.5. Disposition of Reports:

13.1.5.1. Flight medicine personnel send reports of medical examination and supporting documents on all applicants to: DOT/FAA, Manager Aeromedical Certification Branch AAM-300, Civil Aeromedical Institute PO BOX 26080, Oklahoma City, OK 73126. The examiner issues FAA Form 8420-2, 8500-2, or 8500-9 as required.

13.1.5.2. In all cases, the examining facility maintains the file copy of FAA Form 8500-8 with supporting documentation and disposes of it according to current directives.

13.1.6. Supply of FAA Medical Forms and Publications. To obtain FAA forms, use FAA Form 8500-11, *Medical Forms and Stationary Requisition*, or write to DOT/FAA, AAM-410, Civil Aeromedical Institute, P.O. Box 25082, Oklahoma City, OK 73125-5061.

Chapter 14

EXAMINATION AND CERTIFICATION OF AIR RESERVE COMPONENT MEMBERS NOT ON EXTENDED ACTIVE DUTY

14.1. Purpose of This Chapter. This chapter implements DoD Directive 1205.9, 6 October 1960, as required by 10 U.S.C. 12644. Establishes procedures for accomplishing, reviewing, certifying, and administratively processing medical examinations on ARC members not on EAD who are assigned to the Ready Reserve and Standby Reserve. Use AFI 48-123/AFRC Supplement when managing cases on unit assigned reservists.

14.2. Terms Explained:

14.2.1. Air Reserve Component (ARC). Unit and individual members of the Air National Guard (ANG) and Air Force Reserve (AFRC, IMA).

14.2.2. ARC Members of the Ready Reserve:

Air National Guard. Administered by ANG/SGP.

Air Force Reserve Unit Member. Administered by HQ AFRC/SGP.

Individual Mobilization Augmentee (IMA). Administered by HQ ARPC/SGS.

Participating Individual Ready Reserve Members, Category E, and Reinforcement Designees (RD) Category H. Administered by, HQ ARPC/SGS, Denver, CO.

14.2.3. Nonparticipating Members of the Ready, Standby, and Retired Reserve. Administered by HQ ARPC/SGS, Denver, CO. These members are ordered to EAD only in time of war or national emergency declared by the Congress.

14.3. Medical Standards Policy. Each ARC individual must be medically qualified for deployment and worldwide duty according to **Chapter 7**.

14.4. Specific Responsibilities:

14.4.1. Commander or Supervisor. Each ARC commander or active force supervisor ensures an ARC member is medically qualified for worldwide duty. Each commander and supervisor notifies the servicing medical facility when he/she becomes aware of any changes in an ARC member's medical status.

14.4.2. ARC Member. Each ARC member is responsible for promptly reporting a disease, injury, operative procedure or hospitalization not previously reported to his or her commander, supervisor, or supporting medical facility personnel. Any concealment or claim of disability made with the intent to defraud the government results in legal action and possible discharge from the ARC.

14.4.3. ARC Physicians. Responsible for determining ARC member's medical qualifications for continued worldwide duty IAW this instruction and appropriate ARC supplemental guidance.

14.4.4. Air Force medical service personnel record any injury or disease incurred or contracted by ARC members during any training period on appropriate medical forms since the injury or disease is the basis for a claim against the government, to include initiation of a Line of Duty Determination.

14.5. General Responsibilities/ARC Medical Units:

14.5.1. Establish health and dental records for each ARC member. File a medical examination (SF Form 88 and 93 as required); annual medical certificate (AF Form 895) and all supporting military and civilian medical documentation in the ARC member's health record.

14.5.2. Send a copy of the medical examination on a medically qualified ANG member to the appropriate State Adjutant General, according to local state directives.

14.5.3. Send original IMA medical examinations to HQ ARPC/SGS. Denver CO. All IMA medical examinations are subject to review by HQ ARPC/SG to determine qualification for reserve participation. HQ ARPC/SG is the final authority in determining the IMAs medical qualification for world wide duty.

14.5.4. All medical examinations accomplished on Unit-Assigned Reservists are subject to review by HQ AFRC/SGP to verify their medical qualification for continued military duty. HQ AFRC/SGP is the final authority in determining the medical qualifications for Unit-Assigned Reservists.

14.5.5. All Air National Guard medical examinations are maintained by the servicing medical unit and are subject to review by ANG/SGP to verify qualification for participation. ANG/SGP is the final authority in determining Air National Guard member qualification for worldwide duty.

14.5.6. Send complete medical case files on ARC members with questionable medical conditions or found medically disqualified to: For Air National Guard members, send to: ANG/SGPS, 3500 Fetchet Avenue, Andrews AFB, MD 20762-5157, for unit assigned reserve members, send to: HQ AFRC/SGP, 155 Second Street, Robins AFB, GA 31098-1635, for IMAs send to: HQ ARPC/SGS, 6760 East Irvington Place, #7200, Denver, CO 80280-7200.

14.6. Inactive/Retired Reserve. Members assigned to the inactive or Retired Reserve who meet the following medical requirements can be returned to active reserve participation:

14.6.1. Satisfy **Chapter 7** and **Attachment 3** standards for accession.

NOTE:

If member has been assigned to the inactive or Retired Reserve for less than 12 months, then they must satisfy **Chapter 7** and **Attachment 2** standards for worldwide duty.

14.6.2. Disqualifying medical condition or defect is repaired or resolved (if previously found medically disqualified for worldwide duty).

14.6.3. Medically qualified for worldwide duty by HQ ARPC/SG for reassignment into the IMA program; by HQ AFRC/SGP for reassignment into the Reserve unit program; or by HQ ANG/SGP for reassignment into the ANG unit program. (Medical certification by appropriate ARC/SG only required if applicant previously found medically disqualified for worldwide duty, on a “4” profile or assignment limitation code (ALC) C at the time of reassignment from active military status).

14.7. Reenlistment. Ensure members who want to reenlist but have not completed a medical examination or annual medical certificate in the past 12 months, complete AF Form 895, *Annual Medical Certificate*. Individuals with changes in medical status are scheduled by their commander or supervisor for a medical examination to determine eligibility for reenlistment.

14.8. Pay or Points. Annually, prepare the appropriate form for Reinforcement Designees not participating for pay or points. Members who feel their medical qualification is in question attach medical documentation to the appropriate form and return the entire package to HQ ARPC/DSFS, Denver, CO 80280-5000.

14.9. General Officers. Forward all periodic medical examinations on general officers or colonels serving in general officer positions to the appropriate ARC/SG at the address indicated in paragraph **14.5.6.** above. Reserve medical units will forward to HQ AFRC/SGPS, a copy of all physical examinations accomplished on reserve wing commanders.

14.10. Voluntary EAD:

14.10.1. Standards:

14.10.1.1. ARC members must have a periodic medical examination within 24 months prior to entry and a current HIV test within 180 days prior to entry to EAD.

14.10.1.2. Members age 40 or older must have an exercise tolerance treadmill test if the member's cardiac risk index (CRI) is 10,000 or greater.

Formula: $CRI = \frac{chol}{hdl} - 1\ (age)2$

14.10.1.3. ARC members must meet medical qualification standards in **Attachment 2**.

14.10.1.4. On entering EAD, the member must complete DD Form 220, *Active Duty Report*, statement number 1, item 18.

14.11. Involuntary EAD:

14.11.1. General Information.

14.11.1.1. An ARC member who has a current medical examination according to **Attachment 8** can be involuntarily ordered to EAD for a period of 45 calendar days.

14.11.1.2. The health records of the ARC member are reviewed for disqualifying defects according to **Attachment 2**. Members found medically disqualified or questionably qualified for worldwide duty are evaluated prior to entry on EAD.

14.11.1.3. An ARC member ordered to EAD due to mobilization is medically processed according to appropriate directives.

14.12. Annual Training (AT) or Active Duty for Training (ADT) or Inactive Duty for Training (IDT). Commanders ensure members reporting for duty are medically qualified under current directives. Members with medical conditions which render questionable their medical qualifications for continued worldwide duty are evaluated for fitness for duty.

14.13. Inactive Duty for Training :

14.13.1. General Information:

14.13.1.1. ARC members who are ill, sustain an injury, or do not consider themselves medically qualified for military duty can request excusal from training.

14.13.1.2. If a member reports for duty and does not consider himself or herself medically qualified, the member is scheduled by the ARC commander or active duty supervisor for a medical evaluation during the IDT period. If the member is not qualified for worldwide duty, a medical evaluation is sent to HQ AFRC/SGP, HQ ARPC/SGS, OR ANG/SGP as appropriate. The member is excused from training pending a review of the case. For ANG members, the State Air Surgeon may grant an interim waiver for IDT in the likelihood the member is returned to duty.

14.13.1.3. When a commander, supervisor, or medical personnel determines an ARC member's medical condition is unfit, he or she is evaluated by the servicing medical squadron and is excused from all military duties pending further medical disposition.

14.14. Medical Examination:

14.14.1. General Information:

14.14.1.1. Medical personnel perform medical examinations according to **Chapter 1** and AFPAM 48-133. Consult the AFRC supplement to this instruction and AFPAM 48-133 when accomplishing medical examinations on AFRC unit assigned reservists.

14.14.1.2. Dental personnel complete a Type II dental examination at the time of the periodic physical examination. ARC flying personnel require this examination every 3 years (SF 88). Bite wing radiographs are accomplished at the discretion of the examining dental officer for diagnostic assistance.

14.14.1.3. ARC members complete AF Form 895 within 12 months of the date of last medical certificate for those years in which a medical examination is not required. ARC aircrew members require this form in years that a short flying exam (AF Form 1446) is accomplished.

14.14.1.3.1. ARC members with positive response made on AF Form 895, *Annual Medical Certificate*, require the member to be interviewed by a senior medical technician (SMT) as soon as possible, but not later than the UTA following completion of the AF Form 895. This interview can be conducted by telephone.

14.14.1.3.2. The SMT annotates their findings in the member's health record on SF 600. The member is required to provide all supporting civilian health or dental documentation for inclusion in the health or dental record.

14.14.1.3.3. If the SMT determines qualification is questionable, the case is referred to a military physician for review and disposition.

14.14.1.3.4. ARC MPF and commander are notified by the ARC medical squadron when a member cannot continue the UTA because of a medical condition. AF Form 422 is utilized for notification, as appropriate.

14.14.1.4. IMAs notify their commander or supervisor of positive responses on AF Form 895. The commander or supervisor schedules the member for a fitness for duty evaluation to determine

medical qualification for worldwide duty. The member is released from duty pending final disposition by HQ ARPC/SGS.

14.14.2. Dental Class III.

14.14.2.1. ARC members placed in dental class III are not medically qualified for continued military duty. Manage AFRC members IAW Paragraph **14.16.** of this instruction unless the dental officer has determined the member may continue reserve participation in restricted status.

14.14.2.2. The examining military dental officer has the authority to allow reservists in dental class III to continue Reserve participation at home duty station only while undergoing corrective dental treatment. The dental officer will determine the length of time (not to exceed 1 year) given to a member to complete dental treatment or improve to at least dental class II. An AF Form 422 accomplished IAW the AFRC supplement to AFPAM 48-133 will be accomplished on those reservists in dental class III who are allowed to continue reserve participation. If the member refuses to sign the AF Form 422, the member will be immediately processed IAW paragraph **14.16.** of this instruction.

14.14.2.2.1. Aircrew members in dental class III will be placed on DNIF status unless the examining dental officer determines the member may continue reserve participation and the flight surgeon determines flying safety will not be compromised. Aircrew in this status will be limited to local sorties only.

14.14.2.3. ANG Dental III members are immediately placed on physical profile P4T. The State Air Surgeon may grant an interim waiver for IDT only. Aircrew members in dental class III will be placed on DNIF, and an AF Form 1042, *Medical Recommendations for Flying or Special Operational Duty*, will be accomplished and may not perform flying duty while in Dental Class III. For additional guidance, please see AFI 47-101, *Managing Air Force Dental Services*.

14.15. Scheduling Periodic Medical Examinations. Schedule a medical examination in accordance with **Attachment 9**.

14.15.1. General Information:

14.15.1.1. Guard and reserve unit members are scheduled for medical examinations at ANG or AFRC medical squadrons. If this is not possible, schedule the periodic medical examination with the nearest DoD MTF.

14.15.1.2. IMA members' periodic medical examinations are scheduled by the member after the receipt of a certified request for the examination from HQ ARPC/SGS. IMA flying personnel are notified of examination requirements by HQ ARPC/DPRC. It is normal for them to schedule their periodic medical examinations with active units. After the IMA receives a scheduled date from the MTF, the IMA contacts HQ ARPC/SGS to forward a copy of the most recent SF 88, 93, HIV screening results, SF 603, and any significant interval history to the MTF. If the medical information is not received within 72 hours prior to the examination, the MTF contacts HQ ARPC/SGS to obtain the information. MTFs make every effort to accomplish the medical examination in one day.

14.15.1.2.1. A civilian physician or dentist performs a medical or dental examination for IMAs at government expense if prior approval is obtained from HQ ARPC/SGS.

14.16. Medical Evaluations to Determine Fitness for Duty:

14.16.1. Medical evaluations to determine medical and dental qualification for military duty are accomplished for the following reasons:

14.16.1.1. Disqualifying or questionable medical conditions discovered during the periodic medical examination or on the AF form 895.

14.16.1.2. Notification or awareness of a change in the member's medical status.

14.16.1.3. ARC member believes he or she is medically disqualified for military duty.

14.16.1.4. Reservists with medical or dental conditions which are questionable or disqualifying for military duty must an evaluation accomplished and forwarded to the appropriate ARC/SG for review and appropriate action. Members will be given a minimum of 60 days from the date of notification to provide civilian medical or dental information to the medical squadron prior to case submission to the ARC/SG. The local military provider may give the member more time as considered necessary to provide the requested information. However, under no circumstances will the time exceed 1 year.

14.16.2. Notification. The commander or supervisor notifies the ARC member, in writing, to report for the medical evaluation.

14.16.3. Accompanying Documents. The following documents are included in the reports forwarded to the appropriate component surgeon (see paragraph **14.5.**) for review. Unless otherwise specified all reports contain the original and two copies of each document, properly collated and stapled into three separate stacks.

14.16.3.1. For unit assigned or IMA reserve members:

14.16.3.1.1. A complete physical exam (only when a medical condition is discovered during the periodic exam).

14.16.3.1.2. AF Form 895 (see AFRESMAN 48-101).

14.16.3.1.3. Civilian medical and dental documentation.

14.16.3.1.4. Current letter from member's private physician or dentist.

14.16.3.1.5. AF Form 422 properly formatted (see AFRESMAN 48-101).

14.16.3.1.6. SF 502. The narrative summary must provide a clear picture of the member's current medical health as well as the circumstances leading to it.

14.16.3.2. For ANG members.

14.16.3.2.1. SF 93, updated and current within six months

14.16.3.2.2. SF 502, narrative summary should include:

14.16.3.2.2.1. Date and circumstance of occurrence

14.16.3.2.2.2. Response to treatment

14.16.3.2.2.3. Current clinical status

14.16.3.2.2.4. Proposed treatment

14.16.3.2.2.5. Current medications

14.16.3.2.2.6. The extent to which the condition interferes with performance of military duty (see **Attachment 18**, Deployment Criteria)

14.16.3.2.2.7. Prognosis

14.16.3.2.3. Civilian medical documentation. Medical documentation from the member's civilian health care provider will be included in all waiver cases submitted on ARC members. The provider will review this information and reference it in the narrative summary.

14.16.3.2.4. A written statement from the member's immediate commanding officer or supervisor describing the impact of the member's medical condition on normal duties and ability to deploy or mobilize.

14.16.4. Reports. A member who is unable to travel submits a report from his or her attending physician to their commander or supervisor who, in turn, submits the report to the servicing ARC medical squadron for review and determination of fitness for duty.

14.17. Failure to Complete Medical Requirements (Refer to AFRESMAN 48-101 for unit assigned reservist). Reserve members who fail to complete medical/dental requirements may not perform military duty IAW AFM 36-8001. An AF Form 422 will be accomplished IAW with the AFRC supplement to AFPAM 48-133. The numerical profile will not be changed. NOTE: ANG members who fail to complete any requirements (i.e., periodic medical examination, dental, immunizations, AF Form 895, etc.) are placed on P4T status.

14.17.1. Flying Status. ARC members on flying status who fail to complete a required medical examination are suspended from flying status in accordance with applicable directives.

14.17.2. Refusal. ANG members with a known medical or dental condition who refuse to comply with a request for medical information or evaluation are considered medically unfit for continued military duty and are processed IAW AFI 36-3209, *Separation and Retirement Procedures for ANG and AFR Members*.

Chapter 15

MEDICAL EXAMINATION/ASSESSMENT/MISC--ACCOMPLISHMENT AND RECORDING

15.1. General Information. The health record is a medical and legal document. Accuracy and completeness in all entries is essential.

15.1. (AFMC) Each medical record must be reviewed to identify any medical conditions or behavioral risks that require further evaluation or counseling.

15.2. Medical History. If the examinee has a completed SF Form 93, "on record" do not accomplish a new form.

15.2.1. Changes. Make an addendum to the most current or complete SF Form 93 by adding any significant items of interval history since the last SF Form 93 was accomplished.

15.2.2. Additional Space. Use SF Form 507, *Medical Record-Report on ____ or Continuation of SF ____***,** as an attachment to the SF Form 93 when additional space is required. (See AFPAM 48-133).

15.2.3. SF Form 93. SF Form 93 is to be updated and attached to SF Form 88, or AF Form 1446, *Medical Examination--Flying Personnel*, or the Preventive Health Assessment (PHA)**,** where required, when medical examinations are accomplished for the following purposes:

15.2.3.1. Entry into active military service.

15.2.3.2. Appointment or enlistment in the Air Force or its Reserve Forces**.**

15.2.3.3. Retirement or separation from active military service as specified by this instruction.

15.2.3.4. Periodic flying and non-flying examinations as specified in **Attachment 8**.

15.2.3.5. Whenever an examination is sent for higher authority review.

15.2.3.6. Whenever considered necessary by the examining health care provider; for example, after a significant illness or injury or commander directed physical assessment.

15.2.3.7. Examination of an ARC member. NOTE: For ANG short flying exams (AF Form 1446), accomplish an AF Form 895 in place of the updated SF 93.

15.2.3.8. Lost medical records. Accomplish a PHA with SF Form 93.

15.2.3.8. (AFMC) As specified in Attachment 19.

15.3. Interval Medical History. Once a complete medical history has been recorded on a SF Form 93, only **significant** items of medical history since the last medical examination are recorded. This is called the interval medical history.

15.3. (AFMC) An interval history is required for each PHA. Sources other than those listed above may be used to collect information for the history. These include the Dental Form 696, web-based questionnaires, telephone interviews, or other modalities. Regardless of how it is collected, it must be immediately reviewed and forwarded for inclusion in the medical record and available to review at the time of the administrative portion of the PHA.

15.3.1. Changes in Flight Status. Any significant medical condition requiring hospitalization, excusal, grounding, profile change or suspension from flying status is recorded as part of the interval medical history. The information concerning the interval medical history is obtained by questioning the examinee and by a thorough review of the examinee's health records.

15.3.2. Updates. The interval medical history is recorded on SF Form 93, item 25 or continued on SF 507. Reference each update to the SF Form 93 with the current date, followed by any significant items of medical history since last examination.

15.3.3. Significant Medical History. Use SF Form 93 (Items 8-12 and 15) as a guide in determining items to include as significant medical history.

NOTE:

Do not record "routine" items such as URIs, viral illnesses, etc., unless hospitalization was required or the illness is of a frequent or chronic nature.

15.3.4. Denial Statement. After recording the interval medical history, the following denial statement is recorded: "No other significant medical or surgical history to report since last examination (enter the date of that examination in parentheses)."

15.3.5. No Interval Medical History Statement. If the examinee had no interval medical history, record the current date followed by the statement: "No interval medical or surgical history to report since last examination dated (enter the date of that examination in parentheses)." See AFPAM 48-133 for denial statement used when accomplishing the initial SF Form 93.

15.4. Medical Examinations: The results of medical examinations are recorded on SF Form 88 or approved substitutes in accordance with AFPAM 48-133.

15.5. AF Form 1446, *Medical Examination--Flying Personnel.* AF Form 1446 is used to record findings when a periodic flying (short) examination is done. See **Attachment 8**.

15.6. DD Form 2697 , *Report of Medical Assessment.* DoD directs that DD Form 2697 be accomplished for all members separating or retiring from active duty, consult **Chapter 5**.

15.7. Adaptability Rating for Military Aviation (ARMA) and other military duties, such as for Air Traffic Control Duty (ARMA-ATC), Space (ARMA-SPACE) and Missile Duty (ARMA-MISSILE), etc., is the responsibility of the examining flight surgeon, as is the scope and extent of the interview. Initial (entry into training) unsatisfactory adaptability ratings are usually rendered for poor motivation for flying (or other duty), or evidence of a potential safety of flight risk, etc. See **A7.24.** and AFPAM 48-133, *Physical Examination Techniques* for further information.

15.8. DD Form 2766, *Adult Preventive and Chronic Care Flowsheet*. DD Form 2766 is used to record results of tests such as blood type, G6-PD, DNA, GO, NO-GO pills, etc., and also used as a deployment document as the AF Form 1480A, IAW AFI 10-403, paragraph. 1.5.17 which requires the medical group commander to provide a current DD Form 2766 for all deploying personnel.

15.8. (AFMC) See AFPAM 44-155, Chapter 4.

15.9. (Added-AFMC) Health History Tool (HHT). Local policy will determine the frequency and which HHT (ie., 16 question Overprint SF 600, or MDG specific equivalent) will be utilized. Whatever variation is used, it must provide the individuals a self-reporting tool to identify their health concerns and hsould be accomplished prior to the PHA (i.e., during the fitness exam, dental exam, etc.)

15.9.1. (Added-AFMC) The HHT once completed however, must be reviewed as soon as possible (immediately for those on PRP), to ensure there are no indicators that require immediate intervention such as mental health issues that could have an impact on the individual's PRP status. Indicators having immediate impact on PRP status or major health care concerns require that further evaluation or counseling needs be identified and the individual scheduled for any needed follow-up.

15.10. (Added-AFMC) IMR Requirements. All IMR requirements must be reviewed, evaluated, and accomplished as part of the complete PHA process.

15.10.1. (Added-AFMC) Immunizations.

15.10.1.1. (Added-AFMC) Immunizations personnel verify currency; immunize individual's; and update the Air Force Complete Immunizations Tracking Application (AFCITA) IAW AFJI 48-110, *Immunizations and Chemoprophylaxis.*

15.10.1.2. (Added-AFMC) When a required immunization becomes due, the IMR status will change to red. When the immunization is completed or the requirement in AFCITA is deleted, the IMR status will revert to green.

15.10.2. (Added-AFMC) Dental Classification.

15.10.2.1. (Added-AFMC) Dental classification is managed through the Dental Classification Management System (DCMS) automatically downloaded to PIMR

15.10.2.2. (Added-AFMC) A dental classification of 1 or 2 will show IMR green, 3 or 4 will show as red.

15.10.3. (Added-AFMC) AF Form 422, **Physical Profile Serial Report.**

15.10.3.1. (Added-AFMC) Profiles will be managed within the PIMR software.

15.10.3.2. (Added-AFMC) Providers will initiate the profile as indicated in Chapter 10 and guidance in AFPAM 48-133, *Physical Exam Techniques*, Chapter 10, para 10.3.

15.10.4. (Added-AFMC) Medical Readiness Lab Tests.

15.10.4.1. (Added-AFMC) All those listed in para 1.2.4. above with the exception of the PIP are monitored in PIMR. If these tests have not been accomplished and/or have not been entered into the PIMR software they will show as red.

15.10.4.2. (Added-AFMC) To turn this portion of the PIMR software to green, the information must be entered manually.

15.10.5. (Added-AFMC) Health Records Review (HRR) Date.

15.10.5.1. (Added-AFMC) This date is manually entered into the PIMR system by a PCM team member and is the indication that the complete PCM review above has been accomplished.

15.10.5.2. (Added-AFMC) The first day of the 13th month after the last assessment, this area in PIMR turns yellow indicating the individual is overdue for an assessment. On rare occasions,

such as an unannounced rapid deployment, an individual's PHA could be delayed up to a maximum of six months (or 18 months total).

5.10.5.3. (Added-AFMC) After 18 months, PIMR status turns red reflecting that the person should have an assessment completed prior to any deployment.

15.10.6. (Added-AFMC) Other Specific Data.

15.10.6.1. (Added-AFMC) Attachment 19 reflects any special populations (i.e., flying personnel), that have additional requirements programmed into the PIMR software.

15.10.7. (Added-AFMC) Medical Equipment Data.

15.10.7.1. (Added-AFMC) Items such as gas mask inserts, QNFT, etc, will be entered into PIMR but will not affect the IMR status until October 2002 to allow the data to be entered during one normal PHA cycle**.**

Chapter 16

SPECIAL EVALUATION REQUIREMENTS

16.1. General. This chapter establishes minimum evaluation requirements for cases submitted to certification and waiver authorities. All cases require appropriate follow-up and documentation of potentially disqualifying conditions. The *Medical Waiver Guide* provides additional guidance in the preparation of cases for flying waivers.

16.2. Artificial Dentures. During dental evaluation document the satisfactory restoration of masticatory function, appearance, and clear speech. Complete dental prosthesis is demonstrated by adequate phonetics, retention, stability, interocclusal space, and occlusion. Oral tissues supporting the prosthesis must be in good health.

16.3. Head Trauma. Minimum observation periods and evaluation requirements are listed in **Table 16.1.**

NOTE:

The severity of injury is a governing factor. Head injuries more than 10 years old do not require evaluation in the absence of sequelae. Refer to the specific attachments for information on the evaluation and disposition of head injuries with sequelae.

Table 16.1. Evaluation of Head Injury.

Degree of Head Injury	Minimum Observation Time	Evaluation Requirements
Mild(see paragraph **A7.23.** for criteria).*Coordinate all actions with MAJCOM/SG to include submission of tests to the ACS.*	**1 month**	**Enlistment, Induction, Appointment**: Complete Neurological Examination by a Physician-**Flying Class I, IA, III**: Complete Neurological and Mental Status Examination by a Flight Surgeon**Flying Class II**: 1. Complete Neurological and Mental Status Examination by a Flight Surgeon. 2. Neuropsychological Testing as Specified by the Clinical Science Division, Neuropsychiatry Branch, Brooks AFB TX, within 30 days of head injury (Send results of testing to the ACS for review prior to RTFS).

Moderate(see paragraph **A7.23.** for criteria).*Coordinate all actions with MAJCOM/SG to include submission of tests to the ACS.*	**2 years**	**Enlistment, Induction, Appointment, Flying Class I, IA, III**: 1. Complete Neurological Evaluation by a Neurologist or Internist. 2. CT Scan. 3. Neuropsychological Evaluation (Consists of the following tests, as a minimum,: MMPI, Halstead Reitan, and WAIS-R).**Flying Class II**: 1. Complete Neurological and Mental Status Examination by a Neurologist. 2. CT of the head (within 48 hrs). 3. MRI of head (if possible, within 48 hrs). 4. EEG Routine (with a sleep sample). 5. Neuropsychological Testing as Specified by the Neuropsychiatry Branch, Brooks AFB TX., within 30 days of head injury (Send testing results to the ACS for review prior to RTFS). 6. ACS evaluation 6 months following injury.
Severe(see paragraph **A7.23.** for criteria).*Coordinate all actions with MAJCOM/SG to include submission of tests to the ACS.*	**5 years** for closed head trauma**10 years** for penetrating head trauma	**Enlistment, Induction, Appointment, Flying Class III**: 1. Complete Neurological Evaluation by a Neurologist. 2. CT Scan. 3. Neuropsychological Evaluation (Consists of the following tests, as a minimum,: MMPI, Halstead-Reitan, and WAIS-R).**Flying Class I, IA**: Not waiverable. Exceptions may be granted after a 10-year period of observation.**Flying Class II:** 1. Complete Neurological and Mental Status Examination by a Neurologist. 2. CT of head (within 48 hrs). 3. MRI of head (if possible, within 48 hrs). 4. EEG Routine (with a sleep sample). 5. Neuropsychological Testing as Specified by the Neuropsychiatry Branch, Brooks AFB TX, within 30 days of head injury (Send results of testing to the ACS for review prior to RTFS).6. ACS evaluation 6 months following injury.

16.4. Elevated serum cholesterol . Male aircrew members age 40 or greater, or female aircrew members age 50 or greater, meeting either of the criteria below require further management per the *Medical Waiver Guide* "Hyperlipidemia":

16.4.1. Fasting calculated low density lipoprotein (LDL) greater than 190 mg/dl

16.4.2. Fasting calculated low density lipoprotein (LDL) greater than 160 mg/dl with one or more of the following risk factors:

16.4.2.1. Positive family history of atherosclerotic heart disease

16.4.2.2. Current smoker

16.4.2.3. Hypertension, treated or not

16.4.2.4. High density lipoprotein (HDL) cholesterol less than 35 mg/dl

16.4.3. Initial applicants for commission, enlistment, Flying Class II and III that are 40 years of age and older are required to obtain an Exercise Tolerance Test (ETT) if their cardiac risk index (CRI) is 10,000 or greater.

FORMULA: CRI = [(cholesterol/HDL)-1]age^2

16.5. Intraocular Pressure:

16.5.1. Routine Determination. Refer examinees with the following intraocular pressures to a qualified ophthalmologist for consultation:

16.5.1.1. Two or more current determinations of 22 mmHg or higher.

16.5.1.2. A difference of 4 mmHg or greater between right and left eyes.

16.5.2. Ophthalmology Evaluations. Ophthalmology evaluations include, where appropriate, a dilated examination of the disc with a stereoscopic magnifying lens (Hruby, Goldmann, 90D), visual fields, applanation tonometry, and stereo 35 mm disc photos (when available).

16.6. Malocclusion, Teeth. Report of examination by a dentist with comment as to whether incisal and masticatory functions are adequate for an ordinary diet, plus a comment on the degree of facial deformity with the jaw in natural position and whether there is interference with speech or wear of protective equipment.

16.7. Sickle Cell Trait. Positive sickle cell screening tests on personnel performing flying duty or required to meet flying medical standards are confirmed by hemoglobin electrophoresis. A one-time certification, by the proper certification authority in **Attachment 9**, is required for all flying personnel and flying training applicants with sickle cell trait. For the purpose of maintaining a central registry of Air Force flying personnel with sickling disorders, the certification authority notifies AFMOA/SGOA, Bolling AFB DC. Include the following information; name (last, first, MI), rank, SSN, flying class, percent of hemoglobin-S, and certification date.

16.8. Hepatitis, History Of. Hepatitis B and C antigen/antibody testing, ALT, and GGPT (in cases of confirmed Hepatitis A, no additional testing is required).

16.9. Color Vision. Initial enlistment or commission examinations have no standards for color vision. Color vision tests are accomplished on all accessions (enlistment and commission) since many Air Force specialties require normal color vision. Failure of the test is defined as five or more incorrect responses (including failure to make responses in the appropriate amount of time), in reading the 14 test plates of the Pseudoisochromatic Plate (PIP) set.

NOTE:

No other tests for color vision are authorized.

16.10. Allergic Disorders, History Of. Be cautious of self-imposed diagnoses. Record all historical details such as age of onset, seasonal and geographical variation, severity, frequency and duration, medication used, efficacy of treatment, and date of last occurrence. Nasal smear of eosinophils will be done if acute allergic rhinitis is suspected.

16.11. Backache, Severe or Incapacitating, History)Of. Current orthopedic consultation which reports strength, stability, mobility, and functional capacity of the back. Report of appropriate x rays. Summary of past treatment from a cognizant physician, if applicable.

16.12. Blood Pressure, Elevated, Finding or History Of:

16.12.1. Record the blood pressure (sitting position) for a minimum of one blood pressure reading a day for 5 days. Prolonged rest or sedation is not allowed. If the blood pressure is persistently elevated, medical consultation is indicated (See AFI 48-133).

16.12.2. AFROTC and US military academy examinees will, when found to have disqualifying blood pressure on initial examinations, be rechecked for a preponderance based on at least three readings at successive 1-hour intervals during a 1-day period.

16.12.3. If not medically contraindicated, terminate all medication for at least 2 weeks before referral to a consultant or another medical facility for further work-up.

16.12.4. When reports of medical examinations are sent to higher headquarters for review and the examinations indicate the presence of hypertension, it is important that the member's response to treatment be documented in order to facilitate proper disposition of the case. A minimum of 5 days, twice daily, blood pressures under specified therapy are required for the record.

16.13. Diabetes, Family history of (parent, sibling, or more than one grandpar ent). Fasting blood sugar will be obtained and recorded on the initial evaluation and subsequent periodic assessments/examinations.

NOTE:

State in the report the method of blood sugar determination and the normal values of the laboratory used.

16.14. Enuresis, or History of, in Late Childhood or Adolescence. Comment on the examinee's affirmative reply to question of "bed wetting" to include the number or frequency of incidents and age at last episode.

16.15. Flatfoot, Symptomatic Finding or History of. Current orthopedic consultation with a detailed report of strength, stability, mobility, and functional capacity of the foot and the medical need for orthotics. Report of appropriate x rays.

16.16. Speech Disorders and Noticeable Communication Problems. These should be investigated during the initial physical for accession, or when application for flying (any flying class), or other special duty is required. At a minimum, a Reading Aloud Test (RAT) is required as specified in this instruction in the applicable attachment(s). Consult AFPAM 48-133 for proper procedure for performing the RAT.

16.17. Substandard Standing & Sitting Height. See **Table 16.2.** below. Consult AFPAM 48-133 for proper procedures for accomplishing measurements.

NOTE:

Flight surgeon, flight nurse and aeromedical evacuation technician applicants with stature less than 64" should be submitted for waiver if their functional reach is at least 76" and felt by the examining flight surgeon to not compromise flying safety. Consult AF Pam 48-133 for proper procedures for accomplishing functional arm reach.

Table 16.2. Disqualifying Standing & Sitting Height Standards for Accession, Flying Class 1, 1A, II, II (Flight Surgeon), & III

TYPE PHYSICAL > greater than< less than	STANDING HEIGHT(MALE)	STANDING HEIGHT (FEMALE)	SITTING HEIGHT (ALL)
Accession	>80" or < 60"	>80" or <58"	-
FLYING CLASS 1	>77" or <64"	>77" or <64"	>40" or <34"
FLYING CLASS 1A	>77" or <64"	>77" or <64"	>40" or <33"
FLYING CLASS II	>77" or <64"	>77" or <64"	-
FLYING CLASS II(FLT SG)	>77" or <64"	>77 or <64"	>40" or <33"
FLYING CLASS III	>77" or < 64"	>77" or <64"	-

16.18. Amsler Grid Test. Due to the advent of laser technology, the Amsler grid test is an efficient way to examine the central 10 degrees of the visual field in a very effective manner without the necessity of high-tech equipment. Baseline is accomplished at undergraduate flying training. Consult AFPAM 48-133 for proper testing procedures.

Chapter 17

OCCUPATIONAL HEALTH EXAMINATIONS

17.1. Purpose. Occupational health examinations are done to monitor the health status of individuals as it relates to their work environment. The examinations are conducted to assist in maintaining a fit force essential to mission readiness and to assure the Air Force meets its obligation under the Occupational Safety and Health Act of 1970 (29 USC 651) to provide a safe and healthful workplace.

17.1. (AFMC) The MTF develops local policy on how OHMEs will be conducted. Policy must be established at bases where Active Duty members receive OHMEs through an Occupational Medicine Service (OMS), as to how and where their PHAs will be done (through the OMS or their PCM) and how the results are updated in PIMR.

17.2. Who Receives These Examinations. These examinations are accomplished on all workers identified by the local Occupational Health Working Group (OHWG) as being at potential risk for occupational illness.

17.3. PES. Schedules and performs occupational health examinations/assessments.

17.3. (AFMC) Prepares scheduling products for occupational health examinations/assessments.

17.3.1. (Added-AFMC) Provides scheduling products to the UHM.

17.3.2. (Added-AFMC) Monitors and reports no-shows.

17.3.3. (Added-AFMC) Liaison to the PCMs/OMS.

17.3.3.1. (Added-AFMC) Provides oversight to the application of medical standards IAW this instruction as well as other Air Force instructions dealing with classification and training and readiness issues.

17.3.3.2. (Added-AFMC) Schedules and monitors the completion of physical exams from outside agencies such as, DoDMERB, ROTC Detachments, recruiters, other military branches, and NASA. Reviews and forwards completed medical examinations to the appropriate authority.

17.3.3.3. (Added-AFMC) Answers questions regarding the application of medical standards to all types of medical examinations and profile reports.

17.3.4. (Added-AFMC) Conducts and monitors the Hearing Conservation Program unless an OMS is located at your facility.

17.3.5. (Added-AFMC) In coordination with Public Health, tracks the examination requirements for active duty military members and civilians through the Aerospace Information Management System (ASIMS) and/or Command Core System (CCS). *An interface to CCS through PIMR is currently in development.*

17.4. Results. Results of occupational health examinations are maintained in accordance with AFOSH standards and are one source of input to the multidisciplinary Occupational Health Program.

17.4 (Added-AFMC) All required exams and frequencies must be manually entered by the PCM teams into the PHA module of PIMR.

17.4.1. (Added-AFMC) Prior to certifying that a PHA is complete, the PCM teams locate and review all associated documentation and ensure all OHME requirements have been accomplished either in conjunction with, or prior to the PHA.

17.4.2. (Added-AFMC) Upon completion of the PCM review, referrals for further evaluation are made if appropriate. The PCM maintains responsibility for tracking results and follow-up with the examinee until all referrals are completed.

17.5. Types of Examinations:

17.5.1. Preplacement or Baseline. These are specific tests and examinations done to establish and document baseline data for future use in the evaluation of potential occupational exposures.

17.5.2. Special Purpose Periodic. For active duty personnel, these will normally be performed as part of the PHA. These are specific tests and examinations done at intervals to evaluate and document the health effects of occupational exposures. The frequency and extent of these assessments are determined from the type of health risk, results of workplace monitoring, and recorded findings of previous health examinations.

17.5.3. Termination. These are specific tests and examinations to assess pertinent aspects of the worker's health, normally done upon termination of employment (separation or retirement). Additionally, termination examinations are required for individuals being reassigned from hazardous to non-hazardous duties or by a specific AFOSH standard. AFOSH Standard 161-10, *Health Hazards Control for Laser Radiation,* requires examination upon termination and permanent change of station or permanent change of assignment from laser related duties.

17.6. Examination Requirements. The scope of these examinations is determined locally, after consideration of all relevant exposure factors and regulatory guidance. AFOSH Standard 161-17, *Standardized Occupational Health Program,* outlines examinations required by Air Force publications and lists resource material which can assist in making decisions on the appropriateness of examinations. Additional guidance is provided in DoD Manual 6055.5, *Occupational Health Surveillance Manual* (AFOSH Standard 161-17).

17.7. Records Required. The following forms are prepared and disposed of as outlined in AFOSH Standard 161-17**.**

17.7.1. AF Form 2766, *Clinical Occupational Health Examination Requirements***.** Used to provide written instructions to the PES for the accomplishment of occupational health examinations.

17.7.2. AF Form 2769, *Supplemental Data Sheet*. Used to record biological indicator test results when SF Form 88, is not appropriate; that is, when biological indicator tests, but not a medical examination, is required, or when item 50 of SF Form 88 is inadequate.

17.7.3. SF Form 78, *Certificate of Medical Examinations*. Provides a listing of functional and environmental factors essential to the examination and placement of civilian workers. Examiner records findings and conclusions on this form and returns the completed document to the responsible CCPO.

NOTE:

For those personnel who are employed to perform duties requiring occupational health examination, the Civilian Personnel Office (CPO) sends a copy of page 1, parts A, B, and C to the MTF outpatient records section. This copy of the SF Form 78 is used to establish individual health records.

17.7.4. DD Form 2215**,** *Reference Audiogram***.** Used to record initial audiometric test results with which later audiometric test results can be compared.

17.7.5. DD Form 2216, *Hearing Conservation Data*. Used to record the results of periodic and follow-up audiometry for individuals routinely exposed to hazardous noise.

NOTE:

Before this form is used, a reference audiogram must already be filed in the individual's health record.

17.7.6. SF Form 520, *Electrocardiographic Record*. If required.

17.7.7. AF Form 422, *Physical Profile Serial Report*, may be used to communicate occupational status to non-medical agencies when required (replaces AF Form 2770, *Assessment & Disposition*).

17.8. Consultations. If the health care provider suspects an individual's illness is job-related, the practitioner notes pertinent historical and clinical data on SF Form 513, *Medical Record--Consultation Sheet*, and sends it to Public Health.

Chapter 18

AEROMEDICAL CONSULTATION SERVICE

18.1. The Aeromedical Consultation Service (ACS) Conducts Specialized Aero medical Evaluations.

18.1.1. Eligibility Requirements. Persons eligible for referral to ACS include:

18.1.1.1. Active Duty Air Force and ARC personnel on flying status or persons medical disqualified when approved by the MAJCOM surgeon or AFMOA/SG.

18.1.1.2. Members of active ACS clinical study groups not on flying status (inactive flyers and disqualified members).

18.1.1.3. ACS evaluation appointments for 6J, 7J, 8J, and 9J aviators are invitational only, and are not mandatory medical evaluations (funding may be local or personal).

18.1.1.4. Initial ACS evaluations of inactive flyers only if reassignment to active flying is pending.

18.1.1.5. Army and Navy personnel with approval of U.S. Army Aeromedical Center (USAAMC) Fort Rucker, AL or Naval Operational Medicine Institute (NOMI), Pensacola, FL.

18.1.1.6. Military personnel of foreign countries when approved by the State Department and AFMOA/SG.

18.1.1.7. Applicants for flying duty with approval by HQ AETC/SG or AFMOA/SG.

18.1.1.8. Under special circumstances, astronauts may be given Secretarial Designee Status for ACS evaluation.

18.2. Referral Procedures.

18.2.1. Initial Evaluations: The referring flight surgeon prepares an aeromedical summary with supporting documents and recommends ACS evaluation through the appropriate MAJCOM/SG. MTFs will send original records of special studies mentioned in the aeromedical summary i.e., electrocardiogram (ECG) tracings, echocardiogram tape, electroencephalogram (EEG) tracings, Holter monitor tracings, magnetic resonance imaging (MRI) film, all x-ray films and specialty consultations, etc. It is recommended that the aeromedical summary and supporting studies be sent by certified mail. Facsimiles for initial ACS evaluation are not acceptable.

18.2.2. Re-evaluations: **With approval of the respective MAJCOM/SG**, medical facilities may forward ACS re-evaluations directly to the ACS. Forward an aeromedical summary with all supporting documents and studies (original and 3 copies) to the ACS. An information copy of the case must be forwarded to the MAJCOM/SG.

18.2.3. ARC members must include documents as required in Paragraph **8.2.2.**

18.3. Scheduling Procedures

18.3.1. The approving authority sends the request to the Aeromedical Consultation Service: USAFSAM/AFC, 2507 Kennedy Circle, Brooks AFB, TX 78235- 5117.

18.3.2. The ACS notifies MAJCOM/SG of the member's scheduled appointment.

18.3.3. The ACS notifies the MTF of the appointment date and furnishes reporting instructions. The ACS will only reschedule appointments due to mission essential reasons. To request a change in appointment date the local MTFs may contact the ACS directly.

18.3.4. Members scheduled for ACS evaluations will be briefed by the referring local flight surgeon regarding ACS requirements and reporting instructions. This briefing should not be delegate to 4FOX1's.

18.3.5. The MTF publishes the TDY orders and provides the funds to support the TDY (for ARC personnel, the member's squadron publishes orders and provides funds for the TDY).

18.3.6. The orders state that the TDY is for aeromedical evaluation, and that 10 days, in addition to travel time is authorized. Orders should direct travel to ACS by the most expeditious means possible.

18.3.7. Send health records, by certified mail to arrive at the ACS 10 days before the scheduled appointment.

18.4. Consultation Procedures.

18.4.1. The ACS evaluates and makes recommendations to the certification or waiver authority.

18.4.2. An abbreviated summary and recommendation report is sent electronically to the certification and waiver authority within 3 workdays of member's departure.

18.4.3. Waiver and certification authorities may issue an interim waiver based on this information.

18.4.4. The local MTF should contact the appropriate MAJCOM/SG and not AFMOA/SG for inquiries regarding interim waivers.

18.4.5. The completed ACS report is sent to the certification or waiver authority within 30 workdays following member's departure. Final review and disposition of each case rests with the waiver authority specified in **Attachment 10**.

18.5. Distribution of Reports

18.5.1. The ACS combines referral documents with a copy of the ACS report and sends the complete package to the certification or waiver authority and referral MTF. In addition, the ACS maintains a copy of all medical documentation.

18.6. Enhanced Flight Screening – Medical (EFS-M). EFS-M is managed by the ACS and conducted at two sites: the ACS and the USAFA. Approved in 1994, EFS-M is a high technology medical screening program of pilot candidates who are undergoing Enhanced Flight Screening (EFS). The purpose of EFS-M screening is to detect medically disqualifying conditions.

18.6.1. EFS-M Testing.

18.6.1.1. The EFS-M test battery encompasses three general areas as follows:

18.6.1.1.1. Corneal topography, red lens testing, and color vision testing.

18.6.1.1.2. Echocardiography.

18.6.1.1.3. Clinical Psychology. The Multidimensional Aptitude Battery (MAB), and the Cog Screen-Aeromedical Edition must be completed. As these tests are used for baselining purposes, they will not affect qualification for the EFS program. The Revised NEO Personality Inventory and the Armstrong Laboratory Aviator Personality Survey are currently under evaluation for validation and are therefore optional.

18.6.2. EFS-M Certification & Waiver Authority.

18.6.2.1. HQ AETC/SGPS is the certification and waiver authority for EFS-M. HQ AETC/SGPS may forward controversial cases to AFMOA/SG as required.

CHARLES H. ROADMAN, II, Lt General, USAF, MC
Surgeon General

Attachment 1

GLOSSARY OF REFERENCES AND SUPPORTING INFORMATION

References

DoDD 1332.18, *Separation or Retirement for Physical Disability*

DoDD 5154.24, *Armed Forces Institute of Pathology (AFIP)*

DoDD 6130.3, *Physical Standards for Appointment, Enlistment and Induction*

DoD Manual 6055.5, *Occupational Health Surveillance Manual*

10 USC Chap 61

10 USC 113

10 USC 8013

10 USC 12408

Title 38, United States Code

Executive Order 9397

Occupational Safety and Health Act of 1970 (29 USC 651)

AFPD 36-27, *Social Actions*

(AFMC) AFI 44-155, *Put Prevention Into Practice*

AFI 44-157, *Medical Evaluation Boards (MEB) and Continued Military Service*

AFPD 48-1, *Aerospace Medical Program*

(AFMC) AFJI 48-110, *Immunizations and Chemoprophylaxis*

AFI 11-401, *Flight Management*

AFI 36-2101, *Classifying Military Personnel (Officers and Airmen)*

AFI 36-2104, *Nuclear Weapons Personnel Reliability Program*

AFMAN 36-2108, *Airman Classification*

AFI 36-2018, *Medical Examination of Applicants for United States Service Academies, Reserve Officer Training Corps (ROTC) Scholarship Programs, Including the AF, Army, and Navy Two and Three-Year College Scholarship Programs (CSP), and the Uniformed Services University of the Health Sciences (USUHS)*

AFI 36-2626, *Airman Retraining Program*

AFI 36-3212, *Physical Evaluation for Retention, Retirement or Separation*

AFI 37-138, *Records Disposition--Procedures Responsibilities*

AFI 41-115, *Authorized Health Care and Health Care Benefits in the Military Health Services System (MHSS)*

AFI 48-123/AFRC Supplement, *Air Force Reserve supplement to AFI 48-123 for unit assigned reservists*

AFOSH Standard 161-17, *Standardized Occupational Health Program*

Preventive Health Assessment (PHA) and Individual Medical Readiness Guidelines

Preventive Health Assessemtn and Individual Medical Readiness, Program Managers Guide, April 2001

Abbreviations and Acronyms

ACS—Aeromedical Consultation Service

ADT—Active duty tour

AETC—Air Education and Training Command

AFA—Air Force Academy

(AFMC) AFCITA— Air Force Complete Immunications Tracking Application

AFIP—Armed Forces Institute of Pathology

AFI—Air Force Instruction

AFPC—Air Force Personnel Center

AFRC—Air Force Reserve Command

AFROTC —Air Force Reserve Officer's Training Corps

AFSC—Air Force Specialty Code

AME—Aviation Medical Examiner

AMP—Aerospace Medicine Primary

ANG—Air National Guard (Previously, Air National Guard Readiness Center)

ANG—Air National Guard

ANSI—American National Standards Institute

AR—Adaptability Rating

ARC—Air Reserve Components (ANG, IMA and unit reservists)

ARC SURGEON—HQ AFRC/SGP for unit reservists; HQ ARPC/SGS for IMAs; ANG/SGP for guardsmen

ARMA—Adaptability Rating Military Aviation

ARPC—Air Reserve Personnel Center

(AFMC) ASIMS— Aerospace Information Management System

ASMRO —Armed Services Medical Regulating Officer

AT—Annual Training

AV—Atrioventricular

AWOL—Absent Without Official Leave

BES—Bioenvironmental Engineering Section

BSC—Biomedical Sciences Corps

CCPO —Consolidated Civilian Personnel Office

(AFMC) CCS— Command Core System

cm—Centimeter

CNS—Central Nervous System

CONUS —Continental

(AFMC) CPS— Clinical Preventive Services

CRS—Conditional Reserve Status

CSAF—Chief of Staff United States Air Force

CT—Cover test

DAF—Department of the Air Force

DAFSC —Duty Air Force Specialty Code

dB—Decibel

DBMS —Director of Base Medical Services

DC—Dental Corps

DEROS —Date Eligible for Return from Overseas

DNIC—Duties Not Involving Controlling

DNIF—Duties Not Involving Flying

DODD —Department of Defense Directive

DODMERB—Department of Defense Medical Examination Review Board

DOS—Date of separation

DPA-V—Depth perception apparatus Verhoeff

DSM—Diagnostic and Statistical Manual

EAD—Extended active duty

ECG—Electrocardiogram

EFS—Enhanced Flight Screening

EFS-M—Enhanced Flight Screening - Medical

ELISA—Enzyme-linked immunosorbent assay

ENT—Ear, nose, and throat

EPTS—Existed prior to service

ETS—Expiration of term of service

FAA—Federal Aviation Administration

FALANT—Farnsworth lantern test

FAR—Federal Air Regulation

FEB—Flying Evaluation Board

FMO—Flight Management Officer

FTS-ABS —Fluorescent treponemal antibody absorption

GLC—G induced loss of consciousness

(AFMC) GPM— Group practice manager

(AFMC) GSU— Geographically separated unit

G6PD—Glucose 6 phosphate dehydrogenase

(AFMC) HCI— Health care integrator

HDL—High density lipopr

(AFMC) HEAR— Health Enrollment Assessment Review

(AFMC) HHT— Health History Tool

HPSP—Health Professions Scholarship Program

HIV—Human Immunodeficiency Virus

HOSM —Host Operations System Management

HQ AFMOA/SGO—Headquarters Air Force Medical Operations Agency

HQ AFMOA/SGOA—Headquarters Air Force Medical Operations Agency, Aerospace Medicine Directorate

HQ AFRC/SGP—Headquarters Air Force Reserve Command, Aerospace Medicine Division

HQ USAF/SG—Headquarters United States Air Force Surgeon General

(AFMC) HRR— Health records review

IDT—Inactive duty for training

IMA—Individual mobilization augmentee

(AFMC) IS— Information systems

ISO—International Standards Organization

LAS—Limited assignment status

LASIK —Laser In Situ Keratomilieusis

LOC—Loss of consciousness

MAJCOM—Major command

MC—Medical Corps

(AFMC) MDG— Medical Group

MEB—Medical Evaluation Board

MEPS—Military Entrance Processing Station

(AFMC) MHS— Military Healthcare Services

MIMSO —Military Indoctrination for Medical Service Officers

mm—Millimeter

mmHg —Millimeters of mercury

MSC —Medical Service Corps

MTF—Medical Treatment Facility

MPF—Military Personnel Flight

MVP—Mitral Valve Prolapse

NATO—North Atlantic Treaty Organization

NC—Nurse Corps

NIBH—Not indicated by history

NOK —Next of kin

NVG—Night vision goggles

(AFMC) OHME— Occupational health medical examination

OTS—Officer Training School

OU—Oculi Unitas (both eyes)

OVT—Optec Vision Tester (Replaced the VTA-ND)

PA—Physician's Assistant

PC—Point of convergence

PCA—Permanent change of assignment

(AFMC) PCM— Primary care manager

PCS—Permanent change of station

PEB—Physical Evaluation Board

PEBLO—Physical Evaluation Board Liaison Officer

PEBRH—Physical Evaluation Board Referral Hospital

PES—Physical Examination and Standards

PFT—Pulmonary function test

PHA—Preventive Health Assessment

(AFMC) PHWG— Population Health Working Group

(AFMC) PIMR— Preventive Health Assessment and Individual Medical Readiness

PIP—Pseudoisochromatic Plates

POC—Professional Officers Course

PMMA—Polymethyl Methacrylate

PRK—Photo Refractive Keratectomy

(AFMC) PRP— Personnel Reliabilit Program

(AFMC) QNFT— Quantitative fit test

RBC—Red blood cell

RD—Reinforcement designees

RK—Radial Keratotomy

ROTC—Reserve Officer Training Corps

RPR—Rapid plasma reagin

RPW—Repatriated Prisoner of War

RTFS—Return to Flying Status

SAT—Strength Aptitude Test

SATP—Security Assistance Training Program

SMOC —Space and Missile Operations Crew

SSN—Social security number

STS—Serologic test for syphilis

TDRL—Temporary Disability Retirement List

TDY—Temporary duty

TPSK—Topographical Pattern Suggestive of Keratoconus

(AFMC) UDM—Unit deployment monitor

UFT—Undergraduate flight training

(AFMC) UHM—nit health monitor

UNT—Undergraduate navigator training

UPT—Undergraduate pilot training

USAFA—United States Air Force Academy

USAFSAM/AFC—United States Air Force School of Aerospace Medicine/Department of Aerospace Medicine, Clinical Sciences Division

USAFSAM/AFCI—United States Air Force School of Aerospace Medicine/Department of Aerospace Medicine, Clinical Sciences Division/ECG Library

USAFSAM/AFCI—United States Air Force School of Aerospace Medicine/Department of Aerospace Medicine, Clinical Sciences Division, Internal Medicine Branch

USAFSAM/AFCO—United States Air Force School of Aerospace Medicine/Department of Aerospace Medicine, Clinical Sciences Division, Ophthalmology Branch

USAFSAM/AFCF—United States Air Force School of Aerospace Medicine/Department of Aerospace Medicine, Clinical Sciences Division, Flight Medicine Branch

USAFSAM/AFH—United States Air Force School of Aerospace Medicine/Department of Aerospace Medicine, Hyperbaric Medicine

USUHS —Uniformed Services University of Health Sciences

VASCI—Veterans administration spinal cord injury

VTA-ND —(See OVT)

VDRL—Venereal Disease Research Laboratory

WAVR-File —Centralized waiver repository

Attachment 2

MEDICAL STANDARDS FOR CONTINUED MILITARY SERVICE

Conditions listed in this Attachment require Medical Evaluation Board (MEB) processing for active duty members, worldwide duty evaluation for ARC members when appropriate, and are not all-inclusive. ARC members must be placed on a "4" profile under the appropriate PULHES heading on AF Form 422. Any condition in the opinion of the provider of care is felt to be unacceptable for continued military service is reason for performing an MEB for active duty and ANG members or worldwide duty medical evaluation for ARC members. Questionable conditions should be addressed to the senior profile officer, and if required, to HQ AFPC/DPAMM for active duty members and to the appropriate ARC/SG for ARC members.

A2.1. Head.

A2.1.1. The loss of substance of the skull, with or without prosthetic replacement accompanied by residual signs or symptoms which preclude satisfactory performance of duty or unrestricted station assignability.

A2.1.2. An unprotected skull defect 3 cm in diameter or larger.

A2.2. Mouth, Nose, Pharynx, Larynx, and Trachea.

A2.2.1. Larynx.

A2.2.1.1. Paralysis of the larynx. Characterized by bilateral vocal cord paralysis seriously interfering with speech or adequate airway.

A2.2.1.2. Stenosis of the larynx. Of a degree causing respiratory compromise.

A2.2.1.3. Obstructive edema. Obstructive edema of the glottis, if recurrent.

A2.2.1.4. Obstructive sleep apnea requiring Continuous Positive Airway Pressure (CPAP) device.

A2.2.2. Nose, Pharynx, and Trachea.

A2.2.2.1. Rhinitis. Atrophic rhinitis, characterized by bilateral atrophy of nasal mucus membranes, with severe crusting, concomitant severe headaches, and foul, fetid odor.

A2.2.2.2. Sinusitis. Severe and chronic which is suppurative, complicated by polyps, or does not respond to treatment.

A2.2.2.3. Stenosis of trachea causing respiratory embarrassment.

A2.3. Ears and Hearing.

A2.3.1. Ears.

A2.3.1.1. Mastoidectomy. Followed by chronic infection requiring frequent or prolonged specialized medical care.

A2.3.1.2. Infections of ears or mastoids. When satisfactory performance of duty is prevented or because of the requirement for extensive and prolonged treatment.

A2.3.1.3. Meniere's syndrome. Recurring attacks of sufficient frequency and severity as to require frequent or prolonged medical care.

A2.3.2. Hearing.

A2.3.2.1. Hearing loss which precludes safe, effective performance of duty despite use of hearing aid.

A2.4. Dental. Diseases and abnormalities of the jaw or associated tissues which despite treatment, prevent normal mastication, normal speech or the wearing of required life support or chemical/biological warfare ensemble, or which otherwise interferes with performance.

A2.5. Eyes and Vision. All ophthalmological cases must include visual acuity and Goldmann perimeter charts for peripheral visual field.

A2.5.1. Any disease, injury, infection process, or sequelae involving the eye which is resistant to treatment and/or results in:

A2.5.1.1. Distant visual acuity which cannot be corrected to at least 20/40 in the better eye.

A2.5.1.2. The central field of vision in the better eye is less than 20 degrees from fixation in any direction.

A2.5.2. Aphakia, bilateral.

A2.5.3. Night blindness of such a degree that the member requires assistance in travel at night.

A2.5.4. Even if the requirements in **A2.5.** above are met, the following manifestations of eye conditions are disqualifying:

A2.5.4.1. Glaucoma with demonstrable changes in the optic disc or visual fields or not amenable to treatment.

A2.5.4.2. Retinal detachment, bilateral.

A2.5.4.3. Retinal detachment, unilateral, which results from organic progressive disease or results in uncorrectable diplopia, or visual acuity or visual field defects worse than specified above.

A2.5.4.4. Enucleated eye.

A2.5.4.5. Vision correctable only by the use of bilateral contact lenses or uncommon corrective devices, e.g. telescopic lenses.

A2.5.4.6. Aniseikonia when incapacitating signs or symptoms exist that are not easily treatable with standard ophthalmic spectacle lenses.

A2.5.4.7. Diplopia when symptoms are severe, constant, and in a zone less than 20 degrees from the primary position.

A2.5.4.8. Hemianopsia when bilateral, permanent, and based on an organic defect.

A2.5.4.9. Visual acuity which cannot be corrected to at least:

Better eye /Worse eye

20/20	20/400
20/30	20/200
20/40	20/100
20/50	20/80
20/60	20/60

A2.5.4.10. History of keratorefractive surgery, of any kind, accomplished to modify the refractive power of the cornea, or of lamellar, penetrating keratoplasty. Radial Keratotomy is also disqualifying. RK is not compatible for continued worldwide duty, medical evaluation board (MEB) is required.

A2.6. Lungs and Chest Wall.

A2.6.1. Active tuberculosis, where curative therapy requires 15 or more months.

A2.6.2. Symptoms of chronic or recurrent pulmonary disease, or residuals of surgery, which preclude satisfactory performance of duty. These may include:

A2.6.2.1. Significant fatigue or dyspnea on mild exertion supported by appropriate pulmonary function and blood gas studies.

A2.6.2.2. Requirement for an inordinate amount of medical observation or care over prolonged periods.

A2.6.3. Recurrent spontaneous pneumothorax when the underlying defect is not correctable by surgery.

A2.6.4. Pneumonectomy.

A2.6.5. Asthma, recurrent bronchospasm, or reactive airway disease, unless due to well defined avoidable precipitant cause.

A2.7. Heart and Vascular System.

A2.7.1. Heart disease.

A2.7.1.1. Arteriosclerotic heart disease, when associated with congestive heart failure, persistent major rhythm disturbances, repeated angina attacks, silent ischemia at a low to moderate workload or objective evidence of myocardial infarction. The following considerations pertain to myocardial infarction:

A2.7.1.1.1. Maintenance on any type of medication for the treatment or prevention of angina, congestive heart failure, or major rhythm disturbances (ventricular tachycardia, ventricular fibrillation, symptomatic paroxysmal supraventricular tachycardia, atrial flutter, or atrial fibrillation).

A2.7.1.1.2. Individuals sustaining a myocardial infarct will have MEB processing within 90 calendar days. ARC members should undergo MEB processing 9-12 months following infarction.

A2.7.1.1.3. Refer to paragraph **10.10.2.** when managing cases on ARC members.

A2.7.1.1.4. Final evaluation of cases for continued active duty, and where time permits, for separation or retirement, is conducted not more than 1 year post-infarct, provided the member's clinical course is uneventful.

A2.7.1.2. Treadmill is required by medical and disability reviewing authorities in adjudication of infarction cases.

A2.7.1.2.1. Exercise Treadmill Test (ETT).

A2.7.1.2.1.1. Must achieve minimum of 85% maximum predicted heart rate for age unless heart rate is limited by medically necessary beta blockers, in which case 3 Bruce stages (9 minutes exercise) should be attained.

A2.7.1.2.1.2. Normal blood pressure response.

A2.7.1.2.1.3. No reversible ischemic ST changes (i.e., no flat or downsloping ST depressions at 80 ms past the J point; applicable only if baseline ST segments are normal; if not, imaging study is necessary.

A2.7.1.2.1.4. No significant arrhythmias.

A2.7.1.2.1.5. No symptoms or objective evidence of ischemia, angina or congestive heart failure.

A2.7.1.2.1.6. Thallium, stress echocardiogram or stress MUGA imaging if indicated by ETT (see above).

A2.7.1.2.1.6.1. No evidence of significant territories of reversible ischemia.

A2.7.1.2.1.7. Additional testing (if indicated).

A2.7.1.2.1.7.1. Baseline echocardiogram or MUGA.

A2.7.1.2.1.7.2. Evaluate left ventricular systolic function and wall motion.

A2.7.1.2.1.8. Clinical status.

A2.7.1.2.1.8.1. No angina or evidence of ischemia.

A2.7.1.2.1.8.2. No evidence of congestive heart failure.

A2.7.1.2.1.8.3. No major rhythm disturbances.

A2.7.1.2.1.8.4. No more than mild reduction in ejection fraction (i.e., greater than 45%)

NOTE:

MEBs on cardiac cases must include the New York Heart Association (NYHA) or Canadian Heart classification.

A2.7.1.3. Paroxysmal ventricular tachycardia, ventricular fibrillation.

A2.7.1.4. Pacemakers or implantable cardioverter-defibrillators.

A2.7.1.5. Paroxysmal supraventricular tachycardia, atrial flutter unless successfully ablated by catheter based method (radiofrequency ablation) and not associated with structural heart disease.

A2.7.1.6. Atrial fibrillation, other than infrequent “lone” atrial fibrillation, not associated with structural heart disease and not requiring medication.

A2.7.1.7. Myocarditis and degeneration of the myocardium..

A2.7.1.8. Cardiomyopathy, any etiology, including hypertrophic obstructive type, idiopathic dilated type, toxic, restrictive.

A2.7.1.9. Endocarditis, infectious (acute or subacute), and marantic.

A2.7.1.10. Pericarditis.

A2.7.1.10.1. Chronic constrictive pericarditis, unless successful surgery has been performed and return of normal hemodynamics objectively documented.

A2.7.1.10.2. Chronic serous pericarditis.

A2.7.1.11. Acute rheumatic valvulitis or sequelae of chronic rheumatic heart disease (see also, valvular heart disease below).

A2.7.1.12. Premature ventricular contractions. When they interfere with the satisfactory performance of duty.

A2.7.1.13. Atrioventricular block, other than first degree or asymptomatic Type I second degree AV block without structural heart disease. Higher degrees of block must be individually evaluated, even if asymptomatic.

A2.7.1.14. Peripheral vascular disease, if symptomatic, including claudication, skin changes or cerebrovascular events.

A2.7.1.15. Periarteritis nodosa.

A2.7.1.16. Chronic venous insufficiency (postphlebitic syndrome). When symptomatic or requiring elastic support or chronic anticoagulation.

A2.7.1.17. Raynaud's phenomenon, if frequent, severe, associated with systemic disease or would limit worldwide assignability.

A2.7.1.18. Thromboangiitis obliterans.

A2.7.1.19. Deep venous thrombosis with repeated attacks requiring treatment or prophylaxis, or pulmonary embolus.

A2.7.1.20. Varicose veins. Severe and symptomatic.

A2.7.1.21. Congenital anomalies. Coarctation of aorta, atrial or ventricular septal defect and other congenital anomalies unless satisfactorily treated by surgical correction.

A2.7.1.22. Valvular heart disease, including:

A2.7.1.22.1. Symptomatic mitral valve prolapse requiring treatment.

A2.7.1.22.2. Moderate to severe aortic stenosis (valvular, subvalvular or supravalvular), even if asymptomatic.

A2.7.1.22.3. Moderate to severe mitral regurgitation, any etiology, if symptomatic or associated with subnormal ejection fraction. Successful mitral repair with preservation of ejection

fraction, no need for anticoagulants or anti-arrhythmics may be waived if exercise tolerance is normal, but MEB processing should precede surgery.

A2.7.1.22.4. Severe valvular or subvalvular pulmonic stenosis. Successful correction of valvular pulmonic stenosis with balloon valvuloplasty may be waiverable, but MEB processing should precede the procedure.

A2.7.1.22.5. Symptomatic mitral stenosis, generally associated with mitral valve area less than 1.0 cm sq.

A2.7.1.22.6. Severe aortic insufficiency if symptomatic, associated with left ventricular dilation or dysfunction.

A2.7.2. Hypertensive cardiovascular disease.

A2.7.2.1. Diastolic pressure consistently more than 110 mmHg following an adequate period of therapy in an ambulatory status or history of hypertension associated with any of the following:

A2.7.2.1.1. More than minimal demonstrable changes in the brain.

A2.7.2.1.2. Heart disease related to the hypertension, including atrial fibrillation, moderate to severe left ventricular hypertrophy, and symptomatic systolic or diastolic dysfunction.

A2.7.2.1.3. Unequivocal impairment of renal function.

A2.7.2.1.4. Grade III (Keith-Wagener-Parker) changes in the fundi.

A2.7.2.1.5. Multiple drug therapy with the requirement for an inordinate amount of medical supervision.

A2.7.2.2. Aneurysm or history of repair.

A2.7.2.3. Reconstructive surgery, including:

A2.7.2.3.1. Grafts.

A2.7.2.3.2. Prosthetic devices that are attached to or implanted for cardiovascular therapeutic purposes, regardless of result. Intracoronary stents may, in certain instances, be acceptable without MEB if associated with a good result, no myocardial infarction has occurred, and a six month post-procedure treadmill is non-ischemic. Worldwide Duty Medical Processing is required for ARC members 6-12 months following procedure with associated myocardial damage; three months if no myocardial damage.

A2.7.2.3.3. Surgery of the heart, pericardium, or vascular system.

A2.7.2.3.4. Member has undergone coronary vascular surgery, regardless of the result. Coronary angioplasty, may in certain instances, be acceptable without MEB if no myocardial infarction has occurred, a good result is obtained, and six month post-procedure treadmill or equivalent test is non-ischemic.

NOTES:

1. Conditions above must have MEB processing within 90 calendar days of surgery regardless of the results, unless stated otherwise.
2. Refer to paragraph **10.10.2.** when managing cases on ARC members.

A2.8. Blood, Blood-Forming Tissue, and Immune System Diseases.

A2.8.1. Anemia, symptomatic.

A2.8.2. Leukopenia, chronic.

A2.8.3. Hemolytic disease, chronic. Symptomatic or with recurrent crises.

A2.8.4. Polycythemia, symptomatic.

A2.8.5. Purpura and other bleeding disorders.

A2.8.6. Thromboembolic disease.

A2.8.7. Splenomegaly, chronic, inoperable.

A2.8.8. Other such diseases when response to therapy is unsatisfactory or when therapy is prolonged or requires intense medical supervision such as use of anticoagulants other than aspirin or persantine.

A2.8.9. Leukemia.

A2.8.10. Immunodeficiency.

A2.8.11. Sickle cell disease and heterozygous sickling disorders other than sickle cell trait are disqualifying.

NOTE:

Those individuals with sickling disorders who develop symptoms attributable to the trait must undergo MEB evaluation. (Refer to paragraph **10.10.2.** for ARC members).

A2.9. Abdomen and Gastrointestinal System.

A2.9.1. Esophageal.

A2.9.1.1. Achalasia (cardiospasm), manifested by dysphagia not controlled by dilation with frequent discomfort, or inability to maintain normal vigor and nutrition.

A2.9.1.2. Esophagitis, persistent and severe.

A2.9.1.3. Diverticulum of the esophagus which causes frequent regurgitation, obstruction, and weight loss, and does not respond to treatment.

A2.9.1.4. Stricture of the esophagus which requires an essentially liquid diet, frequent dilation and hospitalization, and causes difficulty in maintaining weight and nutrition.

A2.9.2. Gastritis. Severe, chronic gastritis with repeated symptoms requiring hospitalization and confirmed by gastroscopic examination.

A2.9.3. Hernia.

A2.9.3.1. Hiatus hernia with severe symptoms not relieved by dietary or medical therapy or with recurrent bleeding in spite of prescribed therapy.

A2.9.3.2. Other types of hernias, if operative repair is contraindicated for medical reasons, or if not amenable to surgical repair.

A2.9.4. Ulcer. Peptic, duodenal or gastric with repeated incapacitations or absences from duty because of recurrence of symptoms despite good medical management and supported by laboratory and X-ray evidence of activity or severe deformity.

A2.9.5. Cirrhosis of the liver. Recurrent jaundice or ascites or demonstrable esophageal varices or history of bleeding from them.

A2.9.6. Hepatitis. Chronic, when symptoms persist after a reasonable time following the acute stage and there is objective evidence of impairment of liver function.

A2.9.7. Amebic abscess residuals. Persistent abnormal liver function tests and failure to maintain weight and normal vigor after appropriate treatment.

A2.9.8. Pancreatitis, chronic. Recurrent pseudocystitis or frequent abdominal pain requiring hospitalization or steatorrhea, or disturbance of glucose metabolism requiring insulin.

A2.9.9. Peritoneal adhesions. Recurring episodes of intestinal obstruction, characterized by abdominal colicky pain, and vomiting, and requiring frequent admissions to the hospital.

A2.9.10. Granulomatous enteritis or enterocolitis or Crohn's disease.

A2.9.11. Ulcerative colitis.

A2.9.12. Stricture of rectum. Severe symptoms of obstruction characterized by intractable constipation, pain on defecation, and difficult bowel movements which require the regular use of laxatives, enemas, or repeated hospitalization.

A2.9.13. Proctitis, chronic. Moderate to severe symptoms of bleeding, painful defecation, or tenesmus, and diarrhea with repeated admissions to the hospital.

A2.9.14. Anus. Impairment of sphincter control with fecal incontinence.

A2.9.15. Familial polyposis.

A2.9.16. Surgery.

A2.9.16.1. Colectomy, partial, when more than mild symptoms of diarrhea remain.

A2.9.16.2. Colostomy, when permanent.

A2.9.16.3. Enterostomy, when permanent.

A2.9.16.4. Gastrectomy, total.

A2.9.16.5. Gastrectomy, subtotal with or without vagotomy, or gastrojejunostomy or pyloroplasty with or without vagotomy, when, in spite of good medical management, the individual:

A2.9.16.5.1. Develops incapacitating dumping syndrome.

A2.9.16.5.2. Develops frequent episodes of incapacitating epigastric distress with characteristic circulatory symptoms or diarrhea.

A2.9.16.5.3. Continues to demonstrate significant weight loss.

A2.9.16.6. Gastrostomy, when permanent.

A2.9.16.7. Ileostomy, when permanent.

A2.9.16.8. Pancreatectomy, except for partial pancreatectomy for a benign condition which does not result in moderate residual symptoms.

A2.9.16.9. Pancreaticoduodenostomy, pancreaticogastrostomy, and pancreaticojejunostomy.

A2.9.16.10. Proctectomy.

A2.9.16.11. Proctoplexy, proctoplasty, proctorrhaphy, or proctotomy, if fecal incontinence remains after appropriate treatment.

A2.10. Genitourinary System.

A2.10.1. Genitourinary Conditions.

A2.10.1.1. Cystitis. When complications or residuals of treatment themselves preclude satisfactory performance of duty.

A2.10.1.2. Dysmenorrhea. Not amenable to treatment, and incapacitating.

A2.10.1.3. Endometriosis. Symptomatic and incapacitating.

A2.10.1.4. Hypospadias. Not amenable to treatment.

A2.10.1.5. Incontinence of urine. Not amenable to treatment.

A2.10.1.6. Kidney:

A2.10.1.6.1. Calculus in kidney, symptomatic and incapacitating.

A2.10.1.6.2. Congenital anomaly, resulting in frequent or recurring infections or when there is evidence of obstructive uropathy not responding to medical or surgical treatment.

A2.10.1.6.3. Cystic kidney (polycystic kidney), when renal function is impaired, or is the focus of frequent infection.

A2.10.1.6.4. Hydronephrosis, more than mild, and causing continuous or frequent symptoms.

A2.10.1.6.5. Hypoplasia of the kidney, associated with elevated blood pressure or frequent infections or reduction in renal function.

A2.10.1.6.6. Nephritis, chronic, with renal function impairment.

A2.10.1.6.7. Nephrosis, other than mild.

A2.10.1.6.8. Pyelonephritis or pyelitis, chronic, which has not responded to medical or surgical treatment, with evidence of persistent hypertension or reduction in renal function.

A2.10.1.7. Menopausal or premenstrual syndrome. Physiologic or artificial, significantly interfering with the satisfactory performance of duty.

A2.10.1.8. Strictures of the urethra or ureter. Severe and not amenable to treatment.

A2.10.1.9. Urethritis. Chronic, not responsive to treatment and necessitating frequent absences from duty.

A2.10.2. Genitourinary and Gynecological Surgery.

A2.10.2.1. Cystectomy.

A2.10.2.2. Cystoplasty. If reconstruction is unsatisfactory, or if refractory symptomatic infections persist.

A2.10.2.3. Nephrectomy. When after treatment, there is infection or pathologic change (anatomic or functional) in the remaining kidney.

A2.10.2.4. Nephrostomy or pyelostomy, if drainage persists.

A2.10.2.5. Gonadectomy. Bilateral, when following treatment and convalescent period, there remain incapacitating mental or constitutional symptoms.

A2.10.2.6. Penis. Amputation of. When urine is voided in such a manner that clothing or surroundings are soiled, or results in severe mental symptoms.

A2.10.2.7. Ureterointestinal or direct cutaneous urinary diversion.

A2.10.2.8. Ureterocystostomy. When both ureters are markedly dilated with irreversible changes.

A2.10.2.9. Ureteroplasty.

A2.10.2.9.1. When unilateral procedure is unsuccessful and nephrectomy is necessary, consider on the basis of the standard for nephrectomy.

A2.10.2.9.2. When bilateral and surgical repair is unsuccessful and associated with significant complications or sequelae (for example, hydronephrosis, residual obstruction or therapeutically refractive pyelonephritis).

A2.10.2.10. Ureterosigmoidostomy.

A2.10.2.11. Ureterostomy. External or cutaneous.

A2.10.2.12. Urethrostomy. External or when a satisfactory urethra cannot be restored.

A2.10.2.13. Major abnormalities and defects of the genitalia such as change of sex, a history thereof, or complications (adhesions, disfiguring scars, etc.). Residual to surgical corrections of these conditions.

A2.11. Neurologic Disorders.

A2.11.1. Amyotrophic lateral sclerosis.

A2.11.2. Myelopathic muscular atrophy, including residuals of poliomyelitis.

A2.11.3. Progressive muscular atrophy.

A2.11.4. Chorea. Chronic and progressive.

A2.11.5. Friedreich's ataxia.

A2.11.6. Hepatolenticular degeneration.

A2.11.7. Seizure disorder.

A2.11.7.1. For Active Duty, MEB processing must be done within 90 calendar days of the first episode.

A2.11.7.2. For ARC members refer to paragraph **10.10.2.**

A2.11.7.3. Seizures following omission of prescribed medication or ingestion of alcoholic beverages are not indicative of the controllability of the disorder.

A2.11.8. Migraine. Manifested by frequent disabling attacks which last for several consecutive days, and are unrelieved by treatment.

A2.11.9. Multiple sclerosis.

A2.11.10. Myasthenia gravis

A2.11.11. Transverse myelopathy.

A2.11.12. Narcolepsy. When attacks are not controlled by medication.

A2.11.13. Paralysis agitans.

A2.11.14. Peripheral nerve conditions such as:

A2.11.14.1. Neuralgia, when symptoms are severe, persistent, and do not respond to treatment.

A2.11.14.2. Neuritis or paralysis due to peripheral nerve injury, when manifested by more than moderate, permanent functional impairment.

A2.11.15. Syringomyelia.

A2.11.16. Other neurological conditions. Any other neurological condition, regardless of etiology, when after adequate treatment, there remain residuals, such as persistent severe headaches, weakness or paralysis of important muscle groups, deformity, incoordination, pain or sensory disturbance, disturbance of consciousness, speech, or mental defects, or personality changes of such a degree as to definitely interfere with the performance of duty.

A2.12. Psychoses, Psychoneuroses, Other Axis I Diagnosis, and Other Mental Conditions. All psychiatricevaluations must include social and industrial impairment (S & I). In cases subject to administrative separation, the member's commander contacts the local MPF and Staff Judge Advocate for specific citation authority.

A2.12.1. Psychoses. Any psychotic episode.

A2.12.2. Psychoneuroses (affective, anxiety, somatiform, dissociative, eating, or psychosexual disorders). Persistent or recurrent, requiring hospitalization or the need for continuing psychiatric support. (Incapacity because of neurosis must be distinguished from weakness of motivation or underlying personality disorder).

NOTE:

RC Members who require medication to function are deemed not Worldwide Duty/Mobility qualified.

A2.12.3. Disorders of Intelligence. Individuals determined to have primary mental deficiency or special learning defect which interferes with the satisfactory performance of duty are unsuitable and subject to administrative separation. They must be referred to their unit commander.

A2.12.4. Other Mental Conditions. Unsatisfactory duty performance due to disorders of character or behavior, personality disorders, transient situational reactions, personality disruptions, emotional instability, sexual perversion or habit reactions render an individual unsuitable and subject to administrative separation. Interference with effective duty performance is dealt with through appropriate

administrative channels. Alcoholism that interferes with effective duty performance renders an individual unsuitable and subject to administrative separation. Provisions for rehabilitation and disposition are in appropriate directives.

A2.12.5. MEB evaluation is indicated in those instances when medical complications or sequelae of alcoholism (for example, recurrent jaundice or ascites, esophageal varices, chronic pancreatitis, organic central nervous system (CNS) disorders, etc.) preclude satisfactory performance of duty and worldwide assignability. For ARC members refer to **10.10.2.**

A2.12.6. Drug dependency renders an individual unsuitable and subject to administrative separation. MEB evaluation is indicated in those instances where drug dependency is the proximate result of a neurotic, psychotic, or organic medical condition. For ARC members refer to **10.10.2.**

A2.12.7. "Flying phobia" of sufficient magnitude to preclude military air transportation is dealt with administratively unless the condition is the proximate result of a psychotic disorder or a bona fide primary neurotic disorder.

A2.13. Extremities.

A2.13.1. Upper extremities.

A2.13.1.1. Amputation of part or parts of an upper extremity which results in impairment equivalent to the loss of use of a hand.

A2.13.1.2. Joint ranges of motion which do not equal or exceed the following:

A2.13.1.3. For shoulder:

A2.13.1.3.1. Forward elevation to 90 degrees.

A2.13.1.3.2. Abduction to 90 degrees.

A2.13.1.4. For elbow:

A2.13.1.4.1. Flexion to 100 degrees.

A2.13.1.4.2. Extension to 45 degrees of flexion.

A2.13.1.5. Chronic dislocation, when not reparable or when surgery is contraindicated.

A2.13.2. Lower Extremities.

A2.13.2.1. Hip dislocation.

A2.13.2.2. Amputation of a toe or toes which precludes the ability to run or walk without a perceptible limp or to perform duty in a satisfactory manner.

A2.13.2.3. Any loss greater than specified above to include foot, leg, or thigh.

A2.13.2.4. Feet:

A2.13.2.4.1. Hallux valgus when moderately severe, with exostosis or rigidity and pronounced symptoms, or severe with arthritic changes.

A2.13.2.4.2. Pes planus, symptomatic, more than moderate with pronation on weight bearing which prevents the wearing of a military shoe, or when associated with trophic changes.

A2.13.2.4.3. Talipes cavus when severe, with moderate discomfort on prolonged standing and walking, metatarsalgia, or which prevents the wearing of a military shoe.

A2.13.2.5. Internal derangement of the knee.

A2.13.2.5.1. Residual instability following remedial measures if more than moderate in degree or with recurring episodes of effusion or locking, resulting in frequent incapacitation.

A2.13.2.5.2. If complicated by arthritis.

A2.13.2.6. Joint Ranges of Motion. Motion which does not equal or exceed the measurements listed below:

A2.13.2.6.1. Hip.

Flexion to 90 degrees.

Extension to 0 degrees.

A2.13.2.6.2. Knee.

Flexion to 90 degrees.

Extension to 15 degrees.

A2.13.2.6.3. Shortening of an extremity which exceeds 5 centimeters (2 inches).

A2.13.2.7. Miscellaneous.

A2.13.2.7.1. Arthritis.

A2.13.2.7.1.1. Arthritis due to infection associated with persistent pain and marked loss of function, with X-ray evidence, and documented history of recurrent incapacitation.

A2.13.2.7.1.2. Arthritis due to trauma, when surgical treatment fails or is contraindicated and there is functional impairment of the involved joint so as to preclude satisfactory performance of duty.

A2.13.2.7.1.3. Osteoarthritis, with severe symptoms associated with impairment of function, supported by X-ray evidence and documented history of recurrent incapacity for prolonged periods.

A2.13.2.7.1.4. Rheumatoid arthritis or rheumatoid myositis, with substantiated history of frequent incapacitating episodes supported by objective and subjective findings.

A2.13.2.7.2. Chondromalacia or Osteochondritis dessicans. Severe, manifested by frequent joint effusion, more than moderate interference with function, or with severe residuals from surgery.

A2.13.2.7.3. Fractures.

A2.13.2.7.3.1. Malunion when, after appropriate treatment, there is severe malunion with marked deformity or more than moderate loss of function.

A2.13.2.7.3.2. Nonunion when, after an appropriate healing period, the nonunion persists with severe loss of function.

A2.13.2.7.3.3. Bone fusion defect when manifested by severe pain or loss of function.

A2.13.2.7.3.4. Callus, excessive, following fracture, when functional impairment precludes satisfactory performance of duty and the callus does not respond to adequate treatment.

A2.13.2.7.4. Joints.

A2.13.2.7.4.1. Arthroplasty, with severe pain, limitation of motion, and limitation of function, joint prosthesis or total joint replacement.

A2.13.2.7.4.2. Bony or fibrous ankylosis, with severe pain involving major joints or spinal segments, or ankylosis in unfavorable positions or ankylosis with marked loss of function.

A2.13.2.7.4.3. Contracture with marked loss of function and the condition is not remediable by surgery.

A2.13.2.7.4.4. Loose bodies within a joint with marked functional impairment complicated by arthritis to such a degree as to preclude favorable results of treatment.

A2.13.2.7.5. Muscles. Flaccid or spastic paralysis or loss of substance of one or more muscles, producing loss of function which precludes satisfactory performance of military duty.

A2.13.2.7.5.1. Myotonia congenita, significantly symptomatic.

A2.13.2.7.6. Osteitis deformans. Involvement of single or multiple bones with resultant deformities, or symptoms severely interfering with function.

A2.13.2.7.7. Osteoarthropathy. Hypertrophic, secondary, with severe pain in one or multiple joints and with moderate loss of function.

A2.13.2.7.8. Osteomyelitis, chronic. Recurrent episodes not responsive to treatment or involving the bone to a degree which interferes with stability and function.

A2.13.2.7.9. Tendon transplant. Unsatisfactory restoration of function.

A2.14. Spine, Scapulae, Ribs, and Sacroiliac Joints.

A2.14.1. Congenital anomalies presenting functional impairment of a degree to preclude the satisfactory performance of duty.

A2.14.2. Spina bifida, with demonstrable signs and moderate symptoms of root or cord involvement.

A2.14.3. Coxa vara, more than moderate with pain, deformity and arthritic changes.

A2.14.4. Herniation of nucleus pulposus, when symptoms and associated objective findings are of such a degree as to require repeated hospitalization or frequent absences from duty.

A2.14.5. Spondylolysis or spondylolisthesis, when symptoms and associated objective findings are of such a degree as to require repeated hospitalization or frequent absences from duty.

A2.14.6. Deviation or curvature of spine. More than moderate, or interfering with function or causing unmilitary appearance.

A2.15. Skin and Cellular Tissues.

A2.15.1. Acne, severe, unresponsive to treatment, and interfering with the satisfactory performance of duty or wear of the uniform or use of military equipment.

A2.15.2. Atopic dermatitis, severe or requiring frequent hospitalization.

A2.15.3. Cysts and tumors. Refer to paragraph **A2.17.**

A2.15.4. Dermatitis herpetiformis, which fails to respond to therapy.

A2.15.5. Eczema, chronic, regardless of type, when there is moderate involvement or when there are repeated exacerbations in spite of continuing treatment.

A2.15.6. Elephantiasis or chronic lymphedema, not responsive to treatment.

A2.15.7. Epidermolysis bullosa.

A2.15.8. Erythema multiforme, severe, and chronic or recurrent.

A2.15.9. Exfoliative dermatitis, chronic.

A2.15.10. Fungus infections, superficial, if not responsive to therapy and resulting in frequent absences from duty.

A2.15.11. Hidradenitis, suppurative, and folliculitis decalvans.

A2.15.12. Hyperhidrosis of the hands or feet when severe or complicated by a dermatitis or infection, either fungal or bacterial, and not amenable to treatment.

A2.15.13. Leukemia cutis and mycosis fungoides.

A2.15.14. Lichen planus, generalized and not responsive to treatment.

A2.15.15. Lupus erythematosus, chronic discoid variety with extensive involvement or when the condition does not respond to treatment.

A2.15.16. Neurofibromatosis, if disfigurement is extensive or when associated with manifestation of other organ system involvement.

A2.15.17. Pemphigus, not responsive to treatment and with moderate constitutional or systemic symptoms.

A2.15.18. Psoriasis or parapsoriasis, extensive and not controlled by treatment or controllable only with potent cytotoxic agents.

A2.15.19. Radiodermatitis, if resulting in malignant degeneration at a site not amenable to treatment.

A2.15.20. Scars and keloids, so extensive they seriously interfere with the function of the body area or they interfere with proper fit and wear of military equipment.

A2.15.21. Tuberculosis of the skin, if not responsive to therapy. Refer to paragraph **A2.16.**

A2.15.22. Ulcers of the skin, not responsive to treatment after an appropriate period of time or if they result in frequent absences from duty.

A2.15.23. Urticaria, chronic, severe, and not amenable to treatment.

A2.15.24. Other skin diseases, if chronic or of a nature which requires frequent medical care or interferes with the satisfactory performance of military duty.

A2.16. Endocrine and Metabolic Conditions.

A2.16.1. Acromegaly.

A2.16.2. Adrenal hyperfunction, not responding to therapy.

A2.16.3. Adrenal hypofunction.

A2.16.4. Diabetes insipidus, requiring antidiuretic hormone replacement therapy.

A2.16.5. Diabetes mellitus, diagnosed, including diet controlled and those requiring insulin or oral hypoglycemic drugs, MEB processing is done within 90 calendar days. For ARC members refer to **10.10.2.** (See note at **A3.32.**).

A2.16.6. Gout, with frequent acute exacerbations in spite of therapy, or with severe bone, joint, or kidney damage.

A2.16.7. Hyperinsulinism, when caused by a malignant tumor, or when the condition is not readily controlled.

A2.16.8. Hyperparathyroidism, when residuals or complications such as renal or bony defects preclude satisfactory performance of military duty.

A2.16.9. Hyperthyroidism, with severe symptoms which do not respond to treatment.

A2.16.10. Hypoparathyroidism, with objective evidence and severe symptoms not controlled by maintenance therapy.

A2.16.11. Osteomalacia, when residuals after therapy are of such degree or nature as to limit physical activity to a significant degree.

A2.17. Systemic Disease.

A2.17.1. HIV seropositivity, confirmed.

A2.17.2. Amyloidosis, generalized.

A2.17.3. Dermatomyositis polymyositis complex.

A2.17.4. Leprosy, any type.

A2.17.5. Lupus erythematosus, disseminated, chronic.

A2.17.6. Myasthenia gravis.

A2.17.7. Mycoses, active, not responsive to therapy, or requiring prolonged treatment, or when complicated by disqualifying residuals.

A2.17.8. Panniculitis, relapsing, febrile, nodular.

A2.17.9. Porphyria.

A2.17.10. Sarcoidosis, progressive, with severe or multiple organ involvement and not responsive to therapy (See paragraph **A2.6.**).

A2.17.11. Scleroderma, Generalized or of the linear type which seriously interferes with the function of an extremity or body area involved or progressive systemic sclerosis including CREST Syndrome (calcinosis, Raynaud's phenomenon, esophageal hypomotility, sclerodactyly, and telangiectasia).

A2.17.12. Tuberculosis, Generalized.

A2.18. Tumors and Malignant Diseases.

A2.18.1. Malignant neoplasms or residuals of treatment.

A2.18.2. Neoplastic conditions of lymphoid and blood-forming tissues.

A2.18.3. Benign neoplasms, when the condition prevents the satisfactory performance of duty and the condition is not remediable or a remedial operation is refused.

NOTE:

All members with neoplastic disease must meet an MEB within 90 calendar days of initial diagnosis or as soon as the medical condition has stabilized. Basal cell, squamous cell carcinoma and carcinoma-in-situ of the cervix which have been adequately excised (as evidenced by pathology report, or basal cell carcinoma which has been treated by electrodessication and curettage by a dermatologist credentialed to perform the procedure) are exempted from Tumor Board Action and do not require MEB. For ARC members refer to **10.10.2.**

A2.19. Sexually Transmitted Diseases.

A2.19.1. Symptomatic neurosyphilis, in any form.

A2.19.2. Complications or residuals of sexually transmitted disease, of such chronicity or degree of severity the individual is incapable of performing duty.

A2.20. General and Miscellaneous Conditions and Defects.

A2.20.1. The individual is precluded from a reasonable fulfillment of the purpose of his or her employment in the military service.

A2.20.2. The individual's health or well being would be compromised if he or she were to remain in the military service.

A2.20.3. The individual's retention in the military service would prejudice the best interests of the government. Questionable cases are referred to MEB or to the appropriate ARC surgeon for those ARC members who are not on EAD and are not authorized disability processing.

A2.20.4. The individual has an EPTS defect or condition for which corrective surgery is contemplated.

A2.20.5. The individual requires an indefinite (permanent) excusal from fitness testing.

A2.20.6. The individual's travel by military air transportation is precluded for medical reasons.

(See paragraph **A2.12.** concerning "flying phobia").

A2.20.7. The individual has an assignment canceled due to a medical condition. Present to an

MEB, or within 10 calendar days, provide narrative summary to HQ AFPC/**DPAMM** for review in lieu of MEB.

A2.20.8. The individual continues to have a 4-T profile 1 year after the defect became disqualifying and has not yet met an MEB.

A2.20.9. The individual has been hospitalized 90 calendar days and return to duty within 3 more months is not expected. MEB should be accomplished when the patient's future qualification for further military service is foreseeable and should not be delayed until receipt of maximum hospital benefit.

A2.20.10. The individual refuses required medical, surgical, or dental treatment or diagnostic procedures.

A2.20.11. The individual requires determination of his or her competency for pay purposes.

A2.20.12. The individual has had a sanity determination required by the Manual for

Courts-Martial and the psychiatric findings indicate the member's suitability for continued military service is questionable.

A2.20.13. The individual has coexisting medical defects that are thought to be the primary cause of unacceptable behavior or unsatisfactory performance.

A2.20.14. Inability to receive any mobility required immunization.

Attachment 3

MEDICAL STANDARDS FOR APPOINTMENT, ENLISTMENT, AND INDUCTION

Conditions listed in Attachment 2, Medical Standards for Continued Military Service also apply.

A3.1. Head.

A3.1.1. Abnormalities that are apparently temporary in character resulting from recent injuries until a period of 3 months has elapsed. These include severe contusions and other wounds of the scalp and cerebral concussion. See paragraph **A3.19.**

A3.1.2. Chronic arthritis. Complete or partial ankylosis, or recurrent dislocation of the temporomandibular joint.

A3.1.3. Deformities of the skull. In the nature of depressions, exostoses, etc., of a degree that would prevent the individual from wearing a protective mask or military headgear.

A3.1.4. Deformities of the skull. Of any degree associated with evidence of disease of the brain, spinal cord, or peripheral nerves.

A3.1.5. Depressed fractures that required surgical elevation or were associated with a laceration of the dura mater or focal necrosis of the brain (see paragraph **A3.19.**).

A3.1.6. Loss or congenital absence of the bony substance of the skull not successfully corrected by reconstructive materials.

A3.1.7. All cases involving absence of the bony substance of the skull that have been corrected but in which the defect is in excess of 1 square inch (6.45cm2) or the size of a 25-cent piece.

A3.2. Neck.

A3.2.1. Cervical ribs. If symptomatic, or so obvious that they are found on routine medical examination. (Detection based primarily on X-rays in not considered to meet this criterion.)

A3.2.2. Congenital cysts. Of branchial cleft origin or those developing from the remnants of the thyroglossal duct, with or without fistulous tracts.

A3.2.3. Fistula. Chronic draining, of any type.

A3.2.4. Nonspastic contraction. Of the muscles of the neck or cicatricial contracture of the neck to the extent that it interferes with the wearing of a uniform or military equipment or is so disfiguring as to make the individual objectionable in common social relationships.

A3.2.5. Spastic contraction. Of the muscles of the neck, persistent, and chronic.

A3.2.6. Tumor of thyroid or other structures of the neck. See paragraph **A3.36.**

A3.3. Mouth.

A3.3.1. Hard palate, Perforation of.

A3.3.2. Cleft lip, unless satisfactorily repaired by surgery.

A3.3.3. Leukoplakia, stomatitis or ulcerations of the mouth, if severe.

A3.3.4. Ulcerations, perforation, or extensive loss of substance of the hard or soft palate, extensive adhesions of the soft palate to the pharynx, or complete paralysis of the soft palate. Unilateral paralysis of the soft palate that does not interfere with speech or swallowing and is otherwise asymptomatic is not disqualifying. Loss of the uvula that does not interfere with speech or swallowing is not disqualifying.

A3.4. Nose and Sinuses.

A3.4.1. Allergic manifestations.

A3.4.1.1. Atrophic rhinitis.

A3.4.1.2. Allergic rhinitis. If moderate or severe and not controlled by oral medications, desensitization, or topical corticosteroid medication.

A3.4.2. Anosmia or parosmia.

A3.4.3. Choana, atresia or stenosis of, if symptomatic.

A3.4.4. Epistaxis, chronic recurrent.

A3.4.5. Nasal polyps or a history of nasal polyps, unless surgery was performed at least 1 year before examination and there is no evidence of recurrence.

A3.4.6. Nasal septum, Perforation of:

A3.4.6.1. Associated with the interference of function, ulceration, crusting, or when the result of organic disease.

A3.4.6.2. If progressive.

A3.4.6.3. If respiration is accompanied by a whistling sound.

A3.4.7. Sinusitis. Acute.

A3.4.8. Sinusitis. Chronic when more than mild:

A3.4.8.1. Evidenced by any of the following: chronic purulent nasal discharge, nasal polyps, hyperplastic changes of the nasal tissue, or symptoms requiring frequent medical attention.

A3.4.8.2. Confirmed by transillumination or X-ray examination or both.

A3.4.9. Vasomotor rhinitis, if moderate or severe and not controlled by medication.

A3.5. Pharynx, Trachea, and Larynx.

A3.5.1. Laryngeal paralysis, sensory or motor, due to any cause.

A3.5.2. Larynx, Organic disease of, such as neoplasm, polyps, granuloma, ulceration, or chronic laryngitis.

A3.5.3. Dysphonia plicae ventricularis.

A3.5.4. Tracheostomy or tracheal fistula.

A3.6. Other Defects and Diseases of the Mouth, Nose, Throat, Pharynx, Trachea, and Larynx.

A3.6.1. Aphonia, or history of, or recurrent, if the cause was such as to make a subsequent attack probable.

A3.6.2. Deformities or conditions of the mouth, tongue, throat, pharynx, larynx, and nose that interfere with mastication and swallowing of ordinary food, or with speech or breathing.

A3.6.3. Destructive syphilitic disease of the mouth, nose, throat, or larynx (see paragraph **A3.37.**).

A3.6.4. Pharyngitis and nasopharyngitis, chronic, with positive history and objective evidence, if of such a degree as likely to result in excessive time lost in the military environment.

A3.7. Ears.

A3.7.1. Auditory canal.

A3.7.1.1. Atresia or severe stenosis of the external auditory canal.

A3.7.1.2. Tumors of the external auditory canal except mild exostoses.

A3.7.1.3. Severe external otitis, acute or chronic.

A3.7.2. Auricle. Microtia, severe; or severe traumatic deformity, unilateral or bilateral.

A3.7.3. Mastoids.

A3.7.3.1. Mastoiditis, acute or chronic.

A3.7.3.2. Residual of mastoid operation with marked external deformity that prevents or interferes with the wearing of a protective mask or helmet.

A3.7.3.3. Mastoid fistula.

A3.7.4. Meniere's syndrome.

A3.7.5. Middle ear.

A3.7.5.1. Acute or chronic otitis media of any type.

A3.7.5.2. Presence of attic perforation in which presence of cholesteatoma is suspected.

A3.7.5.3. History of surgery involving the middle ear, excluding myringotomy.

A3.7.5.4. Cholesteatoma or history thereof.

A3.7.6. Tympanic membrane.

A3.7.6.1. Any perforation of the tympanic membrane.

A3.7.6.2. Surgery to repair perforated tympanic membrane within 120 days.

A3.7.6.3. Thickening or scarring of the tympanic membrane associated with hearing level by audiometric test of 30 dB or more average for the speech frequencies (500, 1000, and 2000 cycles per second) in either ear regardless of the hearing level in the other ear.

A3.7.7. Other diseases and defects of the ear which obviously prevent satisfactory performance of duty or that require frequent and prolonged treatment.

A3.8. Hearing. (See also paragraph **A3.7.**) The cause for rejection for appointment, enlistment, and induction is a hearing loss greater than the acceptable hearing levels described below:

Audiometers calibrated to the International Standards Organization 1964 (ISO 1964) or the American National Standards Institute (ANSI 1989), shall be used to test the hearing of all applicants for appointment, enlistment, or induction. All audiometric tracings or audiometric readings recorded on reports of medical examination or other medical records will be clearly identified.

Acceptable Audiometric Hearing Levels are:

Pure tone at 500, 1000, and 2000 cycles per second of not more than 30 dB on the average (either ear), with no individual level greater than 35 dB at these frequencies. Pure tone level not more than 45 dB at 3000 cycles per second each ear, and 55 dB at 4000 cycles per second each ear.

A3.9. Dental.

A3.9.1. Diseases of the jaw or associated tissues that are not easily remediable, and will incapacitate the individual or otherwise prevent the satisfactory performance of duty. This includes temporomandibular disorders or myofascial pain dysfunction not easily corrected.

A3.9.2. Severe malocclusion that interferes with normal mastication or requires early and protracted treatment; or relationship between mandible and maxilla that prevents satisfactory future prosthodontic replacement.

A3.9.3. Insufficient natural healthy teeth or lack of a serviceable prosthesis, preventing adequate mastication and incision of a normal diet. This includes complex (multiple fixture) dental implant systems that have associated complications that severely limit assignments and adversely affect performance of worldwide duty. Dental implants that are no longer functional must not interfere with continuation of wear of the implant prosthesis or prevent removal and replacement with a conventional prosthesis.

A3.9.4. Orthodontic appliances for continued treatment, attached or removable. Retainer appliances are permissible, provided all active orthodontic treatment has been satisfactorily completed

A3.10. Eyes.

A3.10.1. Lids.

A3.10.1.1. Blepharitis, chronic, of more than mild degree. Cases of acute blepharitis will be rejected until cured.

A3.10.1.2. Blepharospasm.

A3.10.1.3. Dacryocystitis, acute or chronic.

A3.10.1.4. Dacryostenosis

A3.10.1.5. Destruction of the lids, complete or extensive, sufficient to impair protection of the eye from exposure.

A3.10.1.6. Adhesions of the eyelids to each other or to the eyeball that interfere with vision.

A3.10.1.7. Growth or tumor of the eyelid other than small early basal cell tumors of the eyelid, which can be cured by treatment, and small nonprogressive asymptomatic benign lesions. See also paragraph **A3.36.**

A3.10.1.8. Marked inversion or eversion of the eyelids sufficient to cause troublesome watering of eyes (entropion or ectropion).

A3.10.1.9. Lagophthalmos.

A3.10.1.10. Ptosis, any, except benign etiologies which are not progressive and do not interfere with vision.

A3.10.1.11. Trichiasis, severe.

A3.10.2. Conjunctiva.

A3.10.2.1. Conjunctivitis, chronic, including trachoma; allergic conjunctivitis; acute conjunctivitis until cured.

A3.10.2.2. Pterygium.

A3.10.2.2.1. Recurring after two operative procedures.

A3.10.2.2.2. Encroaching on the cornea in excess of 3 millimeters, interfering with vision, or if progressive (as evidenced by marked vascularity on a thickened elevated head).

A3.10.2.3. Xerophthalmia.

A3.10.3. Cornea.

A3.10.3.1. Corneal dystrophy of any type, including keratoconus of any degree.

A3.10.3.2. History of keratorefractive surgery accomplished to modify the refractive power of the cornea, or of lamellar, penetrating keratoplasty. Laser surgery to reconfigure the cornea is also disqualifying.

A3.10.3.3. Keratitis, acute or chronic, including history of.

A3.10.3.4. Ulcer, corneal; history or recurrent ulcers or recurrent corneal abrasions (including herpetic ulcers).

A3.10.3.5. Vascularization or opacification of the cornea from any cause that is progressive or reduces vision below the standards prescribed in paragraph **A3.11.**

A3.10.4. Uveal tract.

A3.10.4.1. Acute, chronic or recurrent inflammation of the uveal tract (iris, ciliary body, or choroid), except healed traumatic iritis.

A3.10.5. Retina.

A3.10.5.1. Angiomatoses, phakomatoses, retinal cysts, and other congenitohereditary conditions that impair or may impair visual function.

A3.10.5.2. Retinitis, chorioretinitis, or other inflammatory conditions, unless single episode that has healed, is not expected to recur, and does not interfere with vision.

A3.10.5.3. Degenerations of the macula to include macular cysts, holes, and other degenerations (hereditary or acquired degenerative changes and other conditions affecting the macula, including all types of primary and secondary pigmentary degenerations).

A3.10.5.3.1. Degenerations and dystrophies of the retina that impair or may impair visual function.

A3.10.5.3.2. Vitreous opacities or disturbances which may cause loss of visual acuity.

A3.10.5.4. Detachment of the retina, history of surgery for same, or peripheral retinal injury or degeneration that may cause retinal detachment.

A3.10.5.5. Inflammation of the retina (histoplasmosis, toxoplasmosis, or vascular conditions of the retina to include Coats' disease, diabetic retinopathy, Eales' disease, and retinitis proliferans), unless a single episode which has healed and does not interfere with vision.

A3.10.5.6. Hemorrhages, exudates, or other retinal vascular disturbances.

A3.10.6. Optic nerve.

A3.10.6.1. Congenito-hereditary conditions of the optic nerve or any other central nervous system pathology affecting or that may affect the efficient function of the optic nerve.

A3.10.6.2. Optic neuritis, neuroretinitis, or secondary optic atrophy resulting therefrom or documented history of attacks of retrobulbar neuritis.

A3.10.6.2.1. Optic neuropathy.

A3.10.6.3. Optic atrophy (primary or secondary).

A3.10.6.4. Papilledema.

A3.10.7. Lens.

A3.10.7.1. Aphakia (unilateral or bilateral), pseudophakia, or lens implant.

A3.10.7.2. Dislocation of lens, partial or complete.

A3.10.7.3. Opacities or irregularities of the lens or lens capsule which interfere with vision or which are considered to be progressive.

A3.10.8. Ocular mobility and motility.

A3.10.8.1. Diplopia, documented, in any field of gaze, either constant or intermittent from any cause or of any degree, including history of.

A3.10.8.2. Nystagmus, with both eyes fixing, congenital or acquired.

A3.10.8.3. Strabismus of 40 prism diopters or more, uncorrectable by lenses to less than 40 diopters.

A3.10.8.4. Strabismus of any degree accompanied by documented diplopia.

A3.10.8.5. Strabismus, surgery for the correction of, within the preceding 6 months.

A3.10.9. Miscellaneous defects and diseases.

A3.10.9.1. Abnormal conditions of the eye or visual fields due to diseases of the CNS. Meridian-specific visual field minimums are:

Temporal 85 degrees.

Superior-Temporal 55 degrees.

Superior 45 degrees.

Superior-Nasal 55 degrees.

Nasal 60 degrees.

Inferior-Nasal 50 degrees.

Inferior 65 degrees.

Inferior-Temporal 85 degrees.

A3.10.9.1.1. Absence of an eye.

A3.10.9.2. Asthenopia, severe.

A3.10.9.3. Exophthalmos, unilateral or bilateral.

A3.10.9.4. Glaucoma, primary or secondary, or preglaucoma as evidenced by intraocular pressure above 21mmHg, or the secondary changes in the optic disc or visual field loss associated with glaucoma.

A3.10.9.5. Hemianopsia of any type.

A3.10.9.6. Abnormal pupils or loss of normal pupillary reflex reactions to light or accommodation to distance or Adie's syndrome.

A3.10.9.7. Loss of visual fields due to organic disease.

A3.10.9.8. Night blindness.

A3.10.9.9. Residuals of old contusions, lacerations, penetrations, etc., impairing visual function required for satisfactory performance of military duty.

A3.10.9.10. Retained intraocular foreign body.

A3.10.9.11. Tumors. See **A3.10.** above and paragraph **A3.36.**

A3.10.9.12. Any organic disease of the eye or adnexa not specified above, which threatens vision or visual function.

A3.10.9.12.1. History of any ocular surgery to include lasers of any type.

A3.11. Vision.

A3.11.1. Distant visual acuity. Distant visual acuity of any degree that does not correct with spectacle lenses to at least one of the following:

20/40 in one eye and 20/70 in the other eye.

20/30 in one eye and 20/100 in the other eye.

20/20 in one eye and 20/400 in the other eye.

A3.11.2. Near visual acuity. Near visual acuity of any degree that does not correct to 20/40 in the better eye.

A3.11.3. Refractive error. Any refractive error in spherical equivalent of worse than -8.00 or +8.00 diopters; or if ordinary spectacles cause discomfort by reason of ghost images, prismatic displacement, etc.; if an opthalmological consultation reveals a condition which is disqualifying; or if refractive error is corrected by orthokeratology or keratorefractive surgery.

A3.11.4. Contact lenses. Complicated cases requiring contact lenses for adequate correction of vision, such as keratoconus, corneal scar, and irregular astigmatism.

A3.11.5. Color vision. Although there is no standard, color vision will be tested, since adequate color vision is a prerequisite for entry into many military specialties.

A3.12. Lungs, Chest Wall, Pleura, and Mediastinum.

A3.12.1. Abnormal elevation of the diaphragm, either side.

A3.12.2. Abscess of the lung.

A3.12.3. Acute infectious processes of the lung, chest wall, pleura, or mediastinum, until cured.

A3.12.4. Asthma, including reactive airway disease, exercise induced bronchospasm or asthmatic bronchitis, reliably diagnosed at any age.

NOTE:

Reliable diagnostic criteria should consist of any of the following elements: (a) substantiated history of cough, wheeze, and or dyspnea which persists or recurs over a prolonged period of time (generally more than 6 months), or if the diagnosis of asthma is in doubt, (b) a test for reversible airflow obstruction (greater than a 15 percent increase in FEV, following administration of an inhaled bronchodilator) or airway hyperreactivity (exaggerated decrease in airflow induced by a standard bronchoprovocation challenge such as methacholine inhalation or a demonstration of exercise-induced bronchospasms) must be performed. Bronchoprovocation or exercise testing should be performed by a board certified pulmonologist or allergist.

A3.12.5. Bronchitis, chronic with pulmonary function impairment that would interfere with duty performance or restrict activities.

A3.12.6. Bronchiectasis.

A3.12.7. Bronchopleural fistula.

A3.12.8. Bullous or generalized pulmonary emphysema.

A3.12.9. Chronic fibrous pleuritis of sufficient extent to interfere with pulmonary function, or which produces dyspnea on exertion.

A3.12.10. Chronic mycotic diseases of the lung including coccidioidomycosis, residual cavitation or more than a few small-size inactive and stable residual nodules demonstrated to be due to mycotic disease.

A3.12.11. Congenital malformation or acquired deformities of the chest wall that reduce the chest capacity or diminish respiratory or cardiac functions to a degree that interferes with vigorous physical exertion.

A3.12.12. Empyema, residual intrapleural collection or unhealed sinuses of chest wall following operation or other treatment for empyema.

A3.12.13. Extensive pulmonary fibrosis from any cause, producing dyspnea on exertion or significant reduction in pulmonary function tests.

A3.12.14. Foreign body in trachea or bronchus.

A3.12.15. Foreign body of the chest wall causing symptoms.

A3.12.16. Foreign body of the lung or mediastinum causing symptoms or active inflammatory reaction.

A3.12.17. Lobectomy, history of, with residual pulmonary disease. Removal of more than one lobe is cause for rejection regardless of the absence of residuals.

A3.12.18. Multiple cystic disease of the lung; solitary cyst; large and incapacitating.

A3.12.19. New growth of breast, mastectomy, acute mastitis, chronic cystic mastitis of more than mild degree or if symptomatic.

A3.12.20. Osteomyelitis of rib, sternum, clavicle, scapula, or vertebra.

A3.12.21. Other symptomatic traumatic lesions of the chest or its contents.

A3.12.22. Pleurisy with effusion, within the previous 2 years, unknown origin.

A3.12.23. Pneumothorax during the year preceding examination if due to simple trauma or surgery; during the 3 years preceding examination if of spontaneous origin. Surgical correction is acceptable if no significant residual disease or deformity remains and the pulmonary function tests are within normal limits. Recurrent spontaneous pneumothorax ipsilaterally is disqualifying regardless of cause, after one failed attempt at surgical correction or pleural sclerosis.

A3.12.24. Sarcoidosis. See paragraph **A3.38.**

A3.12.25. Significant abnormal findings of the chest wall, lung, or lungs, pleura, or mediastinum.

A3.12.26. Silicone injections, without encapsulation, in breasts for cosmetic purposes. Surgical placement of encapsulated implants is acceptable if a minimum of 9 months has elapsed since surgery and site is well-healed with no complications reported.

A3.12.27. Suppurative periostitis of rib, sternum, clavicle, scapula, or vertebra.

A3.12.28. Tuberculosis lesions. See paragraph **A3.38.**

A3.12.29. Unhealed recent fracture of ribs, sternum, clavicle, or scapula, or unstable fracture regardless of fracture age.

A3.13. Heart.

A3.13.1. All valvular heart diseases. Including those improved by surgery, except mitral valve prolapse and bicuspid aortic valve. These latter two conditions are not reasons for rejection unless there is associated tachyarrhythmia, mitral regurgitation, aortic stenosis, insufficiency, or cardiomegaly.

A3.13.2. Coronary artery disease.

A3.13.3. History of symptomatic arrhythmia (or electrocardiographic evidence of arrhythmia).

A3.13.3.1. Supraventricular tachycardia, atrial flutter, and atrial fibrillation unless there has been no recurrence during the preceding 2 years off all medications. Ventricular tachycardia or fibrillation. Premature atrial or ventricular contractions are disqualifying when sufficiently symptomatic to require treatment or result in physical or psychological impairment. Multifocal premature ventricular contractions are disqualifying irrespective of symptoms or treatment. However, healthy highly trained individuals can have multifocal premature ventricular contractions or nonsustained ventricular tachycardia with a normal prognosis. Cases may be considered on an individual basis by each Service waiver authority. Ventricular arrhythmias are disqualifying when associated with physiologic or actuarial significance.

A3.13.3.2. Left bundle branch block, Mobitz type II second degree atrioventricular (AV) block, third degree AV block, accelerated AV conduction (Wolff-Parkinson-White syndrome) and Lown-Ganong-Levine syndrome associated with an arrhythmia. Conduction disturbances such as first degree AV block, left anterior hemiblock, right bundle branch block or Mobitz type I second degree AV block are not disqualifying when asymptomatic and are not associated with underlying cardiovascular disease.

A3.13.4. Hypertrophy or dilation of the heart. As evidenced by chest X-ray, electrocardiogram (ECG), or echocardiogram. Cardiomyopathy, myocarditis, or history of congestive heart failure from any cause even though currently compensated. Care must be taken to avoid rejection of highly conditioned individuals with sinus bradycardia, increased cardiac volume, and apparent abnormal cardiac enlargement, as indicated by ECG and X-ray.

A3.13.5. Pericarditis. Except in individuals who have been free of symptoms for 2 years and manifest no evidence of cardiac restriction or persistent pericardial effusion.

A3.13.6. Persistent tachycardia (resting pulse rate of 100 per minute or greater), regardless of cause.

A3.13.7. Congenital anomalies. Of heart and great vessels with physiologic or actuarial significance, which have not been totally corrected.

A3.14. Vascular System.

A3.14.1. Abnormalities of the arteries and blood vessels, aneurysms, atherosclerosis, arteritis.

A3.14.2. Hypertensive vascular disease. Evidenced by 3 consecutive averaged diastolic blood pressure measurements greater than 90 mmHg or 3 consecutive averaged systolic pressures greater than 140 mmHg. High blood pressure requiring medication or a history of treatment including dietary restriction.

A3.14.3. Pulmonary or systemic embolization, (history of).

A3.14.4. Vasomotor disturbance. Including orthostatic hypotension and Raynaud's phenomenon.

A3.14.5. Vein diseases. Recurrent thrombophlebitis, thrombophlebitis during the preceding year, or any evidence of venous incompetence, such as large or symptomatic veins, edema, and skin ulceration.

A3.15. Blood and Blood-Forming Tissue Diseases.

A3.15.1. Anemia: Any hereditary or acquired anemia that cannot be permanently corrected with therapy before appointment or induction.

A3.15.2. Hemorrhagic disorders: Any congenital or acquired state resulting in a tendency to bleed due to platelet, coagulation, or vascular abnormality.

A3.15.3. Leukopenia. Chronic or recurrent, associated with increased susceptibility to infection.

A3.15.4. Myeloproliferative or myelodysplastic disease, or history thereof.

A3.15.5. Thromboembolic disease. Thromboembolism at any time.

A3.15.6. Immunodeficiency diseases. Any congenital or acquired immunodeficiency state regardless of etiology.

A3.15.7. Miscellaneous conditions such as porphyria, hemochromatosis, amyloidosis, and postsplenectomy status (except when secondary to causes stated in paragraph **A3.16.**).

A3.16. Abdominal Organs and Gastrointestinal System.

A3.16.1. Esophagus. Organic disease or authenticated history of, such as ulceration, varices, achalasia, or other dismotility disorders; chronic or recurrent esophagitis if confirmed by X-ray or endoscopic examinations.

A3.16.2. Stomach and duodenum.

A3.16.2.1. Gastritis, chronic hypertrophic, severe.

A3.16.2.2. Current ulcer of the stomach or duodenum, if diagnosis is confirmed by X-ray examinations, or endoscopy. History of ulcer is not disqualifying if appropriate, effective therapy has been rendered.

A3.16.2.3. Authenticated history of surgical operations for gastric or duodenal ulcer, i.e., partial or total gastric resection, gastrojejunostomy, pyloroplasty, truncal or selective vagotomy (or history of such operative procedures for any other cause or diagnosis).

A3.16.2.4. Duodenal diverticula with symptoms or sequelae (hemorrhage, perforation, etc.).

A3.16.2.5. Congenital abnormalities of the stomach or duodenum causing symptoms or requiring surgical treatment, except a history of surgical correction of hypertrophic pyloric stenosis of infancy is not disqualifying if currently asymptomatic.

A3.16.3. Small and large intestine.

A3.16.3.1. Intestinal obstruction or authenticated history of more than one episode if either occurred during the preceding 5 years or if resulting condition remains, producing significant symptoms or requiring treatment.

A3.16.3.2. Symptomatic Meckel's diverticulum.

A3.16.3.3. Megacolon of more than minimal degree.

A3.16.3.4. Inflammatory lesions; diverticulitis, regional enteritis, ulcerative colitis, proctitis.

A3.16.3.5. Intestinal resection; however, minimal intestinal resection in infancy or childhood (e.g. for intussusception) is acceptable if the individual has been asymptomatic since the resection and if the appropriate consultant finds no residual impairment.

A3.16.3.6. Malabsorption syndromes.

A3.16.4. Gastrointestinal bleeding. A history of, unless the cause has been corrected and is not otherwise disqualifying.

A3.16.5. Hepato-pancreatico-biliary tract.

A3.16.5.1. Hepatitis within the preceding 6 months; or persistence of symptoms after 6 months, with objective evidence of impairment of liver function and chronic hepatitis, including hepatitis B carriers.

A3.16.5.2. Hepatic cysts. Congenital cystic disease parasitic, protozoal, or other cysts.

A3.16.5.3. Cirrhosis regardless of the absence of manifestations such as jaundice, ascites, or known esophageal varices; abnormal liver function, with or without history of chronic alcoholism.

A3.16.5.4. Cholecystectomy, sequelae of, such as postoperative stricture of the common bile duct, reforming of stones in hepatic or common bile ducts, incisional hernia, or postcholecystectomy syndrome when symptoms are of such a degree as to interfere with normal performance of duty.

A3.16.5.5. Cholecystitis, acute or chronic, with or without cholelithiasis.

A3.16.5.6. Bile duct abnormalities or strictures.

A3.16.5.7. Pancreas, acute or chronic disease of, if proven by laboratory tests, or medical records; and congenital anomalies such as annular pancreas, cystic disease, etc.

A3.16.6. Anorectal.

A3.16.6.1. Fistula in ano.

A3.16.6.2. Incontinence.

A3.16.6.3. Anorectal stricture.

A3.16.6.4. Excessive mucous production with soiling.

A3.16.6.5. Hemorrhoids, internal or external, when large, symptomatic, or history of bleeding.

A3.16.6.6. Rectal prolapse.

A3.16.6.7. Symptomatic rectocele.

A3.16.6.8. Symptomatic anal fissure.

A3.16.6.9. Chronic diarrhea, regardless of cause.

A3.16.7. Spleen.

A3.16.7.1. Splenomegaly until the cause is corrected and is not otherwise disqualifying.

A3.16.7.2. Splenectomy, except when done for the following:

A3.16.7.2.1. Trauma.

A3.16.7.2.2. Causes unrelated to diseases of the spleen.

A3.16.7.2.3. Hereditary spherocytosis.

A3.16.7.2.4. Disease involving the spleen when followed by correction of the condition for at least 2 years and is not otherwise disqualifying.

A3.16.7.3. Tumors (See paragraph **A3.6.**).

A3.16.7.3.1. Abdominal wall.

A3.16.7.3.1.1. Scars.

A3.16.7.3.1.2. Scars, abdominal, regardless of cause, the hernial bulging of which interferes with movement.

A3.16.7.3.1.3. Scar pain associated with disturbance of function of abdominal wall or contained viscera.

A3.16.7.3.1.4. Sinuses of the abdominal wall, to include persistent urachus and persistent omphalomesenteric duct.

A3.16.7.3.2. Hernia.

A3.16.7.3.2.1. Hernia other than small asymptomatic umbilical or asymptomatic hiatal.

A3.16.7.3.2.2. History of operation for hernia within the preceding 60 days.

A3.16.7.4. Other. Congenital or acquired abnormalities, such as gastrointestinal bypass or stomach stapling for control of obesity; and defects that preclude satisfactory performance of military duty or require frequent and prolonged treatment.

A3.17. Genitalia and Reproductive Organs (See also paragraph A3.36.).

A3.17.1. Abnormal uterine bleeding including menorrhagia, metrorrhagia or polymenorrhea.

A3.17.2. Amenorrhea. Primary or secondary if unexplained or otherwise disqualifying.

A3.17.3. Dysmenorrhea. Incapacitating to a degree recurrently necessitating absences of more than a few hours from routine activities.

A3.17.4. Endometriosis, or confirmed history thereof.

A3.17.5. Hermaphroditism.

A3.17.6. Hydrocele or left varicocele, if painful, or any right varicocele unless urological evaluation reveals no disease.

A3.17.7. Menopausal syndrome. Physiologic or artificial if manifested by more than mild constitutional or mental symptoms, or artificial menopause if less than 13 months have elapsed since cessation

of menses. In all cases of artificial menopause, the clinical diagnosis will be reported; if accomplished by surgery, the pathology report shall be obtained and recorded.

A3.17.8. Ovarian cysts. Persistent, clinically significant.

A3.17.9. Pelvic inflammatory disease (PID). Acute or chronic.

A3.17.10. Penile infectious lesions, including herpes genitalis and condyloma accuminata, not amenable to treatment.

A3.17.11. Pregnancy.

A3.17.12. Testicle or testicles: See also paragraph **A3.36.**

A3.17.12.1. Absence of both testicles, or unexplained absence of a testicle.

A3.17.12.2. Undiagnosed enlargement or mass of testicles or epididymis.

A3.17.12.3. Undescended testicle(s).

A3.17.13. Urethritis. Acute or chronic (see also paragraph **A3.37.**).

A3.17.14. Uterus.

A3.17.14.1. Congenital absence of.

A3.17.14.2. Generalized enlargement of the uterus due to any cause.

A3.17.14.3. Pap smears graded abnormal, or any smear in which the descriptive terms condyloma accuminatum, human papilloma virus, dysplasia, carcinoma-in-situ, or invasive cancer are used.

A3.17.15. Vagina.

A3.17.15.1. Congenital abnormalities that interfere with physical activities.

A3.17.15.2. Condyloma accuminatum or herpes genitalia, acute or chronic, not amenable to treatment.

A3.17.16. Vulva.

A3.17.16.1. Condyloma accuminatum or herpes genitalia, acute or chronic, not amenable to treatment.

A3.17.16.2. Dystrophic conditions.

A3.17.16.3. Vulvitis, acute or chronic**.**

A3.17.16.4. Major abnormalities and defects of the genitalia. Such as a change of sex, a history thereof, or dysfunctional residuals from surgical correction of these conditions.

A3.18. Urinary System (See paragraphs A3.32. and A3.36.).

A3.18.1. Cystitis, chronic. Individuals with acute cystitis are unacceptable until the condition is cured.

A3.18.2. Enuresis. Determined to be a symptom of an organic defect not amenable to treatment. (See also paragraph **A3.23.**).

A3.18.3. Epispadias or hypospadias. When accompanied by evidence of infection of the urinary tract or if clothing is soiled when voiding.

A3.18.4. Hematuria, cylindruria, pyuria, or other findings indicative of renal tract disease.

A3.18.5. Incontinence of urine.

A3.18.6. Kidney.

A3.18.6.1. Absence of one kidney, regardless of cause.

A3.18.6.2. Acute or chronic infections of the kidney.

A3.18.6.3. Cystic or polycystic kidney, confirmed, history of.

A3.18.6.4. Horseshoe kidney.

A3.18.6.5. Hydronephrosis or pyonephrosis.

A3.18.6.6. Nephritis, acute or chronic.

A3.18.6.7. Pyelitis, pyelonephritis.

A3.18.7. Orchitis, chronic, or chronic epididymitis.

A3.18.8. Penis, amputation of, if the resulting stump is insufficient to permit micturition in a normal manner.

A3.18.9. Peyronie's disease.

A3.18.10. Prostate gland, hypertrophy of, with urinary retention; chronic prostatitis.

A3.18.11. Proteinuria under normal activity (at least 48 hours post strenuous exercise) greater than 200 mg/24 hours or a protein to creatinine ratio greater than 0.2 in a random urine sample, unless nephrologic consultation determines the condition to be benign orthostatic proteinuria.

A3.18.12. Renal calculus.

A3.18.12.1. Substantiated history of recurrent renal calculus or bilateral renal calculus at any time.

A3.18.12.2. Verified history of renal calculus with evidence of stone formation within the preceding 12 months, current symptoms, or positive x-ray for calculus, or nephrocalcinosis.

A3.18.13. Skenitis.

A3.18.14. Urethra, Stricture of.

A3.18.15. Urinary fistula.

A3.18.16. Other diseases and defects of the urinary system that obviously preclude satisfactory performance of duty or require frequent and prolonged treatment.

A3.19. Neurological Disorders.

A3.19.1. Cerebrovascular conditions. Any history of subarachnoid or intracerebral hemorrhage, embolism, vascular insufficiency, arteriovenous malformation or aneurysm, whether transient or with secondary infarction involving the CNS.

A3.19.2. Congenital malformations if associated with neurological manifestations or if the process is expected to be progressive; meningocele even if uncomplicated.

A3.19.3. Degenerative and hereditodegenerative disorders affecting the cerebrum, basal ganglia, cerebellum, spinal cord, peripheral nerves, or muscles.

A3.19.4. Recurrent headaches of all types of sufficient severity or frequency as to interfere with normal function or a history of such headaches within 3 years.

A3.19.5. Head injury.

A3.19.5.1. Applicants with a history of head injury are unacceptable at any time if they display any of the following:

A3.19.5.1.1. Late post-traumatic epilepsy (occurring more than 1 week after injury).

A3.19.5.1.2. Permanent motor or sensory deficits.

A3.19.5.1.3. Impairment of intellectual functions.

A3.19.5.1.4. Alteration of personality.

A3.19.5.1.5. Central nervous system shunt of any type.

A3.19.5.2. Applicants with a history of severe head injury are unfit for a period of at least 5 years after which they may be considered fit if complete neurological and neuropsychological evaluation (See **Table 16.1.**) show no residual dysfunction or complications. Severe head injuries are defined by one or more of the following:

A3.19.5.2.1. Unconsciousness or amnesia, alone or in combination, of 24 hours duration or longer.

A3.19.5.2.2. Depressed skull fracture.

A3.19.5.2.3. Laceration or contusion of the dura or brain.

A3.19.5.2.4. Epidural, subdural, subarachnoid or intracerebral hematoma.

A3.19.5.2.5. Associated abscess or meningitis.

A3.19.5.2.6. Cerebrospinal fluid rhinorrhea or otorrhea persisting more than 7 days.

A3.19.5.2.7. Early post-traumatic seizure(s), occurring within one week of injury but more than 30 minutes after the injury.

A3.19.5.2.8. Focal neurological signs.

A3.19.5.2.9. Radiographic evidence of retained metallic or bony fragments.

A3.19.5.2.10. Leptomeningeal cysts or arteriovenous fistula.

A3.19.5.3. Applicants with a history of moderate head injury are unfit for a period of at least 2 years after which they may be considered fit if complete neurological evaluation (see **Table 16.1.**) shows no residual dysfunction or complications. Moderate head injuries are defined as unconsciousness or amnesia, alone or in combination, of 1 to 24 hours duration or linear skull fracture.

A3.19.5.4. Applicants with a history of mild head injury as defined by a period of unconsciousness or amnesia, alone or in combination, of 1 hour or less, are unfit for at least 1 month after which they may be acceptable if neurological evaluation (see **Table 16.1.**) shows no residual dysfunction or complications.

A3.19.5.5. Persistent post-traumatic sequelae, as manifested by headache, vomiting, disorientation, spatial disequilibrium, personality changes, impaired memory, poor mental concentration, shortened attention span, dizziness, altered sleep patterns, or any findings consistent with organic brain syndrome, are disqualifying until full recovery has been confirmed by complete neurological and neuropsychological evaluation.

A3.19.5.6. Infectious diseases, such as:

A3.19.5.6.1. Meningitis, encephalitis, or poliomyelitis within 1 year before examination, or if there are residual neurological defects which would interfere with satisfactory performance of military duty.

A3.19.5.6.2. Neurosyphilis of any form (general paresis, tabes dorsalis, meningovascular syphilis).

A3.19.5.7. Narcolepsy, cataplexy, sleep apnea syndrome (see paragraph **A3.39.**), and similar states except that sleep paralysis is not disqualifying by itself.

A3.19.5.8. Paralysis, tremor or weakness, deformity, discoordination, pain, sensory disturbance, intellectual deficit, disturbances of consciousness, or personality abnormalities regardless of cause if there is any indication that such involvement is likely to interfere with prolonged normal function in any practical manner or is progressive or recurrent.

A3.19.5.9. All forms of generalized or partial epilepsy that have persisted beyond the age of 5. Waiver consideration may be given if an applicant has been free of seizures with a normal electroencephalogram (EEG) while off all anti-epileptic medications for a period of 5 years immediately preceding the medical examination for military service. Waiver requests will be referred according to **Attachment 10** and must include the interpretation and tracing of an awake and sleep EEG of good quality(*) plus results of a head imaging study (CT or MRI) all obtained within 3 months of the examination, a current neurology evaluation containing details of the seizure history, such as the date of initial onset, etiology, diagnosis, treatment rendered, recurrency, the results of clinical examination to establish current status, a diagnosis, and a prognosis outlining any risk factors or restrictions.

NOTE:

For the purpose of waiver consideration, an EEG of good quality should be at least a 16 channel study that includes a minimum of 20 minutes of artifact-free recording, 3 to 5 minutes of hyperventilation, photic stimulation, and recorded sleep. The interpretation should be accomplished by a certified electroencephalographer.

A3.19.5.10. Any substantiated history of acquired chronic or recurrent disorders such as myasthenia gravis, polymyositis, and multiple sclerosis.

A3.19.5.11. Central nervous system shunts of all kinds.

Concepts and terms used in paragraphs **A3.20.** *through* **A3.25.** *are in consonance with the Diagnostic and Statistical Manual, American Psychiatric Association, DSM-III-R, 1987.*

A3.20. Disorders With Psychotic Features. The cause for rejection is a history of a mental disorder with gross impairment in reality testing. This does not include transient disorders associated with intoxication, severe stress or secondary to a toxic, infectious or other organic process.

A3.21. Mood Disorders. The causes for rejection are symptoms, diagnosis, or history of a major mood disorder requiring maintenance treatment or hospitalization.

A3.22. Anxiety, Somatoform, Dissociative, or Factitious Disorders (Alternatively May Be Addressed asNeurotic Disorders).

A3.22.1. History of such disorders resulting in any or all of the below:

A3.22.1.1. Hospitalization.

A3.22.1.2. Prolonged care by a physician or other professional.

A3.22.1.3. Loss of time from normal pursuits for repeated periods even if for brief duration.

A3.22.1.4. Symptoms or behavior of a repeated nature that impaired social, school, or other work efficiency.

A3.22.2. History of an episode of such disorders within the preceding 12 months which was sufficiently severe to require professional attention or absence from work or school for more than a brief period (maximum of 7 days).

A3.23. Personality, Behavior, or Academic Skills Disorders.

A3.23.1. Personality or behavior disorders, as evidenced by frequent encounters with law enforcement agencies, antisocial attitudes or behavior which, while not sufficient cause for administrative rejection, are tangible evidence of impaired characterological capacity to adapt to military service.

A3.23.2. Personality or behavior disorders where it is evident by history, interview, or psychological testing that the degree of immaturity, instability, personality inadequacy, impulsiveness or dependency will seriously interfere with adjustment in the Armed Forces as demonstrated by inability to maintain reasonable adjustment in school, with employers and fellow workers, and other social groups.

A3.23.3. Other behavior problems including but not limited to conditions such as authenticated evidence of functional enuresis or encopresis not due to an organic condition (see paragraph **A3.18.**), sleepwalking or eating disorders that are habitual or persistent (occurring beyond age 12), or stammering or stuttering of such a degree that the individual is normally unable to express himself or herself clearly or to repeat commands.

A3.23.4. Specific Academic Skills Defects: Chronic history of academic skills or perceptual defects secondary to organic or functional mental disorders that interfere with work or school after age 12. Current use of medication to improve or maintain academic skills (e.g., methylphenidate hydrochloride) is disqualifying.

A3.23.5. Suicide. History of attempted suicide or other suicidal behavior.

A3.24. Psychosexual Conditions.

A3.24.1. Transsexualism and other gender identity disorders.

A3.24.2. Exhibitionism, transvestism, voyeurism and other paraphilias.

A3.25. Substance Misuse.

A3.25.1. Alcohol dependence or history of.

A3.25.2. Drug dependence or history of.

A3.25.3. Drug abuse characterized by:

A3.25.3.1. Evidence of use of any controlled, hallucinogenic, or other intoxicating substance at time of examination, when the use cannot be accounted for as the result of the advice of a recognized health care practitioner.

A3.25.3.2. Documented misuse or abuse of any controlled substance (including cannabinoids or anabolic steroids) requiring professional care within a 1-year period before examination. Use of marijuana or other cannabinoids (not habitual use) or experimental or casual use of other drugs short of dependence may be waived by the appropriate waiver authority in **Attachment 9** if there is evidence of current drug abstinence and the individual is otherwise qualified for service.

A3.25.3.3. The repeated self-procurement and self-administration of any drug or chemical substance, including cannabinoids or anabolic steroids, with such frequency that it appears that the applicant has accepted the use of or reliance on these substances as part of his or her pattern of behavior. (See also appropriate Armed Forces instructions.)

A3.25.3.4. The use of LSD in a 2-year period before the examination.

A3.25.4. Alcohol abuse. Use of alcoholic beverages which leads to misconduct, unacceptable social behavior, poor work or academic performance, impaired physical or mental health, lack of financial responsibility or a disrupted personal relationship. (See also appropriate Armed Forces instructions.)

A3.26. Upper Extremities (See paragraph A3.28.).

A3.26.1. Limitation of motion. An individual shall be considered unacceptable if the joint ranges of motion are less than the measurements listed below. Methods of measurement are in **Attachment 13**.

A3.26.1.1. Shoulder.

A3.26.1.1.1. Forward elevation to 90 degrees.

A3.26.1.1.2. Abduction to 90 degrees.

A3.26.1.2. Elbow.

A3.26.1.2.1. Flexion to 100 degrees.

A3.26.1.2.2. Extension to 15 degrees.

A3.26.1.3. Wrist. A total range of 60 degrees (extension plus flexion). Radial and ulnar deviation combined arch 30 degrees.

A3.26.1.4. Hand.

A3.26.1.4.1. Pronation to 45 degrees.

A3.26.1.4.2. Supination to 45 degrees.

A3.26.1.5. Fingers. Inability to clench fist, pick up a pin or needle, and grasp an object.

A3.26.1.6. Thumb. Inability to touch tips of at least 3 fingers.

A3.26.2. Hand and fingers.

A3.26.2.1. Absence of the distal phalanx of either thumb.

A3.26.2.2. Absence or loss of distal and middle phalanx of an index, middle or ring finger of either hand irrespective of the absence or loss of little finger.

A3.26.2.3. Absence of more than the distal phalanx of any two of the following fingers: index, middle finger or ring finger, of either hand.

A3.26.2.4. Absence of hand or any portion thereof except for fingers as noted above.

A3.26.3. Hyperdactylia.

A3.26.4. Scars and deformities of the fingers or hand that impair circulation, are symptomatic, or which impair normal function to such a degree as to interfere with the satisfactory performance of military duty.

A3.26.5. Intrinsic paralysis or weakness (either median or ulnar nerves) sufficient to produce physical findings in the hand (e.g., muscle atrophy or weakness).

A3.26.6. Wrist, forearm, elbow, arm, and shoulder. Recovery from disease or injury of wrist, forearm, elbow, arm, or shoulder with residual weakness or symptoms such as to preclude satisfactory performance of duty. Grip strength of less than 75 percent of predicted normal when injured hand is compared with the normal hand (nondominant is 80 percent of dominant grip).

A3.27. Lower Extremities (See paragraph A3.28.).

A3.27.1. Limitation of motion. An individual will be considered unacceptable if the joint ranges of motion are less than the measurements listed below. Methods of measurement are in **Attachment 14**.

A3.27.1.1. Hip.

A3.27.1.1.1. Flexion to 90 degrees (minimum).

A3.27.1.1.2. No demonstrable flexion contracture.

A3.27.1.1.3. Extension to 10 degrees (beyond 0).

A3.27.1.1.4. Abduction to 45 degrees.

A3.27.1.1.5. Rotation 60 degrees (internal and external combined).

A3.27.1.2. Knee.

A3.27.1.2.1. Full extension.

A3.27.1.2.2. Flexion to 90 degrees.

A3.27.1.3. Ankle.

A3.27.1.3.1. Dorsiflexion to 10 degrees.

A3.27.1.3.2. Plantar flexion to 30 degrees.

A3.27.1.3.3. Eversion and inversion (total to 5 degrees).

A3.27.1.4. Toes. Stiffness that interferes with walking, marching, running, or jumping.

A3.27.2. Foot and ankle.

A3.27.2.1. Absence of one or more small toes if function of the foot is poor or running or jumping is prevented; absence of a foot or any portion thereof except for toes as noted herein.

A3.27.2.2. Absence of great toe(s); loss of dorsal flexion thereof if function of the foot is impaired.

A3.27.2.3. Claw toes preventing the wearing of military footwear.

A3.27.2.4. Clubfoot if any residual varus or equinus of the hind foot, degenerative changes in the mid or hind foot or significant stiffness or deformity prevents foot function or wearing of military footwear.

A3.27.2.5. Pes planus, pronounced cases, with decided eversion of the foot and marked bulging of the inner border, due to rotation of the talus, regardless of the presence or absence of symptoms.

A3.27.2.6. Pes planus, tarsal coalition.

A3.27.2.7. Hallux valgus, if severe, or of any degree if associated with marked exostosis or bunion which would prevent wearing of military footwear.

A3.27.2.8. Hammer toe, hallux limitus, or hallux rigidus that interferes with the wearing of military footwear.

A3.27.2.9. Effects of disease, injury, or deformity including hyperdactylia that prevent running, are accompanied by disabling pain, or prohibit the wearing of military footwear.

A3.27.2.10. Ingrown toenails, if severe, and not remediable.

A3.27.2.11. Obliteration of the transverse arch associated with permanent flexion of the small toes.

A3.27.2.12. Overriding of any of the toes, if symptomatic or sufficient to interfere with the wearing of military footwear.

A3.27.2.13. Pes cavus, symptomatic or with contracted plantar fascia, dorsiflexed toes, tenderness under the metatarsal heads, or callosities under the weight bearing areas.

A3.27.2.14. Plantar fascitis that is refractory to medical treatment or will impair function of the foot.

A3.27.2.15. Neuroma. Confirmed and refractory to medical treatment or will impair function of the foot.

A3.27.3. Leg, knee, thigh, and hip.

A3.27.3.1. Loose or foreign bodies within the knee joint.

A3.27.3.2. Physical findings of an unstable or internally deranged joint. History of anterior or posterior cruciate ligament injury, even if repaired, is disqualifying.

A3.27.3.3. History of surgical correction of knee ligaments.

A3.27.3.4. Authenticated history of congenital dislocation of the hip, osteochondritis of the hip (Legg-Perthes disease) or slipped femoral epiphysis of the hip. These conditions may be waiverable if there is no x-ray evidence of residual deformity or degenerative changes, or any clinically significant limitation of motion.

A3.27.3.5. Authenticated history of hip dislocation within 2 years before examination or degenerative changes on X-ray from old hip dislocation.

A3.27.3.6. Osteochondritis of the tibial tuberosity (Osgood-Schlatter's disease), if symptomatic or with obvious prominence of the part and X-ray evidence of separated bone fragment.

A3.27.4. General.

A3.27.4.1. Deformities of one or both lower extremities that have interfered with function to such a degree as to prevent the individual from following a physically active vocation in civilian life or that would interfere with satisfactory completion of prescribed training and performance of military duty.

A3.27.4.2. Diseases or deformities of the hip, knee, or ankle joint that interfere with walking, running, or weight bearing.

A3.27.4.3. Pain in the lower back or leg that is intractable and disabling to the degree of interfering with walking, running, weight bearing.

A3.27.4.4. Shortening of a lower extremity resulting in a noticeable limp or scoliosis.

A3.28. Miscellaneous Conditions of the Extremities (See also paragraphs A3.26. and A3.27.).

A3.28.1. Arthritis.

A3.28.1.1. Active, subacute or chronic arthritis.

A3.28.1.2. Chronic osteoarthritis or traumatic arthritis of isolated joints of more than a minimal degree, that has interfered with the following of a physically active vocation in civilian life or that prevents the satisfactory performance of military duty.

A3.28.2. Chronic retropatellar knee pain syndrome with or without confirmatory aorthroscopic evaluation.

A3.28.3. Disease of any bone or joint, healed, with such resulting deformity or rigidity that function is so impaired it will interfere with military service.

A3.28.4. Dislocation, old unreduced; substantiated history of recurrent dislocations of major joints; instability of a major joint.

A3.28.5. Fractures.

A3.28.5.1. Malunited fractures.

A3.28.5.2. Ununited fractures, except for ulnar styloid process.

A3.28.5.3. Any old or recent fracture in which a plate, pin, metal rod, wire or screws used for fixation were left in place; pin, wire, or screw not subject to easy trauma is not disqualifying.

A3.28.6. Injury of a bone or joint of more than a minor nature, yet without fracture or dislocation that occurred within the preceding 6 weeks.

A3.28.7. Joint replacement.

A3.28.8. Muscular paralysis, contracture, or atrophy, if progressive or of sufficient degree to interfere with military service.

A3.28.9. Myotonia congenita.

A3.28.10. Osteochondritis dessicans.

A3.28.11. Osteochondromatosis, or multiple cartilanginous exostoses.

A3.28.12. Osteomyelitis. Active or recurrent, any bone or substantiated history of osteomyelitis of any of the long bones.

A3.28.13. Osteoporosis.

A3.28.14. Scars. Extensive, deep, or adherent to the skin and soft tissues or neuromas of an extremity that are painful, that interfere with muscular movements, that prevent the wearing of military clothing or equipment, or that show a tendency to breakdown.

A3.28.15. Implants. Silastic or other devices implanted to correct orthopedic abnormalities.

A3.29. Spine and Sacroiliac Joints (See paragraph A3.28.).

A3.29.1. Arthritis (See paragraph **A3.28.**).

A3.29.2. Complaint of a disease or injury of the spine or sacroiliac joints with or without objective signs that has prevented the individual from successfully following a physically active vocation in civilian life. Substantiation or documentation of the complaint without objective physical findings is required.

A3.29.3. Deviation or curvature of spine from normal alignment, structure, or function if: there is lumbar scoliosis greater than 20 degrees, thoracic scoliosis greater than 30 degrees, and kyphosis or lordosis greater than 55 degrees when measured by the Cobb method.

A3.29.4. It prevents the individual from following a physically active vocation in civilian life.

A3.29.5. It interferes with the wearing of a uniform or military equipment.

A3.29.6. It's symptomatic and associated with positive physical findings and demonstrable by x-ray.

A3.29.7. Diseases of the lumbosacral or sacroiliac joints of a chronic type associated with pain referred to the lower extremities, muscular spasm, postural deformities, or limitation of motion of the lumbar region of the spine.

A3.29.8. Fusion involving more than two vertebrae. Any surgical fusion is disqualifying.

A3.29.9. Granulomatous diseases either active or healed.

A3.29.10. Healed fractures or dislocations of the vertebra. A compression fracture, involving less than 25 percent of a single vertebra is not disqualifying if the injury occurred more than 1 year before examination and the applicant is asymptomatic. A history of fractures of the transverse or spinous processes is not disqualifying if the applicant is asymptomatic.

A3.29.11. Juvenile epiphysitis with any degree of residual change indicated by x-ray or kyphosis.

A3.29.12. Ruptured nucleus pulposus (herniation of intervertebral disk) or history of operation for this condition.

A3.29.13. Spina bifida when symptomatic, or there is more than one vertebra involved, dimpling of the overlying skin, or a history of surgical repair.

A3.29.14. Spondylolysis that is symptomatic or likely to interfere with performance of duty or limit assignments is disqualifying, even if successfully fused.

A3.29.15. Weak or painful back requiring external support; that is, corset or brace. Recurrent sprains or strains requiring limitation of physical activity or frequent treatment.

A3.29.16. Spondylolisthesis.

A3.30. Scapulae, Clavicles, and Ribs (See paragraph A3.28.).

A3.30.1. Fractures until well-healed, and until determined that the residuals thereof will not prevent the satisfactory performance of military duty.

A3.30.2. Injury within the preceding 6 weeks, without fracture or dislocation, of more than a minor nature.

A3.30.3. Osteomyelitis.

A3.30.4. Prominent scapulae interfering with function or with the wearing of a uniform or military equipment.

A3.31. Skin and Cellular Tissues.

A3.31.1. Acne. Severe, or when extensive involvement of the neck, shoulders, chest, or back would be aggravated by or interfere with the wearing of military equipment and not amenable to treatment. Patients under treatment with isotretinoin (Accutane) are medically unacceptable until 8 weeks after completion of a course of therapy.

A3.31.2. Atopic dermatitis or Eczema. With active or residual lesions in characteristic areas (face, neck, antecubital or popliteal fossae, occasionally wrists and hands), or documented history thereof after the age of 5.

A3.31.3. Contact dermatitis involving rubber or other materials used in any type of required protective equipment.

A3.31.4. Cysts.

A3.31.4.1. Cysts, other than pilonidal. Of such a size or location as to interfere with the normal wearing of military equipment.

A3.31.4.2. Cysts, pilonidal. Pilonidal cysts, if evidenced by the presence of a tumor, mass, or a discharging sinus. History of pilonidal cystectomy within 1 year before examination is disqualifying.

A3.31.5. Dermatitis factitia.

A3.31.6. Dermatitis herpetiformis.

A3.31.7. Elephantiasis or chronic lymphedema.

A3.31.8. Epidermolysis bullosa.

A3.31.9. Fungus infections, systemic or superficial types, if extensive and not amenable to treatment.

A3.31.10. Furunculosis. Extensive, recurrent, or chronic.

A3.31.11. Hyperhidrosis of hands or feet. Chronic or severe.

A3.31.12. Ichthyosis. Severe.

A3.31.13. Keloid formation. If the tendency is marked or interferes with the wearing of military equipment.

A3.31.14. Leprosy. Any type.

A3.31.15. Leukemia cutis; mycosis fungoides, Hodgkin's disease. (see paragraph **A3.36.** for additional remarks on Hodgkins disease.)

A3.31.16. Lichen planus.

A3.31.17. Neurofibromatosis (Von Recklinghausen's Disease).

A3.31.18. Nevi or vascular tumors, if extensive, interfere with function, or exposed to constant irritation.

A3.31.19. Pemphigus or pemphigoid.

A3.31.20. Photosensitivity. Any primary sun-sensitive condition, such as polymorphous light eruption or solar urticaria; any dermatosis aggravated by sunlight such as lupus erythematosus.

A3.31.21. Psoriasis, or a verified history thereof.

A3.31.22. Radiodermatitis.

A3.31.23. Scars. Those that are extensive, deep, or adherent that they may interfere with the wearing of military clothing or equipment, exhibit a tendency to ulcerate, or interfere with function. Includes scars at skin graft donor or recipient sites if in an area susceptible to trauma.

A3.31.24. Scleroderma (See paragraph **A3.38.**).

A3.31.25. Tattoos which will significantly limit effective performance of military service.

A3.31.26. Urticaria, chronic.

A3.31.27. Warts, plantar, that have materially interfered with a useful vocation in civilian life.

A3.31.28. Xanthoma, if disabling or accompanied by hyperlipidemia.

A3.31.29. Any other chronic skin disorder of a degree or nature that requires frequent outpatient treatment or hospitalization, or interferes with the satisfactory performance of duty.

A3.32. Endocrine and Metabolic Disorders.

A3.32.1. Adrenal dysfunction of any degree.

A3.32.2. Cretinism.

A3.32.3. Diabetes mellitus. Any type, including a history of juvenile onset (insulin dependent type I).

NOTE:

The criteria for the diagnosis of diabetes consist of (a) diabetic symptoms with a casual glucose greater than or equal to 200 mg/dl, (b) Fasting plasma glucose greater than or equal to 126 mg/dl, or (c) 2 hour plasma glucose greater than or equal to 200 mg/dl during an OGTT. The diagnosis is considered provisional until confirmed by any of these methods on a subsequent day. Values for fasting plasma glucose

greater than or equal to 110 but less than 126 mg/dl are considered to represent impaired fasting glucose; 2 hPG levels greater than or equal to 140 but less than 200 mg/dl represent impaired glucose tolerance.

A3.32.4. Gigantism or acromegaly.

A3.32.5. Glycosuria. Persistent, when associated with impaired glucose tolerance or renal tubular defects that cause aminoaciduria, phosphaturia, and renal tubular acidosis.

A3.32.6. Gout.

A3.32.7. Hyperinsulinism.

A3.32.8. Hyperparathyroidism and hypoparathyroidism.

A3.32.9. Hypopituitarism.

A3.32.10. Myxedema. Spontaneous or postoperative (with clinical manifestations).

A3.32.11. Nutritional deficiency diseases (including sprue, beriberi, pellagra, and scurvy).

A3.32.12. Thyroid disorders.

A3.32.12.1. Goiter. Simple goiter with definite pressure symptoms, or so large as to interfere with the wearing of a military uniform or military equipment.

A3.32.12.2. Hyperthyroidism or thyrotoxicosis.

A3.32.12.3. Hypothyroidism, symptomatic or uncontrolled by medication.

A3.32.12.4. Thyroiditis.

A3.32.13. Other endocrine or metabolic disorders that obviously prevent satisfactory performance of duty or which require frequent or prolonged treatment. (Such as cystic fibrosis, porphyria, and amyloidosis.)

A3.33. Height. The cause for rejection for Air Force male applicants is height less than 60 inches or more than 80 inches. The cause for rejection for Air Force female applicants is height less than 58 inches or more than 80 inches.

A3.34. Weight. Body composition measurements may be used as the final determinant in evaluating an applicant's acceptability. For AF applicants who exceed the weight in relation to height which is prescribed in **Attachment 16**. Body fat standards will apply as outlined in **Attachment 16**.

A3.35. Body Build.

A3.35.1. Congenital malformation of bones and joints. (See paragraphs **A3.36.**, **A3.37.**, and **A3.38.**).

A3.35.2. Deficient muscular development that would interfere with the completion of required training.

A3.35.3. Evidence of congenital asthenia or body build that would interfere with the completion of required training.

A3.36. Tumors and Malignant Diseases.

A3.36.1. Benign Tumors of the:

A3.36.1.1. Head or face that interfere with function or prevent the wearing of face or protective masks or helmet.

A3.36.1.2. Eyes, ears, or upper airway that interfere with function.

A3.36.1.3. Thyroid or other neck structures such as to interfere with function or the wearing of a uniform or military equipment.

A3.36.1.4. Breast (male or female), chest, or abdominal wall that would interfere with military duty.

A3.36.1.5. Respiratory, gastrointestinal, genitourinary, or musculoskeletal systems that interfere with function or the wearing of a uniform or military equipment.

A3.36.1.6. Musculoskeletal system likely to continue to enlarge, be subjected to trauma during military service or show malignant potential.

A3.36.1.7. Skin which interfere with function, have malignant potential, interfere with military duty or the wearing of the uniform or military equipment.

A3.36.1.8. Central nervous system or history of, or if likely to recur.

A3.36.1.9. Peripheral nerves that interfere with function, have malignant potential, interfere with military duty or the wearing of the uniform or military equipment.

A3.36.2. Malignant Tumors. Malignant tumors diagnosed by acceptable laboratory procedures, and even though surgically removed or otherwise treated, with exceptions as noted. **(**Individuals who have a history of childhood cancer and who have not received any surgical or medical cancer therapy for 5 years and are free of cancer will be considered, on a case-by-case basis for acceptance into the Armed Forces. Applicants must provide complete information about the history and present status of their cancer.)

A3.36.2.1. Malignant tumors of the auditory canal, eye, or orbit (see paragraph **A3.10.**) or upper airway.

A3.36.2.2. Malignant tumors of the breast (male or female).

A3.36.2.3. Malignant tumors of the lower airway or lung.

A3.36.2.4. Malignant tumors of the heart.

A3.36.2.5. Malignant tumors of the gastrointestinal tract, liver, bile ducts, or pancreas.

A3.36.2.6. Malignant tumors of the genitourinary system male or female. Wilm's tumor and germ cell tumors of the testis treated surgically or with chemotherapy in childhood, after a 2-year disease-free interval off all treatment may be considered on a case-by-case basis for service.

A3.36.2.7. Malignant tumors of the musculoskeletal system.

A3.36.2.8. Malignant tumors of the central nervous system and its membranous coverings, unless 5 years postoperative, off treatment, without recurrence, and without otherwise disqualifying residuals of surgery or the original lesion.

A3.36.2.9. Malignant tumors of the endocrine glands.

A3.36.2.10. Malignant melanoma or history thereof. Other skin tumors such as basal cell and squamous cell carcinomas surgically removed are not disqualifying.

A3.36.2.11. Malignant tumors of the hematopoietic system.

A3.36.2.11.1. Lymphomatous diseases.

A3.36.2.11.1.1. Non-Hodgkin's lymphoma (all types).

A3.36.2.11.1.2. Hodgkin's disease, active or recurrent. Hodgkin's disease treated with radiation therapy or chemotherapy (or both) and disease-free off treatment for 5 years may be considered for service. Large cell lymphoma will likewise be considered on a case-by-case basis after a 2 year disease-free interval off all therapy.

A3.36.2.11.1.3. Leukemias. All types, except acute lymphoblastic leukemia treated in childhood without evidence of recurrence.

A3.36.2.11.1.4. Multiple myeloma.

A3.37. Sexually Transmitted Diseases. In general, the finding of acute, uncomplicated venereal disease that can be expected to respond to treatment is not a cause for medical rejection for military service. The causes for rejection are:

A3.37.1. Chronic sexually transmitted disease that has not satisfactorily responded to treatment. The finding of a positive serologic test for syphilis following adequate treatment is not in itself considered evidence of chronic venereal disease. (See paragraph **A3.39.**)

A3.37.2. Complications and permanent residuals of sexually transmitted disease when they are progressive, or of such a nature as to interfere with the satisfactory performance of duty, or are subject to aggravation by military service.

A3.37.3. Neurosyphilis (See paragraph **A3.19.**).

A3.38. Systemic Diseases.

A3.38.1. Amyloidosis.

A3.38.2. Ankylosing spondylitis.

A3.38.3. Eosinophilic granuloma. Eosinophilic granuloma, when occurring as a single localized bony lesion and not associated with soft tissue or other involvement, should not be a cause for rejection once healing has occurred. All other forms of the Histiocytosis X spectrum should be rejected, however.

A3.38.4. Lupus erythematosus.

A3.38.5. Mixed connective tissue disease.

A3.38.6. Polymyositis dermatomyositis complex.

A3.38.7. Progressive systemic sclerosis, including CREST variant. A single plaque of localized scleroderma (morphea) that has been stable for at least 2 years is not disqualifying.

A3.38.8. Psoriatic arthritis.

A3.38.9. Reiter's disease.

A3.38.10. Rheumatoid arthritis.

A3.38.11. Rhabdomyolysis, or history thereof.

A3.38.12. Sarcoidosis, unless there is substantiated evidence of a complete spontaneous remission of at least 2 years duration.

A3.38.13. Sjogren's syndrome.

A3.38.14. Tuberculosis.

A3.38.14.1. Active tuberculosis in any form or location, or substantiated history of active tuberculosis within the previous 2 years.

A3.38.14.2. Substantiated history of one or more reactivations or relapses of tuberculosis in any form or location or other definite evidence of poor host resistance to the tubercle bacillus.

A3.38.14.3. Residual physical or mental defects from past tuberculosis that would prevent the satisfactory performance of duty.

A3.38.14.4. Individuals with a past history of active tuberculosis more than 2 years before enlistment, induction, and appointment are not disqualified provided they have received a complete course of standard chemotherapy for tuberculosis. In addition, individuals with a tuberculin reaction 10mm or greater and without evidence of residual disease in pulmonary or non-pulmonary sites are eligible for enlistment, induction, and appointment provided they have or will be treated with chemoprophylaxis in accordance with the guidelines of the American Thoracic Society and US Public Health Service.

A3.38.15. Vasculitis (Bechet's, Wegener's granulomatosis, polyarteritis nodosa).

A3.39. General and Miscellaneous Conditions and Defects.

A3.39.1. Allergic manifestations: A reliable history of life threatening generalized reaction with anaphylaxis to stinging insects. Reliable history of a moderate to severe reaction to common foods, spices or food additives.

A3.39.2. Any acute pathological condition, including acute communicable diseases, until recovery has occurred without sequelae.

A3.39.3. Any deformity, abnormality, defect or disease that impairs general functional ability to such an extent as to prevent satisfactory performance of military duty.

A3.39.4. Chronic metallic poisoning, especially beryllium, manganese, and mercury. Undesirable residuals from lead, arsenic, or silver poisoning make the applicant unacceptable.

A3.39.5. Cold injury, residuals of, such as: frostbite, chilblain, immersion foot, trench foot, deep seated ache, paresthesia, hyperhidrosis, easily traumatized skin, cyanosis, amputation of any digit, or ankylosis.

A3.39.6. Cold urticaria and angioedema, hereditary angioedema.

A3.39.7. Reactive tests for syphilis such as the rapid plasma reagin (RPR) or Venereal Disease Research Laboratory (VDRL) followed by a reactive, confirmatory Fluorescent Treponemal Antibody Absorption (FTA-ABS) test unless there is a documented history of adequately treated syphilis. In the absence of clinical findings, the presence of a reactive RPR or VDRL followed by a negative FTA-ABS test is not disqualifying if a cause for the false positive reaction can be identified and is not otherwise disqualifying or if the test reverts to a nonreactive status during an appropriate follow-up period (3 to 6 months).

A3.39.8. Filariasis, trypanosomiasis, amebiasis, schistosomiasis, uncinariasis (hookworm) associated with anemia, malnutrition, etc., or other similar worm or animal parasitic infestations, including the carrier states thereof, if more than mild.

A3.39.9. Heat pyrexia (heatstroke, sunstroke, etc.). Documented evidence of a predisposition (including disorders of sweat mechanism and a previous serious episode), recurrent episodes requiring medical attention, or residual injury resulting therefrom (especially cardiac, cerebral, hepatic, and renal).

A3.39.10. Industrial solvent and other chemical intoxication, chronic, including carbon disulfide, trichloroethylene, carbon tetrachloride, and methyl cellosolve.

A3.39.11. Mycotic infection of internal organs.

A3.39.12. Myositis or fibrositis, severe, chronic.

A3.39.13. Presence of HIV-I or antibody. Presence is confirmed by repeatedly reactive Enzyme Linked Immunoassay (ELISA) serological test and positive immunoelectrophoresis (Western Blot) test, or other Food and Drug Administration-approved confirmatory test.

A3.39.14. Malignant hyperthermia.

A3.39.15. Residual of tropical fevers and various parasitic or protozoal infestations that, in the opinion of the medical examiner, prevent the satisfactory performance of military duty.

A3.39.16. Rheumatic Fever during the previous 2 years, or any history of recurrent attacks; Sydenham's chorea at any age.

A3.39.17. Sleep apnea (obstructive sleep apnea or sleep disordered breathing) which causes daytime hypersomnolence or snoring that interferes with the sleep of others or when an appliance such as CPAP is required for control.

A3.39.18. Motion sickness. An authenticated history of frequent, incapacitating motion sickness after the 12th birthday is disqualifying. For entrance into military academies or ROTC scholarship programs, admission of frequent, incapacitating motion sickness will suffice for disqualification.

Attachment 4

MEDICAL STANDARDS FOR GROUND BASED CONTROLLER DUTY

Conditions in Attachment 2, Medical Standards for Continued Military Service also apply. For conditions listed in Attachment 2, ensure a Medical Evaluation Board (MEB) has been performed and final disposition made prior to submission of a waiver request.

Applicability. The standards in Attachment 4 apply to all ground based aircraft controllers including **air traffic controllers, weapons controllers, combat controllers and weapons directors (AFSC 1C5X1D).**

A4.1. Ear, Nose, and Throat.

A4.1.1. Symptomatic allergic rhinitis, seasonal or perennial not controlled by desensitization or use of topical nasal steroids.

A4.1.2. Any disease or malformation of the nose, mouth, pharynx or larynx that might interfere with enunciation or clear voice communication.

A4.1.3. Any disturbance of equilibrium.

A4.1.4. Obstructions of the nose from any cause which prevent nasal respiration.

A4.2. Hearing.

A4.2.1. Hearing loss greater than that specified for H-1 profile for initial selection. Hearing loss greater than that specified for H-2 profile for continued controller duty**.**

A4.2.2. Use of hearing aid.

A4.3. Eye.

A4.3.1. Intraocular tension.

A4.3.1.1. Glaucoma, as evidenced by tension of 30 mmHg or greater, or the secondary changes in the optic disc or visual field associated with glaucoma.

A4.3.1.2. Ocular hypertension (preglaucoma). Two or more determinations of 22 mmHg or greater but less than 30 mmHg, or a difference of 4 mmHg or greater between the two eyes.

A4.3.2. Nystagmus, except on versional end points.

A4.3.3. Contact lenses that correct near visual acuity only or that are bifocal, or that are fit with the monovision techniques.

A4.3.4. Diplopia in any field of gaze, either constant or intermittent, including history of.

A4.3.5. Monocularity.

A4.3.6. History of keratorefractive surgery of any type to include radial keratotomy (RK), photorefractive keratectomy (PRK), and other similar surgical procedures accomplished to modify the refractive power of the cornea or of lamellar or penetrating keratoplasty or orthokeratology.

A4.3.7. Extraocular muscle paralysis or paresis with loss of ocular motility in any direction.

A4.3.8. Absence of conjugate alignment in any quadrant.

A4.4. Distant Vision.

A4.4.1. Uncorrected, worse than 20/400 each eye.

A4.4.2. Corrected, worse than 20/20 each eye.

A4.5. Near Vision.

A4.5.1. Uncorrected, no standard.

A4.5.2. Corrected vision worse than 20/20 in each eye.

A4.6. Heterotropias and Heterophorias.

A4.6.1. Any heterotropia.

A4.6.2. Heterophorias. More than 1.5 prism diopter of hyperphoria, 10 prism diopters of esophoria, or six prism diopters of exophoria requires a thorough evaluation for other eye pathology motor and sensory abnormalities, by a competent eye care professional. If no other eye pathology is found and all other aspects of the examination are normal, a waiver can be considered.

A4.7. Color Vision. Color vision testing must be performed monocularly under approved and standardized illuminant (i.e.,Illuminant C). Five or more incorrect responses in either eye (including failure to make responses in the allowed time interval) in reading the 14 test plate versions of one of the following Pseudoisochromatic Plate (PIP) sets: Dvorine, the original version of the AO (excludes Richmond PIP version), or Ishihara.

NOTE:

No other PIP versions, such as Richmond PIP, or Beck Engraving versions, or other tests for color vision, are authorized for qualification purposes. Also note that the Farnsworth Lantern (FALANT) has been dropped as an USAF qualifying test.

A4.8. Depth Perception.

A4.8.1. Initial Testing for controller duty. Failure of the Vision Test Apparatus near and distant

(VTA-DP or OVT) screening depth perception test results in a full evaluation by a competent eye care professional.

A4.8.2. Continued controller duty. New failure of the VTA-DP or OVT, when passed previously, requires evaluation by a competent eye care professional to rule out correctable causes, i. e., refractive error, anisometropia or macular disease. If the controller has previously failed the VTA-DP and passes the near stereopsis test (Verhoeff or Titmus), no further work-up is required.

A4.9. Visual Fields. Any visual field defect.

A4.10. Night Vision. Unsatisfactory night vision as determined by history for initial controller duty. In trained controllers, this history is confirmed by the appropriate electrophysiological tests requested by the Aeromedical Consultation Service ophthalmologists.

A4.11. Cardiovascular System.

A4.11.1. History of myocardial infarction, angina pectoris, or other evidence of coronary heart disease including silent ischemia.

A4.11.2. History of dysrhythmia with symptoms of hemodynamic compromise.

A4.11.3. Symptomatic valvular heart disease or asymptomatic moderate to severe valvular disease associated with hypertrophy, chamber enlargement, or ventricular dysfunction (see **Attachment 2**).

A4.11.4. Aneurysm or AV fistula of a major vessel.

A4.11.5. Hypertension, or history of hypertension on antihypertensive medication. Hypertension is evidenced by average systolic blood pressure greater than 140 mmHg or average diastolic blood pressure greater than 90 mmHg. Patients may be followed initially as in paragraph **A7.17.**

A4.11.6. Resting pulse rate greater than 110 or less than 45 beats per minute.

A4.11.7. ECG evidence of significant conduction defects, to include Wolff-Parkinson-White syndrome.

A4.12. Blood, Blood-forming Tissues, and Immune System.

A4.12.1. Anemia of any etiology.

A4.12.2. Blood donation: 8 hr restriction from controller duty following blood donation (formal flight surgeon restriction not required).

A4.13. Abdomen and Gastrointestinal System.

A4.13.1. Gastrointestinal hemorrhage or history of, regardless of cause.

A4.13.2. Peptic ulcer disease or any complication of peptic ulcer disease. An uncomplicated ulcer that has been inactive for 3 months and does not require medication (except the occasional use of antacids) is not disqualifying.

A4.13.3. Cholelithiasis.

A4.14. Genitourinary System.

A4.14.1. History of recurrent or bilateral renal calculus.

A4.14.2. Retained renal calculus, except parencymal.

A4.14.3. Cystostomy.

A4.14.4. Neurogenic bladder.

A4.14.5. Renal transplant.

A4.15. Neurological Disorders.

A4.15.1. History of any medically unexplained disturbance of consciousness or where surgical intervention was necessary to correct the precipitating cause.

A4.15.2. History of any of the following types of headaches:

A4.15.2.1. Recurrent headaches of the vascular, migraine, or cluster (Horton's cephalgia or histamine headache) type.

A4.15.2.2. A single incapacitating headache of any type (e.g.,loss of consciousness, aphasia, ataxia, vertigo or mental confusion).

A4.15.2.3. Headaches of any type which are of sufficient severity to likely interfere with controlling duties.

A4.15.2.4. Acephalgic migraines.

NOTE:

A waiver for migraines may be considered following one year of symptom free observation. Migrainous strokes and migraines complicated by neurological deficits other than transient visual changes are not waiverable.

A4.15.3. History of recurrent vertigo or dysequilibrium disorders.

A4.15.4. Cerebrovascular disease to include transient ischemic attack (TIA), cerebral infarction, thrombotic or embolic, or transient global amnesia.

A4.15.5. Demyelinating and autoimmune diseases.

A4.15.6. Extrapyramidal, hereditary, and degenerative diseases of the nervous system.

A4.15.7. Infections of the nervous system.

A4.16. Psychiatric Disorders.

A4.16.1. Alcohol dependence or abuse (DSM IV) or any disease the proximate cause of which is alcoholism. Waiver may be considered when all of the following conditions are met:

A4.16.1.1. The MTF Alcohol & Drug Abuse Prevention & Treatment (ADAPT) Program treatment team determines that the individual has made satisfactory progress and has maintained abstinence without the aid of medications for a period of 6 months from the date of entering treatment.

NOTE:

Any relapse (as determined by the treatment team) or use of medication to deter alcohol use resets the 6-month observation period for waiver consideration.

A4.16.1.2. In the opinion of the flight surgeon, privileged mental health provider, and the unit commander, and based on the ADAPT program assessment, the individual has a low potential for recidivism and can be expected to remain stable under stress.

A4.16.1.3. The individual has no medical complications or sequelae due to past alcohol abuse or dependence.

A4.16.1.4. The individual states in writing that he or she understands the waiver is valid only if total abstinence from alcohol is maintained and that a verifiable break in abstinence once the waiver period has begun is considered medically disqualifying and not waiverable. The written statement by the individual must be accomplished at the initial waiver request and reaccomplished each time a request is submitted for renewal of the waiver, and is included with the waiver request. To ensure unit commanders are aware of the need to observe individuals with past alcohol prob-

lems, new commanders are briefed on those in their units with waivers when the individual changes assignment or there has been a change of command.

A4.16.2. Unsatisfactory adaptability rating for ground based controller duties.

A4.16.3. Anxiety disorders.

NOTE:

Fear of controlling which does not meet the DSM III criteria of simple phobia (300.29) is handled administratively.

A4.16.4. A personality disorder that is severe enough to have repeatedly manifested itself by overt acts disqualifies the individual from controller duties, but can not be used as a medical reason for separation from active duty.

A4.16.5. History of attempted suicide or suicidal behavior.

A4.16.6. Depression disorders including major depression, dysthymia and depression not otherwise specified.

A4.16.7. All organic brain syndromes.

A4.16.8. Any personality disorder, neurosis, or mental condition that may render the individual unable to safely perform controller duties.

A4.17. Musculoskeletal, Spine, and Extremities. Any disease, condition, or deformity of the musculoskeletal system which may impair duty performance or access to control facilities, is likely to progress, or which requires frequent use of analgesic or anti-inflammatory medication for control.

A4.18. Endocrine and Metabolic.

A4.18.1. Diabetes insipidus.

A4.18.2. Hypoglycemia, whether functional or a result of pancreatic tumor.

A4.18.3. Thyroid disorders.

A4.18.4. Other endocrine or metabolic disorders which preclude satisfactory performance of controller duties.

A4.19. Miscellaneous Causes for Rejection.

A4.19.1. Use of any medication whose known actions may affect alertness, judgment, cognition, special sensory function, mood, or coordination.

A4.19.2. Air Traffic Controllers cannot perform controller duties for at least 8 hours after receiving a local or regional anesthetic agent.

A4.19.3. Exacerbation of any medical condition for which a waiver has been granted.

A4.19.4. Blood donation requires a verbal DNIC for 8 hrs and does not require flight surgeon clearance to return to duties.

A4.20. Additional Testing.

A4.20.1. HIV antibody testing is required for all applicants for initial controller duty. Record the results of cholesterol, HDL, and triglycerides in item 50, SF 88.

A4.20.2. An adaptability rating for control duty (AR-CD) and a reading aloud test (RAT) is required on all applicants for initial controller duty. Record the results in item 72, SF 88. The RAT and instructions are in AFI 36-2018, *Medical Examination of Applicants for United States Service Academies, Reserve Officer Training Corps (ROTC) Scholarship Programs, Including the AF, Army, and Navy Two and Three-Year College Scholarship Programs (CSP), and the Uniformed Services University of the Health Sciences (USUHS).*

A4.21. FAA Certificate. Civilian contract Air traffic controllers performing controller duty on Air National Guard (ANG), Air Force Reserve on Active Duty Air Force installations shall have a Class II FAA certifying physical examination performed by a designated civilian Aeromedical Examiner (AME) in accordance with 14 CFR Part 67 (FAA Airman Medical Standards and Certification). Federally-employed air traffic controllers may have Class II FAA examinations performed only by those AMEs designated by the FAA Regional Flight Surgeon to perform controller examinations. Applications for Statements of Demonstrated Ability (SODA), or waivers, will be processed through the Mike Monroney Aeronautical Center as per the Guide for Aviation Medical Examiners.

Attachment 5

SPACE AND MISSILE OPERATIONS CREW DUTY (SMOC)

Conditions in Attachment 2, Medical Standards for Continued Military Service also apply. For conditions listed in Attachment 2, ensure a Medical Evaluation Board (MEB) has been performed and final disposition made prior to submission of a waiver request.

A5.1. Vision.

A5.1.1. Defective Color Vision. Color vision testing must be performed monocularly under approved and standardized illuminant (i.e.,Illuminent C). Five or more incorrect responses in either eye (including failure to make responses in the allowed time interval) in reading the **14 test plate versions** of one of the following Pseudoisochromatic Plate (PIP) sets: Dvorine, the original version of the AO (excludes Richmond PIP version), or Ishihara.

NOTE:

No other PIP versions, such as Richmond PIP, or Beck Engraving versions, or other tests for color vision, are authorized for qualification purposes. Also note that the Farnsworth Lantern (FALANT) has been dropped as a USAF qualifying test.

A5.1.1.1. A waiver will be considered for trained personnel who fail the above tests.

A5.1.1.2. An on-the-job color vision test is required for waiver.

A5.1.1.3. Waiver will be valid for the current system only. No waiver will be required for individuals assigned to staff positions not requiring crew duty. Reassignment to a new system will require a new on-the-job evaluation and waiver.

A5.1.2. Corrected visual acuity worse than 20/20 in the better eye near and distant.

NOTE:

Individuals found on routine examination to be less than 20/20 in the better eye in either near or distant, or both, but correctable to at least 20/20 near and distant in one eye may continue to perform Space and Missile Operations duties until the appropriate corrective lenses arrive. These lenses must be ordered by the most expeditious means.

A5.2. Hearing. A hearing profile less than H-2 for initial selection or less than H-3 for continued SMOC duty.

A5.3. Head and Neck.

A5.3.1. Any disease or malformation of the nose, mouth, pharynx, or larynx that might interfere with enunciation or clear voice communication as demonstrated by the reading aloud test.

A5.3.2. Symptomatic allergic rhinitis or vasomotor rhinitis not controlled by desensitization, use of topical nasal steroids, or oral antihistamines which do not cause drowsiness.

A5.3.3. Any defect that would interfere with wearing oxygen equipment, protective head gear, or other safety equipment.

A5.4. Neuropsychiatric.

A5.4.1. Any psychiatric condition which would result in a psychiatric profile of worse than S-1.

A5.4.2. History of claustrophobia.

A5.4.3. Any psychiatric condition, or history thereof, which in the opinion of the examining flight surgeon, would interfere with the performance of space and missile operations crew duty.

A5.4.4. Alcohol dependence or abuse (DSM IV) or any disease the proximate cause of which is alcoholism. Waiver may be considered when all of the following conditions are met:

A5.4.4.1. The MTF Alcohol & Drug Abuse Prevention & Treatment (ADAPT) Program treatment team determines the individual has made satisfactory progress and has maintained abstinence without the aid of medications for a period of 6 months from the date of entering treatment.

NOTE:

Any relapse (as determined by the treatment team) or use of medication to deter alcohol use resets the 6 month observation period for waiver consideration.

A5.4.4.2. In the opinion of the flight surgeon, privileged mental health provider, and the unit commander, and based on the ADAPT program assessment, the individual has a low potential for recidivism and can be expected to remain stable under stress.

A5.4.4.3. The individual has no medical complications or sequelae due to past alcohol abuse or dependence.

A5.4.4.4. The individual states in writing that he or she understands the waiver is valid only if total abstinence from alcohol is maintained and that a verifiable break in abstinence once the waiver period has begun is considered medically disqualifying and not waiverable. This written statement by the individual must be accomplished at the initial waiver request and reaccomplished each time a request is submitted for renewal of the waiver, and is included with the waiver request. To ensure unit commanders are aware of the need to observe individuals with past alcohol problems, new commanders are briefed on those in their units with waivers when the individual changes assignment or there has been a change in command.

NOTE:

Documentation of these conditions must be submitted with waiver request.

A5.4.5. Headaches except mild, minor, non-recurrent headaches controlled by single doses of aspirin, acetaminophen, or a nonsteroidal anti-inflammatory agent.

A5.4.6. Unsatisfactory adaptability rating for space and missile operations duty.

A5.4.7. History of attempted suicide, either suicide attempt or gesture.

A5.4.8. History of seizures within the past 5 years, or usage of medications to control seizures within the past 5 years.

A5.4.9. Head injuries.

A5.4.9.1. Head injury of a mild degree (**A7.23.**) with a normal neurological examination (**Table 16.1.**) does not require waiver action.

A5.4.9.2. Head injury of a moderate or severe degree will require waiver action after normal neurological testing as delineated in **Table 16.1.**

A5.5. Medication.

A5.5.1. The following medications are approved for use in missileers and space operators. However, many of the medical conditions for which these medications may be used may be temporarily or permanently disqualifying for missile or space operations.

A5.5.2. Injectable medications.

A5.5.2.1. Crew members cannot perform crew duties for at least 8 hours after receiving a local or regional anesthetic agent.

A5.5.2.2. Injectable steroids may be used to treat inflammatory conditions or ganglion cysts. Crew members should be restricted from duties for a minimum of 8 hours following the procedure.

A5.5.3. Medications which may be used without medical consultation.

A5.5.3.1. Over the counter skin antiseptics, topical antifungals, 1 percent Hydrocortisone cream, or benzoyl peroxide for minor wounds and skin diseases which do not interfere with the performance of duties or wear of personal equipment.

A5.5.3.2. Single doses of over-the-counter aspirin, acetaminophen or ibuprofen to provide analgesia for minor self-limiting conditions.

A5.5.3.3. Antacids for mild isolated episodes of epigastric distress.

A5.5.3.4. Hemorrhoidal suppositories.

A5.5.3.5. Bismuth subsalicylate for mild afebrile cases of diarrhea.

A5.5.3.6. Psyllium hydrophilic mucilloid (Metamucil) or other bulk forming agents.

A5.5.3.7. Throat lozenges for relief of minor throat discomfort.

A5.5.3.8. Oxymetazoline or Phenylephrine nasal spray.

A5.5.3.9. Pseudoephedrine HCL 30 mg for mild isolated episodes of congestion.

A5.5.3.10. Guaifenesin cough syrup for mild isolated episodes of coughing.

A5.5.4. Medication prescribed by a flight surgeon which may be used without removal from crew duty.

A5.5.4.1. Isoniazid for prophylactic therapy of tuberculin converters who do not have active tuberculosis.

A5.5.4.2. Oral contraceptives, implantable timed release progestin, estrogen alone or with progestin as replacement therapy.

A5.5.4.3. Chloroquine phosphate, primaquine phosphate, or doxycycline for antimalarial prophylaxis.

A5.5.4.4. Pyridostigmine for chemical warfare prophylaxis.

A5.5.4.5. Topical antibiotics.

A5.5.4.6. Topical tretinoin for control of acne as long as local irritation does not interfere with wear of the life-support equipment.

A5.5.4.7. Topical benzoyl peroxide 5-10%.

A5.5.4.8. Topical steroids.

A5.5.4.9. Topical fungicides.

A5.5.4.10. Salicylic acid plaster**.**

A5.5.4.11. Topical Acyclovir.

A5.5.4.12. Oral Antibiotics.

A5.5.4.13. Vaginal creams or suppositories for treatment of vaginitis.

A5.5.4.14. Immunobiologics.

A5.5.4.15. Nicorette or transdermal nicotine.

A5.5.4.16. Resin binding agents such as cholestyramine for control of hyperlipidemia.

A5.5.4.17. Oral and topical decongestants for the temporary relief of minor flu-like symptoms.

A5.5.4.18. Benzonatate pearls or guifenesin cough syrup.

A5.5.4.19. Nasal steroids or cromolyn nasal spray for control of mild to moderate allergic rhinitis, nonallergic rhinitis, or vasomotor rhinitis. Observation for control of the rhinitis (usually 7 to 14 calendar days) is required. Claritin (loratidine) for the control of seasonal allergic rhinitis.

A5.5.4.20. Nonsteroidal anti-inflammatory agents.

A5.5.4.21. Lindane cream or lotion.

A5.5.4.22. Docusate sodium for acute constipation.

A5.5.4.23. Ophthalmic antibiotic drops for mild conjunctivitis which does not affect vision.

A5.5.4.24. Otic antibiotic drops for external otitis.

A5.5.5. Medication prescribed by a flight surgeon which may be used without removal from crew duty once the potential for idiosyncratic reaction has been excluded.

A5.5.5.1. Nonsedating antihistamines for relief of minor allergy symptoms. Should only be given if the crewmember has taken this medication in the past without drowsiness.

A5.5.5.2. Chlorothiazide or hydrochlorothiazide for control of hypertension or hypercalciuria.

A5.5.5.3. Triamterene, lisinopril, nifedipine, or diltiazem for control of hypertension.

A5.5.5.4. Probenecid for treatment of gout or hyperuricemia.

A5.5.5.5. Allopurinol for treatment of gout or hyperuricemia.

A5.5.5.6. Combination therapy of thiazide with triamterene, probenecid, allopurinol, or oral potassium supplements, to control hypertension.

A5.5.5.7. Epinephrine derivatives without added action agents, or betablockers (Timolol, Levobunolol, Betaxolol) all for topical use only, to control glaucoma.

A5.5.5.8. Synthroid for treatment of thyroid hypofunction or for thyroid suppression.

A5.5.5.9. Folic acid in the treatment of sprue.

A5.5.5.10. Sucralfate (1 gram once daily) for prevention of recurrent, uncomplicated duodenal ulcers. Minimum 7 days observation required.

A5.5.5.11. Ranitidine, omeprazole, and famotidine.

A5.5.5.12. Griseofulvin or fluconazole for treatment of fungal infections after a 4-week ground trial.

A5.5.5.13. Clomiphene citrate for treatment of infertility.

A5.5.5.14. Lovastatin, pravastatin and gemfibrozil for control of hypercholesterolemia.

A5.5.5.15. Acyclovir (oral), for treatment of HSV or suppressive therapy.

A5.5.6. All medications not listed above are disqualifying for space and missile crew duty and will require a waiver from HQ AFSPC.

A5.6. General.

A5.6.1. Any medical condition, the natural history of which is to incapacitate an individual suddenly and without warning.

A5.6.2. Confirmed presence of Human Immunodeficiency Virus (HIV) or antibody.

A5.6.3. Exacerbation of any medical condition for which a waiver has been granted.

A5.7. Continuation of Space and Missile Operations Crew Duty.

A5.7.1. When space and missile operations members report to a new base for duty or training, the flight surgeon performs an informal examination, using SF 600, *Health Record-Chronological Record of Medical Care*, only as extensive as considered necessary to ensure the individual is qualified to perform their duties. Students reporting for training must have a physical examination certified by HQ AFSPC/SGPA before entering training.

A5.7.1.1. When the flight surgeon becomes aware that a member's qualification has changed, flight medicine immediately notifies the operational unit using the AF Form 1042.

A5.7.1.2. Only a flight surgeon may make the determination as to the crew member’s ability to perform crew duty. A follow up visit to the flight surgeons’ office is not always needed to return a crew member to crew duty, but may be requested by the patient, flight surgeon or commander. If the flight surgeon determines that he does not need a return visit for him to return to crew duty, the 1042 must be annotated that no return is necessary.

A5.7.1.3. When a crew member receives care by a non-flight surgeon provider, the member should be seen immediately by a flight surgeon for appropriate aeromedical disposition. If a flight surgeon is not immediately available, the member should be temporarily removed from space and missile duties until seen by a flight surgeon.

A5.7.2. PES personnel complete Preventive Health Assessment (PHA) annually within the 6 month period preceding the last day of the birth month. This applies to:

A5.7.2.1. All 13SXX and 1C6XX personnel whether on crew duty or not, and any individual of another AFSC assigned to operational crew duty maintaining mission ready or equivalent status

A5.7.2.2. Students undergoing training and applicants who have been certified for training but have not yet entered training, and space and missile operators who are not assigned to crew duty.

A5.7.3. Flight surgeons should perform medical examinations for continued space and missile operations crew duty and initial training.

A5.7.4. When space operators are assigned to remote locations where no flight surgeons are available, the following exceptions apply:

A5.7.4.1. The crew member's physical examination is valid for up to 18 months. If the member continues to extend past this time, a physical exam using either AF Form 1446 or SF 88 and 93 will be accomplished using the resources available at the location. This examination will then be forwarded to AFSPC/SGPA for review and certification. Any credentialed provider may care for the crew members while deployed to the remote site.

A5.7.4.2. If the crewmember is prescribed any medication other than the medications listed in **A5.5.** "Medications which may be used without medical consultation" or has any condition which has the potential to interfere with satellite controlling duties then the credentialed provider should place the individual on DNIC (Duties Not to Include Controlling) status using the AF Form 1042.

A5.7.4.3. The following procedure will be used for returning an individual to controlling duties. The credentialed provider or other designated representative shall consult a flight surgeon in theatre, at the site support Flight Surgeon's Office, or HQ AFSPC/SGPA by phone to discuss the crewmembers condition. The credentialed provider or designated representative will, upon the recommendation of the consulting flight surgeon, RTFS the crew member by signing the AF Form 1042 in the flight surgeon's block and annotating in the remarks section, the name of the flight surgeon who recommends the RTFS.

A5.8. Additional Testing.

A5.8.1. HIV antibody testing is required for all applicants for initial duty. Record the results of cholesterol, HDL, and triglycerides in item 50, SF 88.

A5.8.2. An adaptability rating for space and missile operations crew duty and a reading aloud test

(RAT) is required on all applicants for initial duty. Record the results in item 72, SF 88. The

RAT and instructions are in AFI 36-2018.

A5.9. Pregnancy:

A5.9.1. Pregnancy is not necessarily disqualifying for space and missile duties. It may be appropriate to remove an individual from crew duties if she is experiencing some side effects from her pregnancy (i.e. hyperemesis, preeclampsia). The following guidelines should be used for routine pregnancy.

A5.9.1.1. Missileers - remove from alert duty after 24 weeks gestation.

A5.9.1.2. Spacelift Operators and Space Warning Operators - remove from shift duty after 32 weeks gestation.

A5.9.1.3. Satellite Command and Control and Space Surveillance Operators - remove from shift duty after 36 weeks gestation

Attachment 6

AIR VEHICLE OPERATOR (AVO) DUTY

Conditions in Attachment 2 apply (Rated personnel in direct control of UAVs maintain Flying Class II standards in paragraph 7.5. and Attachment 2 and Attachment 7. Unrated and medically disqualified rated personnel in direct control of UAVs and sensor operators maintain Air Vehicle Operator Duty standards in Attachment 2 and Attachment 6 Unrated personnel required to perform frequent and regular aerial flights must meet Flying Class III standards in Attachment 7.) For conditions listed in Attachment 2, ensure a Medical Evaluation Board (MEB) has been performed and final disposition made prior to submission of a waiver request.

A6.1. Ear, Nose, and Throat.

A6.1.1. Symptomatic allergic rhinitis, seasonal or perennial not controlled by desensitization or use of topical nasal steroids.

A6.1.2. Any disease or malformation of the nose, mouth, pharynx or larynx that might interfere with enunciation or clear voice communication.

A6.1.3. Any disturbance of equilibrium.

A6.1.4. Obstructions of the nose from any cause which prevent nasal respiration.

A6.2. Hearing.

A6.2.1. Hearing loss greater than that specified for H-1 profile for initial selection. Hearing loss greater than that specified for H-2 profile for continued AVO duty.

A6.2.2. Use of hearing aid.

A6.3. Vision.

A6.3.1. Intraocular pressure.

A6.3.1.1. Glaucoma, as evidenced by IOP of 30 mmHg or greater, or the secondary changes in the optic disc or visual field associated with glaucoma.

A6.3.1.2. Ocular hypertension (Preglaucoma). Two or more determinations of 22 mmHg or greater but less than 30 mmHg, or a difference of 4 mmHg or greater between the two eyes.

A6.3.2. Nystagmus, except on versional end points.

A6.3.3. Contact lenses that correct near visual acuity only or that are bifocal, or that are fit with the monovision techniques.

A6.3.4. Monocularity.

A6.3.5. History of keratorefractive surgery of any type to include radial keratotomy (RK), photorefractive keratectomy (PRK), laser in situ keratomileusis (LASIK) and other similar surgical procedures accomplished to modify the refractive power of the cornea or of lamellar or penetrating keratopasty or orthokeratology.

A6.3.6. Extraocular muscle paralysis or paresis with loss of ocular motility in any direction.

A6.3.7. Diplopia and absence of conjugate alignment in any quadrant.

A6.4. Distant Vision.

A6.4.1. Corrected vision no worse than 20/20 in each eye.

A6.5. Near Vision.

A6.5.1. Uncorrected, no standard.

A6.5.2. Corrected vision worse than 20/20 in each eye.

A6.6. Heterotropias and Heterophorias.

A6.6.1. Any heterotropia including microtropia.

A6.6.2. Heterophorias. More than 1.5 prism diopter of hyperphoria, 10 prism diopters of esophoria, or six prism diopters of exophoria requires a thorough evaluation for other eye pathology to include motor and sensory abnormalities, by an ophthalmologist or optometrist and include all tests required under paragraph **A7.11.** If no other eye pathology to include is found and all other aspects of the examination are normal, a waiver can be considered.

A6.7. Color Vision. Color vision testing must be performed monocularly under approved and standardized illuminant (i.e.,Illuminant C). Five or more incorrect responses in either eye (including failure to make responses in the allowed time interval) in reading the **14 test plate versions** of one of the following Pseudoisochromatic Plate (PIP) sets: Dvorine, the original version of the AO (excludes Richmond PIP version), or Ishihara.

NOTE:

No other PIP versions, such as Richmond PIP, or Beck Engraving versions, or other tests for color vision, are authorized for qualification purposes. Also note that the Farnsworth Lantern (FALANT) has been dropped as an USAF qualifying test.

A6.8. Visual Fields. Any visual field defect.

A6.9. Cardiovascular System.

A6.9.1. History of myocardial infarction, angina pectoris, or other evidence of coronary heart disease.

A6.9.2. History of dysrhythmia with symptoms of hemodynamic compromise.

A6.9.3. Symptomatic valvular heart disease.

A6.9.4. Aneurysm or AV fistula of a major vessel.

A6.9.5. Hypertension, or history of hypertension on antihypertensive medication. Hypertension is evidenced by average systolic blood pressure greater than 140 mmHg or average diastolic blood pressure greater than 90 mmHg. Patients may be followed initially as in paragraph **A7.17.**

A6.9.6. Resting pulse rate greater than 100 or less than 45 beats per minute.

A6.9.7. ECG evidence of conduction defects, to include Wolff-Parkinson-White syndrome.

A6.10. Blood, Blood-forming Tissues, and Immune System.

A6.10.1. Anemia of any etiology.

A6.10.2. Blood donation: 8 hour restriction from AVO duty following blood donation (formal flight surgeon restriction not required).

A6.11. Abdomen and Gastrointestinal System.

A6.11.1. Gastrointestinal hemorrhage or history of, regardless of cause.

A6.11.2. Peptic ulcer disease or any complication of peptic ulcer disease. An uncomplicated ulcer that has been inactive for 3 months and does not require medication (except the occasional use of ant-acids) is not disqualifying.

A6.11.3. Cholelithiasis.

A6.12. Genitourinary System.

A6.12.1. History of recurrent or bilateral renal calculus.

A6.12.2. Retained renal calculus, except parencymal.

A6.12.3. Cystostomy.

A6.12.4. Neurogenic bladder.

A6.12.5. Renal transplant.

A6.13. Neurological Disorders.

A6.13.1. History of any medically unexplained disturbance of consciousness or where surgical intervention was necessary to correct the precipitating cause.

A6.13.2. Any recurring headaches of the vascular, migraine, or cluster (Horton's cephalgia or histamine headache) type or incapacitating tension headaches. Acephalgic migraine.

A6.13.3. History of recurrent vertigo or dysequilibrium disorders.

A6.13.4. Cerebrovascular disease to include transient ischemic attack (TIA), cerebral infarction, thrombotic or embolic, or transient global amnesia.

A6.13.5. Demyelinating and autoimmune diseases.

A6.13.6. Extrapyramidal, hereditary, and degenerative diseases of the nervous system.

A6.13.7. Infections of the nervous system.

A6.14. Psychiatric Disorders.

A6.14.1. Any psychiatric condition which would result in a psychiatric profile of less than S-1.

A6.14.2. History of claustrophobia.

A6.14.3. Any psychiatric condition, which in the opinion of the examining flight surgeon, would interfere with the performance of AVO duty.

A6.14.4. Alcohol dependence or abuse (DSM IV) or any disease the proximate cause of which is alcoholism. Waiver may be considered when all the conditions are met in Attachment **A4.16.**

A6.14.5. Unsatisfactory adaptability rating for AVO duties.

A6.14.6. Anxiety disorders.

NOTE:

Fear of AVO duties which does not meet the DSM IV criteria of simple phobia (300.29) is handled administratively.

A6.14.7. A personality disorder that is severe enough to have repeatedly manifested itself by overt acts disqualifies the individual from AVO duties, but can not be used as a medical reason for separation from active duty.

A6.14.8. History of attempted suicide or suicidal behavior.

A6.14.9. Depression disorders including major depression, dysthymia and depression not otherwise specified.

A6.14.10. All organic brain syndromes.

A6.14.11. Any personality disorder, neurosis, or mental condition that may render the individual unable to safely perform AVO duties.

A6.15. Musculoskeletal, Spine, and Extremities. Any disease, condition, or deformity of the musculoskeletal system which may impair duty performance or access to control facilities, is likely to progress, or which requires frequent use of analgesic or anti-inflammatory medication for control.

A6.16. Endocrine and Metabolic.

A6.16.1. Diabetes mellitus.

A6.16.2. Diabetes insipidus.

A6.16.3. Hypoglycemia, whether functional or a result of pancreatic tumor.

A6.16.4. Thyroid disorders.

A6.16.5. Other endocrine or metabolic disorders which preclude satisfactory performance of

AVO duties.

A6.17. Miscellaneous Causes for Rejection.

A6.17.1. Use of any medication whose known actions may affect alertness, judgment, cognition, special sensory function, mood, or coordination.

A6.17.2. Exacerbation of any medical condition for which a waiver has been granted.

A6.18. Medication .

A6.18.1. Any medical condition, the natural history of which is to incapacitate an individual suddenly and without warning.

A6.18.2. Exacerbation of any medical condition for which a waiver has been granted.

A6.19. Continuation of Air Vehicle Operator Duty.

A6.19.1. When AVOs report to a new base for duty or training, the flight surgeon performs an informal examination, using SF 600, Health Record-Chronological Record of Medical Care, only as extensive as considered necessary to ensure the individual is qualified to perform their duties. Students reporting for training must have a physical examination certified by HQ ACC/SGPA before entering training.

A6.19.2. When the flight surgeon becomes aware that a member's qualification has changed, flight medicine immediately notifies the operational unit.

A6.19.3. PES personnel complete AF Form 1446, *Medical Examination - Flying Personnel*, within the 6-month period preceding the last day of the birth month on all years that a member is not scheduled for a complete medical examination. This requirement applies to students undergoing training and applicants who have been certified for training but have not yet entered training.

A6.19.4. A flight surgeon should perform medical examinations for continued AVO duty and initial training. In those cases where a flight surgeon is not available the physical must be sent to the HQ ACC/SG for review and certification.

A6.20. Additional Testing.

A6.20.1. HIV antibody testing is required for all applicants for initial AVO duty. Record the results of cholesterol, HDL, and triglycerides in item 50, SF 88.

A6.20.2. An adaptability rating for AVO duty (AVO-D) and a reading aloud test (RAT) is required on all applicants for initial AVO duty. Record the results in item 72, SF 88. The RAT and instructions are in AFI 36-2018, Medical Examination of Applicants for United States Service Academies, Reserve Officer Training Corps (ROTC) Scholarship Programs, Including the AF, Army, and Navy Two and Three-Year College Scholarship Programs (CSP), and the Uniformed Services University of the Health Sciences (USUHS).

Attachment 7

MEDICAL STANDARDS FOR FLYING DUTY

Conditions listed in **Attachment 2**, Medical Standards for Continued Military Service and **Attachment 3**, Appointment, Enlistment, and Induction apply. For conditions listed in **Attachment 2**, ensure a Medical Evaluation Board (MEB) has been performed and final disposition made prior to submission of a flying waiver request.

A7.1. Head, Face, Neck, and Scalp (Flying Classes I, IA, II, and III).

A7.1.1. Injuries to the head (See paragraph **A7.23.**).

A7.1.2. Loss or congenital absence of bone substance of the skull.

A7.1.3. Chronic arthritis, complete or partial ankylosis, or recurrent dislocation of the temporomandibular joint.

A7.1.4. Congenital cysts of branchial cleft origin or those developing from the remains of a thyroglossal duct, with or without fistulous tracts.

A7.1.5. Chronic draining fistulae of the neck, regardless of cause.

A7.1.6. Contractions of the muscles of the neck if persistent or chronic. Cicatricial contracture of the neck to the extent it interferes with function or the wear of equipment.

A7.1.7. Cervical ribs if symptomatic or symptoms can be induced by abduction, scalenus, or costoclavicular maneuvers.

A7.1.8. Any anatomic or functional anomaly of head or neck structures, which interfere with normal speech, ventilation of the middle ear, breathing, mastication, swallowing, or wear of aviation or other military equipment.

A7.2. Nose, Sinuses, Mouth, and Throat.

A7.2.1. Flying Classes II and III.

A7.2.1.1. Allergic rhinitis, unless mild in degree and considered unlikely to limit the examinee's flying activities. Waivers are considered if symptoms are controlled by desensitization or topical medication (or both).

A7.2.1.2. Chronic nonallergic or vasomotor rhinitis, unless mild, asymptomatic, and not associated with eustachian tube dysfunction. Waivers are considered if symptoms are controlled by topical medication.

A7.2.1.3. Nasal polyps.

A7.2.1.4. Deviations of the nasal septum, septal spurs, enlarged turbinates or other obstructions to nasal ventilation which result in clinical symptoms. Symptomatic atresia or stenosis of the choana.

A7.2.1.5. Epistaxis, chronic, recurrent.

A7.2.1.6. Chronic sinusitis unless mild in degree and considered unlikely to limit the examinee's flying activities.

A7.2.1.7. Recurrent calculi of the salivary glands or ducts.

A7.2.1.8. Deformities, injuries, or destructive diseases of the mouth (including teeth), nose, throat, pharynx, or larynx that interfere with ventilation of the paranasal sinuses and, or middle ear, breathing, easily understood speech, or mastication and swallowing of ordinary food.

A7.2.1.9. Atrophic rhinitis.

A7.2.1.10. Perforation of the nasal septum.

A7.2.1.11. Anosmia or parosmia.

A7.2.1.12. Salivary fistula.

A7.2.1.13. Ulcerations, perforation, or extensive loss of substance of the hard or soft palate; extensive adhesions of the soft palate to the pharynx; or complete paralysis of the soft palate. Unilateral paralysis of the soft palate which does not interfere with speech or swallowing and is otherwise asymptomatic is not disqualifying.

A7.2.1.14. Chronic pharyngitis and nasopharyngitis.

A7.2.1.15. Chronic laryngitis. Neoplasm, polyps, granuloma, or ulceration of the larynx.

A7.2.1.15.1. Aphonia or history of recurrent aphonia if the cause was such as to make subsequent attacks probable. Painful Dysphonia Plicae Ventricularis.

A7.2.1.15.2. Tracheostomy or tracheal fistula.

A7.2.1.15.3. Malformations, injuries or diseases of the esophagus, such as ulceration, diverticulum, varices, stricture, achalasia, pronounced dilation, or peptic esophagitis.

A7.2.2. Flying Classes I and IA. In addition to the above:

A7.2.2.1. A verified history of allergic, nonallergic, or vasomotor rhinitis, after age 12.

A7.2.2.2. Any surgical procedure for sinusitis, polyposis or hyperplastic tissue. Waiver may be considered if recovery is complete and individual has been asymptomatic for 1 year.

A7.3. Ears.

A7.3.1. Flying Classes II and III.

A7.3.1.1. History of surgery involving the middle ear, excluding cholesteatoma below.

A7.3.1.2. Residual of mastoid surgery.

A7.3.1.3. Inability to perform the VALSALVA maneuver.

A7.3.1.4. Perforation of the tympanic membrane. Surgery to repair perforated tympanic membrane is disqualifying until healing is complete and hearing is normal.

A7.3.1.5. Tinnitus when associated with active disease.

A7.3.1.6. Abnormal labyrinthine function.

A7.3.1.7. Recurrent episodes of vertigo with or without nausea, vomiting, tinnitus, and hearing loss.

A7.3.1.8. Any conditions that interfere with the auditory or vestibular functions.

A7.3.1.9. Cholesteatoma or history of surgical removal of cholesteatoma.

A7.3.1.10. Atresia, tuberosity, severe stenosis or tumors of the external auditory canal which prevents an adequate view of the tympanic membrane or effective therapeutic access to the entire external auditory canal.

A7.3.2. Classes I, IA, II (flight surgeon applicants) and III (initial applicants). In addition to the above:

A7.3.2.1. Applicants must demonstrate satisfactory performance of the Reading Aloud Test (RAT).

A7.3.2.2. History of radical mastoidectomy.

A7.3.2.3. History of abnormal labyrinthine function, unexplained or recurrent vertigo.

A7.3.2.4. Surgical repair of perforated tympanic membrane within the last 120 calendar days.

A7.4. Hearing, Flying Class II and III. Hearing loss greater than H-1 profile or asymmetric hearing loss requires work-up by an audiologist (audiology evaluation for initial waiver and waiver renewals must have been accomplished within 12 months of submission to waiver authority). Waivers are required for H-3 hearing loss or greater. Indefinite waivers are not authorized.

A7.4.1. H-2 profile alone does not require waiver. However, an evaluation **sufficient to rule-out conductive or retrocochlear pathology** should be conducted. This includes full audiologic evaluation and, where appropriate, referral for ENT consultation. Referral to ENT may be at the discretion of the audiologist or referring facility. Restriction from flying is not required during work-up.

A7.4.2. H-3 profile requires waiver.

A7.4.2.1. For members with new H-3 profiles (i.e., those whose hearing has recently changed to H-3, and who have not been previously worked-up), restriction from flying is appropriate.

NOTE:

*Members with long-standing, stable H-3 not previously evaluated, require work-up and waiver, but need not be restricted from flying, unless in the opinion of the flight surgeon they represent a danger to flying safety.

A7.4.2.2. Interim waiver may be granted by MAJCOM/SG after determination of acceptable hearing proficiency (occupational aircrew hearing assessment), pending complete audiology evaluation (indefinite waivers are not authorized).

A7.4.2.3. Validate hearing proficiency in one of two ways prior to issuance of medical waiver for H-3 profile:

A7.4.2.3.1. Inflight hearing test as described in SAM TR73-29

A7.4.2.3.2. Written validation, signed by the flying squadron commander or operations officer, of the adequacy of the member's hearing to perform safely in assigned aircrew duties in the flying environment.

A7.4.2.4. Waiver is contingent upon complete audiologic and where appropriate, ENT evaluation.

NOTE:

* The audiologist must rule out conductive and retrocochlear disease. The audiologist may defer ENT evaluation.

A7.4.2.5. The occupational aircrew hearing assessment is deferred for inactive flyers. They may receive a Flying Class IIC waiver specifying the completion of the occupational aircrew hearing assessment before return to active flying.

A7.4.3. Asymmetric hearing loss (greater than, or equal to, 25dB difference, comparing left and right ear, at any two consecutive frequencies) requires full audiological work-up with further clinical evaluation as indicated, and requires a waiver (indefinite waivers are not authorized). Restriction from flying is not required during work-up.

A7.4.4. The following tests are suggested as a complete audiologic evaluation:

A7.4.4.1. Pure tone air and bone conduction thresholds.

A7.4.4.2. Speech reception thresholds.

A7.4.4.3. Speech discrimination testing, to include high intensity discrimination.

A7.4.4.4. Immittance audiometry.

A7.4.4.5. Tympanograms.

A7.4.4.6. Ipsilateral and contralateral acoustic reflexes (levels not exceeding 110 dB HL).

A7.4.4.7. Acoustic reflex decay (500 and 1000 Hz, with levels not exceeding 110 dB HL).

A7.4.4.8. Otoacoustic emissions (transient evoked or distortion product).

A7.4.5. The following tests may be required if indicated by the above:

A7.4.5.1. Auditory brainstem response.

A7.4.5.2. MRI.

NOTE:

*Audiology reevaluation is required for waiver renewals if a shift of greater than 10dB is noted from the "initial" audiology evaluation used for the initial waiver in any one frequency from 1,000 Hz to 4,000 Hz. Additionally, audiology evaluations submitted to the waiver authority must have been accomplished within 12 months. These rules apply to all hearing waivers.

A7.5. Dental.

A7.5.1. Flying Classes II and III.

A7.5.1.1. Personnel wearing orthodontic appliances need not have appliances removed for physical qualification. After consultation with the treating orthodontist, the local flight surgeon may qualify the individual for flying duties if there is no effect on speech or the ability to wear equipment with comfort.

A7.5.1.2. Severe malocclusion which interferes with normal mastication or requires protracted treatment.

A7.5.1.3. Diseases of the jaw or associated structures such as cysts, tumors, chronic infections, and severe periodontal conditions which could interfere with normal mastication, until adequately treated.

A7.5.1.4. Aircrew members in Dental Class III or who have a significant dental defect which may be expected to cause a dental emergency during flight will be grounded. ARC members are managed IAW paragraph **14.14.1.** of this instruction.

A7.5.2. Classes I and IA. In addition to the above:

A7.5.2.1. Dental defects such as carious teeth, malformed teeth, defective restorations, or defective prosthesis, until corrected.

A7.5.2.2. Anticipated or ongoing treatment with fixed orthodontic appliances.

A7.6. Eye, Flying Classes I, IA, II, and III.

A7.6.1. Lids/Adnexa.

A7.6.1.1. Any condition of the eyelids which impairs normal eyelid function or comfort or potentially threatens visual performance.

A7.6.1.2. Epithora, nasolacrimal duct obstruction.

A7.6.1.3. Ptosis, any, except benign etiologies which are not progressive and do not interfere with vision in any field of gaze or direction.

A7.6.1.4. Dacryocystitis, acute or chronic.

A7.6.1.4.1. Dacryostenosis

A7.6.2. Conjunctiva.

A7.6.2.1. Conjunctivitis, chronic, seasonal.

A7.6.2.2. Trachoma, unless healed without scarring.

A7.6.2.3. Xerophthalmia.

A7.6.2.4. Pterygium which encroaches on the cornea more than 1mm or interferes with vision, or is progressive, or causes refractive problems

A7.6.3. Cornea.

A7.6.3.1. Keratitis, chronic or acute, including history of.

A7.6.3.2. Corneal ulcer of any kind, including history of recurrent corneal ulcers or recurrent corneal erosions.

A7.6.3.3. Vascularization or opacification of the cornea, from any cause, when it is progressive, interferes with vision or causes refractive problems.

A7.6.3.4. History of traumatic corneal laceration unless it does not interfere with vision, nor is likely to progress.

A7.6.3.5. Corneal dystrophy of any type, including keratoconus of any degree.

NOTE:

*UPT Applicants who demonstrate a topographical pattern suggestive of keratoconus, referred to as TPSK, but who do not have any other clinical signs of keratoconus, may be eligible for waiver. However, these members must have been processed through EFS-Medical for eligibility. Test results from outside agencies, or civilian sources do not qualify. Members identified with TPSK may be waivered into the ACS TPSK Study/Management Group, only after evaluation by the ACS. Members identified with TPSK will be informed that their participation in this study group is mandatory for consideration of waiverability into UFT and continued flying. Reevaluation periodically at the ACS will be required for waiver renewal.

A7.6.3.6. History of radial keratotomy (RK) or any other surgical or laser procedure, such as photorefractive keratectomy (PRK) and laser in situ keratomileusis (LASIK) accomplished to modify the refractive power of the cornea or for any other reason, such as phototherapeutic keratectomy (PTK), are not waiverable.

A7.6.3.7. Orthokeratology, active or a history of within six months of application to UFT**.**

A7.6.3.8. Lamellar or penetrating keratoplasty (corneal transplant).

A7.6.4. Uveal Tract. Acute, chronic or recurrent inflammation of the uveal tract (iris, ciliary body, or choroid), except for healed traumatic iritis.

A7.6.5. Retina/Vitreous.

A7.6.5.1. Retinal detachment and history of same.

A7.6.5.2. Degenerations and dystrophies of the retina including retinoschisis and all types of central and peripheral pigmentary degenerations.

A7.6.5.3. Degenerations and dystrophies of the macula, macular cysts, and holes.

A7.6.5.4. Retinitis, chorioretinitis, or other inflammatory conditions of the retina, unless single episode which has healed, is expected not to recur, and does not impair central or peripheral vision.

A7.6.5.5. Angiomatoses, phakomatoses, retinal cysts and other conditions which impair or may impair vision.

A7.6.5.6. Hemorrhages, exudates or other retinal vascular disturbances.

A7.6.5.7. Vitreous opacities or disturbances which may cause loss of visual acuity.

A7.6.6. Optic Nerve.

A7.6.6.1. Congenito-hereditary conditions that interfere or may interfere with central or peripheral vision.

A7.6.6.2. Optic neuritis, of any kind, including retrobulbar neuritis, papillitis, neuroretinitis, or a documented history of same.

A7.6.6.3. Papilledema.

A7.6.6.4. Optic atrophy (primary or secondary) or optic pallor.

A7.6.6.5. Optic nerve cupping greater than 0.4 or an asymmetry between the cups of greater than 0.2.

A7.6.6.6. Optic neuropathy.

A7.6.7. Lens.

A7.6.7.1. Aphakia, unilateral or bilateral.

A7.6.7.2. Dislocation of a lens, partial or complete.

A7.6.7.3. Opacities or irregularities of the lens which interfere with vision or are considered to be progressive.

A7.6.7.4. Pseudophakia (intraocular lens implant).

A7.6.7.5. Posterior capsular opacification.

A7.6.8. Other Defects and Disorders.

A7.6.8.1. Asthenopia, if severe.

A7.6.8.2. Exophthalmos, unilateral or bilateral.

A7.6.8.3. Nystagmus of any type, except on versional end points.

A7.6.8.4. Diplopia in any field of gaze, either constant or intermittent, including history of

A7.6.8.5. Visual field defects, any type, including hemianopsia.

A7.6.8.6. Abnormal pupils or loss of normal pupillary reflexes, with the exception of physiological anisocoria.

A7.6.8.7. Retained intraocular foreign body.

A7.6.8.8. Absence of an eye.

A7.6.8.9. Anophthalmos or microphthalmus.

A7.6.8.10. Any traumatic, organic, or congenital disorder of the eye or adnexa, not specified above, which threatens to intermittently or permanently impair visual function.

A7.6.8.11. Migraine or its variants, to include acephalgic migraine (See paragraph **A7.23.**).

A7.6.8.12. History of any ocular surgery to include lasers of any type.

A7.7. Vision and Refraction.

Table A7.1. Vision and Refractive Error Standards.

	Vision Limits for Each Eye				Refraction Limits			
Flying Class	**Distant Vision**		**Near Vision**		**Any Meridian**	**Astig-matism**	**Aniso-metropia**	**Contact Lenses** Notes5,6,7,13
	Uncorr	Corrected	Uncorr	Corrected				
I Notes 2,10,12,13	20/70	20/20	20/20	-	+2.00 -1.50	1.50	2.00	Note 1
IA Note 2,10,12,13	20/200	20/20	20/40	20/20	+3.00 -2.75	2.00	2.50	Note 1
II (Pilot) Note 13	20/400	20/20 Note 3,11	-	20/20 Notes:3,9	+3.50 -4.00	2.00	2.50 Note 4	
II/III Note 13	20/400	20/20 Note 3,12	-	20/20 Notes: 3, 9	+5.50 -5.50 Note 8	3.00	3.50 Note 4	

NOTES:

1. Use of hard, rigid, or gas permeable (hard) contact lenses within 3 months before the examination or soft contact lenses 1 month before examination is prohibited. Document SF 88 appropriately to ensure this requirement has been met.
2. These medical standards apply for USAFA, AFROTC cadets at the time of AF commissioning physical, AF active duty members, civilian applicants for flying training, and applicants from the Reserve and Guard components during the initial flying physical.
3. Individuals found on routine examination to be 20/20 in one eye and 20/25 in the other but correctable to 20/20 in each eye may continue flying until the appropriate corrective lenses arrive. These lenses must be ordered by the most expeditious means. **Be advised that this policy should only be used if the condition does not cause acute change in stereopsis performance (i.e., failure of depth perception screening tests).**
4. Anisometropias greater than Flying Class II or III standards may be considered for waiver if the OVT (or VTA) stereopsis is normal and the aviator has no asthenopic symptoms due to poor fusional control, or diplopia.
5. Complex refractive errors that can be corrected only by contact lenses are disqualifying.
6. All aircrew members are prohibited from using contact lenses for treatment of medical conditions unless they have been specifically prescribed and issued or approved by the ACS.
7. Optional wear of contact lenses for aircrew members is outlined in **Attachment 17**.
8. Waivers may only be considered after the individual has a normal ophthalmological examination to include a dilated fundus exam and possesses plastic lens spectacles which correct them to 20/20 in each eye and meets the USAF standards for approved commercially obtained spectacles for aircrew duties (see **Attachment 17**.7).
9. Actively flying personnel should be corrected to 20/20 at the nearest cockpit working distance.

10. The Air Force Chief of Staff retains Exception To Policy (ETP) authority for vision and refractive limits for UFT applicants.
11. Flying Class II aviators should be refracted to their best corrected visual acuity. Use of spectacles to correct to better than 20/20 is at the discretion of the crewmember.
12. For qualification purposes, cycloplegic refraction readings should be recorded for that required to read the 20/20 line in each eye. However, continue refraction to best visual acuity and report the best achievable corrected visual acuity as a clinical baseline. (Thus, acuity and refractive error numbers may not correlate). Cycloplegic refractions that cannot achieve the 20/20 line will need clinical evaluation or re-evaluation.
13. Crewmembers who wear corrective spectacles or contact lenses must carry a spare set of clear prescription spectacles on their person while performing aircrew duties, see AFI 11-206, paragraph 6.3.3. Additionally, only 15 percent (N-15) transmittance neutral density gray spectacle lenses are approved for flying duty, see AFR 167-3, para 2-4d. Consult other guidance, such as AFMOA or MAJCOM policy letters pertaining to aircrew spectacles.

A7.8. Heterophoria and Heterotropia.

A7.8.1. Flying Class III except InFlight Refuelers.

A7.8.1.1. Esophoria greater than 15 prism diopters.

A7.8.1.2. Exophoria greater than 8 prism diopters.

A7.8.1.3. Hyperphoria greater than 2 prism diopters.

A7.8.1.4. Heterotropia greater than 15 prism diopters.

A7.8.2. Flying Class I, IA, II, Inflight Refuelers and individuals required to perform scanner duties.

A7.8.2.1. Esophoria greater than 10 prism diopters.

A7.8.2.2. Exophoria greater than 6 prism diopters.

A7.8.2.3. Hyperphoria greater than 1.5 prism diopters.

A7.8.2.4. Heterotropia, including microtropias.

A7.8.2.5. Point of convergence (PC) greater than 100mm.

NOTE:

*Accomplish and record PC measurements only at the time of initial flying class I, IA, II-Flight Surgeon, and III - Inflight Refueler applicant exams. The PC is no longer required on periodic examinations.

A7.8.2.6. History of extraocular muscle surgery is cause for complete evaluation of ocular motility by a competent eye care professional to look for residual heterophorias, heterotropias (including microtropias), and motor sensory problems.

NOTE:

*The evaluation must include all of the motility tests listed in **A7.11.** Further processing of such cases will proceed in accordance with **A7.11.** as well.

A7.9. Near Point of Accommodation.

A7.9.1. Flying Classes II and III. No standards.

A7.9.2. Flying Classes I and IA. Near point of accommodation less than minimum for age specified in **Attachment 11**.

A7.10. Color Vision, Classes I, IA, II and III . Color vision testing must be performed monocularly under an approved and standardized illuminant (i.e., Illuminant C). Five or more incorrect responses in either eye (including failure to make responses in the allowed time interval) in reading the 14 test plates versions of one of the following Pseudoisochromatic Plate (PIP) sets is considered a failure: Dvorine, the original version of the AO (excludes Richmond PIP version), or Ishihara (record responses as correct/ total).

NOTE:

*No other PIP versions, such as the Richmond PIP, or Beck Engraving versions, or other tests for color vision are authorized for qualification purposes. Also note that the Farnsworth Lantern (FALANT) has been dropped as an USAF qualifying test.

A7.10.1. Flying Class I/IA/II/III: Must possess normal color vision as demonstrated by passing the approved PIP.

A7.10.2. Flying Class II-Flight Surgeon Applicants: Same as above.

NOTE:

*FS applicants with mild color vision defects may be considered for a FCIIA waiver. FCIIA waiver authority is delegated to HQ AETC/SG. Controversial cases will be referred to AFMOA/SGOA. See **Attachment 10**, Certification & Waiver Authority.

A7.11. Depth Perception/Stereopsis.

A7.11.1. Flying Class III (other than Inflight Refuelers and individuals required to perform scanner duties). No standard.

A7.11.2. Flying Class I, IA, II-Flight Surgeon Applicant and III-Inflight Refueler Applicants and individuals required to perform scanner duties. Failure of the Vision Test Apparatus (VTA-DP) or its newer replacement, the Optec Vision Tester (OVT), screening depth perception test with uncorrected refractive errors should be retested with refraction correction in place, regardless of level of unaided visual acuity. Failure even with correction is disqualifying, but may be considered for waiver consideration by higher waiver authorities, only after completion of a full evaluation by an ophthalmologist or optometrist, to include **all** of the following: ductions, versions, cover test and alternate cover test in primary and 6 cardinal positions of gaze, AO Vectograph Stereopsis Test at 6 meters (4 line version), AO Suppression Test at 6 meters, Randot or Titmus Stereopsis Test, Red Lens Test, and 4 Diopter Base out Prism Test at 6 meters. These tests are designed to identify and characterize motility/alignment disorders, especially microtropias and monofixation syndrome. The results of these tests done locally are considered to be preliminary, but will be used by waiver authorities to determine whether a candidate should be permanently disqualified without any waiver consideration, to identify if there are potentially correctable causes, and to determine whether further evaluation is required.

NOTE:

*A prospective Undergraduate Flying Training (UFT) Microtropia Study/Management Group is established at the ACS with minimally defective stereopsis secondary to monofixation syndrome or microstrabismus that are considered appropriate for waiver consideration. Potential Study Group members must meet the criteria established by the ACS to be eligible for this Study/Management Group. All potential candidates must be evaluated at the ACS Ophthalmology Branch if recommended and approved by HQ AETC/SGPS. AETC/SGPS is the waiver authority.

A7.11.3. Flying Class II and III-Inflight Refuelers and individuals required to perform scanner duties. A new failure of the VTA-DP or OVT requires evaluation by an ophthalmologist or optometrist to determine the cause of the failure and to rule out correctable causes, i.e., refractive error and anisometropia. If any new failure still is unable to pass the VTA or OVT with proper optical correction, then all of the motility tests listed above under Flying Class I in **A7.11.** must be accomplished as a prerequisite for any further waiver consideration.

A7.11.4. If the aviator has previously failed the VTA or OVT, and has previously been evaluated, and has either, normal motility or a stable previously known waivered motility disorder, and can pass another stereopsis test, such as the Verhoeff, Titmus, Randot, or Howard Dolman, no further work-up or waiver is required. However, such cases should already have been granted an initial waiver for this consideration. If not, a waiver is required.

NOTE:

*If the local flight surgeon feels that the degree of depth perception may not be compatible with the present aircraft or duties of assignment, further work-up and waiver will be required. Consultation at the ACS is indicated for any rated aircrew member with defective, questionable or change in stereopsis or depth perception or a significant change in the level of stereopsis performance.

A7.12. Field of Vision.

A7.12.1. Flying Classes I, IA, II and III.

A7.12.1.1. Contraction of the normal visual field in either eye to within 30 degrees of fixation in any meridian.

A7.12.1.2. Central scotoma, whether active or inactive, including transitory migraine related or any other central scotoma which is due to active pathological process.

A7.12.1.3. Any peripheral scotoma, other than physiologic.

A7.13. Night Vision, Flying Classes I, IA, II, and III. Unsatisfactory night vision as determined by history for initial flying. In trained aviators, this history is confirmed by the appropriate electrophysiological tests requested by the Aeromedical Consultation Service ophthalmologists. Dark field and empty field myopia due to accommodation are normal physiologic responses.

A7.14. Red Lens Test.

A7.14.1. Flying Classes II and III (except Inflight Refuelers). No standards.

A7.14.2. Flying Classes I and IA and Inflight Refuelers and individuals required to perform scanner duties. Any diplopia or suppression during the Red Lens Test which develops within 20 inches of the center of the screen (30 degrees) is considered a failure. Complete evaluation of ocular motility/alignment by a qualified ophthalmologist or optometrist is required as a prerequisite for higher waiver authorities to determine if ACS evaluation is required.

NOTE:

*See paragraph **A7.11.**

A7.15. Intraocular Pressure, Flying Classes I, IA, II, and III.

A7.15.1. Glaucoma. As evidenced by intraocular pressures of 30 mmHg or greater, or the secondary changes in the optic disc or visual field associated with glaucoma. Trained aircrew with glaucoma require consultation (review or evaluation) with the ACS prior to waiver consideration.

NOTE:

*Pigmentary dispersion syndrome (PDS) is not medically disqualifying for flying (includes Initial Flying Classes) unless associated with elevated intraocular pressures above 22 mmHg. PDS with elevated IOP, referred to as Pigmentary Glaucoma Suspect, (PGS) requires local ophthalmology evaluation. A confirmed diagnosis of Pigmentary Glaucoma Suspect (PGS) is disqualifying for all initial Flying Classes. Trained aircrew with PGS require consultation (review or evaluation) with the ACS prior to waiver consideration.

A7.15.2. Ocular hypertension (Preglaucoma). Two or more determinations of 22 mmHg or greater, but less than 30 mmHg, or 4 mmHg or more difference between the two eyes. (See paragraph **16.5.**).

NOTE:

*Abnormal pressures obtained by a noncontact (air puff) tonometer or Schiotz must be verified by applanation.

A7.16. Lungs and Chest Wall.

A7.16.1. Flying Classes II and III.

A7.16.1.1. Pulmonary tuberculosis, including tuberculous pleuritis or pleurisy of unknown etiology with positive tuberculin test.

A7.16.1.2. History of spontaneous pneumothorax. A single episode of spontaneous pneumothorax does not require waiver if PA inspiratory and expiratory chest radiograph and thin-cut CT-scan show full expansion of the lung and no demonstrable pathology which would predispose to recurrence.

A7.16.1.3. Pulmonary blebs or bullae, unless corrected by surgical treatment, recovery is complete, and pulmonary function tests are normal.

A7.16.1.4. Bronchiectasis, unless corrected by surgical treatment, recovery is complete, and pulmonary function tests are normal.

A7.16.1.5. Sarcoidosis.

A7.16.1.6. Pleural effusion.

A7.16.1.7. Empyema, residual sacculation or unhealed sinuses of the chest wall following surgery for empyema.

A7.16.1.8. Chronic bronchitis if pulmonary function is impaired to such a degree as to interfere with duty performance or to restrict activities.

A7.16.1.9. Asthma of any degree, or a history of asthma, reactive airway disease, intrinsic or extrinsic bronchial asthma, exercise-induced bronchospasm, or IgE (Immunoglobulin E) mediated asthma.

A7.16.1.10. Bullous or generalized pulmonary emphysema, demonstrated by pulmonary function tests.

A7.16.1.11. Cystic disease of the lung.

A7.16.1.12. Silicosis or extensive pulmonary fibrosis with functional impairment or abnormal pulmonary function tests.

A7.16.1.13. History of lung abscess.

A7.16.1.14. Chronic mycotic infection of the lung. Residuals of infection, including cavitation, except for scattered nodular parenchymal and hilar calcifications.

A7.16.1.15. Foreign body in the trachea, bronchus, lung, or chest wall.

A7.16.1.16. Chronic adhesive (fibrous) pleuritis of sufficient extent to interfere with pulmonary function and exercise tolerance.

A7.16.1.17. History of bi-lobectomy, lobectomy or multiple segmental resections if there is significant reduction of vital capacity, timed vital capacity, or maximum breathing capacity, or if there is residual pulmonary pathology.

A7.16.1.18. Suppurative periostitis, osteomyelitis, caries, or necrosis of the ribs, sternum, clavicle, scapulae, or vertebrae.

A7.16.1.19. Congenital malformation or acquired deformities which reduce the chest capacity or diminish respiratory or cardiac functions to a degree which interferes with vigorous physical exertion or produce disfigurement when the examinee is dressed.

A7.16.1.20. Chronic cystic mastitis.

A7.16.1.21. History of pulmonary embolus.

A7.16.1.22. Silicone implants, injections, or saline inflated implants in breasts for cosmetic purposes. See paragraph **A3.12.**

A7.16.1.23. Sleep apnea and other clinical sleep disorders.

A7.16.2. Flying Classes I and IA. In addition to the above:

A7.16.2.1. History of spontaneous pneumothorax. A single episode may be considered for waiver after 3 years if pulmonary evaluation shows complete recovery with full expansion of the lung and no demonstrable pathology that would predispose to recurrence.

A7.16.2.2. Chronic adhesive pleuritis which produces any findings except minimal blunting of the costophrenic angles.

A7.16.2.3. History of sarcoidosis.

A7.17. Cardiovascular System.

A7.17.1. Flying Classes II and III.

A7.17.1.1. History of cardiac surgery.

A7.17.1.2. Heart pump failure, regardless of cause.

A7.17.1.3. Hypertrophy or dilatation of the heart verified by echocardiogram, unless evaluation demonstrates it to be normal physiological response to athletic conditioning.

A7.17.1.4. Persistent tachycardia with a resting pulse rate of more than 100.

A7.17.1.5. Elevated blood pressure (measured in the sitting position) as follows:

A7.17.1.5.1. In applicants for flying training or initial flying duty, evidenced by average systolic pressure greater than 140 mmHg, or average diastolic pressure of greater than 90 mmHg obtained from the 5-day blood pressure check.

A7.17.1.5.2. History of elevated blood pressure requiring chronic medication for control.

A7.17.1.5.3. In trained flying personnel evidenced by:

A7.17.1.5.3.1. Average systolic blood pressure greater than 140 mmHg or average diastolic blood pressure greater than 90 mmHg.

NOTE:

*Asymptomatic personnel with average systolic blood pressure ranging between 141 mmHg and 160 mmHg, or average diastolic blood pressure ranging between 91 mmHg and 100 mmHg, may remain on flying status for up to 6 months (from the date the elevated blood pressure was first identified) while undergoing non-pharmacological intervention to achieve acceptable values.

A7.17.1.5.3.2. Any elevation in blood pressure due to secondary metabolic or pathologic causes until the underlying cause has been corrected, provided the primary condition is not disqualifying.

A7.17.1.5.4. Orthostatic or symptomatic hypotension or recurrent vasodepressor syncope.

A7.17.1.5.5. Pericarditis, myocarditis, or endocarditis, or history of these conditions.

A7.17.1.5.6. Any significant congenital abnormalities of the heart and vessels, unless corrected by surgery without residuals or complications. A minimum recovery period of 6 months following surgery is mandatory before waiver is considered together with repeat studies including invasive testing as applicable, demonstrating functional correction. Uncomplicated dextrocardia and minor atrial and ventricular septal defects may be acceptable without surgical correction.

A7.17.1.5.7. Acute rheumatic fever; a verified history of rheumatic fever or chorea within the previous 2 years; recurrent attacks of rheumatic fever or chorea at any time; evidence of residual cardiac damage.

A7.17.1.5.8. Coronary artery disease, symptomatic or asymptomatic. History of myocardial ischemia. Coronary artery disease strongly suspected by symptoms or tests for myocardial ischemia or infarction unless ruled out by angiography (other definitive evaluation of coronary patency and function will be considered on a case-by-case basis). History of coronary artery surgery or other intervention is generally not waiverable, but will be reviewed by ACS on request of MAJCOM/ SGPA or AFMOA/SGOA.

A7.17.1.5.9. History of symptomatic major dysrhythmia. Asymptomatic major dysrhythmias require ACS review. Major dysrhythmias include supraventricular tachycardia, atrial flutter or fibrillation, ventricular tachycardia or fibrillation, and asystole.

A7.17.1.5.10. Verified history of major electrocardiographic conduction defects, such as Mobitz II second-degree A-V block, third degree A-V block, Wolff-Parkinson-White (WPW) syndrome, or Lown-Ganong-Levin (LGL) syndrome. W-P-W pattern may be waiverable if ACS evaluation reveals no dysrhythmias; either WPW or LGL syndrome may be waiverable if corrected.

A7.17.1.5.11. Left anterior and posterior fascicular block and left bundle branch block may be considered for waiver if ACS evaluation reveals no underlying disease.

A7.17.1.5.12. Right bundle branch block may be waiverable after local cardiologic evaluation.

A7.17.1.6. History of valvular heart disease to include pulmonic, mitral, and tricuspid valvular regurgitation greater than mild, aortic regurgitation greater than trace, and any degree of valvular stenosis. Mitral valve prolapse (MVP) and bicuspid aortic valve are also medically disqualifying.

A7.17.1.7. Resting ECG findings considered to be "borderline," or known to be serial changes from previous records unless a cardiac evaluation as directed by the ECG Library reveals no underlying disease. Refer to ACS “Disposition for ECG findings.”

A7.17.1.8. All electrocardiographic tracings read as abnormal. Waiver is not considered until evaluation recommended by ACS has been completed.

A7.17.1.9. Borderline or abnormal noninvasive cardiac studies.

NOTE:

*For rated officers, copies of any study, i.e., ECG, holter monitor, thallium scan, ETT-TM, or echocardiogram video tape MUST be forwarded to the ECG Library, Brooks AFB TX for review.

A7.17.1.10. History of recurrent thrombophlebitis or thrombophlebitis with persistent thrombus, evidence of circulatory obstruction, or deep venous incompetence in the involved veins.

A7.17.1.11. Varicose veins with complications or if more than mild.

A7.17.1.12. Peripheral vascular disease, including Raynaud's disease, thromboangiitis obliterans, erythromelalgia, arteriosclerotic, or diabetic vascular disease.

A7.17.1.13. Aneurysm of any vessel or history of correction by surgery.

A7.17.1.14. Syphilitic heart disease.

A7.17.1.15. History of significant traumatic heart disease.

A7.17.1.16. Hypersensitive carotid sinus.

A7.17.1.17. Arteritis of any artery.

A7.17.1.18. Inadequate arterial blood supply to any extremity.

A7.17.1.19. Vasculitis.

A7.17.2. Flying Classes I and IA. **In addition to the above:**

A7.17.2.1. Wolff-Parkinson-White electrocardiographic pattern; may be waiverable for flying training if corrected.

A7.17.2.2. Any major vascular synthetic graft.

A7.17.2.3. Elevated blood pressure (see **A7.17.** above).

A7.18. Blood, Blood-Forming Tissue, and Immune System Diseases. Flying Classes I, IA, II and III:

A7.18.1. Anemia of any etiology. Hematocrit values less than 38 for men or 36 for women should be evaluated; decreasing hematocrit values, even if in the normal range, may also be an indication for workup. Waiver for trained aircrew is permissable for stable anemia not due to an otherwise disqualifying condition, as long as the hematocrit does not fall below 32 percent.

A7.18.2. Loss of 200 cc or more of blood is disqualifying for at least 72 hours. Platelet pheresis is disqualifying for 72 hours.

A7.18.3. Polycythemia; a hematocrit above 50 in men, or above 47 in women, should be evaluated. Waiver is not favorably considered if the hematocrit is above 55 percent.

A7.18.4. Hemoglobinopathies and thalassemias.

A7.18.4.1. Homozygous hemoglobin abnormalities.

A7.18.4.2. Sickle cell disease or heterozygous sickling disorders other than sickle cell trait.

A7.18.4.3. Sickle cell trait if the individual has a history of symptoms associated with a sickling disorder or symptomology attributable to intravascular sickling during decompression in an altitude chamber. Review and certification by proper authority (see **Attachment 9**) is required for all aircrew members with sickle cell trait after evaluation as outlined in paragraph **16.7.**

A7.18.5. Hemorrhagic states and thromboembolic disease:

A7.18.5.1. Coagulopathies.

A7.18.5.2. Thromboembolic disease, except for acute, non-recurrent conditions.

A7.18.5.3. Thrombocytopenia or thrombocytosis. Platelet counts less than 100,000/mm^3 or greater than 400,000 mm^3 should be evaluated. Thrombocytosis greater than 750,000/mm^3 is not waiverable.

A7.18.5.4. Platelet dysfunctions.

A7.18.6. Leukopenia (granulocytopenia). White blood cell counts should fall within the range of 3,500 to 12,000 cells/mm^3--counts in the range of 750 to 3500 cells/mm^3 should be fully evaluated. Granulocyte counts of less than 750 cells/mm^3 are not waiverable.

A7.18.7. All leukemias and other myeloproliferative disorders.

A7.18.8. All lymphomas including mycosis fungoides and Sezary syndrome.

A7.18.9. Plasma cell dyscrasias.

A7.18.9.1. Multiple myeloma.

A7.18.9.2. Macroglobulinemia.

A7.18.10. Immunodeficiency syndromes, primary or acquired. Confirmed presence of Human Immunodeficiency Virus (HIV) or antibody. AFMOA/SGOA retains waiver authority for all flying classes.

A7.18.11. Generalized lymphadenopathy or splenomegaly until the cause is corrected.

A7.19. Abdomen and Gastrointestinal System.

A7.19.1. Flying Classes II and III.

A7.19.1.1. Gastrointestinal hemorrhage or history of, regardless of cause. Waiver may be considered for any condition that is clearly attributable to a specific, nonpersistent cause.

A7.19.1.2. Peptic ulcer disease, active or refractory.

A7.19.1.3. Peptic ulcer complicated by hemorrhage, obstruction or perforation.

A7.19.1.4. Hernia other than small asymptomatic umbilical or hiatal.

A7.19.1.5. History of viral hepatitis, with carrier status, persistent transaminase elevation or evidence of chronic active or persistent hepatitis.

A7.19.1.6. Wounds, injuries, scars, or weakness of the muscles of the abdominal wall which are sufficient to interfere with function.

A7.19.1.7. Sinus or fistula of the abdominal wall.

A7.19.1.8. Chronic or recurrent esophagitis including reflux esophagitis.

A7.19.1.9. Chronic gastritis.

A7.19.1.10. Congenital abnormalities of the bowel if symptomatic or requiring surgical treatment. History of intestinal obstruction if due to any chronic or recurrent disease. Surgery to relieve childhood pyloric stenosis or intussusception is not disqualifying if there is no residual dysfunction.

A7.19.1.11. Crohn's disease (regional enteritis).

A7.19.1.12. Malabsorption syndromes (see paragraph **A7.29.**).

A7.19.1.13. Irritable bowel syndrome.

A7.19.1.14. Ulcerative colitis or proctitis or verified history of same.

A7.19.1.15. Chronic diarrhea, regardless of cause.

A7.19.1.16. Megacolon.

A7.19.1.17. Diverticulitis, symptomatic diverticulosis, or symptomatic Meckel's diverticulum.

A7.19.1.18. Any chronic liver disease whether congenital or acquired. Marked enlargement of the liver from any cause. Hepatic cysts. Congenital hyperbilirubinemias, e.g. Gilbert's disease, do not require waiver if asymptomatic.

A7.19.1.19. Chronic cholecystitis.

A7.19.1.20. Cholelithiasis.

A7.19.1.21. Sphincter of oddi dysfunction or bile duct abnormalities or strictures.

A7.19.1.22. Pancreatitis or history of same.

A7.19.1.23. Congenital anomalies, disease of the spleen. Chronic enlargement of the spleen.

A7.19.1.24. Splenectomy, for any reason except the following:

A7.19.1.24.1. Trauma to an otherwise healthy spleen.

A7.19.1.24.2. Hereditary spherocytosis.

A7.19.1.25. History of gastroenterostomy, gastrointestinal bypass, stomach stapling, or surgery for relief of intestinal adhesions.

A7.19.1.26. Symptomatic esophageal motility disorders.

A7.19.1.27. History of partial resection of the large or small intestines for chronic or recurrent disease.

A7.19.2. Flying Class I and IA. See above.

A7.20. Perianal, Rectum, and Prostate, Flying Classes I, IA, II, and III.

A7.20.1. Proctitis, chronic or symptomatic.

A7.20.2. Stricture or prolapse of the rectum.

A7.20.3. Hemorrhoids which cause marked symptoms or internal hemorrhoids which hemorrhage or protrude intermittently or constantly until surgically corrected.

A7.20.4. Fecal incontinence.

A7.20.5. Anal fistula.

A7.20.6. Ischiorectal abscess.

A7.20.7. Chronic anal fissure.

A7.20.8. Symptomatic rectocele.

A7.20.9. Pilonidal cyst if there is a history of inflammation or discharging sinus in the 2 years preceding examination. Surgery for pilonidal cyst or sinus is disqualifying until the wound is healed, there are no referable symptoms, and no further treatment or medication is required.

A7.20.10. Chronic prostatitis, prostatic hypertrophy, with urinary retention or abscess of the prostate gland.

A7.21. Genitourinary System, Flying Class I, IA, II and III.

A7.21.1. History of recurrent or bilateral renal calculus. Uncomplicated single episode of renal calculus does not require waiver, but should be evaluated.

A7.21.2. Retained renal calculus. Retained calculus located in a papillary duct or any more distal portion of the collecting system may be considered for a flying Class IIA waiver.

A7.21.3. Proteinuria under normal activity (at least 48 hours post strenuous exercise) greater than 200 mg in 24 hours. Waiver may be considered for fixed and reproducible orthostatic proteinuria when the urinary protein to urinary creatinine ratio on a randomly collected urine (not first morning void) is less than or equal to 0.2. It is not necessary to collect a 24 hour urine specimen.

A7.21.4. Persistent or recurrent hematuria.

A7.21.5. Cylindruria, hemoglobinuria, or other findings indicative of significant renal disease.

A7.21.6. Chronic nephritis.

A7.21.7. Stricture of the urethra.

A7.21.8. Urinary fistula.

A7.21.9. Urinary incontinence.

A7.21.10. Absence of one kidney. Functional impairment of either or both kidneys.

A7.21.11. Horseshoe kidney.

A7.21.12. Chronic pyelitis or pyelonephritis.

A7.21.13. Renal ptosis (floating kidney) causing impaired renal drainage, hypertension or pain.

A7.21.14. Hydronephrosis or pyonephrosis.

A7.21.15. Polycystic kidney disease.

A7.21.16. Chronic cystitis.

A7.21.17. Amputation of the penis.

A7.21.18. Hermaphroditism.

A7.21.19. Epispadias or hypospadias with unsatisfactory surgical correction.

A7.21.20. Hydrocele, unless small and asymptomatic

A7.21.21. Large or painful left varicocele. Any right varicocele unless significant underlying pathology has been excluded.

A7.21.22. Undescended testicle. Absence of both testicles.

A7.21.23. Chronic orchitis or epididymitis.

A7.21.24. Urinary diversion.

A7.21.25. Major abnormalities and defects of the genitalia such as a change of sex, a history thereof, or complications (such as adhesions or disfiguring scars) residual to surgical correction of these conditions.

A7.22. Pelvic.

A7.22.1. Flying Classes II and III.

A7.22.1.1. Pregnancy or other symptomatic enlargement of the uterus due to any cause. Pregnancy waivers for trained flying personnel may be requested under the following guidelines: the request is voluntary and must be initiated by the crewmember with concurrence by the squadron commander, flight surgeon, and obstetrician. Physiological training is waived during pregnancy; flying is restricted to pressurized multi-crew, multi-engine, non-ejection seat aircraft; and crewmembers are released from all mobility commitments. The waiver is valid for the 13th through 24th week of gestation.

NOTE:

*Refer to AFRCI 48-101 for further guidance on unit assigned reservists.

A7.22.1.2. Chronic symptomatic vaginitis.

A7.22.1.3. Chronic salpingitis or oophoritis.

A7.22.1.4. Symptomatic uterine fibroids.

A7.22.1.5. Ovarian cysts.

A7.22.1.6. All symptomatic congenital abnormalities of the reproductive system.

A7.22.1.7. Dysmenorrhea, if incapacitating to a degree which necessitates recurrent absences of more than a few hours from routine duty.

A7.22.1.8. Gross irregularity of the menstrual cycle. Menorrhagia, metrorrhagia, polymenorrhea, or amenorrhea.

A7.22.1.9. Menopausal syndrome, either physiologic or surgical, if manifested by more than mild constitutional or psychological symptoms.

A7.22.1.10. Endometriosis, if symptomatic or controlled medically.

A7.22.1.11. Malposition of the uterus, if symptomatic.

A7.22.1.12. Vulvitis, chronic.

A7.22.2. Flying Class I and IA. In addition to above, history of endometriosis.

A7.23. Neurological Disorders.

A7.23.1. Flying Classes II and III.

A7.23.1.1. Infections of the CNS.

A7.23.1.2. Seizure of any type (grand mal, petit mal, focal, etc.).

A7.23.1.3. Disturbances of consciousness (not due to head injury).

A7.23.1.3.1. An isolated episode of neurocardiogenic syncope associated with venipunture or prolonged standing in the sun (or similar benign precipitating event) which is less than 1 minute in duration, without loss of continence, and followed by rapid and complete recovery without sequelae does not require waiver if thorough neurological and cardiovascular evaluation by a flight surgeon reveals no abnormalities.

A7.23.1.3.2. Physiological loss of consciousness (LOC) caused by reduced oxygen tension, general anesthesia, or other medically induced LOC (excluding vasovagal syncope) does not require waiver provided there is full recovery without sequelae.

A7.23.1.3.3. High G loss of consciousness (G-LOC) during a centrifuge run does not require waiver for continued flying duty unless there are neurologic sequelae or evidence that the G-LOC occurrence is associated with coexistant disease or anatomic abnormality. Inflight G-LOC caused by an improperly performed anti-G straining maneuver or a disconnect of the anti-G protective gear is not disqualifying and is managed as a physiological incident. The local flight surgeon completes appropriate post-incident medical evaluation and reports the incident according to applicable directives.

A7.23.1.3.4. All other loss or disturbance of consciousness. For rated personnel, waivers are considered by AFMOA/SGOA only after evaluation at ACS. For non-rated personnel, waiver is at MAJCOM discretion.

NOTE:

*Flying training applicants and students with a history of syncope evaluated according to **Table 16.1.** and certified acceptable for Flying Class I or IA by HQ AETC/SG do not require a waiver for flying Class II for the same history of syncope.

A7.23.1.4. History of any of the following types of headaches:

A7.23.1.4.1. Recurrent headaches of the vascular, migraine, or cluster (Horton's cephalgia or histamine headache) type.

A7.23.1.4.2. A single incapacitating headache of any type (e.g.,loss of consciousness, aphasia, ataxia, vertigo or mental confusion).

A7.23.1.4.3. Headache of any type which are of sufficient severity to likely interfere with flying duties.

A7.23.1.4.4. Acephalgic migraines.

NOTE:

*A waiver for migraines may be considered following one year of symptom free observation. Migrainous strokes and migraines complicated by neurological deficits other than transient visual changes are not waiverable.

A7.23.1.5. Electroencephalographic abnormalities.

A7.23.1.5.1. Truly epileptiform abnormalities to include generalized, lateralized, or focal spikes, sharp waves, spike-wave complexes, and sharp and slow wave complexes during alertness, drowsiness, or sleep are disqualifying. Benign transients such as Small Sharp Spikes (SSS) or Benign Epileptiform Transients of Sleep (BETS), wicket spikes, 6 Hertz (Hz) (phantom) spike and wave, rhythmic temporal theta of drowsiness (psychomotor variant), and 14 and 6Hz positive spikes are not disqualifying.

A7.23.1.5.2. Generalized, lateralized, or focal continuous polymorphic delta activity or intermittent rhythmic delta activity (FIRDA or OIRDA) during the alert state is disqualifying

unless the etiology of the abnormality has been identified and determined not to be a disqualifying disorder.

A7.23.1.6. History of head injury.

A7.23.1.6.1. Head injury associated with any of the following are not waiverable:

A7.23.1.6.1.1. Post-traumatic seizures. (Exception: seizures at the time of injury)

A7.23.1.6.1.2. Persistent neurological deficits indicative of significant parenchymal CNS injury, such as hemiparesis or hemianopsia.

A7.23.1.6.1.3. Evidence of impairment of higher intellectual functions or alterations of personality as a result of injury.

A7.23.1.6.1.4. Cerebrospinal fluid shunts.

A7.23.1.6.2. Severe head injury. Head trauma associated with any of the complications listed below may be considered for Flying Class II and III waiver in 5 years (see **Table 16.1.**).

A7.23.1.6.2.1. Unconsciousness or amnesia or the combination of the two equal to or exceeding 24 hours duration.

NOTE:

*In cases which are defined as severe only due to the duration of loss of consciousness or amnesia and are otherwise minimal, mild, or moderate, a waiver at 2 years may be considered if the evaluation requirements in **Table 16.1.** are met.

A7.23.1.6.2.2. Radiographic evidence of retained metallic or bony fragments.

A7.23.1.6.2.3. Leptomeningeal cysts, aerocele, brain abscess, or arteriovenous fistula.

A7.23.1.6.2.4. Depressed skull fracture (the inner table indented by more than the thickness of the skull) with or without dural penetration.

A7.23.1.6.2.5. Traumatic or surgical laceration or contusion of the dura mater or the brain, or a history of penetrating brain injury.

A7.23.1.6.2.6. Focal neurological signs.

A7.23.1.6.2.7. Epidural, subdural, subarachnoid, or intracerebral hematoma.

NOTE:

*A small epidural collection of blood found only on CT-scan or magnetic resonance imaging (MRI) and without evidence of parenchymal injury either on the imaging study or on neurological examination, followed to resolution without surgery, may be considered for flying class II or III waiver at two years as in the moderate head injury group.

A7.23.1.6.2.8. CNS infection such as abscess or meningitis within 6 months of head injury.

A7.23.1.6.2.9. Cerebrospinal fluid rhinorrhea or otorrhea persisting more than 7 calendar days.

A7.23.1.6.3. Moderate head injury. Head trauma associated with the below criteria may be considered for Flying Class II or III waiver in 2 years (see **Table 16.1.**).

A7.23.1.6.3.1. Unconsciousness for a period of 30 minutes or greater, but less than 24 hours.

A7.23.1.6.3.2. Amnesia for a period of 1 hour or greater but less than 24 hours. (Waiver contingent on a completely normal neurological and neuropsychological evaluation to include computerized tomography (CT) scan.)

*Exception: Waiver may be considered after 6 months of observation if a normal CT-scan was obtained within 2 calendar days of injury.

NOTE:

*In cases which are defined as moderate only due to the duration of loss of consciousness or amnesia and are otherwise minimal, mild, a waiver at 6 months may be considered if the evaluation requirements in **Table 16.1.** are met.

A7.23.1.6.4. Mild head injury. Head trauma which does not meet criteria for more severe injury may be considered for waiver after l month (see **Table 16.1.**).

A7.23.1.6.5. Head trauma with no loss of consciousness, amnesia, or abnormal findings on examination, does not require waiver.

A7.23.1.7. Persistent post-traumatic sequelae, as manifested by headache, vomiting, disorientation, spatial disequilibruim, personality changes, impaired memory, poor mental concentration, shortened attention span, dizziness, altered sleep patterns, or any findings consistent with organic brain syndrome are disqualifying, but may be considered for waiver when full recovery has been confirmed by complete neurological and neuropsychological evaluation.

A7.23.1.8. Craniotomy and skull defects.

A7.23.1.9. Neurosyphilis in any form (meningovascular, tabes dorsalis, or general paresis).

A7.23.1.10. Narcolepsy, cataplexy, and similar states.

A7.23.1.11. Injury of one or more peripheral nerves unless it is not expected to interfere with normal function in any practical manner.

A7.23.1.12. History of subarachnoid hemorrhage, embolism, vascular insufficiency, thrombosis, hemorrhage, arteriosclerosis, arteriovenous malformation, or aneurysm involving the CNS.

A7.23.1.13. History of tumor involving the brain or its coverings.

A7.23.1.14. Personal or family history of hereditary disturbances such as multiple neurofibromatosis, Huntington's chorea, hepatolenticular degeneration, acute intermittent porphyria, spinocerebellar ataxia, peroneal muscular atrophy, muscular dystrophy, and familial periodic paralysis.

A7.23.1.15. Probable evidence or history of degenerative or demyelinating process such as multiple sclerosis, dementia, basal ganglia disease, or Friedreich's ataxia.

A7.23.1.16. History or evidence of such defects as basilar invagination, hydrocephalus, premature closure of the cranial sutures, meningocele, and cerebral or cerebellar agenesis if there is evidence of impairment of normal functions or if the process is expected to be progressive.

A7.23.1.17. Verified history of neuritis, neuralgia, neuropathy, or radiculopathy, whatever the etiology, unless:

A7.23.1.17.1. The condition has completely subsided and the cause is determined to be of no future concern.

A7.23.1.17.2. There is no residual which could be deemed detrimental to normal function in any practical manner.

A7.23.1.18. Polyneuritis, whatever the etiology, unless:

A7.23.1.18.1. Limited to a single episode.

A7.23.1.18.2. The acute state subsided at least 1 year before examination.

A7.23.1.18.3. There is no residual which could be expected to interfere with normal function in any practical manner.

A7.23.1.19. History or evidence of chronic or recurrent diseases, such as myasthenia gravis, polymyositis, or myotonia disorder.

A7.23.1.20. Evidence or history of involvement of the nervous system by a toxic, metabolic or disease process if there is any indication such involvement is likely to interfere with prolonged normal function in any practical manner or is progressive or recurrent, or if there is a significant neurological residual which would interfere with aviation duties.

A7.23.1.21. Tremors, chorea, dystonia or other movement disorders which could interfere with aviation or normal function.

A7.23.2. Flying Classes I and IA. In addition to the above, paroxysmal convulsive disorders. Seizures associated with febrile illness before 5 years of age may be acceptable with waiver if recent neurological evaluation, MRI, and electroencephalogram (EEG) including awake and sleep samples are normal.

A7.23.2.1. History of severe head injury is usually not waiverable and may not be considered until at least 10 years post injury.

A7.24. Psychiatric Disorders (Reference Diagnostic and Statistical Manual of Mental Disorders (DSM-IV)Fourth Edition, American Psychiatric Association)

A7.25. .

A7.25.1. Flying Classes II and III.

A7.25.1.1. Eating Disorders.

A7.25.1.2. Gender Identity Disorders.

A7.25.1.3. Mental Disorders due to a General Medical Condition.

A7.25.1.4. Delirium, Dementia, and Amnestic Disorders, and Other Cognitive Disorders.

A7.25.1.5. Alcohol Dependence or Abuse (DSM IV) or any disease the proximate cause of which is alcoholism. These conditions may be waived by MAJCOM/SG if the following conditions have been met:

A7.25.1.5.1. The MTF Alcohol & Drug Abuse Prevention & Treatment (ADAPT) Program treatment team determines that the individual has made satisfactory progress and has maintained abstinence without the aid of medications for a period of 6 months from the date of entering treatment.

NOTE:

*Any relapse (as determined by the treatment team) or use of medication to deter alcohol use resets the 6-month observation period for waiver consideration.

A7.25.1.5.2. In the opinion of the flight surgeon, privileged mental health provider, and flying unit commander, and based on the ADAPT program assessment, the individual has a low potential for recidivism and can be expected to remain stable under stress.

A7.25.1.5.3. The individual has no medical complications or sequelae due to past alcohol abuse or dependence.

A7.25.1.5.4. The individual states in writing that he or she understands the waiver is valid only if total abstinence from alcohol is maintained and that a verifiable break in abstinence once the waiver period has begun is considered medically disqualifying and not waiverable. This written statement by the individual must be accomplished at the initial waiver request and reaccomplished each time a request is submitted for renewal of the waiver, and is included with the waiver request. To ensure flying unit commanders are aware of the need to observe individuals with past alcohol problems, new commanders are briefed on those in their units with waivers for this condition when the individual changes assignment or there has been a change in command.

A7.25.1.5.5. All other drug abuse or use. These conditions are not waiverable.

A7.25.1.6. Schizophrenia and other Psychotic Disorders.

A7.25.1.7. Mood Disorders.

A7.25.1.7.1. Depressive disorders including major depression, dysthymia, cyclothymia, and depression not otherwise specified.

A7.25.1.7.2. Bipolar disorder.

A7.25.1.8. Anxiety Disorders. Non-phobic fear of flying is considered an administrative not medical problem.

A7.25.1.9. Somatoform Disorders.

A7.25.1.10. Dissociative Disorders.

A7.25.1.11. Sexual paraphilias are not medically disqualifying; however, individuals meeting diagnostic criteria are dealt with administratively.

A7.25.1.12. Sexual dysfunctions and sexual disorders not otherwise specified are not medically disqualifying unless in association with another Axis I disorder.

A7.25.1.13. Sleep disorders if of such magnitude to warrant somatic treatment greater than 30 days duration, or if associated with an Axis I disorder other than an adjustment disorder.

A7.25.1.14. Factitious Disorders.

A7.25.1.15. Impulse Control Disorders Not Elsewhere Classified.

A7.25.1.16. Adjustment Disorders of more than 60 days duration.

A7.25.1.17. Unsatisfactory adaptability rating for military aviation (ARMA) if maladaptive personality traits (not meeting diagnostic criteria for a personality disorder) or a pattern of maladaptive behavior is present that significantly interferes with safety of flight, crew coordination, or mission completion. Motivational issues are referred to administrative channels.

A7.25.1.18. Psychological Factors Affecting Medical Condition.

A7.25.1.19. Personality disorders are not medically disqualifying; however, if social and occupational, administrative or legal ramifications are operant, a psychiatric evaluation may be warranted to clarify suitability for future flying or other duty.

A7.25.1.20. History of attempted suicide or suicidal behavior.

A7.25.2. Flying Classes I and IA. In addition to the above:

A7.25.2.1. History of any of the above diagnoses excluding verifiable simple adjustment disorders not requiring hospitalization.

A7.25.2.2. History of schizophrenia or bipolar disorder in both parents.

A7.25.2.3. Unsatisfactory adaptability rating for military aviation.

A7.25.2.4. History of persistent learning disorder.

A7.25.2.5. Evidence of any condition causing serious chronic impairment of educational goals or chronic behavioral difficulties requiring hospitalization or prolonged treatment.

A7.26. Extremities, Flying Classes I, IA, II, and III.

A7.26.1. General Conditions.

A7.26.1.1. Arthritis of any type of more than minimal degree, which interferes with the ability to follow a physically active lifestyle, or may reasonably be expected to preclude the satisfactory performance of flying duties.

A7.26.1.2. Documented history or findings of rheumatoid arthritis.

A7.26.1.3. Active osteomyelitis or a verified history of osteomyelitis, unless inactive with no recurrence during the 2 years before examination, and without residual deformity sufficient to interfere with function.

A7.26.1.4. Osteoporosis.

A7.26.1.5. Osteochondromatosis or multiple cartilaginous exostoses.

A7.26.1.6. Disease or injury, or congenital anomaly of any bone or joint, with residual deformity, instability, pain, rigidity, or limitation of motion if function is impaired to such a degree it interferes with training, physically active lifestyle, or flying duties.

A7.26.1.7. Unreduced dislocation; substantiated history of recurrent dislocations or subluxations of a major joint if not satisfactorily corrected.

A7.26.1.8. Instability of a major joint if symptomatic and more than mild, or if subsequent to surgery there is evidence of instability, weakness, or significant atrophy.

A7.26.1.9. Malunited fractures which interfere significantly with function.

A7.26.1.10. Symptomatic nonunion of fractures.

A7.26.1.11. Any retained orthopedic fixation device, that interferes with function or easily subject to trauma.

A7.26.1.12. Muscular paralysis, paresis, contracture, or atrophy if progressive or of sufficient degree to interfere with the performance of flying duties.

A7.26.1.13. Demonstrable loose body in any joint (includes osteocartilaginous or metallic foreign objects).

A7.26.1.14. Synovitis with persistent swelling or limitation of motion.

A7.26.1.15. Osteonecrosis.

A7.26.1.16. Chondromalacia, if symptomatic or there is verified history of joint effusion, interference with function, or residuals from surgery.

A7.26.1.17. Joint replacement.

A7.26.1.18. Myotonia congenita.

A7.26.1.19. Scars, extensive, deep or adherent to the skin and soft tissues or neuromas of an extremity which are painful, interfere with movement, preclude the wearing of equipment, or show a tendency to breakdown.

A7.26.1.20. Symptomatic amputation stump (neuroma, bone spur, adherent scar or ulceration).

A7.26.2. Upper Extremity.

A7.26.2.1. Absence of any segment of the hand or digits.

A7.26.2.2. Resection of a joint other than that of a finger.

A7.26.2.3. Hyperdactylia.

A7.26.2.4. Scars and deformities of the fingers or hand which impair circulation, are symptomatic, or impair normal function to such a degree as to interfere with the satisfactory performance of flying duties.

A7.26.2.5. Healed disease or injury of the wrist, elbow or shoulder with residual weakness or symptoms of such a degree as to interfere with the satisfactory performance of flying duty. Grip strength of less than 75 percent of predicted normal when compared with the normal hand (non-dominant is 80 percent of dominant grip).

A7.26.2.6. Limitation of motion. Same as **A3.27.**

A7.26.3. Lower Extremity.

A7.26.3.1. Amputation or absence of any portion of the foot or lower extremity in excess of 1 of the 2nd through 5th toes.

A7.26.3.2. Clubfoot of any degree.

A7.26.3.3. Rigid or spastic flatfoot, Flatfoot, tarsal coalition.

A7.26.3.4. Weak foot with demonstrable eversion of the foot, valgus of the heel, or marked bulging of the inner border due to inward rotation of the talus regardless of the presence or absence of symptoms.

A7.26.3.5. Elevation of the longitudinal arch (pes cavus) if of enough degree to cause subluxation of the metatarsal heads and clawing of the toes. Obliteration of the transverse arch associated with permanent flexion of the small toes.

A7.26.3.6. Any condition, disease, or injury to feet or toes which results in disabling pain, distracting discomfort, inability to satisfactorily perform military aviation, or precludes wear of proper military footgear.

A7.26.3.7. Verified history of congenital dislocation of the hip, osteochondritis of the hip (Legg-Perthes disease), or slipped femoral epiphysis of the hip with X-ray evidence of residual deformity or degenerative changes.

A7.26.3.8. Verified history of hip dislocation within 2 years of examination or degenerative changes on X-ray from old hip dislocation.

A7.26.3.9. Difference in leg length of more than 2.5. cm (from anterior superior iliac spine to the distal tip of the medial malleolus).

A7.26.3.10. Weak Knee. Dislocation of semilunar cartilages or loose foreign bodies within the knee joint; residual instability of the knee ligaments; or significant atrophy or weakness of the thigh musculature in comparison with the normal side; or range of motion less than specified in **A3.27.**

; or other symptoms of internal derangement or a condition which would interfere with the performance of flying duties.

A7.26.3.11. Osteochondritis dessicans of the knee or ankle if there are X-ray changes.

A7.26.3.12. Osteochondritis of the tibial tuberosity (Osgood-Schlatter disease) if symptomatic or with obvious prominence of the part and X-ray evidence of separated bone fragments.

A7.26.3.13. Limitation of motion same as **A3.27.**

A7.26.3.14. Toes-stiffness which interferes with walking, marching, running, or jumping.

A7.27. Spine and Other Musculoskeletal.

A7.27.1. Flying Classes I and IA: Same as Attachment **A3.29.** and the following:

A7.27.1.1. Flying Classes II and III.

A7.27.1.1.1. History of disease or injury of the spine or sacroiliac joints, either with or without objective signs, which has prevented the examinee from successfully following a physically active lifestyle.

A7.27.1.1.2. Arthritis of the spine, all types.

A7.27.1.1.3. Granulomatous disease of the spine, active or healed.

A7.27.1.1.4. Lumbar scoliosis of more than 20 degrees or thoracic scoliosis of more than 25 degrees as measured by the Cobb method

A7.27.1.1.5. Abnormal curvature of the spine of any degree in which there is a noticeable deformity when the examinee is dressed, in which pain or interference with function is present, or which is progressive.

A7.27.1.1.6. Symptomatic spondylolisthesis or spondylolysis.

A7.27.1.1.7. History of frank herniated nucleus pulposus or history of surgery or chemonucleolysis for that condition.

A7.27.1.1.8. Fractures or dislocations of the vertebrae. Compression fractures more than 25 percent or of more than a single vertebra may be considered for categorical IIB waiver. History of fractures of the transverse processes is not disqualifying if asymptomatic.

A7.27.1.1.9. Spina bifida when more than one vertebra is involved, if there is dimpling of the overlying skin, or a history of surgical repair for spina bifida.

A7.27.1.1.10. Juvenile epiphysitis with any degree of residual change indicated by x-ray or kyphosis.

A7.27.1.1.11. Weak or painful back requiring external support.

A7.27.1.1.12. Recurrent disabling low back pain due to any cause.

A7.27.1.1.13. Any surgical fusion.

A7.28. Skin.

A7.28.1. Flying Classes II and III.

A7.28.1.1. Any chronic skin disorder which is severe enough to cause recurrent grounding from flying duties, or is aggravated by or interferes with the wearing of military equipment.

A7.28.1.2. Extensive, deep, or adherent scars which interfere with muscular movements, with the wearing of military equipment, or show a tendency to breakdown.

A7.28.1.3. Atopic dermatitis with active or residual lesions in characteristic areas or a verified history.

A7.28.1.4. Dermatitis herpetiformis.

A7.28.1.5. Eczema which is chronic and resistant to treatment.

A7.28.1.6. Fungus infections of the skin, systemic or superficial, that interfere with duty performance or the wear of life support equipment.

A7.28.1.7. Furunculosis which is extensive, recurrent or chronic.

A7.28.1.8. Hyperhidrosis if chronic or severe.

A7.28.1.9. Leukemia cutis; mycosis fungoides; Hodgkin's disease.

A7.28.1.10. Lichen planus.

A7.28.1.11. Neurofibromatosis.

A7.28.1.12. Photodermatosis unless due to medication.

A7.28.1.13. Psoriasis.

A7.28.1.14. Scleroderma.

A7.28.1.15. Xanthoma if symptomatic or accompanied by hypercholesterolemia or hyperlipoproteinemia.

A7.28.1.16. Chronic urticaria.

A7.28.2. Flying Classes I and IA. In addition to above, psoriasis or verified history of same.

A7.29. Endocrine and Metabolic.

A7.29.1. Flying Classes II and III.

A7.29.1.1. Adiposogenital dystrophy (Frohlich's syndrome).

A7.29.1.2. Adrenal dysfunction of any degree, including pheochromocytoma.

A7.29.1.3. Cretinism.

A7.29.1.4. Diabetes insipidus.

A7.29.1.5. Diabetes mellitus, see note at **A3.32.**

A7.29.1.6. Gigantism or acromegaly.

A7.29.1.7. Thyroid disorders.

A7.29.1.7.1. Goiter if associated with pressure symptoms, or if enlargement is of such degree as to interfere with wearing of a military uniform or military equipment.

A7.29.1.7.2. Hyperthyroidism or thyrotoxicosis.

A7.29.1.7.3. Thyroiditis, acute and subacute.

A7.29.1.7.4. Hypothyroidism.

A7.29.1.8. Gout

A7.29.1.9. Hyperinsulinism, confirmed, symptomatic.

A7.29.1.10. Parathyroid dysfunction.

A7.29.1.11. Hypopituitarism.

A7.29.1.12. Myxedema, spontaneous or postoperative, with clinical manifestations.

A7.29.1.13. Nutritional deficiency diseases (including sprue, beriberi, pellagra, and scurvy) which are more than mild and not readily amenable to therapy or in which permanent pathological changes have been established.

A7.29.1.14. Other endocrine or metabolic disorders which obviously preclude satisfactory performance of military service or which require frequent or prolonged treatment.

A7.29.1.15. Hypercholesterolemia controlled by medication other than resin binders.

A7.29.1.16. Osteopenia.

A7.29.1.17. Hypoglycemia from any endogenous source.

A7.29.2. Flying Classes I and IA. In addition to the above:

A7.29.2.1. Diabetes mellitus (see Note in **A3.32.**). Persistent glucosuria from any cause including fasting renal glucosuria is disqualifying. Glucosuria post-prandially or during glucose loading challenge is not disqualifying in the absence of any renal disease or history of recurrent genitourinary infections. However, this finding requires evaluation.

A7.29.2.2. Any confirmed (repeated) serum cholesterol in excess of 230 mg/dl with one or both of the following criteria present:

A7.29.2.2.1. HDL cholesterol equal to or less than 15 percent of total cholesterol.

A7.29.2.2.2. LDL cholesterol greater than 170 mg/dl.

A7.30. Height and Weight

A7.30.1. Flying Class III

A7.30.1.1. Weight

A7.30.1.1.1. For initial qualification weight in relation to height applies (refer to **Attachment 16**). Additional standard applies for duties in ejection seat aircraft; in no case may weight be less than 103# or greater than 240# for T-38 and 245# for all other ejection seat aircraft.

A7.30.1.1.2. For trained personnel refer to **Attachment 16**. Additional standard applies for duties in ejection seat aircraft; in no case may weight be less than 103# or greater than 240# for T-38 and 245# for all other ejection seat aircraft.

A7.30.2. Flying Class II

A7.30.2.1. Weight

A7.30.2.1.1. For trained personnel refer to **Attachment 16**. Additional standard applies for duties in ejection seat aircraft; in no case may weight be less than 103# or greater than 240# for T-38 and 245# for all other ejection seat aircraft.

A7.30.3. Flying Class I

A7.30.3.1. Weight

A7.30.3.1.1. Weight in relation to height applies (refer to **Attachment 16**). Additional standard applies for Undergraduate Pilot Training; in no case may weight be less than 103# or greater than 240#.

A7.30.4. Flying Classes IA and Initial II (Flight Surgeon)

A7.30.4.1. Weight

A7.30.4.1.1. Weight in relation to height applies (refer to **Attachment 16**). Additional standard applies for training/duties in ejection seat aircraft; in no case may weight be less than 103# or greater than 240# for T-38 and 245# for all other ejection seat aircraft.

NOTES:

1. For UPT students, fighter-track UNT students and trained ejection seat aircrew identified outside of the weight for ejection seat standard, notify Squadron/CC via AF Form 1042 action.
2. IAW AF/XO message R 252140Z APR 01 "Aircrew Weight and Ejection Seats", on 1 May 2002 any aircrew member assigned to ejection seat aircraft who has failed to attain/maintain weight within the ejection seat standard will be cross-flowed to non-ejection seat aircraft. Accordingly:
   a. Prior to 1 May 2002, DNIF is not required for these individuals identified outside of the weight for ejection seat standard. The individual's current weight and the requirement to attain/maintain the ejection seat standard NLT 1 May 2002 will be noted in the comments section of the AF Form 1042.
   b. On 1 May 2002, those individuals identified outside of the weight for ejection seat standard will be placed DNIF and referred to the Squadron/CC for cross-flow into non-ejection seat aircraft IAW XO message (R 252140Z APR 01 "Aircrew Weight and Ejection Seats")

A7.31. Systemic and Miscellaneous Causes for Rejection.

A7.31.1. Flying Classes II and III.

A7.31.1.1. Recurrent decompression sickness (DCS). A single episode of DCS does not require waiver. All episodes of DCS require a minimum of 72 hours DNIF. Consultation with USAFSAM/AFIC (Hyperbaric Medicine) and concurrence of MAJCOM/SG is required before RTFS. In cases of DCS with neurological manifestations, a normal examination by a neurologist is required before RTFS.

A7.31.1.2. Malignancies. History or presence of malignant tumor, cyst or cancer of any sort. Basal cell and squamous cell carcinomas and carcinoma-in-situ of the cervix which have been adequately excised (as evidenced by pathology report, or basal cell carcinoma which have been treated by electrodessication and curretage by a dermatologist credentialed to perform this procedure), are exempted from tumor board action, but are report to tumor registry and are not disqualifying. Childhood malignancy considered cured may be considered for waiver on a case-by-case basis.

A7.31.1.3. Benign tumors which interfere with function or the wear of equipment and tumors which are likely to enlarge or be subjected to trauma during military service or show malignant potential.

A7.31.1.4. Following bleomyocin chemotherapy, AFMOA/SGOA may consider granting a

FCIIC waiver with the following restrictions:

A7.31.1.4.1. "No assignment to aircraft requiring routine use of oxygen equipment. Waiver from altitude chamber exposure. Ground training without supplemental oxygen is acceptable." These restrictions must be annotated in the remarks section of the AF Form 1042.

A7.31.1.5. Bone marrow donation. DNIF the person until their hematocrit and hemoglobin return to their own pre-donation level and all symptoms referable to the donation have been resolved.

A7.31.1.6. Airsickness in flying personnel is not cause for medical disqualification unless there is medical evidence of organic or psychiatric pathology. If airsickness is of such chronicity or severity as to interfere with the performance of flying duties by a rated officer, his or her potential for further use in rated duties are addressed by a Flying Evaluation Board. Copies of these cases are sent through medical channels to AFMOA/SGOA for review before convening a board. Airsickness experienced by nonrated personnel (other than UPT or UNT students) while enrolled in flying courses is medically disqualifying if it is of such severity or chronicity as to interfere with the performance of flying duties. Final determination of medical qualification in these cases are made by the MAJCOM/SG.

A7.31.1.7. Any allergic condition which requires desensitization therapy. Waivers are considered if symptoms are controlled by desensitization or topical medication (or both).

A7.31.1.8. Eosinophilic granuloma.

A7.31.1.9. Gaucher's disease.

A7.31.1.10. Schuller-Christian disease.

A7.31.1.11. Letterer-Siwe's disease.

A7.31.1.12. Chronic metallic poisoning.

A7.31.1.13. Residual of cold injury, such as deep-seated ache, paresthesia, hyperhidrosis, easily traumatized skin, cyanosis, ankylosis, amputation of any digit, or cold urticaria.

A7.31.1.14. Heat pyrexia (heat stroke or heat exhaustion) if a reliable history indicates an abnormally lowered heat tolerance threshold.

A7.31.1.15. History of malignant hyperthermia.

A7.31.1.16. Syphilis, congenital or acquired. A history of primary or secondary syphilis is not disqualifying provided:

A7.31.1.16.1. The examinee has no symptoms of disease.

A7.31.1.16.2. There are no signs of active disease and no residual thereof.

A7.31.1.16.3. Serologic VDRL testing rules out reinfection.

A7.31.1.16.4. There is a verified history of adequate treatment.

A7.31.1.16.5. There is no evidence or history of CNS involvement.

A7.31.1.17. Parasitic infestation, all types until adequately treated.

A7.31.1.18. History of sensitivity or a demonstrated sensitivity of sufficient severity to require permanent exemption from any immunization required by appropriate directives.

A7.31.1.19. History of food-induced anaphylaxis.

A7.31.1.20. Other congenital or acquired abnormalities, defects or diseases which preclude satisfactory performance of flying duty.

A7.31.1.21. Miscellaneous conditions such as porphyria, hemochromatosis, amyloidosis.

A7.31.1.22. Inflammatory idiopathic diseases of connective tissue.

A7.31.1.23. Lupus erythematosus (acute, subacute, or chronic).

A7.31.1.24. Active tuberculosis in any form or location, or substantiated history of active tuberculosis within the previous 2 years.

A7.31.1.25. Sarcoidosis.

A7.31.1.26. History of malignancy.

A7.31.2. Flying Classes I and IA. In addition to the above:

A7.31.2.1. Motion sickness experienced in aircraft, automobiles, or water craft after the age of 12 with any significant frequency. Any history of motion sickness is completely explored.

A7.32. Medication. Use of any medication, except as described below is cause for medical disqualification for flying duty until the grounding condition has been resolved, the medication is no longer required and the effects of the drugs have dissipated.

A7.32.1. Aircrew members cannot fly for at least 8 hours after receiving a local or regional anesthetic agent.

A7.32.2. Aircrew and individuals on the sensitive duty program are not cleared for a minimum of 3 weeks following the use of Ketamine.

A7.32.3. Medications which may be used without medical consultation.

A7.32.3.1. Skin antiseptics, topical antifungals, 1 percent Hydrocortisone cream (more potent topical steroids require waivers), or benzoyl peroxide for minor wounds and skin diseases which do not interfere with the performance of flying duties or wear of personal equipment.

A7.32.3.2. Single doses of over-the-counter aspirin, acetaminophen or ibuprofen to provide analgesia for minor self-limiting conditions.

A7.32.3.3. Antacids for mild isolated episodes of epigastric distress.

A7.32.3.4. Hemorrhoidal suppositories.

A7.32.3.5. Bismuth subsalicylate for mild afebrile cases of diarrhea.

A7.32.3.6. Oxymetazoline or phenylephrine nasal sprays may be used by aircrew as "get me downs" should unexpected ear or sinus block occur during flight. These should not be used to treat symptoms of head congestion existing prior to flight.

A7.32.3.7. Multivitamin, no more than one per day.

A7.32.3.8. Dietary, herbal, and nutritional supplements can only be used with the approval of a flight surgeon. The flight surgeon should consider aeromedical implications of the supplement as well as the probability the supplement will actually enhance performance.

A7.32.4. Medication prescribed by a flight surgeon which may be used without removal from flying duty once the potential for idiosyncratic reaction has been excluded.

A7.32.4.1. Isoniazid for prophylactic therapy of tuberculin converters who do not have active tuberculosis. Minimum of 7 days ground trial.

A7.32.4.2. Oral contraceptives, implantable timed release progestin, injectable sustained duration progestin (for contraception only), estrogen alone or with progestin, as replacement therapy. Min-

imum of 28 days ground trial is required. Changes of dosage or brand requires an additional 28-day observation period.

A7.32.4.3. Chloroquine phosphate, primaquine phosphate, or doxycycline (100 mg daily) for antimalarial prophylaxis. Single dose ground trial is advised.

A7.32.4.4. Pyridostigmine for chemical warfare prophylaxis. Single dose ground trial is advised.

A7.32.4.5. Scopolamine alone or in combination with dextroamphetamine or ephedrine for airsickness in formal flying training programs. Not authorized for solo flight.

A7.32.4.6. Doxycycline (100mg) administered twice a day for 5 days may be used to treat mild diarrhea. Doxycycline may also be used for prophylaxis against diarrhea in deployed personnel. One hundred milligrams should be administered daily during the period of exposure and for at least 2 days following exposure, with the total period of use not to exceed 2 weeks.

A7.32.4.7. Topical antibiotics for control of acne.

A7.32.4.8. Topical tretinoin for control of acne as long as local irritation does not interfere with wear of the life-support equipment.

A7.32.4.9. Topical acyclovir.

A7.32.4.10. Completion of a course of oral penicillin, oxacillin, dicloxacillin, amoxicillin, erythromycin, sulfamethoxazole-trimethoprim, tetracycline, ampicillin, doxycycline, or cephalexin, once the acute infectious process is asymptomatic.

A7.32.4.11. Vaginal creams or suppositories for treatment of vaginitis once asymptomatic.

A7.32.4.12. Temazepam, or zolpidem if such use is essential for the safe performance of mission, and only after MAJCOM/SG coordination and approval. MAJCOM/SG may delegate this approval to wing and detachment level if unit mission so warrants. Single dose ground trial is required for use.

A7.32.4.13. Dextroamphetamine use may be allowed for certain missions. Check with MAJCOM/SG prior to prescribing. Single dose grounding trial is required.

A7.32.4.14. Immunobiologics.

A7.32.4.15. Nicorette or transdermal nicotine. Minimum of 72 hours ground trial.

A7.32.4.16. Resin binding agents such as cholestyramine for control of hyperlipidemia. Note: Niacin is not approved for use by flyers.

A7.32.5. Maintenance medication requiring waiver. Those medications for conditions listed below may be waived by the MAJCOM surgeon. The use of other medications, singly or in combination requires review by AFMOA/SGOA for rated officers and by the MAJCOM surgeon for non-rated flying personnel.

A7.32.5.1. Chlorothiazide or hydrochlorothiazide for control of hypertension or hypercalciuria.

A7.32.5.2. Triamterene for control of hypertension.

A7.32.5.3. Lisinopril for treatment of hypertension (ACS review or evaluation may be required for Flying Class II, refer to current ACS policy). Flying Class II waiver requires a medically monitored centrifuge evaluation. If a medically monitored centrifuge evaluation has not been per-

formed, rated individuals will be considered for a categorical Flying Class IIC waiver (Member must undergo a medically monitored centrifuge evaluation required prior to return to assignment to Fighter, Attack, Reconnaissance (FAR), or trainer aircraft (except T-1).

A7.32.5.4. Probenecid for treatment of gout or hyperuricemia.

A7.32.5.5. Allopurinol for treatment of gout or hyperuricemia.

A7.32.5.6. Combination therapy of thiazide with triamterene, probenecid, allopurinol, or oral potassium supplements.

A7.32.5.7. Epinephrine derivatives without added action agents, or betablockers (Timolol, Levobunolol, Betaxolol) all for topical use only, to control glaucoma.

A7.32.5.8. Synthroid for treatment of thyroid hypofunction or for thyroid suppression.

A7.32.5.9. Tetracycline, erythromycin, doxycycline in standard doses for acne management.

A7.32.5.10. Sulfamethoxazole-trimethoprim, tetracycline, ampicillin, doxycycline for chronic genitourinary infectious or prostatitis once asymptomatic.

A7.32.5.11. Folic acid in the treatment of sprue.

A7.32.5.12. Sucralfate (1 gram once daily) for prevention of recurrent, uncomplicated duodenal ulcers. Minimum 7 days observation required.

A7.32.5.13. Ranitidine.

NOTE:

*Prior requirement for a FCIIA waiver is removed.

A7.32.5.14. Pravachol (Note: May not be delegated locally).

A7.32.5.15. Omeprazole (Note: Prior requirement for a FCIIA waiver is removed).

A7.32.5.16. Nasal steroids or cromolyn nasal spray for control of mild to moderate allergic rhinitis, nonallergic rhinitis, or vasomotor rhinitis. Observation for control of the rhinitis (usually 7 to 14 calendar days) is required. Claritin (loratidine) for the control of seasonal allergic rhinitis.

A7.32.5.17. Griseofulvin for treatment of fungal infections may be granted a one year non-renewable waiver after a 4 week ground trial.

A7.32.5.18. Clomiphene citrate for treatment of infertility.

A7.32.5.19. Lovastatin or pravastatin for treatment of hypercholesterolemia.

A7.32.5.20. Gemfibrozil may be considered for categorical IIA waiver by MAJCOM/SG.

A7.32.5.21. Acyclovir (oral), for treatment of HSV or suppressive therapy.

Attachment 8

MEDICAL STANDARDS FOR MISCELLANEOUS CATEGORIES

A8.1. Attendance at Service Schools. Applicants for all types of training courses must be free of any abnormal physical or mental condition which is likely to interfere with successful completion of the course. Certain technical training courses and AF specialty classifications impose additional requirements.

A8.2. Parachute Duty. The medical standards for applicants for parachute duty training and subsequent parachute duty are the same as those for Flying Class III, and those requirements in this attachment (see **A8.10.**).

A8.3. Marine Diving Duty (Required for Pararescue and Combat Control Duty). The medical standards are those for Flying Class III plus those here and those listed in **A8.10.** Failure to meet standards is cause to reject an examinee for initial Marine Diving duty and for continued duty unless a waiver is granted. Acute medical problems, injuries, or their appropriate therapy may be cause for withholding certification for initial training or temporarily restricting from duty until the problem is resolved.

A8.3.1. Any disease or condition that causes chronic or recurrent disability, sudden incapacitation, or has the potential of being exacerbated by the hyperbaric environment.

A8.3.2. History of injury or procedure involving entrance into thoracic, pericardial, or abdominal cavities in the previous 6 months, or the cranial cavity at any time.

A8.3.3. Ear, Nose, and Throat.

A8.3.3.1. Any history of inner ear pathology.

A8.3.3.2. Any history of inner or middle ear surgery except PE tubes before age 10.

A8.3.3.3. Inability to equalize middle ear pressure.

A8.3.4. Eyes.

A8.3.4.1. Night vision impairments.

A8.3.4.2. Vision worse than 20/70, each eye, near and distant, without correction.

A8.3.4.3. Vision that does not correct to 20/20, each eye, near and distant.

A8.3.5. Pulmonary.

NOTE:

Inspiratory and expiratory Chest X-ray is accomplished within 1 year of entering training.

A8.3.5.1. Congenital and acquired defects which may restrict pulmonary function, cause air-trapping, or affect the ventilation-perfusion balance.

A8.3.5.2. Chronic obstructive or restrictive pulmonary disease of any type.

A8.3.5.3. Pneumothorax.

A8.3.6. Gastrointestinal. History of irritable bowel syndrome.

A8.3.7. Skin and Cellular Tissues. Acute or chronic diseases that are exacerbated by the hyperbaric or marine environment.

A8.3.8. Dental.

NOTE:

Dentist signs the SF 88 for initial Pararescue or Combat Control duty.

A8.3.8.1. All divers should be class I or II before assuming diving duty. Divers who are class III for acute conditions should be temporarily disqualified from diving duty until the acute condition is corrected. Divers who are class III because of a chronic condition (e.g. periodontal disease) receive ongoing dental care for the condition if they are to be considered qualified for diving duty. Divers are restricted from diving duty for 48 hours following operative dental procedures.

A8.3.8.2. Acute infectious diseases of the soft tissues of the oral cavity, until treatment is completed.

A8.3.8.3. Any defect of the oral cavity or associated structures which interfere with effective use of self-contained underwater breathing apparatus (SCUBA).

A8.3.8.4. Dental corrections are corrected and documented in item #44 of the SF 88 prior to entry into initial Pararescue or Combat Control training.

A8.3.9. Blood and Blood-Forming Tissues. Any significant anemia or hemolytic disease.

A8.3.10. Neurologic. Unexplained or recurrent syncope.

A8.3.11. Psychiatric.

A8.3.11.1. Personality disorders, neurosis, immaturity, instability, asocial traits, or psychosis.

A8.3.11.2. Stammering or stuttering.

A8.3.11.3. Alcoholism except those who have successfully completed a recognized rehabilitation and aftercare program. Any relapse is cause for disqualification.

A8.3.11.4. History of claustrophobia.

A8.3.12. Musculoskeletal. Intervertebral disc disease with neurological deficit.

A8.3.13. Height and Weight. Weight in excess of that specified in **Attachment 16**.

A8.3.14. Systemic/Miscellaneous. History of recurrent decompression sickness or single episode of air embolism.

A8.4. Physiological Training and Physiological Training Personnel/Operational Support Flying Duty(ASC 9C).

A8.4.1. The standards listed in **Attachment 3** and this section are disqualifying for physiologic training and operational support flying personnel.

A8.4.2. Clearance to complete physiologic training:

A8.4.2.1. Military personnel on flying status have a current class I, IA, II, or III physical on record (or PHA if applicable).

A8.4.2.2. Military personnel requiring passenger training or who perform aviation duties in ASC 9C, and physiological training personnel are required to have a normal examination of tympanic membranes, lungs and chest, heart, abdomen, neurologic, hemoglobin, weight, blood pressure and pulse documented in the health record.. This examination is valid until the end of the birth month of the next year from the date accomplished.

NOTE:

AF Form 1042 , *Medical Recommendation for Flying or Special Operational Duty*, is issued as satisfactory evidence of completion of the requirements outlined above.

A8.4.2.3. AF, Army, or Navy ROTC cadets will present evidence of satisfactory completion of SF 88, *Report of Medical Examination* or DD Form 2351, *DOD Medical Examination Review Board (DODMERB) Report of Medical Examination*, accomplished within 36 months of the scheduled physiological training.

NOTE:

Before scheduling cadets for training, the ROTC detachment must send the Aerospace Physiology Unit copies of the SF88 , and SF93, *Report of Medical History* , or DD Form 2351, with DD Form 2492, *Report of Medical History* . The Aerospace Physiology Unit will have the local flight surgeon's office review these forms and stamp these documents "Qualified to Participate in Altitude Chamber Training" for all cadets physically qualified. AF Form 1042, is not required for this group of trainees, but any current medical problems must be cleared by the local flight surgeon.

A8.4.3. Civilians undergoing physiological training are required to present a current FAA medical certificate or the forms listed in the paragraph above or a valid AF Form 1042.

A8.4.4. The following conditions are disqualifying for physiological training or operational support flying:

A8.4.4.1. Inability to valsalva.

A8.4.4.2. Current or chronic obstructive ear, nose, throat, sinus or pulmonary disease.

A8.4.4.3. Loss of 200 cc or more blood is disqualifying for at least 72 hours following the loss.

A8.4.4.4. Sickle cell disease or heterozygous sickling disorders other than sickle cell trait.

A8.4.4.5. Sickle cell trait if there is a history of symptoms associated with sickling disorder. Symptomology attributable to intravascular sickling during decompression in an altitude chamber is also disqualifying.

A8.4.4.6. History of migraine, claustrophobia, organic heart disease, or symptomatic hiatal hernia.

A8.4.4.7. Inguinal hernia.

A8.4.4.8. Pregnancy.

A8.4.4.9. Use of medications which may impair mission performance.

A8.4.4.10. Any disease, which in the judgment of the flight surgeon, is likely to limit the performance of duty or place the individual at increased health risk.

A8.4.4.11. Individuals cleared for flying after bleomycin chemotherapy are not to have altitude chamber exposure. Ground training without supplemental oxygen is acceptable. These restrictions must be annotated in the remarks section of AF Form 1042. For further details concerning this unique condition, see AFI 11-403, Aerospace Physiological Training Program.

A8.5. Survival Training Instructor Duty-Selection and Retention. The Survival Training Instructor course is physically demanding and requires the ability to withstand daily running up to 5 miles, 50 push-ups, mountain climbing, heat and cold exposure, hiking and backpacking with a weight up to 70 pounds. A medical examination recorded on SFs 88 and 93 specifically for survival instructor duty is required at the time of application. The MMPI, MCMI, and Shipley-Hartford Institute of Living Scale psychological tests are required as part of the application examination.

A8.5.1. Selection. The causes for rejection are:

A8.5.1.1. Any condition listed in **Attachment 3**.

A8.5.1.2. Profile less than P-1, U-1, L-1, H-2, E-2, S-1, except the uncorrected distant vision is not worse than 20/00 each eye corrected to 20/0.

A8.5.1.3. Speech impediment which interferes with clear enunciation.

A8.5.1.4. History of recurrent or chronic back pain.

A8.5.1.5. Scoliosis over 25 degrees measured by the Cobb method. Any other abnormal curvature of the spine of any degree in which there is a noticeable deformity, or in which there is pain, or interference with function, or which is progressive.

A8.5.1.6. Spondylolysis or spondylolisthesis, if symptomatic.

A8.5.1.7. History of recurrent knee pain or chondromalacia of the patella. A history of knee surgery requires an orthopedic evaluation and a demonstrated ability of at least 1 year of strenuous physical activity not requiring a brace.

A8.5.1.8. History of recurrent shin splints.

A8.5.1.9. History of recurrent ankle sprains.

A8.5.1.10. History of foot pain.

A8.5.1.11. History of stress fractures.

A8.5.1.12. History of any vertebral fractures, except that history of a healed, asymptomatic fracture of the transverse process is not disqualifying.

A8.5.1.13. History of surgery involving a major joint requires an orthopedic evaluation.

A8.5.1.14. History of frost bite or heat exhaustion.

A8.5.1.15. History of asthma, reactive airway disease or exercise induced breathing difficulties.

A8.5.1.16. Allergy to stinging insects, pollen, trees, grasses, or dust unless desensitized and controlled on maintenance dosage.

A8.5.1.17. Deficient night or color vision. Color vision is acceptable if the individual can properly identify the colors on a military topographic map.

A8.5.1.18. Food aversions, insect or snake phobias.

A8.5.1.19. Character and behavior disorders.

A8.5.1.20. History of alcohol or drug abuse.

A8.5.1.21. History of suicidal gesture or attempt.

A8.5.1.22. Intolerance to close or confined spaces.

A8.5.1.23. Mental health condition that indicates the applicant is unable to accept constructive criticism or unable to function in a high stress environment.

A8.5.2. Retention. A trained and experienced survival instructor is considered using these standards as a guide, but continued duty is dependent upon the member's demonstrated ability and performance.

A8.5.3. Certification and Waiver Authority. HQ AETC/SGPS is the medical certification and waiver authority for selection and retention of survival instructors and trainees.

A8.6. Military Training Instructor (MTI) Duty. MTIs have the primary responsibility for conducting basic military training. They instruct, supervise, counsel, and inspect indoors and outdoors under all kinds of environmental situations.

A8.6.1. The MPF refers each MTI applicant to the PES section for:

A8.6.1.1. Health records review.

A8.6.1.2. Physician interview and examination. Additionally, an interview and recommendation by a military psychiatrist or psychologist specifically for MTI duty is mandatory. The results of the interview and examination are recorded in the applicant's outpatient health record on SF 600, Chronological Record of Medical Care.

A8.6.1.3. Current physical profile assessment is recorded on AF Form 422, *Physical Profile Serial Report*, with the statement indicating the applicant was interviewed and examined by a physician and psychiatrist or psychologist.

A8.6.2. Specific causes for rejection are:

A8.6.2.1. Physical profile less than 121221.

A8.6.2.2. Speech impediment which interferes with clear enunciation.

A8.6.2.3. History of injury to, or defects of, the spinal column, major bones, or joints which have caused recurring symptoms.

A8.6.2.4. History of symptomatic defects of the foot including pes planus, bunions, hallux valgus, hammer toes, plantar warts, recurring ingrown toenails, and pes cavus.

A8.6.2.5. History, or recurrent evidence, of a psychiatric condition.

A8.6.2.6. Personality disorder which precludes the applicant from accepting criticism, supervising large groups of students, or functioning effectively in a high stress situation.

A8.6.2.7. Asthma, recurrent bronchospasm, reactive airway disease or emphysema.

A8.6.2.8. Weight which does not meet the requirements of **Attachment 16**.

A8.6.2.9. Any other medical or psychiatric condition which, in the opinion of the examiner, contraindicates duty in a physically and psychologically demanding environment.

A8.6.2.10. Annually, a mental health provider interviews MTIs and reviews their health records to insure their medical fitness for continuation as an MTI. An AF Form 422 serves as the annual medical certification for continued duty.

A8.6.2.11. HQ AETC/SG is the medical certification and waiver authority in the MTI selection and retention process.

A8.7. Duty Requiring Use of Night Vision Goggles (NVG).

A8.7.1. Aircrew members and special operational duty personnel who wear NVGs in the performance of their duties are required to meet no additional vision standards over and above already required for their duty AFSC (exceptions to these are discussed below). The corrected visual acuity standards for each flying class normally yield a visual acuity of at least 20/50 while wearing NVG. The flight surgeon screens the health records of personnel required to wear NVGs initially and periodically thereafter to confirm that the member has passed the most recent annual vision screening. Aircrew who fail this screening, complain of visual problems with or without NVGs, or fail to achieve 20/50 visual acuity in the NVG pre-flight test lane should be referred for a routine clinical eye examination. The flight surgeon should refer to AL-SR-1992-0002, *Night Vision Manual for Flight Surgeons*, for additional guidance.

A8.7.2. Each aircrew or special operational duty member who requires corrective lenses in order to meet the visual acuity standards for flying, and who is required to wear NVGs in the performance of flying duties, should wear soft contact lenses (SCL) with appropriate correction. Members who cannot, or do not wish to, wear SCLs are to wear industrial safety lenses (polycarbonate or 3.0 mm thick CR-39 plastic) when using NVG. Two pairs of aircrew spectacles with safety lenses ground to the appropriate correction can be obtained in the following manner:

A8.7.2.1. If the individual has not had a refraction done within the past year, obtain a current refraction.

A8.7.2.2. Send the current prescription written on a DD Form 771, *Eyewear Prescription*, with verification of NVG duties written in the "Special Lenses or Frame" block to Optical Research Unit USAFSAM/AFCO, 2507 Kennedy Circle, Brooks AFB TX 78235-5117.

A8.7.2.3. Dispense the glasses to the individual with instructions to wear them only when using NVG and to protect the lenses from marring or scratching.

A8.7.2.4. Individuals who still use the old unmodified version (full faceplate) of the AN/PVS-5a NVG, and who are also required to wear spectacles in the performance of their duties, must meet the following additional vision requirements:

A8.7.2.5. Refractive error of no more than plus 2.00 or minus 6.00 diopters in any meridian.

A8.7.2.6. Astigmatism requiring no more than 2.00 diopters of cylinder.

A8.7.2.7. If unable to meet either of the above two requirements, the individual must be able to wear MAG-1 combat spectacles with the full faceplate NVG. MAG-1 combat spectacles with plastic or polycarbonate lenses can be ordered from the Optical Research Unit using the procedures outlined above. Specify MAG-1 combat spectacles on the DD Form 771.

A8.8. Remote or Isolated Duty.

A8.8.1. Verification of Medical Acceptability. All personnel alerted for overseas assignment or assignment to a geographically separated unit (GSU) are sent to the PES section for verification of medical acceptability for assignment. This verification consists of the following:

A8.8.1.1. Thorough health record review in order to determine if the individual has any significant medical problems which might be exacerbated by his or her pending assignment or would be difficult to manage medically at the projected gaining base. This review is accomplished by an experienced Aeromedical journeyman/craftsman. Any questionable conditions will be referred to the profile officer for proper disposition to include coordination with the gaining MAJCOM/SG and HQ AFPC if appropriate.

A8.8.1.2. Completion of AF Form 422 showing that the individual is qualified for worldwide, Remote or Isolated duty.

A8.8.1.3. Annotate the SF 600 that the review and appropriate actions have been accomplished.

A8.8.2. If the individual is going to a base that does not have a USAF medical treatment facility with a PES section, complete a Preventive Health Assessment (PHA) or periodic medical examination as required, if the exam is due during the tour. Air traffic controllers assigned to remote sites where required interval medical examinations are not available are authorized no more than a 6 month deferral period to allow mission completion. This deferred period is effective only while assigned to the remote site. Members must ensure currency once assigned to medical facilities capable of performing examinations. Also complete an audiometric examination if the individual is on the hearing conservation program.

NOTE:

Personnel qualified for worldwide duty in accordance with **Attachment 2** may not be acceptable for remote or isolated duty assignments. Individuals in need of specialized and recurrent medical or dental care are not acceptable. Known conditions which could produce catastrophic or life threatening illness should not be assigned to remote or isolated duty. Assume the independent duty medical technicians are the only level of medical care immediately available to the individual.

A8.8.3. If qualification for worldwide duty is questionable, PES prepares an AF Form 422 according to this instruction and the form is reviewed by the DBMS or designated senior profile officer before sending it to the MPF.

A8.9. Hyperbaric Chamber Training or Duty. The medical standards listed in **Attachment 3** and this section are cause to reject an examinee for initial hyperbaric chamber training duty and for continued duty unless a waiver is granted. Acute medical problems, injuries or their appropriate therapy may be cause for withholding certification for initial training or temporarily restricting from duty until the problem is resolved. The scope of the medical examination is the same as the scope in paragraph. **A8.4.** for Physiological Training duty personnel, ASC: 9C.

A8.9.1. Any disease or condition that causes chronic or recurrent disability, sudden incapacitation or has the potential of being exacerbated by the hyperbaric environment.

A8.9.2. History of injury or procedure involving entrance in to thoracic, pericardial or abdominal cavities in the previous 6 months, or the cranial cavity at any time.

A8.9.3. Ear, Nose Throat.

A8.9.3.1. Any history of inner ear pathology

A8.9.3.2. Any history of inner or middle ear surgery except PE tubes before age 10.

A8.9.3.3. Inability to equalize middle ear pressure.

A8.9.4. Pulmonary.

A8.9.4.1. Abnormal inspiratory or expiratory chest x-ray abnormal.

A8.9.4.2. Chronic obstructive or restrictive pulmonary disease of any type.

A8.9.4.3. History of spontaneous pneumothorax.

A8.9.5. Dental-Class III.

A8.9.6. Anemia, significant chronic or nonreversible.

A8.9.7. Gastrointestinal - tendency to excessive flatulence.

A8.9.8. Neurological - unexplained or recurrent syncope.

A8.9.9. Neurosis, or psychosis.

A8.9.10. History of claustrophobia

A8.10. Medical Certification and Waiver Requirements for Combat Control (1C2X1) and Pararescue(1T2X1) Duty.

A8.10.1. Initial Flying Class III examinations for 1C2X1 duty applicants must meet the requirements in AFI 48-123 attachments for Marine Diving Duty. In order to meet Army and Navy requirements, the following additional test must be documented on the SF 88 (Note: HQ AETC/SGPS retains sole certification and waiver authority):

A8.10.1.1. Item No 32 - Digital rectal and prostate examination, stool for occult blood

A8.10.1.2. Item No 41 - Neurological evaluation by the flight surgeon: each specific item must be addressed (i.e., serial 7’s-normal; deltoid 5/5).

A8.10.1.2.1. Cranial nerves.

A8.10.1.2.2. Serial 7s.

A8.10.1.2.3. Heel-toe.

A8.10.1.2.4. Gait.

A8.10.1.2.5. Muscle strength.

A8.10.1.2.5.1. Deltoid.

A8.10.1.2.5.2. Bicep.

A8.10.1.2.5.3. Tricep.

A8.10.1.2.5.4. Grip.

A8.10.1.2.6. Toe raises.

A8.10.1.2.7. Heel raises.

A8.10.1.2.8. Knee flex.

A8.10.1.2.9. DTRs.

A8.10.1.2.9.1. Bicep.

A8.10.1.2.9.2. Tricep.

A8.10.1.2.9.3. Patellar.

A8.10.1.2.9.4. Achilles.

A8.10.1.2.9.5. Heel-shin slide.

A8.10.1.3. Item No 44 - must read "Type II/Class 1 qualified." Include bite-wing x-rays with package.

A8.10.1.4. Item No 46 - Chest x-ray (inspiratory and expiratory).

A8.10.1.5. Item No 47 – RPR.

A8.10.1.6. Item No 48 - ECG tracing must be reviewed/signed by a physician.

A8.10.1.7. Item No 50 - Must include complete CBS results.

A8.10.1.8. Item No 72 - Reading aloud test (RAT), adaptability rating-diving duty (AR-Diving Duty), adaptability rating for military aviation (ARMA).

A8.10.1.9. Item No. 73 - Must state: "applicant possesses no fear of heights, depths, dark, or confined places. Applicant possesses the ability to hold breath for 60 seconds subsequent to deep breathing."

A8.10.1.10. Item No. 77 - Must state: "(is) initial Flying Class III/Airborne/Combat Control/ Pararescue/Marine Diving Duty."

A8.10.1.11. Item No. 79-82. - Must contain all signatures.

A8.10.2. Trained personnel attending the U.S. Army military free fall, free fall jump master, special forces combat diver, dive supervisor, dive medical technician, or the survival, evasion, resistance and escape course will also need to have their most current physical certified by HQ AETC/SGPS prior to attending training. The same special requirements must be met. (Any personnel attending any Army special school will need to meet these requirements also).

A8.10.3. Only original medical documents will be used for certification by HQ AETC/SGPS. Faxes are unacceptable. Forward the appropriate number of required documents as outline in AFI 48-123, Chapter 8.2.

A8.11. Incentive and Orientation Flights.

A8.11.1. All orientation flight candidates will be referred to the flight medicine clinic for a medical clearance prior to the flight. A flight surgeon will accomplish a medical records review and a physical examination (Scope of examination is determined locally). In lieu of medical record review, civilians should provide a statement of health from their physician to include a summary of medical problems and medications. All individuals (military and civilian) identified for incentive or orientation flights must be able to safely eject without endangering life or limb. Communicate medical clearance and recommendations/restrictions to the flying unit on AF Form 1042. The following guidelines apply:

A8.11.1.1. Individuals considered for any aircraft in the Air Force inventory on line prior to 1967 will use the following as "disqualifiers:"

A8.11.1.2. Standing height greater than 77 inches, with sitting height measurement greater than 40 inches.

A8.11.1.3. Standing height less than 64 inches, with sitting height measurement less than 34 inches.

A8.11.1.4. Buttock to knee measurement no greater than 27.5 inches.

A8.11.1.5. The qualified body weight (nude weight) ranges for USAF ejection seats are as follows:

A8.11.1.5.1. T-37, U-2, B-52: 132 to 201 pounds.

A8.11.1.5.2. A-10, B-1, B-2, F-15, F-16, F-22, F-117, T-38: 140 to 211 pounds.

A8.11.1.5.3. T-6A (JPATS): 103 to 245 pounds.

A8.11.2. Individuals considered for the F-15, F16 or any aircraft utilizing the ACES II ejection system will use the following as "disqualifiers:"

A8.11.2.1. Standing and sitting height (same as above).

A8.11.2.2. Weight less than 130 lbs.

NOTE:

As some individuals may seem suspect, even if within standards, the examining flight surgeon may require a buttock to knee measurement. However, care should be taken not to use the "buttock to knee" measurement in-lieu of the standards. Individuals who do not meet standards will be referred to the flying unit for disposition as the final authority, as the examining flight surgeon and MAJCOM/SG do not have waiver authority for indoctrination and incentive flights.

A8.12. Fire Fighters. Firefighters must meet the medical monitoring protocol of the National Fire Protection Association (NFPA) standard 1582, *Medical Requirements for Fire Fighters*, 1997 Edition. There is no waiver authority for the provisions of this standard. Military firefighters with Category A conditions and Category B conditions for which a direct fitness for duty issue is raised should be evaluated in accordance with the MEB procedures in **Chapter 10**.

Attachment 9

PERIODIC MEDICAL EXAMINATION

Scope Criteria	Periodic Medical Examinations	
Category	**Frequency**	**Qualification**
All officers and airmen on flying status or special operational duty as defined by this instruction; includes Aviation Service Code (ASC) ending with "K."	Annually, within 3 months (maximum of 6 months) preceding the last day of the birth month.	Flying Class II or III or special operational duty as defined by this instruction. Type of examination: PHA with the periodic flying physical as an occupational subcomponent. ARC members: Flying Long physical every 3 years with a Periodic Flying (short) in the 2 intervening years.
All officers and airmen not on flying status or special operational duty and inactive flyers (ASC: 6J, 7J, 8J, or 9J) as defined by this instruction.	Annually ARC members: see notes below.	Worldwide duty Type of examination: Preventive Health Assessment (PHA), active duty only. ARC members: Periodic non-flying examination (SF 88).
General officers	Annually, within 3 months of the last day of the birth month (see note 2).	Flying Class II, III, or worldwide duty as appropriate. Type of Examination: PHA with provider visit. ARC members: Annual periodic examination.
Operational Support Flying Physiological Training Personnel to include members requiring chamber training. Hyperbaric Medicine Personnel. Aviation Service Code 9C Personnel.	Annually (This examination is valid until the end of the birth month of the next year).	Type of examination: PHA with occupational physical as specified in **A8.4.**

Scope Criteria	Periodic Medical Examinations	
Category	**Frequency**	**Qualification**
Ground Based Controllers (non-flying).	Annually.	Ground based controller duties. Type of examination: PHA with occupational physical sufficient to ensure **Attachment 4** Standards are met. Controllers must be seen by a flight surgeon annually. ARC members: SF 88 every 5th year in the scope specified in **Attachment 4**. Periodic Flying (long) every 5th year. Periodic Flying (short) in the intervening years.
Space and Missile Operations Crew Duty.	Annually.	Type of examination: PHA with appropriate occupational examination. ARC members: SF 88 every 5th year in the scope specified in **Attachment 5**. Periodic Flying (long) every 5th year. Periodic Flying (short) in the intervening years.
Air Vehicle Operator Duty.	Annually.	Type of examination: PHA with appropriate occupational examination. Must be seen by Flight Surgeon annually.

NOTES:

1. Complete AF Form 1446, *Medical Examination-Flying Personnel*, each year a complete examination (SF 88) is not required.
2. For ARC general officers on flying status, the AF Form 1446 (on alternate years) is optional at the member's discretion, otherwise a complete exam is required.
3. ANG officers being considered for promotion to general or promotion within the general officer ranks must undergo a medical examination within 6 months of the recognition board. Forward a copy of the promotion medical examination to: ANG/SGPS, 3500 Fetchet Avenue, Andrews AFB, MD 20762-5157.
4. The frequency of periodic exams on ARC members in this category will be every 5th year from date of last exam. Exams may be accomplished 6 months prior to expiration .
5. Papanicolau smear is required on all periodic physical exams accomplished on female ARC members. Members may use results from their private health care provider provided it was accomplished within the last 11 months. The name and address of the member's provider, date accomplished, and results must be recorded on SF88.

6. A mammogram is required at age 40 and with each subsequent periodic examination on female ARC members. Members may use results from their private health care provider provided it was accomplished within the last 11 months. The name and address of the member's provider, date accomplished, and results must be recorded on SF88.

Attachment 10 CERTIFICATION AND WAIVER AUTHORITY

Table A10.1. Certification & Waiver Authority

Category	**Certification Authority** (Notes 8, 11, 12)	**Waiver Authority** (Notes, 1, 2, 8, 11, 10)
Flying Class 1, 1A, Initial II	AETC/SG (Note 6)	AETC/SG
Flying Class II (Notes 3,4,5,10)	-	MAJCOM/SG (Note 17)
Flying Class III (Note 7) **- Initial (Active duty) - Initial (ARC members) - Continued flying**	MAJCOM/SG Appropriate ARC/SG (Note 12) -	AETC/SG Appropriate ARC/SG (Note 12,17) MAJCOM/SG (Note 17)
Special Operational Duty - Initial - Continued Special Operational Duty	MAJCOM/SG Appropriate ARC/SG (Note 17)	AETC/SG MAJCOM/SG Appropriate ARC/SG (Note 17)
Physiological Training/Operational Support Duty (ASC 9C)	Local/Chief, Flight Medicine	Local/Chief, Flight Medicine
Space & Missile Operations Duty - Active Duty - ARC	AETC/SG (Note 14) Appropriate ARC/SG (Note 17)	AFSPC/SG AFSPC/SG
Initial Commission - Extended Active Duty - Air Reserve Components - US Air Force Academy	AETC/SG Appropriate ARC/SG (Note 17) AFA/SG	AETC/SG Appropriate ARC/SG AFA/SG
Change in Commission Status Without Break in Service - Active Duty Members	Note 14	AFPC/DPAMM
Change in Commission Status Entry into: - ANG - IMA Program - Reserve Unit Program	State Air Surgeon (ANG) ARPC/SG Gaining Reserve Medical Squadron Senior Flight Surgeon Note 13	ANG/SG ARPC/SG AFRC/SG
Officer Program Applicants - USAFA - ROTC - USUHS - HPSP - Special Officer Procurement	DODMERB DODMERB DODMERB AETC/SG AETC/SG	AFA/SG AETC/SG SEC DEF /HA AETC/SG AETC/SG
AF Initial Enlistment - Active Duty - ARC	MEPS MEPS/ARC Medical Squadron	AETC/SG Appropriate ARC/SG
Continued military duty - Active duty - ARC	AFPC/DPAMM ARC/SG	- -
Recall to Active Duty ARC	-	AFPC/DPAMM
PALACE CHASE or FRONT	Gaining ARC Medical Squadron	Appropriate ARC/SG
ARC Members Voluntarily Entering EAD	Appropriate ARC/SG (Note 17)	AETC/SG

NOTES:

1. For cases in which AFMOA/SGOA is waiver authority, interim waiver authority by subordinate commands is specifically denied.

2. HQ USAF/SG is the ultimate waiver authority for all medical waivers.

3. Authority to grant categorical Flying Class II with suffixes A, B, or C is retained by AFMOA/SGOA, unless delegated in this AFI or policy letter.

3.1. Exceptions.

3.1.1. Flying Class IIA. MAJCOM/SG may grant the following FCIIA waivers:

H3.1.1.1. Initial and renewal for use of Gemfibrozil for control of hyperlipidemia.

3.1.1.2. Initial and renewal for asymptomatic moderate Aortic Insufficiency (AI) or with otherwise non-disqualifying ventricular dysrhythmias which are considered possibly related to AI (no evidence of left ventricular enlargement or dysfunction) for members seen or case reviewed at the ACS.

3.1.1.3. Initial and renewal for Minimal Coronary Artery Disease (MCAD) for members seen or case reviewed at the ACS.

3.1.1.4. Initial waiver for Aerospace Medicine Primary (AMP) course applicants who possess mild substandard color vision is delegated to HQ AETC/SG. FCIIA restriction will include authorization for a T-37 flight to complete the AMP course.

3.1.2. Flying Class IIB. MAJCOM/SG may grant **renewals only** for waivers initially granted by AFMOA/SGOA.

3.1.3. Flying Class IIC. MAJCOM/SG may grant initial waiver (and renewal) for the following:

3.1.3.1. Asymptomatic mild AI (no evidence of left ventricular enlargement or dysfunction and no significant associated ventricular dysrhythmias) for members seen or case reviewed at the ACS. Members who did not undergo centrifuge evaluation. FCIIC restriction is as follows: “Medically monitored centrifuge evaluation required prior to assignment to Fighter, Attack, Reconnaissance (FAR) or Trainer Aircraft (except T-1).”

3.1.3.2. Mitral valve prolapse (MVP) for members seen or case reviewed at the ACS who did not undergo centrifuge evaluation. See above restriction.

3.1.3.3. Hypertension controlled with Lisinopril for members seen or case reviewed at the ACS. Members who did not undergo centrifuge evaluation. See above restriction.

3.1.3.4. H-3 Profile (inactive flyers). The following restriction applies: "An occupational cockpit hearing evaluation/assessment is required prior to reassignment to active flying."

H3.1.4. Other. MAJCOM/SG may grant initial and renewal waivers for all routine ACS clinical management group evaluations. Controversial cases will be forwarded to AFMOA/SGOA. MAJCOM/SG will forward a copy of **all** FCIIA/B/C actions (memorandum cover letter) as follows: FCIIA, B, or C: forward copy to HQ AFPC/DPAOY1, 550 C Street West, Suite 31, Randolph AFB, TX 78150-4733. Colonel (0-6) forward copy to: HQ AF/DPOA, 1040 AF Pentagon, Washington, DC 20330. All FCIIC waiver actions delegated to MAJCOM/SG, the memorandum cover letter by MAJCOM/SG will be forwarded to AFMOA/SGOA, 110 Luke Avenue, Room 400, Bolling AFB, DC 20330-7050 and HQ USAF/XOOT, 1480 AF Pentagon Washington, DC 20330-1480, to include FCIIC waiver renewals. Ensure the restrictions are contained in the memorandum.

4. Certification and waiver authority for USAF flying personnel while assigned to the National Aeronautics and Space Administration (NASA) is NASA.

5. HQ AFMC/SG has waiver authority on USAF Test Pilot School applicants except for conditions listed in Chapter **8.1.3.**

6. ARC/SG is the certification authority for assigned reserve personnel who apply for the AMP course.

7. Non-rated applicants for flying duty (Class III) and Flight Nurse applicants, who are currently medically qualified and performing flying duty, do not require additional review and certification or reexamination prior to retraining unless the individual is applying for Inflight Refueling Duty, Combat Control Duty, Pararescue Duty, or the individual is on a medical waiver.

Enlisted members applying for commissioning and flight nurse duty may use their most current periodic flying (long) medical examination (appropriately supplemented) if not more than 24 months old, in lieu of accomplishing another physical for the specific purpose of commissioning.

8. The MAJCOM or appropriate ARC/SG for ANG is ANG/SG; for unit-assigned reservists is HQ AFRC/SG; and for IMAs and Retired Reserve members is HQ ARPC/SG.

9. HQ AETC/SG is the certification authority for those individuals undergoing Basic Military Training School (BMTS). For ARC members undergoing BMTS, HQ AETC/SG will coordinate medical disposition with the appropriate ARC/SG.

10. HQ USAF/SG (AFMOA/SGOA) no longer serves as MAJCOM for Direct Reporting Units (DRUs). This responsibility has been delegated as follows: Air Force District of Washington (AFDW), Pentagon is delegated to HQ AMC/SGPA. Others: Air Force Element (AFELM), Defense Intelligence Agency (DIA),

Air Force Operational Test and Evaluation Center (AFOTEC), and others, if not otherwise specified in the table or notes above will be the medical facilities MAJCOM/SG that submits the aeromedical waiver examination package. Waiver authority for HQ AFIA is delegated to HQ AFIA/SG when that position is filled by a senior flight surgeon. Waiver authority for personnel assigned to HQ USSOCOM is delegated to HQ AFSOC.

11. HQ AIA/SG no longer serves as MAJCOM with regards to certification and waiver authority. Authority has been delegated to the MAJCOM to which the member is assigned for duty (e.g., member's MAJCOM is AIA, but he/she is assigned PCS to USAFE, PACAF, etc., for duty, that MAJCOM becomes the certification and waiver authority in accordance with the above table).

12. HQ AETC/SG is sole certification and waiver authority for applicants applying for the Combat Control or Pararescue Duty career fields.

13. Applicants who previously held a commission for 6 months or more in any service component and who are within 36 months of nonmedical separation, will not require their physical exam to be reviewed or certified by HQ AFRC/SG prior to being commissioned in the unit assigned reserve program, unless the applicant does not meet the medical requirements IAW **Attachment 3**.

14. Local Base Certification/Waiver Authority (active duty only). Flight surgeons (AFSC 48G4/3 or 48A4X), normally the Aerospace Medicine Squadron/Flight Commander or the senior SME flight surgeon (tenants only) as specifically identified by the parent MAJCOM, retain this authority. This authority will not be delegated further**.** At locations with flight surgeons who do not meet this criteria, the certification/waiver authority reverts to the MAJCOM of assignment. Non-flight surgeons are not authorized to sign, or certify medical examinations. Flight surgeons granted this authority by their MAJCOM may not certify/waiver ARC aircrew members.

15. Active duty non-aircrew members transitioning into ARC flying positions must have their medical examinations certified by the appropriate ARC Surgeon.

16. The final review authority on Flying Training examinations is the Aerospace Medicine Squadron/ Flight Commander. The final review authority on all other examinations requiring this signature is the senior flight surgeon assigned

17. State certification/waiver authority (ANG only). State Air Surgeons that are current, certified, and trained as specifically identified by ANG/SGP retain this authority. This authority will not be delegated further. At locations where State Air Surgeons are not assigned or are not trained, the certification/waiver authority reverts to ANG/SGP.

Attachment 11

HEARING PROFILE

A11.1. H-1 Profile. The H-1 profile qualifies applicants for Flying Classes I and IA, initial Flying Class II and III, AF Academy, special operational duty, and selected career fields as noted in AFI 36-2108, *Airman Classification.* See note 2.

A11.1.1. Definition: Unaided hearing loss in either ear with no single value greater than:

Hz:	500	1000	2000	3000	4000	6000
dB:	25	25	25	35	45	45

A11.2. H-2 Profile. The H-2 profile qualifies for AF enlistment, commission, initial Space and Missile Operations duty, and continued special operational duty, but requires evaluation for continued flying (See **A7.4.**).

A11.2.1. Definition: Unaided hearing loss in either ear with no single value greater than:

Hz:	500	1000	2000	3000	4000	6000
dB:	35	35	35	45	55	----

A11.3. H-3 Profile. The H-3 profile requires evaluation and MAJCOM review for continued flying, and audiology evaluation for fitness for continued active duty.

A11.3.1. Definition: An H-3 profile is any loss that exceeds the values noted above in the definition of an H-2 profile.

A11.4. H-4 Profile. The H-4 profile requires a Medical Evaluation Board.

A11.4.1. Definition: Hearing loss sufficient to preclude safe and effective performance of duty, regardless of level of pure tone hearing loss and despite use of hearing aids.

NOTES:

1. All personnel working in hazardous noise areas will be enrolled in the Hearing Conservation Program. The Air Force Hearing Conservation Program directive (see appropriate AFOSH Standard) should be consulted. Standard threshold shifts should be appropriately recorded and addressed whenever a significant shift in measured hearing threshold is noted. Such a shift may not result in a profile change.
2. For the purpose of this instruction, ISO 1964 and ANSI S3.6 values are identical.
3. Exceeding the definition/standard for H-1 or H-2 automatically places the individual in the next highest category.

4. The hearing profiles, like other aspects of the Air Force profile system, typically do not apply to civilian personnel. That is, profiles greater than H-1 apply only to active duty personnel.

Attachment 12

ACCOMMODATIVE POWER

(Minimum for Age)

Age	Diopters		Age	Diopters
17	8.8		32	5.1
18	8.6		33	4.9
19	8.4		34	4.6
20	8.1		35	4.3
21	7.9		36	4.0
22	7.7		37	3.7
23	7.5		38	3.4
24	7.2		39	3.1
25	6.9		40	2.8
26	6.7		41	2.4
27	6.5		42	2.0
28	6.2		43	1.5
29	6.0		44	1.0
30	5.7		45	0.6
31	5.4			

Attachment 13

PHYSICAL PROFILE SERIAL CHART

P. Physical Condition

P-1. Free of any identified organic defect or systemic disease.

P-2. Presence of minimally significant organic defect(s) or systemic diseases(s).

P-3. Significant defect(s) or disease(s) under good control, not requiring regular and close medical support. Capable of all basic work commensurate with grade and position.

P-4. Severe organic defect(s) systemic and infectious disease(s), all conditions disqualifying by **Attachment 2** (e.g. diabetes, seizure etc.). See note.

U. Upper Extremities

U-1. Bones, joints, and muscles normal. Able to do hand-to-hand fighting.

U-2. Slightly limited mobility of joints, mild muscular weakness or other musculoskeletal defects which do not prevent hand-to-hand fighting and are compatible with prolonged effort.

U-3. Defect(s) causing moderate interference with function, yet capable of strong effort for short periods.

U-4. Strength, range of motion, and general efficiency of hand, arm, shoulder girdle, and back, including cervical and thoracic spine severely compromised or disqualifying by A2.13. or **A2.13.** See note.

L. Lower Extremities

L-1. Bones, muscles, and joints normal. Capable of performing long marches, continuous standing, running, climbing, and digging without limitation.

L-2. Slightly limited mobility of joints, mild muscular weakness, or other musculoskeletal defects which do not prevent moderate marching, climbing, running, digging, or prolonged effort.

L-3. Defect(s) causing moderate interference with function, yet capable of strong effort for short periods.

L-4. Strength, range of movement, and efficiency of feet, legs, pelvic girdle, lower back, and lumbar vertebrae severely compromised or disqualifying by A2.13. or **A2.13.**. See note.

H. Hearing (Ears)

See **Attachment 11** for hearing profile.

E. Vision (Eyes)

E-1. Minimum vision of 20/200 correctable to 20/20 in each eye.

E-2. Vision correctable to 20/40 in one eye and 20/70 in the other, or 20/30 in one eye and 20/200 in the other eye, or 20/20 in one eye and 20/400 in the other eye.

E-3. Vision which is worse than E-2 profile but better than E-4.

E-4. Visual defects disqualifying by **A2.5.** See note.

S. Psychiatric

S-1. No psychiatric disorder.

S-2. Mild transient psychoneurosis.

S-3. Mild chronic psychoneurosis, moderate transient psychoneurotic reaction.

S-4. All psychosis and the psychoneuroses which are persistent or recurrent, requiring

hospitalization or the need for continuing psychiatric care or disqualifying by **A2.12.** See note.

NOTE:

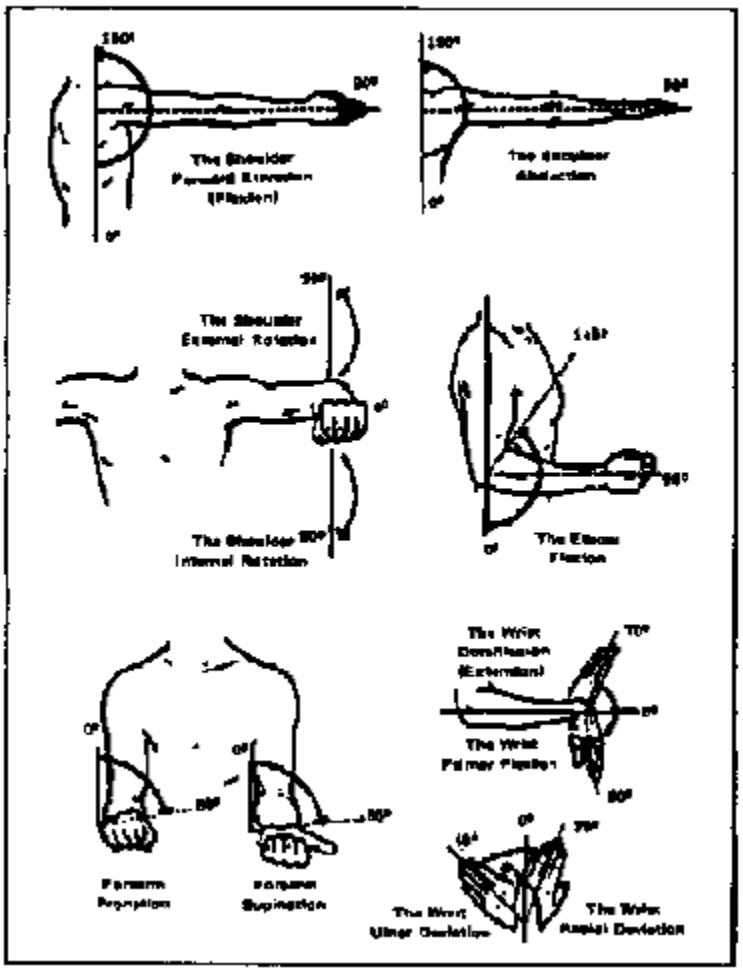
Individuals with a 4 profile are not qualified for world-wide duty. Ensure these members have met an MEB (if required), consult **Attachment 2**, Medical Standards for Continued Military Service, and **Chapter 10** of this instruction. Members on temporary 4 profiles (4T) should be followed per **Chapter 10** if an MEB has not been accomplished.

Attachment 14

UPPER EXTREMITY RANGE OF MOTION

Figure A14.1. Upper Extremity Range Of Motion

UPPER EXTREMITY MOVEMENT

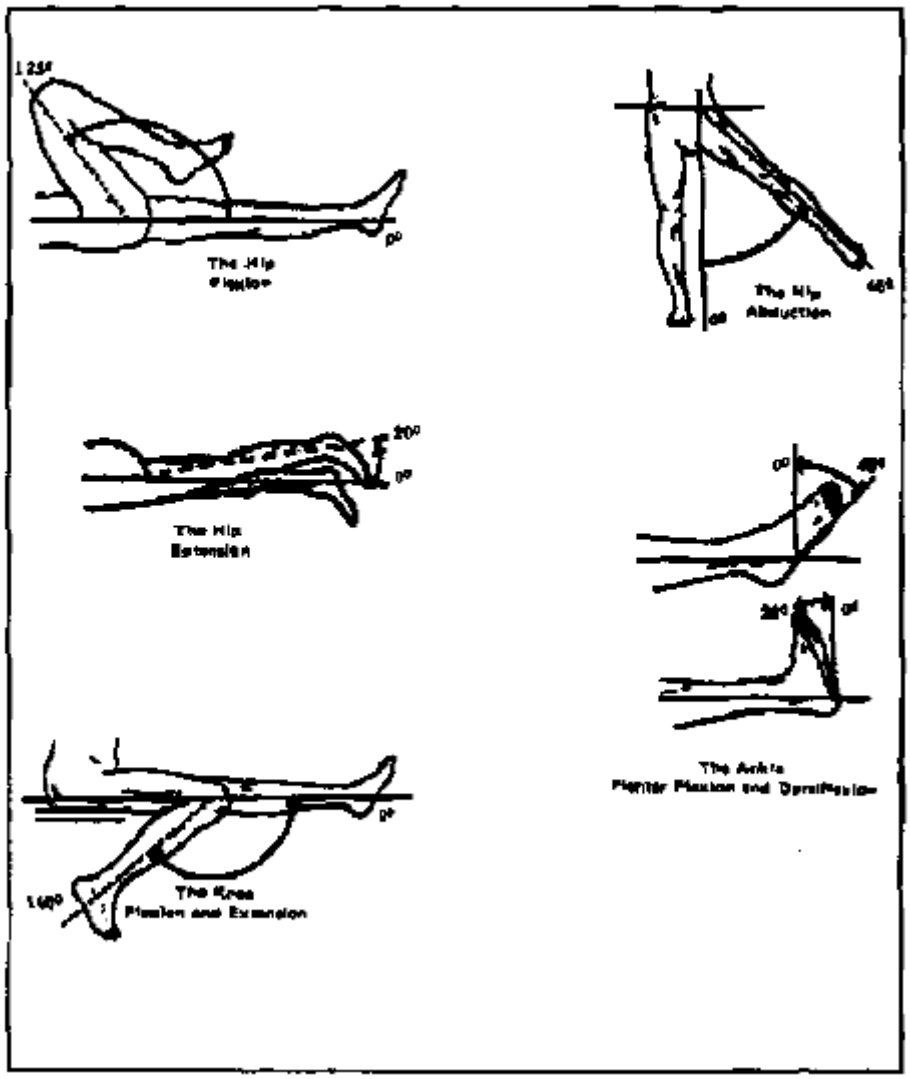


Attachment 15

LOWER EXTREMITY RANGE OF MOTION

Figure A15.1. Lower Extremity Range of Motion

LOWER EXTREMITY MOVEMENT



Attachment 16

HEIGHT AND WEIGHT TABLES

Table A16.1. Height and Weight Tables.

Height (inches/cm)	**Men**		Women	
	Minimum(lb/kg)	Maximum(lb/kg)	Minimum(lb/kg)	Maximum(lb/kg)
58/147.32	98/44.54	149/67.72	88/39.99	132/60.00
59/149.86	99/44.99	151/68.62	90/40.90	134/60.90
60/152.40	100/45.45	153/69.54	92/41.48	136/61.81
61/154.94	102/46.36	155/70.45	95/43.18	138/62.72
62/157.48	103/46.81	158/71.81	97/44.09	141/64.09
63/160.02	104/47.27	160/72.72	100/45.45	142/64.54
64/162.56	105/47.72	164/75.54	103/46.81	146/66.36
65/165.10	106/48.18	169/79.81	106/48.18	150/68.18
66/167.64	107/48.63	174/79.09	108/49.09	155/70.45
67/170.18	111/50.45	179/81.36	111/50.45	159/72.27
68/172.72	115/52.27	184/83.63	114/51.81	164/75.54
69/175.26	119/54.09	189/85.90	117/53.18	168/76.36
70/177.60	123/55.90	194/88.18	119/54.09	173/78.63
71/180.34	127/57.72	199/90.45	122/55.45	177/80.45
72/182.88	131/59.54	205/93.18	125/56.81	182/82.72
73/185.42	135/61.36	211/95.90	128/58.18	188/85.45
74/187.96	139/63.18	218/99.09	130/59.09	194/88.18
75/190.50	143/65.00	224/101.81	133/60.45	199/90.45
76/193.04	147/66.81	230/104.54	136/61.81	205/93.18
77/195.58	151/68.63	236/107.27	139/63.18	210/95.45
78/198.12	153/69.54	242/110.00	141/64.09	215/97.72
79/200.66	157/71.36	248/112.72	144/65.45	221/100.45
80/203.20	161/73.18	254/115.45	147/66.81	226/102.72

Notes: HQ USAF/DP directed policy for Air Force Accessions:

1. If an applicant is weighed and found to be at or below their MAW, a BFM is not required and processing can continue.

2. If an applicant is above their MAW, a BFM is required and can only be administered by approved medical personnel.

3. If the applicant passes the BFM, processing can continue, and if during subsequent processing the applicant's weight is found to be at or below his/her MAW, no further BFM is required.

4. If the initial BFM is failed, the applicant will be temporarily disqualified until such time the MAW is met to continue processing. A failed BFM requires an applicant to pass a BFM on all subsequent weight checks, regardless of weight.

5. Commanders may direct a BFM on any applicant.

6. Military members: Active duty and ARC members: Those found to exceed their MAW are evaluated in accordance with the Air Force Weight Management Program directive.

Attachment 17

USAF AIRCREW CORRECTIVE LENSES

A17.1. Contact Lens Policy. Aircrew may use Soft Contact Lenses (SCL) for visual correction without medical waiver provided they meet the requirements detailed in this attachment and have enrolled in the USAF Aircrew SCL Program. Only USAF approved SCL and related solutions may be used under this program (see **A17.1.4.**). Medical conditions requiring use of contact lenses to obtain 20/20 vision in either eye, requires medical waiver (see **A17.1.10.**).

A17.1.1. Eligibility. Adherence to this policy is required by:

A17.1.1.1. Flying Class I (UFT) electing to wear SCL, on or off duty (see **A17.1.3.**).

A17.1.1.2. Flying Class II electing to wear SCL, on or off duty.

A17.1.1.3. Flying Class III electing to wear SCL while performing flying duties.

NOTES:

Flying Class III electing to wear SCL, but not while performing flying duties, are NOT required to follow the USAF Aircrew SCL policy but are highly encouraged to do so.

USAF contracted DoD civilian aviators and flight instructors electing to wear SCL, on or off duty, may use any FDA approved SCL but must provide documentation to the local Flight Surgeon's Office (FSO) of efficacy of fit. This must include documentation of at least 20/20 vision in each eye with current spectacles immediately after removing SCL and in each eye while wearing SCL for both near and distant vision. Bifocal spectacles used in combination with SCL to correct near vision to 20/20 are permitted as detailed in **A17.1.4.**

A17.1.2. Program Administration/Funding.

A17.1.2.1. Administration of the SCL program is the responsibility of the local FSO.

A17.1.2.2. Active Duty Flying Class II will receive fitting, prescription, and follow-up at local medical group facility (MGF).

A17.1.2.3. Air Reserve Component (ARC) Class II may receive fitting, prescription, and follow-up at local ARC Medical Squadron (MDS) if an eye specialist is assigned. If this capacity does not exist at MDS, fitting, prescription, and follow-up will be provided by a civilian eye care professional.

A17.1.2.4. Active Duty Flying Class III who wear SCL while performing flying duties will receive fitting, prescription, and follow-up at local MGF if the MAJCOM/SG agrees that capacity within MGF exists, and flying squadron commander determines operational justification exists.

A17.1.2.5. ARC Flying Class III may receive fitting, prescription, and follow-up at local MDS if an eye specialist is assigned and flying squadron commander determines operational justification exists.

A17.1.2.6. Flying squadron commander may purchase SCL and supplies from unit funds for Class II and/or III, if operational justification to fly with SCL exist.

A17.1.2.7. Funding is not authorized for Flying Class I.

A17.1.3. UFT Entry to USAF Aircrew SCL Program. Class I must satisfy the following conditions prior to enrollment into the SCL program, **in addition** to those detailed in this attachment.

A17.1.3.1. Only UFT applicants who have been wearing **USAF approved** SCL for at least six months prior to UFT, without difficulty, will be authorized to enter the USAF Aircrew SCL program during UFT. The UFT applicant is responsible to provide civilian SCL documentation to the local FSO. The UFT applicant must be examined and processed by the local FSO and Optometry Clinic to determine adequacy of fit and visual function. Refitting SCL will NOT normally be accomplished during UFT unless operational or medically indicated.

A17.1.3.2. UFT students authorized to enter the USAF Aircrew SCL program must buy their own SCL and solutions.

A17.1.3.3. All UFT applicants are to cease wearing SCL for 30 days prior to the Flying Class I/IA physical examination and prior to the Enhanced Flight Screening physical examination (EFS-M). This is to overcome any temporary alteration in the cornea that may be caused by SCL wear.

A17.1.4. Special Considerations. All aircrew should note that:

A17.1.4.1. Bifocal, multifocal or varifocal SCL are **NOT** permitted.

A17.1.4.2. Monovision SCL correction (one eye corrected to near vision) is **NOT** permitted.

A17.1.4.3. Hard Contact Lenses or Rigid Gas Permeable lenses and Combination (hard/soft) lenses are **NOT** permitted without medical waiver for any aircrew, military or civilian, on flying status, on or off duty, including any aircrew who participate as a crewmember in military flights while on an “inactive” status.

A17.1.4.4. The wearing of spectacles in combination with SCL for distance correction is **NOT** permitted. The use of flat-top or double-D bifocal spectacles in combination with SCL for near correction is permitted, provided the distance portion is plano. Bifocal power may be adjusted for cockpit use (cockpit demands may differ from clinical test range). Progressive Addition (no line) bifocals are **NOT** permitted.

A17.1.4.5. Aircrew wearing or requiring contact lenses for medical reasons must obtain a medical waiver from USAFSAM/AFC.

A17.1.4.6. Only those SCL and related solutions on the Air Force approved list are permitted. This list is issued by USAFSAM/AFCO (formerly AL/AOCO) and is updated each February.

A17.1.5. Aircrew Responsibilities.

A17.1.5.1. Aircrew requesting initial SCL are to visit local FSO for briefing and assessment.

A17.1.5.2. Aircrew wearing SCL are to report use and any complications to local FSO.

A17.1.5.3. Aircrew will receive and be familiar with mandatory instructions for SCL use.

A17.1.5.4. Aircrew are responsible for maintaining the currency of SCL prescriptions.

A17.1.5.5. Aircrew are responsible to follow General Flight Rules (AFI 11-206) which states that aircrew “who wear corrective spectacles or contact lenses must carry a spare set of clear prescription spectacles on their person while performing aircrew duties.”

A17.1.5.6. Aircrew are responsible to ensure that their primary and backup spectacles are current and adequate.

A17.1.5.7. Aircrew must maintain at least one set of replacement SCL that are unused and current. Aircrew on mobility must satisfy requirements listed in **A17.1.9.**

A17.1.5.8. Aircrew buying their own SCL and supplies are responsible to ensure these materials comply with the current Air Force approved list.

A17.1.6. Flight Surgeon Responsibilities.

A17.1.6.1. Administrate the USAF Aircrew SCL program. Document and manage SCL use by all approved aircrew members as defined by this ATTACHMENT.

A17.1.6.2. Brief USAF Aircrew program and ensure aircrew are familiar with the contents of "USAF Aircrew Soft Contact Lens (SCL) Program."

A17.1.6.3. Report all SCL related operational incidents, medical complications, and DNIF days to USAFSAM/AFCO in the format "USAF Aircrew Soft Contact Lens (SCL) Incident Report."

A17.1.7. Eye Clinic Responsibilities.

A17.1.7.1. Examine, fit and prescribe SCL for all active duty Flying Class II, other Active Duty aircrew identified by flying squadron commander, and ARC aircrew authorized to wear SCL in flight and who have access to a unit eye clinic.

A17.1.7.2. Report to local FSO all SCL related incidents and complications.

A17.1.7.3. Obtain from USAFSAM/AFCO each February the updated list of Air Force Approved SCL and related solutions.

A17.1.7.4. Train aircrew in the emergency removal of SCL.

A17.1.8. Medical Requirements for USAF Aircrew SCL Wear. No history of ocular, periocular or medical condition that would require or contraindicate SCL wear. Conditions requiring use of contact lenses to obtain 20/20 vision in either eye, require medical waiver (see **A17.1.10.**).

A17.1.8.1. Visual acuities of 20/20 in each eye with current spectacles for both near and distant vision, immediately after removing SCL.

A17.1.8.2. Visual acuities of 20/20 in each eye while wearing SCL for both near and distant vision. Bifocal spectacles used in combination with SCL to correct near vision to 20/20 are permitted as detailed in **A17.1.4.**

A17.1.8.3. Refractive astigmatism (at spectacle plane) of no greater than 2.00 diopters.

A17.1.9. Mobility Requirements. Aircrew on mobility are required to maintain in mobility bag.

A17.1.9.1. Two replacement SCL for each eye in factory sealed containers if wearing non-disposable SCL.

A17.1.9.2. Three months supply of replacement SCL in factory sealed containers if wearing disposable or frequent replacement SCL.

A17.1.9.3. One pair of clear and one pair of sunglass spectacles, each with current prescription lenses.

A17.1.9.4. Sufficient, current SCL solutions for initial deployment (one month supply).

A17.1.9.5. Squadron Life Support retains responsibility to maintain Air Force approved SCL solutions for deployment.

A17.1.10. Medical Waivers. Aircrew required to wear contact lenses outside the scope of the USAF Aircrew SCL Program must obtain a medical waiver after evaluation by the Aeromedical Consultation Service (USAFSAM/AFC), Brooks AFB, TX. Medical waivers may be given for treatment of medical conditions requiring specialized soft or rigid contact lenses and treatment of refractive errors outside of authorized range.

A17.2. Minimum Acceptable Specifications For Commercially Procured Flying Spectacles Worn By USAF Aircrew.

A17.2.1. Frame Specifications.

A17.2.1.1. Required.

A17.2.1.1.1. Metal frames only (no rimless versions).

A17.2.1.1.2. Flat (preferably black) or matte finish to minimize distracting frame reflections.

A17.2.1.1.3. Silicone nose pads or equivalent, or formfit bridges.

A17.2.1.1.4. Temple mounts at about 10 and 2 o'clock on the eyewire to minimize interference with peripheral field of vision.

A17.2.1.1.5. Thin temples, either contoured or bayonette, for aircrew required to wear flight helmets; capable of being removed or put on with one gloved hand.

A17.2.1.1.6. Meet the minimum requirements of the American National Standards Institute's (ANSI) Z-80 standards for dress eyewear.

A17.2.1.2. Recommended.

A17.2.1.2.1. Monel, phosphur bronze, titanium gold, nickel-silver, or stainless steel construction.

A17.2.1.2.2. Three millimeter minimum bezel thickness.

A17.2.1.2.3. Frame meeting the ANSI Z-87 safety frame standards.

A17.2.2. Lens Specifications.

A17.2.2.1. Required.

A17.2.2.1.1. Lenses may be fabricated from Crown glass, CR-39, polycarbonate, or hi-index plastic. All lenses must meet or exceed the Z-80 ANSI standards for dress eyewear.

A17.2.2.1.2. Thickness: glass and CR 39 lenses (2.2 mm minimum), polycarbonate (1.5 mm minimum) Aircrew using NVGs: all lenses must be 3.0 mm minimum (ANSI Z-87).

A17.2.2.1.3. Clear or neutral gray sunglass tint (sunglass transmission not less than 15%).

A17.2.2.1.4. Scratch resistant coatings for polycarbonate lenses.

A17.2.2.2. Recommended.

A17.2.2.2.1. Anti-reflection coating.

A17.2.2.2.2. Scratch resistant coatings for CR-39, polycarbonate, and hi-index plastic.

A17.2.2.3. Not Allowed.

A17.2.2.3.1. Polarized lenses.

A17.2.2.3.2. Photochromic lenses.

A17.2.2.3.3. Progressive addition (no line) bifocal lenses.

A17.2.2.3.4. Glass lenses other than Crown glass.

NOTE:

Spectacle back-ups are required to be carried by all aircrew who wear SCL in flight (**A17.1.5.** Aircrew Responsibilities). Spectacle wearers are also required to carry back-up spectacles.

Attachment 18

DEPLOYMENT CRITERIA

A18.1. General Considerations. For the purposes of this instruction a deployment is defined as any temporary duty period outside the United States and its dependencies, or during which an individual has no ready access to a permanent fixed military medical treatment facility. Conditions which may seriously compromise the near-term well being if an individual were to deploy are disqualifying for deployment duty. This may involve dependence on certain medications appliances, severe dietary restrictions, frequent special treatments, or a requirement for frequent clinical monitoring.

A18.1.1. Individuals returned to duty as "fit" by Physical Evaluation Boards (PEB) may not meet deployment standards. Such individuals, if they are retained, must have profiles restricting them from deployment duties. They may be assignable to locations with large, fixed military medical treatment facilities.

A18.1.2. The following standards are to be applied after an individual has met either a Medical Evaluation Board (MEB) or a Physical Evaluation Board (PEB).

A18.1.3. ARC members should have Deployment Criteria addressed in the Narrative Summary submitted in the Worldwide Duty medical Evaluation package for the purpose of enabling the ARC/SG to make a valid deployability determination.

A18.2. Standards. To be able to deploy, an individual must be able to:

A18.2.1. Perform duties for a prolonged period (12 hours or more).

A18.2.2. Subsist on field rations for prolonged periods.

A18.2.3. Be free of medical conditions which require special appliances, special treatments, and frequent clinical follow-up.

A18.2.4. Wear or use all required items of uniform or personal protective equipment which includes flak vest, helmet, and the Chemical Warfare Defense Ensemble (CWDE).

A18.2.5. Perform heavy physical work over at least short periods of time.

A18.2.6. Have sufficient unaided hearing to safely perform duty.

A18.2.7. Have sufficient night vision to travel unassisted at night.

A18.2.8. Have sufficient corrected visual acuity to safely perform duty.

A18.2.9. Have normal tolerance to heat and cold.

A18.2.10. Have no increased predisposition to sudden incapacitation.

A18.2.11. Travel by either air or sea.

A18.1.4. (Added) If a member will become due for their PHA during a known deployment, the PHA must be accomplished prior to the deployment. It is not necessary to accomplish a PHA on every individual during their EAF vulnerability window.

A18.3. (Added-AFMC) IMR Rate.

A18.3.1. (Added-AFMC) Individual Status. The IMR status for each individual is coded as follows:

A18.3.1.1. (Added-AFMC) Green—all individual medical readiness requirements have been met and are current.

A18.3.1.2. (Added-AFMC) Yellow—does not downgrade overall PIMR status all or some medical readiness requirements are overdue and need to be brought into compliance.

A18.3.1.3. (Added-AFMC) Red—one or all of the IMR requirements are not met and/or the individual has a condition, which makes them not recommended for deployment.

A18.3.1.4. (Added-AFMC) Aggregate Status:

A18.3.1.4.1. (Added-AFMC) IMR Rate will be reported as the percent of assigned members medically ready for deployment. (Note: Students are not included in the denominator and GSU IMR rates are monitored separately.)

A18.3.1.4.2. (Added-AFMC) The denominators for aggregate data should be evaluated in two ways depending on scope of responsibility. Data for both metrics must be provided through the MDG.

A18.4. (Added-AFMC) Wing IMR Metric.

A18.4.1. (Added-AFMC) Metric tells wing and unit commanders the IMR status of assigned personnel for which the wing is responsible.

A18.4.2. (Added-AFMC) Individuals assigned to GSUs, tenant units, and students are reported separately.

A18.5. (Added-AFMC) Medical IMR Metric. Reflects IMR status of members which MDG is responsible for:

A18.5.1. (Added-AFMC) Members enrolled to the MTF (regardless of where they may be assigned).

A18.5.2.(Added-AFMC) Members assigned to the Wing that are not enrolled in another MTF (includes tenants, students and may contain GSU personnel from other installations).

A18.5.3. (Added-AFMC) Individuals enrolled to another MTF receive their PHA from their assigned PCM.

A18.5.4. (Added-AFMC) Special provisions will be made locally to provide PHAs for individuals assigned to the Wing but enrolled in a non-AF MTF until all military branches (Army, Navy, and Air Force) provide similar services. Unless arrangements are coordinated with another service, individuals must schedule an annual appointment with an AF MTF PCM team to review their PIMR requirements and ensure the appropriate databases are updated.

(Added-AFMC) NOTE: The capability to report the Medical IMR Metrics is in development. Enrollment databases are generally not yet mature enough to provide this information. Until the National Enrollment Database System (NEDS) is fully fielded and reliable, local accommodations may be necessary in order to get to the Medical Metric; however, it is important for medical groups to understand that this is the population for whom they are responsible. They are also responsible to provide the Wing IMR Metric data for assigned personnel.

Attachment 19

PREVENTIVE HEALTH ASSESSMENT (PHA)

A19.1. Introduction. The Preventive Health Assessment (PHA) implements a vastly improved method of applying physical standards to our active duty force and is a significant link in the Put Prevention Into Practice (PPIP) initiative. It has evolved from the periodic physical examination program, focused physical examination and Preventive Health Physical (PHP) initiatives. Currently the PHA program applies only to active duty Air Force members and AGR members of the ANG.

A19.1.1. PHA. PHA is accomplished by focusing on the member's age, sex, health risk factors, medical history and occupation to determine the scope of the assessment. PHA allows each MTF to determine the scheduling method to be utilized for performing PHAs on nonflying personnel. Flying personnel and special operational duty members will continue to be scheduled utilizing their birth month. MTFs should do everything possible to ensure the member does not have to return two or three times to complete their annual medical requirements (multiple visits should be the exception, not the norm).

NOTES:

Consult Air Force Pamphlet 48-134, entitled The Air Force Preventive Health Assessment Program.

A19.1. (Added-AFMC) Introduction. The PHA is an on-going systematic process in which a review of all preventive health requirements for active duty AF members takes place with each patient encounter. If the member has received needed preventive services as part of their routine care, then little or no additional intervention may be required and the PHA may be strictly an administrative review. To make this as seamless as possible, each PCM is charged to manage their enrollees, as they have the best knowledge of their enrollees health needs and should be aware of any examination results.

A19.2. (Added-AFMC) Clinical Preventive Services (CPS).

A19.2.1. (Added-AFMC) CPS are the initial steps toward completing the PHA and are reflected within PIMR as the minimum recommended examinations based on the US Preventive Services Task Force recommendations. The PIMR software uses these guidelines as the basis for determining when individuals are "due" (see Tables 19A/B). Providers may change the recommended frequency for individual patients based on their risk factors. These changes must be reflected in the medical records.

A19.2.2. (Added-AFMC) Requirements are screening tests (i.e., Amsler Grid, audiograms, glaucoma check, etc), which are mandated by AFPAM 48-133, Physical Examination Techniques and AFI 48-123, Medical Examinations and Standards to be accomplished. These tests must be completed at a minimum as prescribed in Tables 19 A/B, but can be completed on a more frequent basis if needed.

A19.2.3 .(Added-AFMC) Every patient encounter is an opportunity to address outstanding preventive health care needs. When these needs are identified, it is imperative that the individual be scheduled and/or provided as quickly as possible.

A19.2.4. (Added-AFMC) At a minimum, preventive health requirements and recommendations should be reviewed at the time of:

A19.2.4.1. (Added-AFMC) Medical in-processing

A19.2.4.2. (Added-AFMC) Routine or acute appointments

A19.2.4.3. (Added-AFMC) The annual HRR

A19.2.4.4. (Added-AFMC) Pre-deployment and post-deployment processing

A19.3. (Added-AFMC) PHA Process: PHA and IMR is a MDG program and the process of completing PHAs is a joint effort between several sections. Numerous ancillary services (lab, radiology, etc) provide support to ensure complete assessments.

A19.4. (Added-AFMC) Responsibilities.

A19.4.1 .(Added-AFMC) PCM Teams: Flight Medicine, Family Health and Family Practice.

A19.4.1.1 .(Added-AFMC) Pull and review medical records prior to the PHA to determine need to see provider.

A19.4.1.1.1. (Added-AFMC) Medical technician's (4N0X1) personnel perform this review.

A19.4.1.1.2. (Added-AFMC) Professional nurses may accomplish this review and conduct interviews to assess patient's clinical needs and train support staff on assessment techniques.

A19.4.2.1. (Added-AFMC) Ensure aviators and special duty personnel (air traffic controllers, ground based controllers, etc) are seen annually.

A19.4.2.2. (Added-AFMC) Ensure any medical condition(s) found to be disqualifying for continued military service are properly profiled and scheduled for appropriate medical follow-up, care and determination of world wide qualification.

A19.4.2.3. (Added-AFMC) Complete the para-professional portions of the PHA to include, vision testing, anthropometric data, blood pressure, interval history, counseling, etc.

A19.4.2.4. (Added-AFMC) Ensures a credentialed provider performs the professional aspects of PHAs and complete a review of all referral and/or screening results.

A19.4.2.5. (Added-AFMC) Ensure required tests/assessments such as PAP smears, cholesterol screening, OHMEs and mammograms are scheduled.

A19.4.2.6. (Added-AFMC) In accordance with local guidance, monitor and track any referrals or screenings and upon completion, ensure patient has received results and the individual's medical records have been appropriately annotated.

A19.4.2.7. (Added-AFMC) Update the PIMR database to reflect current status of enrollees.

A19.5. (Added) Frequency of PHA.

A19.5.1. PHAs on flying personnel will be accomplished on or during their birth month IAW AFI 48-123, Attachment 9.

A19.5.2 (Added-AFMC) . For nonflying personnel, the PHA becomes due 12 months after the last PHA was documented as being completed by record review or PIMR software. Every effort should be made to complete the OHME with the PHA.

A19.6. (Added-AFMC) Special Rules for GSUs.

A19.6.1. (Added-AFMC) GSU IMR rates will be tracked separately and will not be included in the MTF baseline.

A19.6.2. (Added-AFMC) Individuals assigned to a GSU must complete their PHA no less than 90 days prior to their assignment and every three years thereafter (unless occupational health exams are required more frequently) if they are without intrinsic medical support or readily available medical support.

A19.6.3. (Added-AFMC) All PHA and IMR requirements must be current including Clinical Preventive Services, fitness assessment, and any occupational health requirements prior to assignment to a GSU.

A19.6.4. (Added-AFMC) Ongoing preventive care will be the responsibility of their assigned PCM.

A19.6.5. (Added-AFMC) For GSUs with a mobility requirement, special arrangements may be necessary to ensure their readiness status is maintained and tracked.

A19.6.6. (Added-AFMC) MTFs must work with these GSUs to establish local protocols and frequencies.

A19.7. (Added-AFMC) Scope of PHAs. The scope of the PHA is directed by Attachment 9 and Tables 19A and B of this instruction.

Attachment 20

IC 2000-1 TO AFI 48-123, MEDICAL EXAMINATIONS AND STANDARDS

6 NOVEMBER 2000

SUMMARY OF REVISIONS

This revision incorporates Interim Change IC 2000-1. This is a major revision of this AFI. This change incorporates inputs received from field and MAJCOMs since last publication of AFI. A "|" indicates revised material since the last edition.

1.2.2.1. A credentialed flight surgeon of any Service or government agency may perform medical examinations on Air Force flying personnel. When this occurs, forward the documents (physical assessment, etc.) to the examinee's MAJCOM/SG for review and certification. All aircrew members examined by a U.S. military flight surgeon and found qualified to perform flight duties will be returned to flying status upon completion of their examination.

5.5.4. Elective surgery. Ensure elective surgery on procedures, excluding those that are emergent, a threat to life, limb, vision, or prevent undo suffering, are not performed within six months of retirement or separation without prior approval by HQ AFPC/DPAMM. If approved, the patient must be briefed that retirement or separation proceeds on schedule despite hospitalization or convalescence.

7.5.2.1.6.3. Flying Class IIC qualifies rated officers for aviation duty as specified in the remarks section of AF Form 1042, and as annotated on the AMS, SF 88, *Report of Medical Examination*, or AF Form 1446, *Medical Examination -- Flying Personnel*. These waivers are coordinated with HQ USAF/XOOT.

8.1.4.4. Certification and waiver authority for assignment into ARC flying positions may not be delegated lower than MAJCOM/SG level unless authorized by ARC/SG

8.2.2.3. Armed Forces Institute of Pathology (AFIP) opinion, in cases of malignancy (initial waiver request), consult ANG/SG and AFRC/SG for current policy regarding AFIP

8.2.2.4. Any other relevant documentation.

8.2.2.5. Civilian medical documentation. Medical documentation from the member's civilian health care provider will be included in all waiver cases submitted on ARC members. The examining flight surgeon will review this information and reference it in the aeromedical summary.

8.2.2.6. Delete

8.2.2.7. Delete

8.2.2.8. Delete

8.2.2.9. Delete

8.2.2.10. Delete

8.2.2.11. Delete

8.2.2.12. Delete

8.2.2.13. Delete

9.1.1. Applicability. Applies to each Air Force MTF or ARC medical squadron providing support for flying or special operational duty personnel, missile launch crew personnel, controllers, and air vehicle operators. Only flight surgeons can perform aeromedical dispositions.

10.5.1.1. At all standard, special purpose medical examinations, or Preventive Health Assessments. If a member fails to comply with required medical assessments, and because of the member's failure to comply, the Air Force Medical Service is unaware of member's current medical status, a 4T profile will be processed.

10.10. Medical Evaluation Board General Information. Guidance for processing MEBs is contained in AFI 44-157, *Medical Evaluation Boards (MEB) and Continued Military Service*.

14.14.1.3. ARC members complete AF Form 895 within 12 months of the date of last medical certificate for those years in which a medical examination is not required. ARC aircrew members require this form in years that a short flying exam (AF Form 1446) is accomplished.

14.14.2.1. ARC members placed in dental class III are not medically qualified for continued military duty. Manage AFRC members IAW Paragraph **14.16.** of this instruction unless the dental officer has determined the member may continue reserve participation in restricted status.

14.14.2.3. ANG Dental III members are immediately placed on physical profile P4T. The State Air Surgeon may grant an interim waiver for IDT only. Aircrew members in dental class III will be placed on DNIF, and an AF Form 1042, *Medical Recommendations for Flying or Special Operational Duty*, will be accomplished and may not perform flying duty while in Dental Class III. For additional guidance, please see AFI 47-101, *Managing Air Force Dental Services*.

14.16.3.2. For ANG members.

14.16.3.2.1. SF 93, updated and current within six months

14.16.3.2.2. SF 502, narrative summary should include:

14.16.3.2.2.1. Date and circumstance of occurrence

14.16.3.2.2.2. Response to treatment

14.16.3.2.2.3. Current clinical status

14.16.3.2.2.4. Proposed treatment

14.16.3.2.2.5. Current medications

14.16.3.2.2.6. The extent to which the condition interferes with performance of military duty (see **Attachment 18**, Deployment Criteria)

14.16.3.2.2.7. Prognosis

14.16.3.2.5. Delete

14.16.3.2.6. Delete

14.16.3.2.7. Delete

14.16.3.2.8. Delete

14.16.3.2.3. Civilian medical documentation. Medical documentation from the member's civilian health care provider will be included in all waiver cases submitted on ARC members. The provider will review this information and reference it in the narrative summary.

14.16.3.2.4. A written statement from the member's immediate commanding officer or supervisor describing the impact of the member's medical condition on normal duties and ability to deploy or mobilize.

14.17. Failure to Complete Medical Requirements (Refer to AFRESMAN 48-101 for unit assigned reservist). Reserve members who fail to complete medical/dental requirements may not perform military duty IAW AFM 36-8001. An AF Form 422 will be accomplished IAW with the AFRC supplement to AFPAM 48-133. The numerical profile will not be changed. NOTE: ANG members who fail to complete any requirements (i.e., periodic medical examination, dental, immunizations, AF Form 895, etc.) are placed on P4T status.

14.17.2. Refusal. ANG members with a known medical or dental condition who refuse to comply with a request for medical information or evaluation are considered medically unfit for continued military duty and are processed IAW AFI 36-3209, *Separation and Retirement Procedures for ANG and AFR Members*.

15.2.3.7. Examination of an ARC member. NOTE: For ANG short flying exams (AF Form 1446), accomplish an AF Form 895 in place of the updated SF 93.

15.7. Adaptability Rating for Military Aviation (ARMA) and other military duties, such as for Air Traffic Control Duty (ARMA-ATC), Space (ARMA-SPACE) and Missile Duty (ARMA-MISSILE), etc., is the responsibility of the examining flight surgeon, as is the scope and extent of the interview. Initial (entry into training) unsatisfactory adaptability ratings are usually rendered for poor motivation for flying (or other duty), or evidence of a potential safety of flight risk, etc. See **A7.24.** and AFPAM 48-133, *Physical Examination Techniques* for further information.

16.4.3. Initial applicants for commission, enlistment, Flying Class II and III that are 40 years of age and older are required to obtain an Exercise Tolerance Test (ETT) if their cardiac risk index (CRI) is 10,000 or greater.

FORMULA: CRI = [(cholesterol/HDL)-1]age^2

18.2.3. ARC members must include documents as required in Paragraph **8.2.2.**

Attachment 1

GLOSSARY OF REFERENCES AND SUPPORTING INFORMATION

References

DoDD 1332.18, *Separation or Retirement for Physical Disability*

DoDD 5154.24, *Armed Forces Institute of Pathology (AFIP)*

DoDD 6130.3, *Physical Standards for Appointment, Enlistment and Induction*

DoD Manual 6055.5, *Occupational Health Surveillance Manual*

10 USC Chap 61

10 USC 113

10 USC 8013

10 USC 12408

Title 38, United States Code

Executive Order 9397

Occupational Safety and Health Act of 1970 (29 USC 651)

AFPD 36-27, *Social Actions*

AFI 44-157, *Medical Evaluation Boards (MEB) and Continued Military Service*

AFPD 48-1, *Aerospace Medical Program*

AFI 11-401, *Flight Management*

AFI 36-2101, *Classifying Military Personnel (Officers and Airmen)*

AFI 36-2104, *Nuclear Weapons Personnel Reliability Program*

AFMAN 36-2108, *Airman Classification*

AFI 36-2018, *Medical Examination of Applicants for United States Service Academies, Reserve Officer Training Corps (ROTC) Scholarship Programs, Including the AF, Army, and Navy Two and Three-Year College Scholarship Programs (CSP), and the Uniformed Services University of the Health Sciences (USUHS)*

AFI 36-2626, *Airman Retraining Program*

AFI 36-3212, *Physical Evaluation for Retention, Retirement or Separation*

AFI 37-138, *Records Disposition--Procedures Responsibilities*

AFI 41-115, *Authorized Health Care and Health Care Benefits in the Military Health Services System (MHSS)*

AFI 48-123/AFRC Supplement, *Air Force Reserve supplement to AFI 48-123 for unit assigned reservists*

AFOSH Standard 161-17, *Standardized Occupational Health Program*

Abbreviations and Acronyms

ACSAeromedical Consultation Service

ADTActive duty tour

AETCAir Education and Training Command

AFAAir Force Academy

AFIPArmed Forces Institute of Pathology

AFIAir Force Instruction

AFPCAir Force Personnel Center

AFRCAir Force Reserve Command

AFROTC Air Force Reserve Officer's Training Corps

AFSCAir Force Specialty Code

AMEAviation Medical Examiner

AMPAerospace Medicine Primary

ANGAir National Guard (Previously, Air National Guard

Readiness Center)

ANGAir National Guard

ANSIAmerican National Standards Institute

ARAdaptability Rating

ARCAir Reserve Components (ANG, IMA and unit reservists)

ARC SURGEONHQ AFRC/SGP for unit reservists; HQ ARPC/SGS for IMAs; ANG/SGP for guardsmen

ARMAAdaptability Rating Military Aviation

ARPCAir Reserve Personnel Center

ASMRO Armed Services Medical Regulating Officer

ATAnnual Training

AVAtrioventricular

AWOLAbsent Without Official Leave

BESBioenvironmental Engineering Section

BSCBiomedical Sciences Corps

CCPO Consolidated Civilian Personnel Office

cmCentimeter

CNSCentral Nervous System

CONUS Continental United States

CRSConditional Reserve Status

CSAFChief of Staff United States Air Force

CTCover test

DAFDepartment of the Air Force

DAFSC Duty Air Force Specialty Code

dBDecibel

DBMS Director of Base Medical Services

DCDental Corps

DEROS Date Eligible for Return from Overseas

DNIC Duties Not Involving Controlling

DNIFDuties Not Involving Flying

DODD Department of Defense Directive

DODMERBDepartment of Defense Medical Examination

Review Board

DOSDate of separation

DPA-V Depth perception apparatus Verhoeff

DSMDiagnostic and Statistical Manual

EADExtended active duty

ECGElectrocardiogram

EFSEnhanced Flight Screening

EFS-M Enhanced Flight Screening - Medical

ELISAEnzyme-linked immunosorbent assay

ENTEar, nose, and throat

EPTSExisted prior to service

ETSExpiration of term of service

FAAFederal Aviation Administration

FALANTFarnsworth lantern test

FARFederal Air Regulation

FEBFlying Evaluation Board

FMOFlight Management Officer

FTS-ABS Fluorescent treponemal antibody absorption

GLCG induced loss of consciousness

G6PD Glucose 6 phosphate dehydrogenase

HDLHigh density lipoprotein

HPSPHealth Professions Scholarship Program

HIVHuman Immunodeficiency Virus

HOSM Host Operations System Management

HQ AFMOA/SGO Headquarters Air Force Medical Operations Agency

HQ AFMOA/SGOA Headquarters Air Force Medical Operations

Agency, Aerospace Medicine Directorate

HQ AFRC/SGP Headquarters Air Force Reserve Command,

Aerospace Medicine Division

HQ USAF/SG Headquarters United States Air Force Surgeon

General

IDTInactive duty for training

IMAIndividual mobilization augmentee

ISOInternational Standards Organization

LASLimited assignment status

LASIK Laser In Situ Keratomilieusis

LOCLoss of consciousness

MAJCOMMajor command

MCMedical Corps

MEBMedical Evaluation Board

MEPSMilitary Entrance Processing Station

MIMSO Military Indoctrination for Medical Service Officers

mmMillimeter

mmHg Millimeters of mercury

MSC Medical Service Corps

MTFMedical Treatment Facility

MPFMilitary Personnel Flight

MVPMitral Valve Prolapse

NATONorth Atlantic Treaty Organization

NCNurse Corps

NIBHNot indicated by history

NOK Next of kin

NVGNight vision goggles

OTSOfficer Training School

OUOculi Unitas (both eyes)

OVTOptec Vision Tester (Replaced the VTA-ND)

PAPhysician's Assistant

PCPoint of convergence

PCAPermanent change of assignment

PCSPermanent change of station

PEBPhysical Evaluation Board

PEBLOPhysical Evaluation Board Liaison Officer

PEBRHPhysical Evaluation Board Referral Hospital

PESPhysical Examination and Standards

PFTPulmonary function test

PHA Preventive Health Assessment

PIPPseudoisochromatic Plates

POCProfessional Officers Course

PMMAPolymethyl Methacrylate

PRK Photo Refractive Keratectomy

RBCRed blood cell

RDReinforcement designees

RK Radial Keratotomy

ROTCReserve Officer Training Corps

RPRRapid plasma reagin

RPWRepatriated Prisoner of War

RTFS Return to Flying Status

SATStrength Aptitude Test

SATPSecurity Assistance Training Program

SMOC Space and Missile Operations Crew

SSNSocial security number

STSSerologic test for syphilis

TDRLTemporary Disability Retirement List

TDYTemporary duty

TPSKTopographical Pattern Suggestive of Keratoconus

UFTUndergraduate flight training

UNTUndergraduate navigator training

UPTUndergraduate pilot training

USAFA United States Air Force Academy

USAFSAM/AFC United States Air Force School of Aerospace Medicine/Department of Aerospace Medicine, Clinical Sciences Division

USAFSAM/AFCI United States Air Force School of Aerospace Medicine/Department of Aerospace Medicine, Clinical Sciences Division/ECG Library

USAFSAM/AFCI United States Air Force School of Aerospace Medicine/Department of Aerospace Medicine, Clinical Sciences Division, Internal Medicine Branch

USAFSAM/AFCO United States Air Force School of Aerospace Medicine/Department of Aerospace Medicine, Clinical Sciences Division, Ophthalmology Branch

USAFSAM/AFCF United States Air Force School of Aerospace Medicine/Department of Aerospace Medicine, Clinical Sciences Division, Flight Medicine Branch

USAFSAM/AFH United States Air Force School of Aerospace Medicine/Department of Aerospace Medicine, Hyperbaric Medicine

USUHS Uniformed Services University of Health Sciences

VASCIVeterans administration spinal cord injury

VTA-ND (See OVT)

VDRLVenereal Disease Research Laboratory

WAVR-File Centralized waiver repository

Attachment 2

MEDICAL STANDARDS FOR CONTINUED MILITARY SERVICE

Conditions listed in this Attachment require Medical Evaluation Board (MEB) processing for active duty members, worldwide duty evaluation for ARC members when appropriate, and are not all-inclusive. ARC members must be placed on a "4" profile under the appropriate PULHES heading on AF Form 422. Any condition in the opinion of the provider of care is felt to be unacceptable for continued military service is reason for performing an MEB for active duty and ANG members or worldwide duty medical evaluation for ARC members. Questionable conditions should be addressed to the senior profile officer, and if required, to HQ AFPC/DPAMM for active duty members and to the appropriate ARC/SG for ARC members.

A2.1. Head.

A2.1.1. The loss of substance of the skull, with or without prosthetic replacement accompanied by residual signs or symptoms which preclude satisfactory performance of duty or unrestricted station assignability.

A2.1.2. An unprotected skull defect 3 cm in diameter or larger.

A2.2. Mouth, Nose, Pharynx, Larynx, and Trachea.

A2.2.1. Larynx.

A2.2.1.1. Paralysis of the larynx. Characterized by bilateral vocal cord paralysis seriously interfering with speech or adequate airway.

A2.2.1.2. Stenosis of the larynx. Of a degree causing respiratory compromise.

A2.2.1.3. Obstructive edema. Obstructive edema of the glottis, if recurrent.

A2.2.1.4. Obstructive sleep apnea requiring Continuous Positive Airway Pressure (CPAP) device.

A2.2.2. Nose, Pharynx, and Trachea.

A2.2.2.1. Rhinitis. Atrophic rhinitis, characterized by bilateral atrophy of nasal mucus membranes, with severe crusting, concomitant severe headaches, and foul, fetid odor.

A2.2.2.2. Sinusitis. Severe and chronic which is suppurative, complicated by polyps, or does not respond to treatment.

A2.2.2.3. Stenosis of trachea causing respiratory embarrassment.

A2.3. Ears and Hearing.

A2.3.1. Ears.

A2.3.1.1. Mastoidectomy. Followed by chronic infection requiring frequent or prolonged specialized medical care.

A2.3.1.2. Infections of ears or mastoids. When satisfactory performance of duty is prevented or because of the requirement for extensive and prolonged treatment.

A2.3.1.3. Meniere's syndrome. Recurring attacks of sufficient frequency and severity as to require frequent or prolonged medical care.

A2.3.2. Hearing.

A2.3.2.1. Hearing loss which precludes safe, effective performance of duty despite use of hearing aid.

A2.4. Dental. Diseases and abnormalities of the jaw or associated tissues which despite treatment, prevent normal mastication, normal speech or the wearing of required life support or chemical/biological warfare ensemble, or which otherwise interferes with performance.

A2.5. Eyes and Vision. All ophthalmological cases must include visual acuity and Goldmann perimeter charts for peripheral visual field.

A2.5.1. Any disease, injury, infection process, or sequelae involving the eye which is resistant to treatment and/or results in:

A2.5.1.1. Distant visual acuity which cannot be corrected to at least 20/40 in the better eye.

A2.5.1.2. The central field of vision in the better eye is less than 20 degrees from fixation in any direction.

A2.5.2. Aphakia, bilateral.

A2.5.3. Night blindness of such a degree that the member requires assistance in travel at night.

A2.5.4. Even if the requirements in **A2.5.** above are met, the following manifestations of eye conditions are disqualifying:

A2.5.4.1. Glaucoma with demonstrable changes in the optic disc or visual fields or not amenable to treatment.

A2.5.4.2. Retinal detachment, bilateral.

A2.5.4.3. Retinal detachment, unilateral, which results from organic progressive disease or results in uncorrectable diplopia, or visual acuity or visual field defects worse than specified above.

A2.5.4.4. Enucleated eye.

A2.5.4.5. Vision correctable only by the use of bilateral contact lenses or uncommon corrective devices, e.g. telescopic lenses.

A2.5.4.6. Aniseikonia when incapacitating signs or symptoms exist that are not easily treatable with standard ophthalmic spectacle lenses.

A2.5.4.7. Diplopia when symptoms are severe, constant, and in a zone less than 20 degrees from the primary position.

A2.5.4.8. Hemianopsia when bilateral, permanent, and based on an organic defect.

A2.5.4.9. Visual acuity which cannot be corrected to at least:

Better eye /Worse eye

20/20	20/400
20/30	20/200
20/40	20/100
20/50	20/80
20/60	20/60

A2.5.4.10. History of keratorefractive surgery, of any kind, accomplished to modify the refractive power of the cornea, or of lamellar, penetrating keratoplasty. Radial Keratotomy is also disqualifying. RK is not compatible for continued worldwide duty, medical evaluation board (MEB) is required.

A2.6. Lungs and Chest Wall.

A2.6.1. Active tuberculosis, where curative therapy requires 15 or more months.

A2.6.2. Symptoms of chronic or recurrent pulmonary disease, or residuals of surgery, which preclude satisfactory performance of duty. These may include:

A2.6.2.1. Significant fatigue or dyspnea on mild exertion supported by appropriate pulmonary function and blood gas studies.

A2.6.2.2. Requirement for an inordinate amount of medical observation or care over prolonged periods.

A2.6.3. Recurrent spontaneous pneumothorax when the underlying defect is not correctable by surgery.

A2.6.4. Pneumonectomy.

A2.6.5. Asthma, recurrent bronchospasm, or reactive airway disease, unless due to well defined avoidable precipitant cause.

A2.7. Heart and Vascular System.

A2.7.1. Heart disease.

A2.7.1.1. Arteriosclerotic heart disease, when associated with congestive heart failure, persistent major rhythm disturbances, repeated angina attacks, silent ischemia at a low to moderate workload or objective evidence of myocardial infarction. The following considerations pertain to myocardial infarction:

A2.7.1.1.1. Maintenance on any type of medication for the treatment or prevention of angina, congestive heart failure, or major rhythm disturbances (ventricular tachycardia, ventricular fibrillation, symptomatic paroxysmal supraventricular tachycardia, atrial flutter, or atrial fibrillation).

A2.7.1.1.2. Individuals sustaining a myocardial infarct will have MEB processing within 90 calendar days. ARC members should undergo MEB processing 9-12 months following infarction.

A2.7.1.1.3. Refer to paragraph **10.10.2.** when managing cases on ARC members.

A2.7.1.1.4. Final evaluation of cases for continued active duty, and where time permits, for separation or retirement, is conducted not more than 1 year post-infarct, provided the member's clinical course is uneventful.

A2.7.1.2. Treadmill is required by medical and disability reviewing authorities in adjudication of infarction cases.

A2.7.1.2.1. Exercise Treadmill Test (ETT).

A2.7.1.2.1.1. Must achieve minimum of 85% maximum predicted heart rate for age unless heart rate is limited by medically necessary beta blockers, in which case 3 Bruce stages (9 minutes exercise) should be attained.

A2.7.1.2.1.2. Normal blood pressure response.

A2.7.1.2.1.3. No reversible ischemic ST changes (i.e., no flat or downsloping ST depressions at 80 ms past the J point; applicable only if baseline ST segments are normal; if not, imaging study is necessary.

A2.7.1.2.1.4. No significant arrhythmias.

A2.7.1.2.1.5. No symptoms or objective evidence of ischemia, angina or congestive heart failure.

A2.7.1.2.1.6. Thallium, stress echocardiogram or stress MUGA imaging if indicated by ETT (see above).

A2.7.1.2.1.6.1. No evidence of significant territories of reversible ischemia.

A2.7.1.2.1.7. Additional testing (if indicated).

A2.7.1.2.1.7.1. Baseline echocardiogram or MUGA.

A2.7.1.2.1.7.1. Evaluate left ventricular systolic function and wall motion.

A2.7.1.2.1.8. Clinical status.

A2.7.1.2.1.8.1. No angina or evidence of ischemia.

A2.7.1.2.1.8.2. No evidence of congestive heart failure.

A2.7.1.2.1.8.3. No major rhythm disturbances.

A2.7.1.2.1.8.4. No more than mild reduction in ejection fraction (i.e., greater than 45%)

*Note: MEBs on cardiac cases must include the New York Heart Association (NYHA) or Canadian Heart classification.

A2.7.1.3. Paroxysmal ventricular tachycardia, ventricular fibrillation.

A2.7.1.4. Pacemakers or implantable cardioverter-defibrillators.

A2.7.1.5. Paroxysmal supraventricular tachycardia, atrial flutter unless successfully ablated by catheter based method (radiofrequency ablation) and not associated with structural heart disease.

A2.7.1.6. Atrial fibrillation, other than infrequent “lone” atrial fibrillation, not associated with structural heart disease and not requiring medication.

A2.7.1.7. Myocarditis and degeneration of the myocardium..

A2.7.1.8. Cardiomyopathy, any etiology, including hypertrophic obstructive type, idiopathic dilated type, toxic, restrictive.

A2.7.1.9. Endocarditis, infectious (acute or subacute), and marantic.

A2.7.1.10. Pericarditis.

A2.7.1.10.1. Chronic constrictive pericarditis, unless successful surgery has been performed and return of normal hemodynamics objectively documented.

A2.7.1.10.2. Chronic serous pericarditis.

A2.7.1.11. Acute rheumatic valvulitis or sequelae of chronic rheumatic heart disease (see also, valvular heart disease below).

A2.7.1.12. Premature ventricular contractions. When they interfere with the satisfactory performance of duty.

A2.7.1.13. Atrioventricular block, other than first degree or asymptomatic Type I second degree AV block without structural heart disease. Higher degrees of block must be individually evaluated, even if asymptomatic.

A2.7.1.14. Peripheral vascular disease, if symptomatic, including claudication, skin changes or cerebrovascular events.

A2.7.1.15. Periarteritis nodosa.

A2.7.1.16. Chronic venous insufficiency (postphlebitic syndrome). When symptomatic or requiring elastic support or chronic anticoagulation.

A2.7.1.17. Raynaud's phenomenon, if frequent, severe, associated with systemic disease or would limit worldwide assignability.

A2.7.1.18. Thromboangiitis obliterans.

A2.7.1.19. Deep venous thrombosis with repeated attacks requiring treatment or prophylaxis, or pulmonary embolus.

A2.7.1.20. Varicose veins. Severe and symptomatic.

A2.7.1.21. Congenital anomalies. Coarctation of aorta, atrial or ventricular septal defect and other congenital anomalies unless satisfactorily treated by surgical correction.

A2.7.1.22. Valvular heart disease, including:

A2.7.1.22.1. Symptomatic mitral valve prolapse requiring treatment.

A2.7.1.22.2. Moderate to severe aortic stenosis (valvular, subvalvular or supravalvular), even if asymptomatic.

A2.7.1.22.3. Moderate to severe mitral regurgitation, any etiology, if symptomatic or associated with subnormal ejection fraction. Successful mitral repair with preservation of ejection fraction, no need for anticoagulants or anti-arrhythmics may be waived if exercise tolerance is normal, but MEB processing should precede surgery.

A2.7.1.22.4. Severe valvular or subvalvular pulmonic stenosis. Successful correction of valvular pulmonic stenosis with balloon valvuloplasty may be waiverable, but MEB processing should precede the procedure.

A2.7.1.22.5. Symptomatic mitral stenosis, generally associated with mitral valve area less than 1.0 cm sq.

A2.7.1.22.6. Severe aortic insufficiency if symptomatic, associated with left ventricular dilation or dysfunction.

A2.7.2. Hypertensive cardiovascular disease.

A2.7.2.1. Diastolic pressure consistently more than 110 mmHg following an adequate period of therapy in an ambulatory status or history of hypertension associated with any of the following:

A2.7.2.1.1. More than minimal demonstrable changes in the brain.

A2.7.2.1.2. Heart disease related to the hypertension, including atrial fibrillation, moderate to severe left ventricular hypertrophy, and symptomatic systolic or diastolic dysfunction.

A2.7.2.1.3. Unequivocal impairment of renal function.

A2.7.2.1.4. Grade III (Keith-Wagener-Parker) changes in the fundi.

A2.7.2.1.5. Multiple drug therapy with the requirement for an inordinate amount of medical supervision.

A2.7.2.2. Aneurysm or history of repair.

A2.7.2.3. Reconstructive surgery, including:

A2.7.2.3.1. Grafts.

A2.7.2.3.2. Prosthetic devices that are attached to or implanted for cardiovascular therapeutic purposes, regardless of result. Intracoronary stents may, in certain instances, be acceptable without MEB if associated with a good result, no myocardial infarction has occurred, and a six month post-procedure treadmill is non-ischemic. Worldwide Duty Medical Processing is required for ARC members 6-12 months following procedure with associated myocardial damage; three months if no myocardial damage.

A2.7.2.3.3. Surgery of the heart, pericardium, or vascular system.

A2.7.2.3.4. Member has undergone coronary vascular surgery, regardless of the result. Coronary angioplasty, may in certain instances, be acceptable without MEB if no myocardial infarction has occurred, a good result is obtained, and six month post-procedure treadmill or equivalent test is non-ischemic.

*Notes:1. Conditions above must have MEB processing within 90 calendar days of surgery regardless of the results, unless stated otherwise.

2. Refer to paragraph **10.10.2.** when managing cases on ARC members.

A2.8. Blood, Blood-Forming Tissue, and Immune System Diseases.

A2.8.1. Anemia, symptomatic.

A2.8.2. Leukopenia, chronic.

A2.8.3. Hemolytic disease, chronic. Symptomatic or with recurrent crises.

A2.8.4. Polycythemia, symptomatic.

A2.8.5. Purpura and other bleeding disorders.

A2.8.6. Thromboembolic disease.

A2.8.7. Splenomegaly, chronic, inoperable.

A2.8.8. Other such diseases when response to therapy is unsatisfactory or when therapy is prolonged or requires intense medical supervision such as use of anticoagulants other than aspirin or persantine.

A2.8.9. Leukemia.

A2.8.10. Immunodeficiency.

A2.8.11. Sickle cell disease and heterozygous sickling disorders other than sickle cell trait are disqualifying.

*Note: Those individuals with sickling disorders who develop symptoms attributable to the trait must undergo MEB evaluation. (Refer to paragraph **10.10.2.** for ARC members).

A2.9. Abdomen and Gastrointestinal System.

A2.9.1. **Esophageal.**

A2.9.1.1. Achalasia (cardiospasm), manifested by dysphagia not controlled by dilation with frequent discomfort, or inability to maintain normal vigor and nutrition.

A2.9.1.2. Esophagitis, persistent and severe.

A2.9.1.3. Diverticulum of the esophagus which causes frequent regurgitation, obstruction, and weight loss, and does not respond to treatment.

A2.9.1.4. Stricture of the esophagus which requires an essentially liquid diet, frequent dilation and hospitalization, and causes difficulty in maintaining weight and nutrition.

A2.9.2. Gastritis. Severe, chronic gastritis with repeated symptoms requiring hospitalization and confirmed by gastroscopic examination.

A2.9.3. Hernia.

A2.9.3.1. Hiatus hernia with severe symptoms not relieved by dietary or medical therapy or with recurrent bleeding in spite of prescribed therapy.

A2.9.3.2. Other types of hernias, if operative repair is contraindicated for medical reasons, or if not amenable to surgical repair.

A2.9.4. Ulcer. Peptic, duodenal or gastric with repeated incapacitations or absences from duty because of recurrence of symptoms despite good medical management and supported by laboratory and X-ray evidence of activity or severe deformity.

A2.9.5. Cirrhosis of the liver. Recurrent jaundice or ascites or demonstrable esophageal varices or history of bleeding from them.

A2.9.6. Hepatitis. Chronic, when symptoms persist after a reasonable time following the acute stage and there is objective evidence of impairment of liver function.

A2.9.7. Amebic abscess residuals. Persistent abnormal liver function tests and failure to maintain weight and normal vigor after appropriate treatment.

A2.9.8. Pancreatitis, chronic. Recurrent pseudocystitis or frequent abdominal pain requiring hospitalization or steatorrhea, or disturbance of glucose metabolism requiring insulin.

A2.9.9. Peritoneal adhesions. Recurring episodes of intestinal obstruction, characterized by abdominal colicky pain, and vomiting, and requiring frequent admissions to the hospital.

A2.9.10. Granulomatous enteritis or enterocolitis or Crohn's disease.

A2.9.11. Ulcerative colitis.

A2.9.12. Stricture of rectum. Severe symptoms of obstruction characterized by intractable constipation, pain on defecation, and difficult bowel movements which require the regular use of laxatives, enemas, or repeated hospitalization.

A2.9.13. Proctitis, chronic. Moderate to severe symptoms of bleeding, painful defecation, or tenesmus, and diarrhea with repeated admissions to the hospital.

A2.9.14. Anus. Impairment of sphincter control with fecal incontinence.

A2.9.15. Familial polyposis.

A2.9.16. Surgery.

A2.9.16.1. Colectomy, partial, when more than mild symptoms of diarrhea remain.

A2.9.16.2. Colostomy, when permanent.

A2.9.16.3. Enterostomy, when permanent.

A2.9.16.4. Gastrectomy, total.

A2.9.16.5. Gastrectomy, subtotal with or without vagotomy, or gastrojejunostomy or pyloroplasty with or without vagotomy, when, in spite of good medical management, the individual:

A2.9.16.5.1. Develops incapacitating dumping syndrome.

A2.9.16.5.2. Develops frequent episodes of incapacitating epigastric distress with characteristic circulatory symptoms or diarrhea.

A2.9.16.5.3. Continues to demonstrate significant weight loss.

A2.9.16.6. Gastrostomy, when permanent.

A2.9.16.7. Ileostomy, when permanent.

A2.9.16.8. Pancreatectomy, except for partial pancreatectomy for a benign condition which does not result in moderate residual symptoms.

A2.9.16.9. Pancreaticoduodenostomy, pancreaticogastrostomy, and pancreaticojejunostomy.

A2.9.16.10. Proctectomy.

A2.9.16.11. Proctoplexy, proctoplasty, proctorrhaphy, or proctotomy, if fecal incontinence remains after appropriate treatment.

A2.10. Genitourinary System.

A2.10.1. Genitourinary Conditions.

A2.10.1.1. Cystitis. When complications or residuals of treatment themselves preclude satisfactory performance of duty.

A2.10.1.2. Dysmenorrhea. Not amenable to treatment, and incapacitating.

A2.10.1.3. Endometriosis. Symptomatic and incapacitating.

A2.10.1.4. Hypospadias. Not amenable to treatment.

A2.10.1.5. Incontinence of urine. Not amenable to treatment.

A2.10.1.6. Kidney:

A2.10.1.6.1. Calculus in kidney, symptomatic and incapacitating.

A2.10.1.6.2. Congenital anomaly, resulting in frequent or recurring infections or when there is evidence of obstructive uropathy not responding to medical or surgical treatment.

A2.10.1.6.3. Cystic kidney (polycystic kidney), when renal function is impaired, or is the focus of frequent infection.

A2.10.1.6.4. Hydronephrosis, more than mild, and causing continuous or frequent symptoms.

A2.10.1.6.5. Hypoplasia of the kidney, associated with elevated blood pressure or frequent infections or reduction in renal function.

A2.10.1.6.6. Nephritis, chronic, with renal function impairment.

A2.10.1.6.7. Nephrosis, other than mild.

A2.10.1.6.8. Pyelonephritis or pyelitis, chronic, which has not responded to medical or surgical treatment, with evidence of persistent hypertension or reduction in renal function.

A2.10.1.7. Menopausal or premenstrual syndrome. Physiologic or artificial, significantly interfering with the satisfactory performance of duty.

A2.10.1.8. Strictures of the urethra or ureter. Severe and not amenable to treatment.

A2.10.1.9. Urethritis. Chronic, not responsive to treatment and necessitating frequent absences from duty.

A2.10.2. Genitourinary and Gynecological Surgery.

A2.10.2.1. Cystectomy.

A2.10.2.2. Cystoplasty. If reconstruction is unsatisfactory, or if refractory symptomatic infections persist.

A2.10.2.3. Nephrectomy. When after treatment, there is infection or pathologic change (anatomic or functional) in the remaining kidney.

A2.10.2.4. Nephrostomy or pyelostomy, if drainage persists.

A2.10.2.5. Gonadectomy. Bilateral, when following treatment and convalescent period, there remain incapacitating mental or constitutional symptoms.

A2.10.2.6. Penis. Amputation of. When urine is voided in such a manner that clothing or surroundings are soiled, or results in severe mental symptoms.

A2.10.2.7. Ureterointestinal or direct cutaneous urinary diversion.

A2.10.2.8. Ureterocystostomy. When both ureters are markedly dilated with irreversible changes.

A2.10.2.9. Ureteroplasty.

A2.10.2.9.1. When unilateral procedure is unsuccessful and nephrectomy is necessary, consider on the basis of the standard for nephrectomy.

A2.10.2.9.2. When bilateral and surgical repair is unsuccessful and associated with significant complications or sequelae (for example, hydronephrosis, residual obstruction or therapeutically refractive pyelonephritis).

A2.10.2.10. Ureterosigmoidostomy.

A2.10.2.11. Ureterostomy. External or cutaneous.

A2.10.2.12. Urethrostomy. External or when a satisfactory urethra cannot be restored.

A2.10.2.13. Major abnormalities and defects of the genitalia such as change of sex, a history thereof, or complications (adhesions, disfiguring scars, etc.). Residual to surgical corrections of these conditions.

A2.11. Neurologic Disorders.

A2.11.1. Amyotrophic lateral sclerosis.

A2.11.2. Myelopathic muscular atrophy, including residuals of poliomyelitis.

A2.11.3. Progressive muscular atrophy.

A2.11.4. Chorea. Chronic and progressive.

A2.11.5. Friedreich's ataxia.

A2.11.6. Hepatolenticular degeneration.

A2.11.7. Seizure disorder.

A2.11.7.1. For Active Duty, MEB processing must be done within 90 calendar days of the first episode.

A2.11.7.2. For ARC members refer to paragraph **10.10.2.**

A2.11.7.3. Seizures following omission of prescribed medication or ingestion of alcoholic beverages are not indicative of the controllability of the disorder.

A2.11.8. Migraine. Manifested by frequent disabling attacks which last for several consecutive days, and are unrelieved by treatment.

A2.11.9. Multiple sclerosis.

A2.11.10. Myasthenia gravis

A2.11.11. Transverse myelopathy.

A2.11.12. Narcolepsy. When attacks are not controlled by medication.

A2.11.13. Paralysis agitans.

A2.11.14. Peripheral nerve conditions such as:

A2.11.14.1. Neuralgia, when symptoms are severe, persistent, and do not respond to treatment.

A2.11.14.2. Neuritis or paralysis due to peripheral nerve injury, when manifested by more than moderate, permanent functional impairment.

A2.11.15. Syringomyelia.

A2.11.16. Other neurological conditions. Any other neurological condition, regardless of etiology, when after adequate treatment, there remain residuals, such as persistent severe headaches, weakness or paralysis of important muscle groups, deformity, incoordination, pain or sensory disturbance, disturbance of consciousness, speech, or mental defects, or personality changes of such a degree as to definitely interfere with the performance of duty.

A2.12. Psychoses, Psychoneuroses, Other Axis I Diagnosis, and Other Mental Conditions. All psychiatric evaluations must include social and industrial impairment (S & I). In cases subject to administrative separation, the member's commander contacts the local MPF and Staff Judge Advocate for specific citation authority.

A2.12.1. Psychoses. Any psychotic episode.

A2.12.2. Psychoneuroses (affective, anxiety, somatiform, dissociative, eating, or psychosexual disorders). Persistent or recurrent, requiring hospitalization or the need for continuing psychiatric support. (Incapacity because of neurosis must be distinguished from weakness of motivation or underlying personality disorder).

*Note: RC Members who require medication to function are deemed not Worldwide Duty/Mobility qualified.

A2.12.3. Disorders of Intelligence. Individuals determined to have primary mental deficiency or special learning defect which interferes with the satisfactory performance of duty are unsuitable and subject to administrative separation. They must be referred to their unit commander.

A2.12.4. Other Mental Conditions. Unsatisfactory duty performance due to disorders of character or behavior, personality disorders, transient situational reactions, personality disruptions, emotional instability, sexual perversion or habit reactions render an individual unsuitable and subject to administrative separation. Interference with effective duty performance is dealt with through appropriate administrative channels. Alcoholism that interferes with effective duty performance renders an individual unsuitable and subject to administrative separation. Provisions for rehabilitation and disposition are in appropriate directives.

A2.12.5. MEB evaluation is indicated in those instances when medical complications or sequelae of alcoholism (for example, recurrent jaundice or ascites, esophageal varices, chronic pancreatitis, organic central nervous system (CNS) disorders, etc.) preclude satisfactory performance of duty and worldwide assignability. For ARC members refer to **10.10.2.**

A2.12.6. Drug dependency renders an individual unsuitable and subject to administrative separation. MEB evaluation is indicated in those instances where drug dependency is the proximate result of a neurotic, psychotic, or organic medical condition. For ARC members refer to **10.10.2.**

A2.12.7. "Flying phobia" of sufficient magnitude to preclude military air transportation is dealt with administratively unless the condition is the proximate result of a psychotic disorder or a bona fide primary neurotic disorder.

A2.13. Extremities.

A2.13.1. Upper extremities.

A2.13.1.1. Amputation of part or parts of an upper extremity which results in impairment equivalent to the loss of use of a hand.

A2.13.1.2. Joint ranges of motion which do not equal or exceed the following:

A2.13.1.3. For shoulder:

A2.13.1.3.1. Forward elevation to 90 degrees.

A2.13.1.3.2. Abduction to 90 degrees.

A2.13.1.4. For elbow:

A2.13.1.4.1. Flexion to 100 degrees.

A2.13.4.1.2. Extension to 45 degrees of flexion.

A2.13.1.5. Chronic dislocation, when not reparable or when surgery is contraindicated.

A2.13.2. Lower Extremities.

A2.13.2.1. Hip dislocation.

A2.13.2.2. Amputation of a toe or toes which precludes the ability to run or walk without a perceptible limp or to perform duty in a satisfactory manner.

A2.13.2.3. Any loss greater than specified above to include foot, leg, or thigh.

A2.13.2.4. Feet:

A2.13.2.4.1. Hallux valgus when moderately severe, with exostosis or rigidity and pronounced symptoms, or severe with arthritic changes.

A2.13.2.4.2. Pes planus, symptomatic, more than moderate with pronation on weight bearing which prevents the wearing of a military shoe, or when associated with trophic changes.

A2.13.2.4.3. Talipes cavus when severe, with moderate discomfort on prolonged standing and walking, metatarsalgia, or which prevents the wearing of a military shoe.

A2.13.2.5. Internal derangement of the knee.

A2.13.2.5.1. Residual instability following remedial measures if more than moderate in degree or with recurring episodes of effusion or locking, resulting in frequent incapacitation.

A2.13.2.5.2. If complicated by arthritis.

A2.13.2.6. Joint Ranges of Motion. Motion which does not equal or exceed the measurements listed below:

A2.13.2.6.1. Hip.

Flexion to 90 degrees. Extension to 0 degrees.

A2.13.2.6.2. Knee.

Flexion to 90 degrees. Extension to 15 degrees.

A2.13.2.6.3. Shortening of an extremity which exceeds 5 centimeters (2 inches).

A2.13.2.7. Miscellaneous.

A2.13.2.7.1. Arthritis.

A2.13.2.7.1.1. Arthritis due to infection associated with persistent pain and marked loss of function, with X-ray evidence, and documented history of recurrent incapacitation.

A2.13.2.7.1.2. Arthritis due to trauma, when surgical treatment fails or is contraindicated and there is functional impairment of the involved joint so as to preclude satisfactory performance of duty.

A2.13.2.7.1.3. Osteoarthritis, with severe symptoms associated with impairment of function, supported by X-ray evidence and documented history of recurrent incapacity for prolonged periods.

A2.13.2.7.1.4. Rheumatoid arthritis or rheumatoid myositis, with substantiated history of frequent incapacitating episodes supported by objective and subjective findings.

A2.13.2.7.2. Chondromalacia or Osteochondritis dessicans. Severe, manifested by frequent joint effusion, more than moderate interference with function, or with severe residuals from surgery.

A2.13.2.7.3. Fractures.

A2.13.2.7.3.1. Malunion when, after appropriate treatment, there is severe malunion with marked deformity or more than moderate loss of function.

A2.13.2.7.3.2. Nonunion when, after an appropriate healing period, the nonunion persists with severe loss of function.

A2.13.2.7.3.3. Bone fusion defect when manifested by severe pain or loss of function.

A2.13.2.7.3.4. Callus, excessive, following fracture, when functional impairment precludes satisfactory performance of duty and the callus does not respond to adequate treatment.

A2.13.2.7.4. Joints.

A2.13.2.7.4.1. Arthroplasty, with severe pain, limitation of motion, and limitation of function, joint prosthesis or total joint replacement.

A2.13.2.7.4.2. Bony or fibrous ankylosis, with severe pain involving major joints or spinal segments, or ankylosis in unfavorable positions or ankylosis with marked loss of function.

A2.13.2.7.4.3. Contracture with marked loss of function and the condition is not remediable by surgery.

A2.13.2.7.4.4. Loose bodies within a joint with marked functional impairment complicated by arthritis to such a degree as to preclude favorable results of treatment.

A2.13.2.7.5. Muscles. Flaccid or spastic paralysis or loss of substance of one or more muscles, producing loss of function which precludes satisfactory performance of military duty.

A2.13.2.7.5.1. Myotonia congenita, significantly symptomatic.

A2.13.2.7.6. Osteitis deformans. Involvement of single or multiple bones with resultant deformities, or symptoms severely interfering with function.

A2.13.2.7.7. Osteoarthropathy. Hypertrophic, secondary, with severe pain in one or multiple joints and with moderate loss of function.

A2.13.2.7.8. Osteomyelitis, chronic. Recurrent episodes not responsive to treatment or involving the bone to a degree which interferes with stability and function.

A2.13.2.7.9. Tendon transplant. Unsatisfactory restoration of function.

A2.14. Spine, Scapulae, Ribs, and Sacroiliac Joints.

A2.14.1. Congenital anomalies presenting functional impairment of a degree to preclude the satisfactory performance of duty.

A2.14.2. Spina bifida, with demonstrable signs and moderate symptoms of root or cord involvement.

A2.14.3. Coxa vara, more than moderate with pain, deformity and arthritic changes.

A2.14.4. Herniation of nucleus pulposus, when symptoms and associated objective findings are of such a degree as to require repeated hospitalization or frequent absences from duty.

A2.14.5. Spondylolysis or spondylolisthesis, when symptoms and associated objective findings are of such a degree as to require repeated hospitalization or frequent absences from duty.

A2.14.6. Deviation or curvature of spine. More than moderate, or interfering with function or causing unmilitary appearance.

A2.15. Skin and Cellular Tissues.

A2.15.1. Acne, severe, unresponsive to treatment, and interfering with the satisfactory performance of duty or wear of the uniform or use of military equipment.

A2.15.2. Atopic dermatitis, severe or requiring frequent hospitalization.

A2.15.3. Cysts and tumors. Refer to paragraph **A2.17.**

A2.15.4. Dermatitis herpetiformis, which fails to respond to therapy.

A2.15.5. Eczema, chronic, regardless of type, when there is moderate involvement or when there are repeated exacerbations in spite of continuing treatment.

A2.15.6. Elephantiasis or chronic lymphedema, not responsive to treatment.

A2.15.7. Epidermolysis bullosa.

A2.15.8. Erythema multiforme, severe, and chronic or recurrent.

A2.15.9. Exfoliative dermatitis, chronic.

A2.15.10. Fungus infections, superficial, if not responsive to therapy and resulting in frequent absences from duty.

A2.15.11. Hidradenitis, suppurative, and folliculitis decalvans.

A2.15.12. Hyperhidrosis of the hands or feet when severe or complicated by a dermatitis or infection, either fungal or bacterial, and not amenable to treatment.

A2.15.13. Leukemia cutis and mycosis fungoides.

A2.15.14. Lichen planus, generalized and not responsive to treatment.

A2.15.15. Lupus erythematosus, chronic discoid variety with extensive involvement or when the condition does not respond to treatment.

A2.15.16. Neurofibromatosis, if disfigurement is extensive or when associated with manifestation of other organ system involvement.

A2.15.17. Pemphigus, not responsive to treatment and with moderate constitutional or systemic symptoms.

A2.15.18. Psoriasis or parapsoriasis, extensive and not controlled by treatment or controllable only with potent cytotoxic agents.

A2.15.19. Radiodermatitis, if resulting in malignant degeneration at a site not amenable to treatment.

A2.15.20. Scars and keloids, so extensive they seriously interfere with the function of the body area or they interfere with proper fit and wear of military equipment.

A2.15.21. Tuberculosis of the skin, if not responsive to therapy. Refer to paragraph **A2.16.**

A2.15.22. Ulcers of the skin, not responsive to treatment after an appropriate period of time or if they result in frequent absences from duty.

A2.15.23. Urticaria, chronic, severe, and not amenable to treatment.

A2.15.24. Other skin diseases, if chronic or of a nature which requires frequent medical care or interferes with the satisfactory performance of military duty.

A2.16. Endocrine and Metabolic Conditions.

A2.16.1. Acromegaly.

A2.16.2. Adrenal hyperfunction, not responding to therapy.

A2.16.3. Adrenal hypofunction.

A2.16.4. Diabetes insipidus, requiring antidiuretic hormone replacement therapy.

A2.16.5. Diabetes mellitus, diagnosed, including diet controlled and those requiring insulin or oral hypoglycemic drugs, MEB processing is done within 90 calendar days. For ARC members refer to 10.10.2. (See note at **A3.32.**).

A2.16.6. Gout, with frequent acute exacerbations in spite of therapy, or with severe bone, joint, or kidney damage.

A2.16.7. Hyperinsulinism, when caused by a malignant tumor, or when the condition is not readily controlled.

A2.16.8. Hyperparathyroidism, when residuals or complications such as renal or bony defects preclude satisfactory performance of military duty.

A2.16.9. Hyperthyroidism, with severe symptoms which do not respond to treatment.

A2.16.10. Hypoparathyroidism, with objective evidence and severe symptoms not controlled by maintenance therapy.

A2.16.11. Osteomalacia, when residuals after therapy are of such degree or nature as to limit physical activity to a significant degree.

A2.17. Systemic Disease.

A2.17.1. HIV seropositivity, confirmed.

A2.17.2. Amyloidosis, generalized.

A2.17.3. Dermatomyositis polymyositis complex.

A2.17.4. Leprosy, any type.

A2.17.5. Lupus erythematosus, disseminated, chronic.

A2.17.6. Myasthenia gravis.

A2.17.7. Mycoses, active, not responsive to therapy, or requiring prolonged treatment, or when complicated by disqualifying residuals.

A2.17.8. Panniculitis, relapsing, febrile, nodular.

A2.17.9. Porphyria.

A2.17.10. Sarcoidosis, progressive, with severe or multiple organ involvement and not responsive to therapy (See paragraph **A2.6.**).

A2.17.11. Scleroderma, Generalized or of the linear type which seriously interferes with the function of an extremity or body area involved or progressive systemic sclerosis including CREST Syndrome (calcinosis, Raynaud's phenomenon, esophageal hypomotility, sclerodactyly, and telangiectasia).

A2.17.12. Tuberculosis, Generalized.

A2.18. Tumors and Malignant Diseases.

A2.18.1. Malignant neoplasms or residuals of treatment.

A2.18.2. Neoplastic conditions of lymphoid and blood-forming tissues.

A2.18.3. Benign neoplasms, when the condition prevents the satisfactory performance of duty and the condition is not remediable or a remedial operation is refused.

*Note: All members with neoplastic disease must meet an MEB within 90 calendar days of initial diagnosis or as soon as the medical condition has stabilized. Basal cell, squamous cell carcinoma and carcinoma-in-situ of the cervix which have been adequately excised (as evidenced by pathology report, or basal cell carcinoma which has been treated by electrodessication and curettage by a dermatologist credentialed to perform the procedure) are exempted from Tumor Board Action and do not require MEB. For ARC members refer to **10.10.2.**

A2.19. Sexually Transmitted Diseases.

A2.19.1. Symptomatic neurosyphilis, in any form.

A2.19.2. Complications or residuals of sexually transmitted disease, of such chronicity or degree of severity the individual is incapable of performing duty.

A2.20. General and Miscellaneous Conditions and Defects.

A2.20.1. The individual is precluded from a reasonable fulfillment of the purpose of his or her employment in the military service.

A2.20.2. The individual's health or well being would be compromised if he or she were to remain in the military service.

A2.20.3. The individual's retention in the military service would prejudice the best interests of the government. Questionable cases are referred to MEB or to the appropriate ARC surgeon for those ARC members who are not on EAD and are not authorized disability processing.

A2.20.4. The individual has an EPTS defect or condition for which corrective surgery is contemplated.

A2.20.5. The individual requires an indefinite (permanent) excusal from fitness testing.

A2.20.6. The individual's travel by military air transportation is precluded for medical reasons.

(See paragraph **A2.12.** concerning "flying phobia").

A2.20.7. The individual has an assignment canceled due to a medical condition. Present to an

MEB, or within 10 calendar days, provide narrative summary to HQ AFPC/**DPAMM** for review in lieu of MEB.

A2.20.8. The individual continues to have a 4-T profile 1 year after the defect became disqualifying and has not yet met an MEB.

A2.20.9. The individual has been hospitalized 90 calendar days and return to duty within 3 more months is not expected. MEB should be accomplished when the patient's future qualification for further military service is foreseeable and should not be delayed until receipt of maximum hospital benefit.

A2.20.10. The individual refuses required medical, surgical, or dental treatment or diagnostic procedures.

A2.20.11. The individual requires determination of his or her competency for pay purposes.

A2.20.12. The individual has had a sanity determination required by the Manual for

Courts-Martial and the psychiatric findings indicate the member's suitability for continued military service is questionable.

A2.20.13. The individual has coexisting medical defects that are thought to be the primary cause of unacceptable behavior or unsatisfactory performance.

A2.20.14. Inability to receive any mobility required immunization.

Attachment 3

MEDICAL STANDARDS FOR APPOINTMENT, ENLISTMENT, AND INDUCTION

Conditions listed in Attachment 2, Medical Standards for Continued Military Service also apply.

A3.1. Head.

A3.1.1. Abnormalities that are apparently temporary in character resulting from recent injuries until a period of 3 months has elapsed. These include severe contusions and other wounds of the scalp and cerebral concussion. See paragraph **A3.19.**

A3.1.2. Chronic arthritis. Complete or partial ankylosis, or recurrent dislocation of the temporomandibular joint.

A3.1.3. Deformities of the skull. In the nature of depressions, exostoses, etc., of a degree that would prevent the individual from wearing a protective mask or military headgear.

A3.1.4. Deformities of the skull. Of any degree associated with evidence of disease of the brain, spinal cord, or peripheral nerves.

A3.1.5. Depressed fractures that required surgical elevation or were associated with a laceration of the dura mater or focal necrosis of the brain (see paragraph **A3.19.**).

A3.1.6. Loss or congenital absence of the bony substance of the skull not successfully corrected by reconstructive materials.

A3.1.7. All cases involving absence of the bony substance of the skull that have been corrected but in which the defect is in excess of 1 square inch (6.45cm2) or the size of a 25-cent piece.

A3.2. Neck.

A3.2.1. Cervical ribs. If symptomatic, or so obvious that they are found on routine medical examination. (Detection based primarily on X-rays in not considered to meet this criterion.)

A3.2.2. Congenital cysts. Of branchial cleft origin or those developing from the remnants of the thyroglossal duct, with or without fistulous tracts.

A3.2.3. Fistula. Chronic draining, of any type.

A3.2.4. Nonspastic contraction. Of the muscles of the neck or cicatricial contracture of the neck to the extent that it interferes with the wearing of a uniform or military equipment or is so disfiguring as to make the individual objectionable in common social relationships.

A3.2.5. Spastic contraction. Of the muscles of the neck, persistent, and chronic.

A3.2.6. Tumor of thyroid or other structures of the neck. See paragraph **A3.36.**

A3.3. Mouth.

A3.3.1. Hard palate, Perforation of.

A3.3.2. Cleft lip, unless satisfactorily repaired by surgery.

A3.3.3. Leukoplakia, stomatitis or ulcerations of the mouth, if severe.

A3.3.4. Ulcerations, perforation, or extensive loss of substance of the hard or soft palate, extensive adhesions of the soft palate to the pharynx, or complete paralysis of the soft palate. Unilateral paralysis of the soft palate that does not interfere with speech or swallowing and is otherwise asymptomatic is not disqualifying. Loss of the uvula that does not interfere with speech or swallowing is not disqualifying.

A3.4. Nose and Sinuses.

A3.4.1. Allergic manifestations.

A3.4.1.1. Atrophic rhinitis.

A3.4.1.2. Allergic rhinitis. If moderate or severe and not controlled by oral medications, desensitization, or topical corticosteroid medication.

A3.4.2. Anosmia or parosmia.

A3.4.3. Choana, atresia or stenosis of, if symptomatic.

A3.4.4. Epistaxis, chronic recurrent.

A3.4.5. Nasal polyps or a history of nasal polyps, unless surgery was performed at least 1 year before examination and there is no evidence of recurrence.

A3.4.6. Nasal septum, Perforation of:

A3.4.6.1. Associated with the interference of function, ulceration, crusting, or when the result of organic disease.

A3.4.6.2. If progressive.

A3.4.6.3. If respiration is accompanied by a whistling sound.

A3.4.7. Sinusitis. Acute.

A3.4.8. Sinusitis. Chronic when more than mild:

A3.4.8.1. Evidenced by any of the following: chronic purulent nasal discharge, nasal polyps, hyperplastic changes of the nasal tissue, or symptoms requiring frequent medical attention.

A3.4.8.2. Confirmed by transillumination or X-ray examination or both.

A3.4.9. Vasomotor rhinitis, if moderate or severe and not controlled by medication.

A3.5. Pharynx, Trachea, and Larynx.

A3.5.1. Laryngeal paralysis, sensory or motor, due to any cause.

A3.5.2. Larynx, Organic disease of, such as neoplasm, polyps, granuloma, ulceration, or chronic laryngitis.

A3.5.3. Dysphonia plicae ventricularis.

A3.5.4. Tracheostomy or tracheal fistula.

A3.6. Other Defects and Diseases of the Mouth, Nose, Throat, Pharynx, Trachea, and Larynx.

A3.6.1. Aphonia, or history of, or recurrent, if the cause was such as to make a subsequent attack probable.

A3.6.2. Deformities or conditions of the mouth, tongue, throat, pharynx, larynx, and nose that interfere with mastication and swallowing of ordinary food, or with speech or breathing.

A3.6.3. Destructive syphilitic disease of the mouth, nose, throat, or larynx (see paragraph **A3.37.**).

A3.6.4. Pharyngitis and nasopharyngitis, chronic, with positive history and objective evidence, if of such a degree as likely to result in excessive time lost in the military environment.

A3.7. Ears.

A3.7.1. Auditory canal.

A3.7.1.1. Atresia or severe stenosis of the external auditory canal.

A3.7.1.2. Tumors of the external auditory canal except mild exostoses.

A3.7.1.3. Severe external otitis, acute or chronic.

A3.7.2. Auricle. Microtia, severe; or severe traumatic deformity, unilateral or bilateral.

A3.7.3. Mastoids.

A3.7.3.1. Mastoiditis, acute or chronic.

A3.7.3.2. Residual of mastoid operation with marked external deformity that prevents or interferes with the wearing of a protective mask or helmet.

A3.7.3.3. Mastoid fistula.

A3.7.4. Meniere's syndrome.

A3.7.5. Middle ear.

A3.7.5.1. Acute or chronic otitis media of any type.

A3.7.5.2. Presence of attic perforation in which presence of cholesteatoma is suspected.

A3.7.5.3. History of surgery involving the middle ear, excluding myringotomy.

A3.7.5.4. Cholesteatoma or history thereof.

A3.7.6. Tympanic membrane.

A3.7.6.1. Any perforation of the tympanic membrane.

A3.7.6.2. Surgery to repair perforated tympanic membrane within 120 days.

A3.7.6.3. Thickening or scarring of the tympanic membrane associated with hearing level by audiometric test of 30 dB or more average for the speech frequencies (500, 1000, and 2000 cycles per second) in either ear regardless of the hearing level in the other ear.

A3.7.7. Other diseases and defects of the ear which obviously prevent satisfactory performance of duty or that require frequent and prolonged treatment.

A3.8. Hearing. (See also paragraph **A3.7.**) The cause for rejection for appointment, enlistment, and induction is a hearing loss greater than the acceptable hearing levels described below:

Audiometers calibrated to the International Standards Organization 1964 (ISO 1964) or the American National Standards Institute (ANSI 1989), shall be used to test the hearing of all applicants for appointment, enlistment, or induction. All audiometric tracings or audiometric readings recorded on reports of medical examination or other medical records will be clearly identified.

Acceptable Audiometric Hearing Levels are:

Pure tone at 500, 1000, and 2000 cycles per second of not more than 30 dB on the average (either ear), with no individual level greater than 35 dB at these frequencies. Pure tone level not more than 45 dB at 3000 cycles per second each ear, and 55 dB at 4000 cycles per second each ear.

A3.9. Dental.

A3.9.1. Diseases of the jaw or associated tissues that are not easily remediable, and will incapacitate the individual or otherwise prevent the satisfactory performance of duty. This includes temporomandibular disorders or myofascial pain dysfunction not easily corrected.

A3.9.2. Severe malocclusion that interferes with normal mastication or requires early and protracted treatment; or relationship between mandible and maxilla that prevents satisfactory future prosthodontic replacement.

A3.9.3. Insufficient natural healthy teeth or lack of a serviceable prosthesis, preventing adequate mastication and incision of a normal diet. This includes complex (multiple fixture) dental implant systems that have associated complications that severely limit assignments and adversely affect performance of worldwide duty. Dental implants that are no longer functional must not interfere with continuation of wear of the implant prosthesis or prevent removal and replacement with a conventional prosthesis.

A3.9.4. Orthodontic appliances for continued treatment, attached or removable. Retainer appliances are permissible, provided all active orthodontic treatment has been satisfactorily completed

A3.10. Eyes.

A3.10.1. Lids.

A3.10.1.1. Blepharitis, chronic, of more than mild degree. Cases of acute blepharitis will be rejected until cured.

A3.10.1.2. Blepharospasm.

A3.10.1.3. Dacryocystitis, acute or chronic.

A3.10.1.4. Dacryostenosis

A3.10.1.5. Destruction of the lids, complete or extensive, sufficient to impair protection of the eye from exposure.

A3.10.1.6. Adhesions of the eyelids to each other or to the eyeball that interfere with vision.

A3.10.1.7. Growth or tumor of the eyelid other than small early basal cell tumors of the eyelid, which can be cured by treatment, and small nonprogressive asymptomatic benign lesions. See also paragraph **A3.36.**

A3.10.1.8. Marked inversion or eversion of the eyelids sufficient to cause troublesome watering of eyes (entropion or ectropion).

A3.10.1.9. Lagophthalmos.

A3.10.1.10. Ptosis, any, except benign etiologies which are not progressive and do not interfere with vision.

A3.10.1.11. Trichiasis, severe.

A3.10.2. Conjunctiva.

A3.10.2.1. Conjunctivitis, chronic, including trachoma; allergic conjunctivitis; acute conjunctivitis until cured.

A3.10.2.2. Pterygium.

A3.10.2.2.1. Recurring after two operative procedures.

A3.10.2.2.2. Encroaching on the cornea in excess of 3 millimeters, interfering with vision, or if progressive (as evidenced by marked vascularity on a thickened elevated head).

A3.10.2.3. Xerophthalmia.

A3.10.3. Cornea.

A3.10.3.1. Corneal dystrophy of any type, including keratoconus of any degree.

A3.10.3.2. History of keratorefractive surgery accomplished to modify the refractive power of the cornea, or of lamellar, penetrating keratoplasty. Laser surgery to reconfigure the cornea is also disqualifying.

A3.10.3.3. Keratitis, acute or chronic, including history of.

A3.10.3.4. Ulcer, corneal; history or recurrent ulcers or recurrent corneal abrasions (including herpetic ulcers).

A3.10.3.5. Vascularization or opacification of the cornea from any cause that is progressive or reduces vision below the standards prescribed in paragraph **A3.11.**

A3.10.4. Uveal tract.

A3.10.4.1. Acute, chronic or recurrent inflammation of the uveal tract (iris, ciliary body, or choroid), except healed traumatic iritis.

A3.10.5. Retina.

A3.10.5.1. Angiomatoses, phakomatoses, retinal cysts, and other congenitohereditary conditions that impair or may impair visual function.

A3.10.5.2. Retinitis, chorioretinitis, or other inflammatory conditions, unless single episode that has healed, is not expected to recur, and does not interfere with vision.

A3.10.5.3. Degenerations of the macula to include macular cysts, holes, and other degenerations (hereditary or acquired degenerative changes and other conditions affecting the macula, including all types of primary and secondary pigmentary degenerations).

A3.10.5.3.1. Degenerations and dystrophies of the retina that impair or may impair visual function.

A3.10.5.3.2. Vitreous opacities or disturbances which may cause loss of visual acuity.

A3.10.5.4. Detachment of the retina, history of surgery for same, or peripheral retinal injury or degeneration that may cause retinal detachment.

A3.10.5.5. Inflammation of the retina (histoplasmosis, toxoplasmosis, or vascular conditions of the retina to include Coats' disease, diabetic retinopathy, Eales' disease, and retinitis proliferans), unless a single episode which has healed and does not interfere with vision.

A3.10.5.6. Hemorrhages, exudates, or other retinal vascular disturbances.

A3.10.6. Optic nerve.

A3.10.6.1. Congenito-hereditary conditions of the optic nerve or any other central nervous system pathology affecting or that may affect the efficient function of the optic nerve.

A3.10.6.2. Optic neuritis, neuroretinitis, or secondary optic atrophy resulting therefrom or documented history of attacks of retrobulbar neuritis.

A3.10.6.2.1. Optic neuropathy.

A3.10.6.3. Optic atrophy (primary or secondary).

A3.10.6.4. Papilledema.

A3.10.7. **Lens.**

A3.10.7.1. Aphakia (unilateral or bilateral), pseudophakia, or lens implant.

A3.10.7.2. Dislocation of lens, partial or complete.

A3.10.7.3. Opacities or irregularities of the lens or lens capsule which interfere with vision or which are considered to be progressive.

A3.10.8. Ocular mobility and motility.

A3.10.8.1. Diplopia, documented, in any field of gaze, either constant or intermittent from any cause or of any degree, including history of.

A3.10.8.2. Nystagmus, with both eyes fixing, congenital or acquired.

A3.10.8.3. Strabismus of 40 prism diopters or more, uncorrectable by lenses to less than 40 diopters.

A3.10.8.4. Strabismus of any degree accompanied by documented diplopia.

A3.10.8.5. Strabismus, surgery for the correction of, within the preceding 6 months.

A3.10.9. Miscellaneous defects and diseases.

A3.10.9.1. Abnormal conditions of the eye or visual fields due to diseases of the CNS. Meridian-specific visual field minimums are:

Temporal 85 degrees.
Superior-Temporal 55 degrees.

Superior 45 degrees.

Superior-Nasal 55 degrees.

Nasal 60 degrees.

Inferior-Nasal 50 degrees.

Inferior 65 degrees.

Inferior-Temporal 85 degrees.

A3.10.9.1.9. Absence of an eye.

A3.10.9.2. Asthenopia, severe.

A3.10.9.3. Exophthalmos, unilateral or bilateral.

A3.10.9.4. Glaucoma, primary or secondary, or preglaucoma as evidenced by intraocular pressure above 21mmHg, or the secondary changes in the optic disc or visual field loss associated with glaucoma.

A3.10.9.5. Hemianopsia of any type.

A3.10.9.6. Abnormal pupils or loss of normal pupillary reflex reactions to light or accommodation to distance or Adie's syndrome.

A3.10.9.7. Loss of visual fields due to organic disease.

A3.10.9.8. Night blindness.

A3.10.9.9. Residuals of old contusions, lacerations, penetrations, etc., impairing visual function required for satisfactory performance of military duty.

A3.10.9.10. Retained intraocular foreign body.

A3.10.9.11. Tumors. See **A3.10.** above and paragraph **A3.36.**

A3.10.9.12. Any organic disease of the eye or adnexa not specified above, which threatens vision or visual function.

A3.10.9.12.1. History of any ocular surgery to include lasers of any type.

A3.11. Vision.

A3.11.1. Distant visual acuity. Distant visual acuity of any degree that does not correct with spectacle lenses to at least one of the following:

20/40 in one eye and 20/70 in the other eye.
20/30 in one eye and 20/100 in the other eye.
20/20 in one eye and 20/400 in the other eye.

A3.11.2. Near visual acuity. Near visual acuity of any degree that does not correct to 20/40 in the better eye.

A3.11.3. Refractive error. Any refractive error in spherical equivalent of worse than -8.00 or +8.00 diopters; or if ordinary spectacles cause discomfort by reason of ghost images, prismatic displacement, etc.; if an opthalmological consultation reveals a condition which is disqualifying; or if refractive error is corrected by orthokeratology or keratorefractive surgery.

A3.11.4. Contact lenses. Complicated cases requiring contact lenses for adequate correction of vision, such as keratoconus, corneal scar, and irregular astigmatism.

A3.11.5. Color vision. Although there is no standard, color vision will be tested, since adequate color vision is a prerequisite for entry into many military specialties.

A3.12. Lungs, Chest Wall, Pleura, and Mediastinum.

A3.12.1. Abnormal elevation of the diaphragm, either side.

A3.12.2. Abscess of the lung.

A3.12.3. Acute infectious processes of the lung, chest wall, pleura, or mediastinum, until cured.

A3.12.4. Asthma, including reactive airway disease, exercise induced bronchospasm or asthmatic bronchitis, reliably diagnosed at any age.

*Note: Reliable diagnostic criteria should consist of any of the following elements: (a) substantiated history of cough, wheeze, and or dyspnea which persists or recurs over a prolonged period of time (generally

more than 6 months), or if the diagnosis of asthma is in doubt, (b) a test for reversible airflow obstruction (greater than a 15 percent increase in FEV, following administration of an inhaled bronchodilator) or airway hyperreactivity (exaggerated decrease in airflow induced by a standard bronchoprovocation challenge such as methacholine inhalation or a demonstration of exercise-induced bronchospasms) must be performed. Bronchoprovocation or exercise testing should be performed by a board certified pulmonologist or allergist.

A3.12.5. Bronchitis, chronic with pulmonary function impairment that would interfere with duty performance or restrict activities.

A3.12.6. Bronchiectasis.

A3.12.7. Bronchopleural fistula.

A3.12.8. Bullous or generalized pulmonary emphysema.

A3.12.9. Chronic fibrous pleuritis of sufficient extent to interfere with pulmonary function, or which produces dyspnea on exertion.

A3.12.10. Chronic mycotic diseases of the lung including coccidioidomycosis, residual cavitation or more than a few small-size inactive and stable residual nodules demonstrated to be due to mycotic disease.

A3.12.11. Congenital malformation or acquired deformities of the chest wall that reduce the chest capacity or diminish respiratory or cardiac functions to a degree that interferes with vigorous physical exertion.

A3.12.12. Empyema, residual intrapleural collection or unhealed sinuses of chest wall following operation or other treatment for empyema.

A3.12.13. Extensive pulmonary fibrosis from any cause, producing dyspnea on exertion or significant reduction in pulmonary function tests.

A3.12.14. Foreign body in trachea or bronchus.

A3.12.15. Foreign body of the chest wall causing symptoms.

A3.12.16. Foreign body of the lung or mediastinum causing symptoms or active inflammatory reaction.

A3.12.17. Lobectomy, history of, with residual pulmonary disease. Removal of more than one lobe is cause for rejection regardless of the absence of residuals.

A3.12.18. Multiple cystic disease of the lung; solitary cyst; large and incapacitating.

A3.12.19. New growth of breast, mastectomy, acute mastitis, chronic cystic mastitis of more than mild degree or if symptomatic.

A3.12.20. Osteomyelitis of rib, sternum, clavicle, scapula, or vertebra.

A3.12.21. Other symptomatic traumatic lesions of the chest or its contents.

A3.12.22. Pleurisy with effusion, within the previous 2 years, unknown origin.

A3.12.23. Pneumothorax during the year preceding examination if due to simple trauma or surgery; during the 3 years preceding examination if of spontaneous origin. Surgical correction is acceptable if no significant residual disease or deformity remains and the pulmonary function tests are within normal limits. Recurrent spontaneous pneumothorax ipsilaterally is disqualifying regardless of cause, after one failed attempt at surgical correction or pleural sclerosis.

A3.12.24. Sarcoidosis. See paragraph **A3.38.**

A3.12.25. Significant abnormal findings of the chest wall, lung, or lungs, pleura, or mediastinum.

A3.12.26. Silicone injections, without encapsulation, in breasts for cosmetic purposes. Surgical placement of encapsulated implants is acceptable if a minimum of 9 months has elapsed since surgery and site is well-healed with no complications reported.

A3.12.27. Suppurative periostitis of rib, sternum, clavicle, scapula, or vertebra.

A3.12.28. Tuberculosis lesions. See paragraph **A3.38.**

A3.12.29. Unhealed recent fracture of ribs, sternum, clavicle, or scapula, or unstable fracture regardless of fracture age.

A3.13. Heart.

A3.13.1. All valvular heart diseases. Including those improved by surgery, except mitral valve prolapse and bicuspid aortic valve. These latter two conditions are not reasons for rejection unless there is associated tachyarrhythmia, mitral regurgitation, aortic stenosis, insufficiency, or cardiomegaly.

A3.13.2. Coronary artery disease.

A3.13.3. History of symptomatic arrhythmia (or electrocardiographic evidence of arrhythmia).

A3.13.3.1. Supraventricular tachycardia, atrial flutter, and atrial fibrillation unless there has been no recurrence during the preceding 2 years off all medications. Ventricular tachycardia or fibrillation. Pre-

mature atrial or ventricular contractions are disqualifying when sufficiently symptomatic to require treatment or result in physical or psychological impairment. Multifocal premature ventricular contractions are disqualifying irrespective of symptoms or treatment. However, healthy highly trained individuals can have multifocal premature ventricular contractions or nonsustained ventricular tachycardia with a normal prognosis. Cases may be considered on an individual basis by each Service waiver authority. Ventricular arrhythmias are disqualifying when associated with physiologic or actuarial significance.

A3.13.3.2. Left bundle branch block, Mobitz type II second degree atrioventricular (AV) block, third degree AV block, accelerated AV conduction (Wolff-Parkinson-White syndrome) and Lown-Ganong-Levine syndrome associated with an arrhythmia. Conduction disturbances such as first degree AV block, left anterior hemiblock, right bundle branch block or Mobitz type I second degree AV block are not disqualifying when asymptomatic and are not associated with underlying cardiovascular disease.

A3.13.4. Hypertrophy or dilation of the heart. As evidenced by chest X-ray, electrocardiogram (ECG), or echocardiogram. Cardiomyopathy, myocarditis, or history of congestive heart failure from any cause even though currently compensated. Care must be taken to avoid rejection of highly conditioned individuals with sinus bradycardia, increased cardiac volume, and apparent abnormal cardiac enlargement, as indicated by ECG and X-ray.

A3.13.5. Pericarditis. Except in individuals who have been free of symptoms for 2 years and manifest no evidence of cardiac restriction or persistent pericardial effusion.

A3.13.6. Persistent tachycardia (resting pulse rate of 100 per minute or greater), regardless of cause.

A3.13.7. Congenital anomalies. Of heart and great vessels with physiologic or actuarial significance, which have not been totally corrected.

A3.14. Vascular System.

A3.14.1. Abnormalities of the arteries and blood vessels, aneurysms, atherosclerosis, arteritis.

A3.14.2. Hypertensive vascular disease. Evidenced by 3 consecutive averaged diastolic blood pressure measurements greater than 90 mmHg or 3 consecutive averaged systolic pressures greater than 140 mmHg. High blood pressure requiring medication or a history of treatment including dietary restriction.

A3.14.3. Pulmonary or systemic embolization, (history of).

A3.14.4. Vasomotor disturbance. Including orthostatic hypotension and Raynaud's phenomenon.

A3.14.5. Vein diseases. Recurrent thrombophlebitis, thrombophlebitis during the preceding year, or any evidence of venous incompetence, such as large or symptomatic veins, edema, and skin ulceration.

A3.15. Blood and Blood-Forming Tissue Diseases.

A3.15.1. Anemia: Any hereditary or acquired anemia that cannot be permanently corrected with therapy before appointment or induction.

A3.15.2. Hemorrhagic disorders: Any congenital or acquired state resulting in a tendency to bleed due to platelet, coagulation, or vascular abnormality.

A3.15.3. Leukopenia. Chronic or recurrent, associated with increased susceptibility to infection.

A3.15.4. Myeloproliferative or myelodysplastic disease, or history thereof.

A3.15.5. Thromboembolic disease. Thromboembolism at any time.

A3.15.6. Immunodeficiency diseases. Any congenital or acquired immunodeficiency state regardless of etiology.

A3.15.7. Miscellaneous conditions such as porphyria, hemochromatosis, amyloidosis, and postsplenectomy status (except when secondary to causes stated in paragraph **A3.16.**).

A3.16. Abdominal Organs and Gastrointestinal System.

A3.16.1. Esophagus. Organic disease or authenticated history of, such as ulceration, varices, achalasia, or other dismotility disorders; chronic or recurrent esophagitis if confirmed by X-ray or endoscopic examinations.

A3.16.2. Stomach and duodenum.

A3.16.2.1. Gastritis, chronic hypertrophic, severe.

A3.16.2.2. Current ulcer of the stomach or duodenum, if diagnosis is confirmed by X-ray examinations, or endoscopy. History of ulcer is not disqualifying if appropriate, effective therapy has been rendered.

A3.16.2.3. Authenticated history of surgical operations for gastric or duodenal ulcer, i.e., partial or total gastric resection, gastrojejunostomy, pyloroplasty, truncal or selective vagotomy (or history of such operative procedures for any other cause or diagnosis).

A3.16.2.4. Duodenal diverticula with symptoms or sequelae (hemorrhage, perforation, etc.).

A3.16.2.5. Congenital abnormalities of the stomach or duodenum causing symptoms or requiring surgical treatment, except a history of surgical correction of hypertrophic pyloric stenosis of infancy is not disqualifying if currently asymptomatic.

A3.16.3. Small and large intestine.

A3.16.3.1. Intestinal obstruction or authenticated history of more than one episode if either occurred during the preceding 5 years or if resulting condition remains, producing significant symptoms or requiring treatment.

A3.16.3.2. Symptomatic Meckel's diverticulum.

A3.16.3.3. Megacolon of more than minimal degree.

A3.16.3.4. Inflammatory lesions; diverticulitis, regional enteritis, ulcerative colitis, proctitis.

A3.16.3.5. Intestinal resection; however, minimal intestinal resection in infancy or childhood (e.g. for intussusception) is acceptable if the individual has been asymptomatic since the resection and if the appropriate consultant finds no residual impairment.

A3.16.3.6. Malabsorption syndromes.

A3.16.4. Gastrointestinal bleeding. A history of, unless the cause has been corrected and is not otherwise disqualifying.

A3.16.5. Hepato-pancreatico-biliary tract.

A3.16.5.1. Hepatitis within the preceding 6 months; or persistence of symptoms after 6 months, with objective evidence of impairment of liver function and chronic hepatitis, including hepatitis B carriers.

A3.16.5.2. Hepatic cysts. Congenital cystic disease parasitic, protozoal, or other cysts.

A3.16.5.3. Cirrhosis regardless of the absence of manifestations such as jaundice, ascites, or known esophageal varices; abnormal liver function, with or without history of chronic alcoholism.

A3.16.5.4. Cholecystectomy, sequelae of, such as postoperative stricture of the common bile duct, reforming of stones in hepatic or common bile ducts, incisional hernia, or postcholecystectomy syndrome when symptoms are of such a degree as to interfere with normal performance of duty.

A3.16.5.5. Cholecystitis, acute or chronic, with or without cholelithiasis.

A3.16.5.6. Bile duct abnormalities or strictures.

A3.16.5.7. Pancreas, acute or chronic disease of, if proven by laboratory tests, or medical records; and congenital anomalies such as annular pancreas, cystic disease, etc.

A3.16.6. Anorectal.

A3.16.6.1. Fistula in ano.

A3.16.6.2. Incontinence.

A3.16.6.3. Anorectal stricture.

A3.16.6.4. Excessive mucous production with soiling.

A3.16.6.5. Hemorrhoids, internal or external, when large, symptomatic, or history of bleeding.

A3.16.6.6. Rectal prolapse.

A3.16.6.7. Symptomatic rectocele.

A3.16.6.8. Symptomatic anal fissure.

A3.16.6.9. Chronic diarrhea, regardless of cause.

A3.16.7. Spleen.

A3.16.7.1. Splenomegaly until the cause is corrected and is not otherwise disqualifying.

A3.16.7.2. Splenectomy, except when done for the following:

A3.16.7.2.1. Trauma.

A3.16.7.2.2. Causes unrelated to diseases of the spleen.

A3.16.7.2.3. Hereditary spherocytosis.

A3.16.7.2.4. Disease involving the spleen when followed by correction of the condition for at least 2 years and is not otherwise disqualifying.

A3.16.7.3. Tumors (See paragraph **A3.36.**).

A3.16.7.3.1. Abdominal wall.

A3.16.7.3.1.1. Scars.

A3.16.7.3.1.2. Scars, abdominal, regardless of cause, the hernial bulging of which interferes with movement.

A3.16.7.3.1.3. Scar pain associated with disturbance of function of abdominal wall or contained viscera.

A3.16.7.3.1.4. Sinuses of the abdominal wall, to include persistent urachus and persistent omphalomesenteric duct.

A3.16.7.3.2. Hernia.

A3.16.7.3.2.1. Hernia other than small asymptomatic umbilical or asymptomatic hiatal.

A3.16.7.3.2.2. History of operation for hernia within the preceding 60 days.

A3.16.7.4. Other. Congenital or acquired abnormalities, such as gastrointestinal bypass or stomach stapling for control of obesity; and defects that preclude satisfactory performance of military duty or require frequent and prolonged treatment.

A3.17. Genitalia and Reproductive Organs (See also paragraph **A3.36.**).

A3.17.1. Abnormal uterine bleeding including menorrhagia, metrorrhagia or polymenorrhea.

A3.17.2. Amenorrhea. Primary or secondary if unexplained or otherwise disqualifying.

A3.17.3. Dysmenorrhea. Incapacitating to a degree recurrently necessitating absences of more than a few hours from routine activities.

A3.17.4. Endometriosis, or confirmed history thereof.

A3.17.5. Hermaphroditism.

A3.17.6. Hydrocele or left varicocele, if painful, or any right varicocele unless urological evaluation reveals no disease.

A3.17.7. Menopausal syndrome. Physiologic or artificial if manifested by more than mild constitutional or mental symptoms, or artificial menopause if less than 13 months have elapsed since cessation of menses. In all cases of artificial menopause, the clinical diagnosis will be reported; if accomplished by surgery, the pathology report shall be obtained and recorded.

A3.17.8. Ovarian cysts. Persistent, clinically significant.

A3.17.9. Pelvic inflammatory disease (PID). Acute or chronic.

A3.17.10. Penile infectious lesions, including herpes genitalis and condyloma accuminata, not amenable to treatment.

A3.17.11. Pregnancy.

A3.17.12. Testicle or testicles: See also paragraph **A3.36.**

A3.17.12.1. Absence of both testicles, or unexplained absence of a testicle.

A3.17.12.2. Undiagnosed enlargement or mass of testicles or epididymis.

A3.17.12.3. Undescended testicle(s).

A3.17.13. Urethritis. Acute or chronic (see also paragraph **A3.37.**).

A3.17.14. Uterus.

A3.17.14.1. Congenital absence of.

A3.17.14.2. Generalized enlargement of the uterus due to any cause.

A3.17.14.3. Pap smears graded abnormal, or any smear in which the descriptive terms condyloma accuminatum, human papilloma virus, dysplasia, carcinoma-in-situ, or invasive cancer are used.

A3.17.15. Vagina.

A3.17.15.1. Congenital abnormalities that interfere with physical activities.

A3.17.15.2. Condyloma accuminatum or herpes genitalia, acute or chronic, not amenable to treatment.

A3.17.16. Vulva.

A3.17.16.1. Condyloma accuminatum or herpes genitalia, acute or chronic, not amenable to treatment.

A3.17.16.2. Dystrophic conditions.

A3.17.16.3. Vulvitis, acute or chronic**.**

A3.17.16.4. Major abnormalities and defects of the genitalia. Such as a change of sex, a history thereof, or dysfunctional residuals from surgical correction of these conditions.

A3.18. Urinary System (See paragraphs **A3.32.** and **A3.36.**).

A3.18.1. Cystitis, chronic. Individuals with acute cystitis are unacceptable until the condition is cured.

A3.18.2. Enuresis. Determined to be a symptom of an organic defect not amenable to treatment. (See also paragraph **A3.23.**).

A3.18.3. Epispadias or hypospadias. When accompanied by evidence of infection of the urinary tract or if clothing is soiled when voiding.

A3.18.4. Hematuria, cylindruria, pyuria, or other findings indicative of renal tract disease.

A3.18.5. Incontinence of urine.

A3.18.6. Kidney.

A3.18.6.1. Absence of one kidney, regardless of cause.

A3.18.6.2. Acute or chronic infections of the kidney.

A3.18.6.3. Cystic or polycystic kidney, confirmed, history of.

A3.18.6.4. Horseshoe kidney.

A3.18.6.5. Hydronephrosis or pyonephrosis.

A3.18.6.6. Nephritis, acute or chronic.

A3.18.6.7. Pyelitis, pyelonephritis.

A3.18.7. Orchitis, chronic, or chronic epididymitis.

A3.18.8. Penis, amputation of, if the resulting stump is insufficient to permit micturition in a normal manner.

A3.18.9. Peyronie's disease.

A3.18.10. Prostate gland, hypertrophy of, with urinary retention; chronic prostatitis.

A3.18.11. Proteinuria under normal activity (at least 48 hours post strenuous exercise) greater than 200 mg/24 hours or a protein to creatinine ratio greater than 0.2 in a random urine sample, unless nephrologic consultation determines the condition to be benign orthostatic proteinuria.

A3.18.12. Renal calculus.

A3.18.12.1. Substantiated history of recurrent renal calculus or bilateral renal calculus at any time.

A3.18.12.2. Verified history of renal calculus with evidence of stone formation within the preceding 12 months, current symptoms, or positive x-ray for calculus, or nephrocalcinosis.

A3.18.13. Skenitis.

A3.18.14. Urethra, Stricture of.

A3.18.15. Urinary fistula.

A3.18.16. Other diseases and defects of the urinary system that obviously preclude satisfactory performance of duty or require frequent and prolonged treatment.

A3.19. Neurological Disorders.

A3.19.1. Cerebrovascular conditions. Any history of subarachnoid or intracerebral hemorrhage, embolism, vascular insufficiency, arteriovenous malformation or aneurysm, whether transient or with secondary infarction involving the CNS.

A3.19.2. Congenital malformations if associated with neurological manifestations or if the process is expected to be progressive; meningocele even if uncomplicated.

A3.19.3. Degenerative and hereditodegenerative disorders affecting the cerebrum, basal ganglia, cerebellum, spinal cord, peripheral nerves, or muscles.

A3.19.4. Recurrent headaches of all types of sufficient severity or frequency as to interfere with normal function or a history of such headaches within 3 years.

A3.19.5. Head injury.

A3.19.5.1. Applicants with a history of head injury are unacceptable at any time if they display any of the following:

A3.19.5.1.1. Late post-traumatic epilepsy (occurring more than 1 week after injury).

A3.19.5.1.2. Permanent motor or sensory deficits.

A3.19.5.1.3. Impairment of intellectual functions.

A3.19.5.1.4. Alteration of personality.

A3.19.5.1.5. Central nervous system shunt of any type.

A3.19.5.2. Applicants with a history of severe head injury are unfit for a period of at least 5 years after which they may be considered fit if complete neurological and neuropsychological evaluation (See **Table 16.1.**) show no residual dysfunction or complications. Severe head injuries are defined by one or more of the following:

A3.19.5.2.1. Unconsciousness or amnesia, alone or in combination, of 24 hours duration or longer.

A3.19.5.2.2. Depressed skull fracture.

A3.19.5.2.3. Laceration or contusion of the dura or brain.

A3.19.5.2.4. Epidural, subdural, subarachnoid or intracerebral hematoma.

A3.19.5.2.5. Associated abscess or meningitis.

A3.19.5.2.6. Cerebrospinal fluid rhinorrhea or otorrhea persisting more than 7 days.

A3.19.5.2.7. Early post-traumatic seizure(s), occurring within one week of injury but more than 30 minutes after the injury.

A3.19.5.2.8. Focal neurological signs.

A3.19.5.2.9. Radiographic evidence of retained metallic or bony fragments.

A3.19.5.2.10. Leptomeningeal cysts or arteriovenous fistula.

A3.19.5.3. Applicants with a history of moderate head injury are unfit for a period of at least 2 years after which they may be considered fit if complete neurological evaluation (see **Table 16.1.**) shows no residual dysfunction or complications. Moderate head injuries are defined as unconsciousness or amnesia, alone or in combination, of 1 to 24 hours duration or linear skull fracture.

A3.19.5.4. Applicants with a history of mild head injury as defined by a period of unconsciousness or amnesia, alone or in combination, of 1 hour or less, are unfit for at least 1 month after which they may be acceptable if neurological evaluation (see **Table 16.1.**) shows no residual dysfunction or complications.

A3.19.5.5. Persistent post-traumatic sequelae, as manifested by headache, vomiting, disorientation, spatial disequilibrium, personality changes, impaired memory, poor mental concentration, shortened attention span, dizziness, altered sleep patterns, or any findings consistent with organic brain syndrome, are disqualifying until full recovery has been confirmed by complete neurological and neuropsychological evaluation.

A3.19.5.6. Infectious diseases, such as:

A3.19.5.6.1. Meningitis, encephalitis, or poliomyelitis within 1 year before examination, or if there are residual neurological defects which would interfere with satisfactory performance of military duty.

A3.19.5.6.2. Neurosyphilis of any form (general paresis, tabes dorsalis, meningovascular syphilis).

A3.19.5.7. Narcolepsy, cataplexy, sleep apnea syndrome (see paragraph **A3.39.**), and similar states except that sleep paralysis is not disqualifying by itself.

A3.19.5.8. Paralysis, tremor or weakness, deformity, discoordination, pain, sensory disturbance, intellectual deficit, disturbances of consciousness, or personality abnormalities regardless of cause if there is any indication that such involvement is likely to interfere with prolonged normal function in any practical manner or is progressive or recurrent.

A3.19.5.9. All forms of generalized or partial epilepsy that have persisted beyond the age of 5. Waiver consideration may be given if an applicant has been free of seizures with a normal electroencephalogram (EEG) while off all anti-epileptic medications for a period of 5 years immediately preceding the medical examination for military service. Waiver requests will be referred according to **Attachment 10** and must include the interpretation and tracing of an awake and sleep EEG of good quality(*) plus results of a head imaging study (CT or MRI) all obtained within 3 months of the examination, a current neurology evaluation containing details of the seizure history, such as the date of initial onset, etiology, diagnosis, treatment rendered, recurrency, the results of clinical examination to establish current status, a diagnosis, and a prognosis outlining any risk factors or restrictions.

*Note: For the purpose of waiver consideration, an EEG of good quality should be at least a 16 channel study that includes a minimum of 20 minutes of artifact-free recording, 3 to 5 minutes of hyperventilation, photic stimulation, and recorded sleep. The interpretation should be accomplished by a certified electroencephalographer.

A3.19.5.10. Any substantiated history of acquired chronic or recurrent disorders such as myasthenia gravis, polymyositis, and multiple sclerosis.

A3.19.5.11. Central nervous system shunts of all kinds.

Concepts and terms used in paragraphs **A3.20.** *through* **A3.25.** *are in consonance with the Diagnostic and Statistical Manual, American Psychiatric Association, DSM-III-R, 1987.*

A3.20. Disorders With Psychotic Features. The cause for rejection is a history of a mental disorder with gross impairment in reality testing. This does not include transient disorders associated with intoxication, severe stress or secondary to a toxic, infectious or other organic process.

A3.21. Mood Disorders. The causes for rejection are symptoms, diagnosis, or history of a major mood disorder requiring maintenance treatment or hospitalization.

A3.22. Anxiety, Somatoform, Dissociative, or Factitious Disorders (Alternatively May Be Addressed as Neurotic Disorders).

A3.22.1. History of such disorders resulting in any or all of the below:

A3.22.1.1. Hospitalization.

A3.22.1.2. Prolonged care by a physician or other professional.

A3.22.1.3. Loss of time from normal pursuits for repeated periods even if for brief duration.

A3.22.1.4. Symptoms or behavior of a repeated nature that impaired social, school, or other work efficiency.

A3.22.2. History of an episode of such disorders within the preceding 12 months which was sufficiently severe to require professional attention or absence from work or school for more than a brief period (maximum of 7 days).

A3.23. Personality, Behavior, or Academic Skills Disorders.

A3.23.1. Personality or behavior disorders, as evidenced by frequent encounters with law enforcement agencies, antisocial attitudes or behavior which, while not sufficient cause for administrative rejection, are tangible evidence of impaired characterological capacity to adapt to military service.

A3.23.2. Personality or behavior disorders where it is evident by history, interview, or psychological testing that the degree of immaturity, instability, personality inadequacy, impulsiveness or dependency will seriously interfere with adjustment in the Armed Forces as demonstrated by inability to maintain reasonable adjustment in school, with employers and fellow workers, and other social groups.

A3.23.3. Other behavior problems including but not limited to conditions such as authenticated evidence of functional enuresis or encopresis not due to an organic condition (see paragraph **A3.18.**), sleepwalking or eating disorders that are habitual or persistent (occurring beyond age 12), or stammering or stuttering of such a degree that the individual is normally unable to express himself or herself clearly or to repeat commands.

A3.23.4. Specific Academic Skills Defects: Chronic history of academic skills or perceptual defects secondary to organic or functional mental disorders that interfere with work or school after age 12. Current use of medication to improve or maintain academic skills (e.g., methylphenidate hydrochloride) is disqualifying.

A3.23.5. Suicide. History of attempted suicide or other suicidal behavior.

A3.24. Psychosexual Conditions.

A3.24.1. Transsexualism and other gender identity disorders.

A3.24.2. Exhibitionism, transvestism, voyeurism and other paraphilias.

A3.25. Substance Misuse.

A3.25.1. Alcohol dependence or history of.

A3.25.2. Drug dependence or history of.

A3.25.3. Drug abuse characterized by:

A3.25.3.1. Evidence of use of any controlled, hallucinogenic, or other intoxicating substance at time of examination, when the use cannot be accounted for as the result of the advice of a recognized health care practitioner.

A3.25.3.2. Documented misuse or abuse of any controlled substance (including cannabinoids or anabolic steroids) requiring professional care within a 1-year period before examination. Use of marijuana or other cannabinoids (not habitual use) or experimental or casual use of other drugs short of dependence may be waived by the appropriate waiver authority in **Attachment 9** if there is evidence of current drug abstinence and the individual is otherwise qualified for service.

A3.25.3.3. The repeated self-procurement and self-administration of any drug or chemical substance, including cannabinoids or anabolic steroids, with such frequency that it appears that the applicant has

accepted the use of or reliance on these substances as part of his or her pattern of behavior. (See also appropriate Armed Forces instructions.)

A3.25.3.4. The use of LSD in a 2-year period before the examination.

A3.25.4. Alcohol abuse. Use of alcoholic beverages which leads to misconduct, unacceptable social behavior, poor work or academic performance, impaired physical or mental health, lack of financial responsibility or a disrupted personal relationship. (See also appropriate Armed Forces instructions.)

A3.26. Upper Extremities (See paragraph **A3.28.**).

A3.26.1. Limitation of motion. An individual shall be considered unacceptable if the joint ranges of motion are less than the measurements listed below. Methods of measurement are in **Attachment 13**.

A3.26.1.1. Shoulder.

A3.26.1.1.1. Forward elevation to 90 degrees.

A3.26.1.1.2. Abduction to 90 degrees.

A3.26.1.2. Elbow.

A3.26.1.2.1. Flexion to 100 degrees.

A3.26.1.2.2. Extension to 15 degrees.

A3.26.1.3. Wrist. A total range of 60 degrees (extension plus flexion). Radial and ulnar deviation combined arch 30 degrees.

A3.26.1.4. Hand.

A3.26.1.4.1. Pronation to 45 degrees.

A3.26.1.4.2. Supination to 45 degrees.

A3.26.1.5. Fingers. Inability to clench fist, pick up a pin or needle, and grasp an object.

A3.26.1.6. Thumb. Inability to touch tips of at least 3 fingers.

A3.26.2. Hand and fingers.

A3.26.2.1. Absence of the distal phalanx of either thumb.

A3.26.2.2. Absence or loss of distal and middle phalanx of an index, middle or ring finger of either hand irrespective of the absence or loss of little finger.

A3.26.2.3. Absence of more than the distal phalanx of any two of the following fingers: index, middle finger or ring finger, of either hand.

A3.26.2.4. Absence of hand or any portion thereof except for fingers as noted above.

A3.26.3. Hyperdactylia.

A3.26.4. Scars and deformities of the fingers or hand that impair circulation, are symptomatic, or which impair normal function to such a degree as to interfere with the satisfactory performance of military duty.

A3.26.5. Intrinsic paralysis or weakness (either median or ulnar nerves) sufficient to produce physical findings in the hand (e.g., muscle atrophy or weakness).

A3.26.6. Wrist, forearm, elbow, arm, and shoulder. Recovery from disease or injury of wrist, forearm, elbow, arm, or shoulder with residual weakness or symptoms such as to preclude satisfactory performance of duty. Grip strength of less than 75 percent of predicted normal when injured hand is compared with the normal hand (nondominant is 80 percent of dominant grip).

A3.27. Lower Extremities (See paragraph **A3.28.**).

A3.27.1. Limitation of motion. An individual will be considered unacceptable if the joint ranges of motion are less than the measurements listed below. Methods of measurement are in **Attachment 14**.

A3.27.1.1. Hip.

A3.27.1.1.1. Flexion to 90 degrees (minimum).

A3.27.1.1.2. No demonstrable flexion contracture.

A3.27.1.1.3. Extension to 10 degrees (beyond 0).

A3.27.1.1.4. Abduction to 45 degrees.

A3.27.1.1.5. Rotation 60 degrees (internal and external combined).

A3.27.1.2. Knee.

A3.27.1.2.1. Full extension.

A3.27.1.2.2. Flexion to 90 degrees.

A3.27.1.3. Ankle.

A3.27.1.3.1. Dorsiflexion to 10 degrees.

A3.27.1.3.2. Plantar flexion to 30 degrees.

A3.27.1.3.3. Eversion and inversion (total to 5 degrees).

A3.27.1.4. Toes. Stiffness that interferes with walking, marching, running, or jumping.

A3.27.2. Foot and ankle.

A3.27.2.1. Absence of one or more small toes if function of the foot is poor or running or jumping is prevented; absence of a foot or any portion thereof except for toes as noted herein.

A3.27.2.2. Absence of great toe(s); loss of dorsal flexion thereof if function of the foot is impaired.

A3.27.2.3. Claw toes preventing the wearing of military footwear.

A3.27.2.4. Clubfoot if any residual varus or equinus of the hind foot, degenerative changes in the mid or hind foot or significant stiffness or deformity prevents foot function or wearing of military footwear.

A3.27.2.5. Pes planus, pronounced cases, with decided eversion of the foot and marked bulging of the inner border, due to rotation of the talus, regardless of the presence or absence of symptoms.

A3.27.2.6. Pes planus, tarsal coalition.

A3.27.2.7. Hallux valgus, if severe, or of any degree if associated with marked exostosis or bunion which would prevent wearing of military footwear.

A3.27.2.8. Hammer toe, hallux limitus, or hallux rigidus that interferes with the wearing of military footwear.

A3.27.2.9. Effects of disease, injury, or deformity including hyperdactylia that prevent running, are accompanied by disabling pain, or prohibit the wearing of military footwear.

A3.27.2.10. Ingrown toenails, if severe, and not remediable.

A3.27.2.11. Obliteration of the transverse arch associated with permanent flexion of the small toes.

A3.27.2.12. Overriding of any of the toes, if symptomatic or sufficient to interfere with the wearing of military footwear.

A3.27.2.13. Pes cavus, symptomatic or with contracted plantar fascia, dorsiflexed toes, tenderness under the metatarsal heads, or callosities under the weight bearing areas.

A3.27.2.14. Plantar fascitis that is refractory to medical treatment or will impair function of the foot.

A3.27.2.15. Neuroma. Confirmed and refractory to medical treatment or will impair function of the foot.

A3.27.3. Leg, knee, thigh, and hip.

A3.27.3.1. Loose or foreign bodies within the knee joint.

A3.27.3.2. Physical findings of an unstable or internally deranged joint. History of anterior or posterior cruciate ligament injury, even if repaired, is disqualifying.

A3.27.3.3. History of surgical correction of knee ligaments.

A3.27.3.4. Authenticated history of congenital dislocation of the hip, osteochondritis of the hip (Legg-Perthes disease) or slipped femoral epiphysis of the hip. These conditions may be waiverable if there is no x-ray evidence of residual deformity or degenerative changes, or any clinically significant limitation of motion.

A3.27.3.5. Authenticated history of hip dislocation within 2 years before examination or degenerative changes on X-ray from old hip dislocation.

A3.27.3.6. Osteochondritis of the tibial tuberosity (Osgood-Schlatter's disease), if symptomatic or with obvious prominence of the part and X-ray evidence of separated bone fragment.

A3.27.4. General.

A3.27.4.1. Deformities of one or both lower extremities that have interfered with function to such a degree as to prevent the individual from following a physically active vocation in civilian life or that would interfere with satisfactory completion of prescribed training and performance of military duty.

A3.27.4.2. Diseases or deformities of the hip, knee, or ankle joint that interfere with walking, running, or weight bearing.

A3.27.4.3. Pain in the lower back or leg that is intractable and disabling to the degree of interfering with walking, running, weight bearing.

A3.27.4.4. Shortening of a lower extremity resulting in a noticeable limp or scoliosis.

A3.28. Miscellaneous Conditions of the Extremities (See also paragraphs **A3.26.** and **A3.27.**).

A3.28.1. Arthritis.

A3.28.1.1. Active, subacute or chronic arthritis.

A3.28.1.2. Chronic osteoarthritis or traumatic arthritis of isolated joints of more than a minimal degree, that has interfered with the following of a physically active vocation in civilian life or that prevents the satisfactory performance of military duty.

A3.28.2. Chronic retropatellar knee pain syndrome with or without confirmatory aorthroscopic evaluation.

A3.28.3. Disease of any bone or joint, healed, with such resulting deformity or rigidity that function is so impaired it will interfere with military service.

A3.28.4. Dislocation, old unreduced; substantiated history of recurrent dislocations of major joints; instability of a major joint.

A3.28.5. Fractures.

A3.28.5.1. Malunited fractures.

A3.28.5.2. Ununited fractures, except for ulnar styloid process.

A3.28.5.3. Any old or recent fracture in which a plate, pin, metal rod, wire or screws used for fixation were left in place; pin, wire, or screw not subject to easy trauma is not disqualifying.

A3.28.6. Injury of a bone or joint of more than a minor nature, yet without fracture or dislocation that occurred within the preceding 6 weeks.

A3.28.7. Joint replacement.

A3.28.8. Muscular paralysis, contracture, or atrophy, if progressive or of sufficient degree to interfere with military service.

A3.28.9. Myotonia congenita.

A3.28.10. Osteochondritis dessicans.

A3.28.11. Osteochondromatosis, or multiple cartilanginous exostoses.

A3.28.12. Osteomyelitis. Active or recurrent, any bone or substantiated history of osteomyelitis of any of the long bones.

A3.28.13. Osteoporosis.

A3.28.14. Scars. Extensive, deep, or adherent to the skin and soft tissues or neuromas of an extremity that are painful, that interfere with muscular movements, that prevent the wearing of military clothing or equipment, or that show a tendency to breakdown.

A3.28.15. Implants. Silastic or other devices implanted to correct orthopedic abnormalities.

A3.29. Spine and Sacroiliac Joints (See paragraph **A3.28.**).

A3.29.1. Arthritis (See paragraph **A3.28.**).

A3.29.2. Complaint of a disease or injury of the spine or sacroiliac joints with or without objective signs that has prevented the individual from successfully following a physically active vocation in civilian life. Substantiation or documentation of the complaint without objective physical findings is required.

A3.29.3. Deviation or curvature of spine from normal alignment, structure, or function if: there is lumbar scoliosis greater than 20 degrees, thoracic scoliosis greater than 30 degrees, and kyphosis or lordosis greater than 55 degrees when measured by the Cobb method.

A3.29.4. It prevents the individual from following a physically active vocation in civilian life.

A3.29.5. It interferes with the wearing of a uniform or military equipment.

A3.29.6. It's symptomatic and associated with positive physical findings and demonstrable by x-ray.

A3.29.7. Diseases of the lumbosacral or sacroiliac joints of a chronic type associated with pain referred to the lower extremities, muscular spasm, postural deformities, or limitation of motion of the lumbar region of the spine.

A3.29.8. Fusion involving more than two vertebrae. Any surgical fusion is disqualifying.

A3.29.9. Granulomatous diseases either active or healed.

A3.29.10. Healed fractures or dislocations of the vertebra. A compression fracture, involving less than 25 percent of a single vertebra is not disqualifying if the injury occurred more than 1 year before examination and the applicant is asymptomatic. A history of fractures of the transverse or spinous processes is not disqualifying if the applicant is asymptomatic.

A3.29.11. Juvenile epiphysitis with any degree of residual change indicated by x-ray or kyphosis.

A3.29.12. Ruptured nucleus pulposus (herniation of intervertebral disk) or history of operation for this condition.

A3.29.13. Spina bifida when symptomatic, or there is more than one vertebra involved, dimpling of the overlying skin, or a history of surgical repair.

A3.29.14. Spondylolysis that is symptomatic or likely to interfere with performance of duty or limit assignments is disqualifying, even if successfully fused.

A3.29.15. Weak or painful back requiring external support; that is, corset or brace. Recurrent sprains or strains requiring limitation of physical activity or frequent treatment.

A3.29.16. Spondylolisthesis.

A3.30. Scapulae, Clavicles, and Ribs (See paragraph **A3.28.**).

A3.30.1. Fractures until well-healed, and until determined that the residuals thereof will not prevent the satisfactory performance of military duty.

A3.30.2. Injury within the preceding 6 weeks, without fracture or dislocation, of more than a minor nature.

A3.30.3. Osteomyelitis.

A3.30.4. Prominent scapulae interfering with function or with the wearing of a uniform or military equipment.

A3.31. Skin and Cellular Tissues.

A3.31.1. Acne. Severe, or when extensive involvement of the neck, shoulders, chest, or back would be aggravated by or interfere with the wearing of military equipment and not amenable to treatment. Patients under treatment with isotretinoin (Accutane) are medically unacceptable until 8 weeks after completion of a course of therapy.

A3.31.2. Atopic dermatitis or Eczema. With active or residual lesions in characteristic areas (face, neck, antecubital or popliteal fossae, occasionally wrists and hands), or documented history thereof after the age of 5.

A3.31.3. Contact dermatitis involving rubber or other materials used in any type of required protective equipment.

A3.31.4. Cysts.

A3.31.4.1. Cysts, other than pilonidal. Of such a size or location as to interfere with the normal wearing of military equipment.

A3.31.4.2. Cysts, pilonidal. Pilonidal cysts, if evidenced by the presence of a tumor, mass, or a discharging sinus. History of pilonidal cystectomy within 1 year before examination is disqualifying.

A3.31.5. Dermatitis factitia.

A3.31.6. Dermatitis herpetiformis.

A3.31.9. Elephantiasis or chronic lymphedema.

A3.31.10. Epidermolysis bullosa.

A3.31.11. Fungus infections, systemic or superficial types, if extensive and not amenable to treatment.

A3.31.12. Furunculosis. Extensive, recurrent, or chronic.

A3.31.13. Hyperhidrosis of hands or feet. Chronic or severe.

A3.31.14. Ichthyosis. Severe.

A3.31.15. Keloid formation. If the tendency is marked or interferes with the wearing of military equipment.

A3.31.16. Leprosy. Any type.

A3.31.17. Leukemia cutis; mycosis fungoides, Hodgkin's disease. (see paragraph **A3.36.** for additional remarks on Hodgkins disease.)

A3.31.18. Lichen planus.

A3.31.19. Neurofibromatosis (Von Recklinghausen's Disease).

A3.31.20. Nevi or vascular tumors, if extensive, interfere with function, or exposed to constant irritation.

A3.31.21. Pemphigus or pemphigoid.

A3.31.22. Photosensitivity. Any primary sun-sensitive condition, such as polymorphous light eruption or solar urticaria; any dermatosis aggravated by sunlight such as lupus erythematosus.

A3.31.23. Psoriasis, or a verified history thereof.

A3.31.24. Radiodermatitis.

A3.31.25. Scars. Those that are extensive, deep, or adherent that they may interfere with the wearing of military clothing or equipment, exhibit a tendency to ulcerate, or interfere with function. Includes scars at skin graft donor or recipient sites if in an area susceptible to trauma.

A3.31.26. Scleroderma (See paragraph **A3.38.**).

A3.31.27. Tattoos which will significantly limit effective performance of military service.

A3.31.28. Urticaria, chronic.

A3.31.29. Warts, plantar, that have materially interfered with a useful vocation in civilian life.

A3.31.30. Xanthoma, if disabling or accompanied by hyperlipidemia.

A3.31.31. Any other chronic skin disorder of a degree or nature that requires frequent outpatient treatment or hospitalization, or interferes with the satisfactory performance of duty.

A3.32. Endocrine and Metabolic Disorders.

A3.32.1. Adrenal dysfunction of any degree.

A3.32.2. Cretinism.

A3.32.3. Diabetes mellitus. Any type, including a history of juvenile onset (insulin dependent type I).

*Note: The criteria for the diagnosis of diabetes consist of (a) diabetic symptoms with a casual glucose greater than or equal to 200 mg/dl, (b) Fasting plasma glucose greater than or equal to 126 mg/dl, or (c) 2 hour plasma glucose greater than or equal to 200 mg/dl during an OGTT. The diagnosis is considered pro-

visional until confirmed by any of these methods on a subsequent day. Values for fasting plasma glucose greater than or equal to 110 but less than 126 mg/dl are considered to represent impaired fasting glucose; 2 hPG levels greater than or equal to 140 but less than 200 mg/dl represent impaired glucose tolerance.

A3.32.4. Gigantism or acromegaly.

A3.32.5. Glycosuria. Persistent, when associated with impaired glucose tolerance or renal tubular defects that cause aminoaciduria, phosphaturia, and renal tubular acidosis.

A3.32.6. Gout.

A3.32.7. Hyperinsulinism.

A3.32.8. Hyperparathyroidism and hypoparathyroidism.

A3.32.9. Hypopituitarism.

A3.32.10. Myxedema. Spontaneous or postoperative (with clinical manifestations).

A3.32.11. Nutritional deficiency diseases (including sprue, beriberi, pellagra, and scurvy).

A3.32.12. Thyroid disorders.

A3.32.12.1. Goiter. Simple goiter with definite pressure symptoms, or so large as to interfere with the wearing of a military uniform or military equipment.

A3.32.12.2. Hyperthyroidism or thyrotoxicosis.

A3.32.12.3. Hypothyroidism, symptomatic or uncontrolled by medication.

A3.32.12.4. Thyroiditis.

A3.32.13. Other endocrine or metabolic disorders that obviously prevent satisfactory performance of duty or which require frequent or prolonged treatment. (Such as cystic fibrosis, porphyria, and amyloidosis.)

A3.33. Height. The cause for rejection for Air Force male applicants is height less than 60 inches or more than 80 inches. The cause for rejection for Air Force female applicants is height less than 58 inches or more than 80 inches.

A3.34. Weight. Body composition measurements may be used as the final determinant in evaluating an applicant's acceptability. For AF applicants who exceed the weight in relation to height which is prescribed in **Attachment 16**. Body fat standards will apply as outlined in **Attachment 16**.

A3.35. Body Build.

A3.35.1. Congenital malformation of bones and joints. (See paragraphs **A3.36.**, **A3.37.**, and **A3.38.**).

A3.35.2. Deficient muscular development that would interfere with the completion of required training.

A3.35.3. Evidence of congenital asthenia or body build that would interfere with the completion of required training.

A3.36. Tumors and Malignant Diseases.

A3.36.1. Benign Tumors of the:

A3.36.1.1. Head or face that interfere with function or prevent the wearing of face or protective masks or helmet.

A3.36.1.2. Eyes, ears, or upper airway that interfere with function.

A3.36.1.3. Thyroid or other neck structures such as to interfere with function or the wearing of a uniform or military equipment.

A3.36.1.4. Breast (male or female), chest, or abdominal wall that would interfere with military duty.

A3.36.1.5. Respiratory, gastrointestinal, genitourinary, or musculoskeletal systems that interfere with function or the wearing of a uniform or military equipment.

A3.36.1.6. Musculoskeletal system likely to continue to enlarge, be subjected to trauma during military service or show malignant potential.

A3.36.1.7. Skin which interfere with function, have malignant potential, interfere with military duty or the wearing of the uniform or military equipment.

A3.36.1.8. Central nervous system or history of, or if likely to recur.

A3.36.1.9. Peripheral nerves that interfere with function, have malignant potential, interfere with military duty or the wearing of the uniform or military equipment.

A3.36.2. Malignant Tumors. Malignant tumors diagnosed by acceptable laboratory procedures, and even though surgically removed or otherwise treated, with exceptions as noted. **(**Individuals who have a history of childhood cancer and who have not received any surgical or medical cancer therapy for 5 years and are free of cancer will be considered, on a case-by-case basis for acceptance into the Armed Forces. Applicants must provide complete information about the history and present status of their cancer.)

A3.36.2.1. Malignant tumors of the auditory canal, eye, or orbit (see paragraph **A3.10.**) or upper airway.

A3.36.2.2. Malignant tumors of the breast (male or female).

A3.36.2.3. Malignant tumors of the lower airway or lung.

A3.36.2.4. Malignant tumors of the heart.

A3.36.2.5. Malignant tumors of the gastrointestinal tract, liver, bile ducts, or pancreas.

A3.36.2.6. Malignant tumors of the genitourinary system male or female. Wilm's tumor and germ cell tumors of the testis treated surgically or with chemotherapy in childhood, after a 2-year disease-free interval off all treatment may be considered on a case-by-case basis for service.

A3.36.2.7. Malignant tumors of the musculoskeletal system.

A3.36.2.8. Malignant tumors of the central nervous system and its membranous coverings, unless 5 years postoperative, off treatment, without recurrence, and without otherwise disqualifying residuals of surgery or the original lesion.

A3.36.2.9. Malignant tumors of the endocrine glands.

A3.36.2.10. Malignant melanoma or history thereof. Other skin tumors such as basal cell and squamous cell carcinomas surgically removed are not disqualifying.

A3.36.2.11. Malignant tumors of the hematopoietic system.

A3.36.2.11.1. Lymphomatous diseases.

A3.36.2.11.1.1. Non-Hodgkin's lymphoma (all types).

A3.36.2.11.1.2. Hodgkin's disease, active or recurrent. Hodgkin's disease treated with radiation therapy or chemotherapy (or both) and disease-free off treatment for 5 years may be considered for service. Large cell lymphoma will likewise be considered on a case-by-case basis after a 2 year disease-free interval off all therapy.

A3.36.2.11.1.3. Leukemias. All types, except acute lymphoblastic leukemia treated in childhood without evidence of recurrence.

A3.36.2.11.1.4. Multiple myeloma.

A3.37. Sexually Transmitted Diseases. In general, the finding of acute, uncomplicated venereal disease that can be expected to respond to treatment is not a cause for medical rejection for military service. The causes for rejection are:

A3.37.1. Chronic sexually transmitted disease that has not satisfactorily responded to treatment. The finding of a positive serologic test for syphilis following adequate treatment is not in itself considered evidence of chronic venereal disease. (See paragraph **A3.39.**)

A3.37.2. Complications and permanent residuals of sexually transmitted disease when they are progressive, or of such a nature as to interfere with the satisfactory performance of duty, or are subject to aggravation by military service.

A3.37.3. Neurosyphilis (See paragraph **A3.19.**).

A3.38. Systemic Diseases.

A3.38.1. Amyloidosis.

A3.38.2. Ankylosing spondylitis.

A3.38.3. Eosinophilic granuloma. Eosinophilic granuloma, when occurring as a single localized bony lesion and not associated with soft tissue or other involvement, should not be a cause for rejection once healing has occurred. All other forms of the Histiocytosis X spectrum should be rejected, however.

A3.38.4. Lupus erythematosus.

A3.38.5. Mixed connective tissue disease.

A3.38.6. Polymyositis dermatomyositis complex.

A3.38.7. Progressive systemic sclerosis, including CREST variant. A single plaque of localized scleroderma (morphea) that has been stable for at least 2 years is not disqualifying.

A3.38.8. Psoriatic arthritis.

A3.38.9. Reiter's disease.

A3.38.10. Rheumatoid arthritis.

A3.38.11. Rhabdomyolysis, or history thereof.

A3.38.12. Sarcoidosis, unless there is substantiated evidence of a complete spontaneous remission of at least 2 years duration.

A3.38.13. Sjogren's syndrome.

A3.38.14. Tuberculosis.

A3.38.14.1. Active tuberculosis in any form or location, or substantiated history of active tuberculosis within the previous 2 years.

A3.38.14.2. Substantiated history of one or more reactivations or relapses of tuberculosis in any form or location or other definite evidence of poor host resistance to the tubercle bacillus.

A3.38.14.3. Residual physical or mental defects from past tuberculosis that would prevent the satisfactory performance of duty.

A3.38.14.4. Individuals with a past history of active tuberculosis more than 2 years before enlistment, induction, and appointment are not disqualified provided they have received a complete course of standard chemotherapy for tuberculosis. In addition, individuals with a tuberculin reaction 10mm or greater and without evidence of residual disease in pulmonary or non-pulmonary sites are eligible for enlistment, induction, and appointment provided they have or will be treated with chemoprophylaxis in accordance with the guidelines of the American Thoracic Society and US Public Health Service.

A3.38.15. Vasculitis (Bechet's, Wegener's granulomatosis, polyarteritis nodosa).

A3.39. General and Miscellaneous Conditions and Defects.

A3.39.1. Allergic manifestations: A reliable history of life threatening generalized reaction with anaphylaxis to stinging insects. Reliable history of a moderate to severe reaction to common foods, spices or food additives.

A3.39.2. Any acute pathological condition, including acute communicable diseases, until recovery has occurred without sequelae.

A3.39.3. Any deformity, abnormality, defect or disease that impairs general functional ability to such an extent as to prevent satisfactory performance of military duty.

A3.39.4. Chronic metallic poisoning, especially beryllium, manganese, and mercury. Undesirable residuals from lead, arsenic, or silver poisoning make the applicant unacceptable.

A3.39.5. Cold injury, residuals of, such as: frostbite, chilblain, immersion foot, trench foot, deep seated ache, paresthesia, hyperhidrosis, easily traumatized skin, cyanosis, amputation of any digit, or ankylosis.

A3.39.6. Cold urticaria and angioedema, hereditary angioedema.

A3.39.7. Reactive tests for syphilis such as the rapid plasma reagin (RPR) or Venereal Disease Research Laboratory (VDRL) followed by a reactive, confirmatory Fluorescent Treponemal Antibody Absorption (FTA-ABS) test unless there is a documented history of adequately treated syphilis. In the absence of clinical findings, the presence of a reactive RPR or VDRL followed by a negative FTA-ABS test is not disqualifying if a cause for the false positive reaction can be identified and is not otherwise disqualifying or if the test reverts to a nonreactive status during an appropriate follow-up period (3 to 6 months).

A3.39.8. Filariasis, trypanosomiasis, amebiasis, schistosomiasis, uncinariasis (hookworm) associated with anemia, malnutrition, etc., or other similar worm or animal parasitic infestations, including the carrier states thereof, if more than mild.

A3.39.9. Heat pyrexia (heatstroke, sunstroke, etc.). Documented evidence of a predisposition (including disorders of sweat mechanism and a previous serious episode), recurrent episodes requiring medical attention, or residual injury resulting therefrom (especially cardiac, cerebral, hepatic, and renal).

A3.39.10. Industrial solvent and other chemical intoxication, chronic, including carbon disulfide, trichloroethylene, carbon tetrachloride, and methyl cellosolve.

A3.39.11. Mycotic infection of internal organs.

A3.39.12. Myositis or fibrositis, severe, chronic.

A3.39.13. Presence of HIV-I or antibody. Presence is confirmed by repeatedly reactive Enzyme Linked Immunoassay (ELISA) serological test and positive immunoelectrophoresis (Western Blot) test, or other Food and Drug Administration-approved confirmatory test.

A3.39.14. Malignant hyperthermia.

A3.39.15. Residual of tropical fevers and various parasitic or protozoal infestations that, in the opinion of the medical examiner, prevent the satisfactory performance of military duty.

A3.39.16. Rheumatic Fever during the previous 2 years, or any history of recurrent attacks; Sydenham's chorea at any age.

A3.39.17. Sleep apnea (obstructive sleep apnea or sleep disordered breathing) which causes daytime hypersomnolence or snoring that interferes with the sleep of others or when an appliance such as CPAP is required for control.

A3.39.18. Motion sickness. An authenticated history of frequent, incapacitating motion sickness after the 12th birthday is disqualifying. For entrance into military academies or ROTC scholarship programs, admission of frequent, incapacitating motion sickness will suffice for disqualification.

Attachment 4

MEDICAL STANDARDS FOR GROUND BASED CONTROLLER DUTY

Conditions in Attachment 2, Medical Standards for Continued Military Service also apply. For conditions listed in Attachment 2, ensure a Medical Evaluation Board (MEB) has been performed and final disposition made prior to submission of a waiver request.

Applicability. The standards in **Attachment 4** apply to all ground based aircraft controllers including **air traffic controllers, weapons controllers, combat controllers and weapons directors (AFSC 1C5X1D).**

A4.1. Ear, Nose, and Throat.

A4.1.1. Symptomatic allergic rhinitis, seasonal or perennial not controlled by desensitization or use of topical nasal steroids.

A4.1.2. Any disease or malformation of the nose, mouth, pharynx or larynx that might interfere with enunciation or clear voice communication.

A4.1.3. Any disturbance of equilibrium.

A4.1.4. Obstructions of the nose from any cause which prevent nasal respiration.

A4.2. Hearing.

A4.2.1. Hearing loss greater than that specified for H-1 profile for initial selection. Hearing loss greater than that specified for H-2 profile for continued controller duty**.**

A4.2.2. Use of hearing aid.

A4.3. Eye.

A4.3.1. Intraocular tension.

A4.3.1.1. Glaucoma, as evidenced by tension of 30 mmHg or greater, or the secondary changes in the optic disc or visual field associated with glaucoma.

A4.3.1.2. Ocular hypertension (preglaucoma). Two or more determinations of 22 mmHg or greater but less than 30 mmHg, or a difference of 4 mmHg or greater between the two eyes.

A4.3.2. Nystagmus, except on versional end points.

A4.3.3. Contact lenses that correct near visual acuity only or that are bifocal, or that are fit with the mono-vision techniques.

A4.3.4. Diplopia in any field of gaze, either constant or intermittent, including history of.

A4.3.5. Monocularity.

A4.3.6. History of keratorefractive surgery of any type to include radial keratotomy (RK), photorefractive keratectomy (PRK), and other similar surgical procedures accomplished to modify the refractive power of the cornea or of lamellar or penetrating keratoplasty or orthokeratology.

A4.3.7. Extraocular muscle paralysis or paresis with loss of ocular motility in any direction.

A4.3.8. Absence of conjugate alignment in any quadrant.

A4.4. Distant Vision.

A4.4.1. Uncorrected, worse than 20/400 each eye.

A4.4.2. Corrected, worse than 20/20 each eye.

A4.5. Near Vision.

A4.5.1. Uncorrected, no standard.

A4.5.2. Corrected vision worse than 20/20 in each eye.

A4.6. Heterotropias and Heterophorias.

A4.6.1. Any heterotropia.

A4.6.2. Heterophorias. More than 1.5 prism diopter of hyperphoria, 10 prism diopters of esophoria, or six prism diopters of exophoria requires a thorough evaluation for other eye pathology motor and sensory abnormalities, by a competent eye care professional. If no other eye pathology is found and all other aspects of the examination are normal, a waiver can be considered.

A4.7. Color Vision. Color vision testing must be performed monocularly under approved and standardized illuminant (i.e.,Illuminant C). Five or more incorrect responses in either eye (including failure to make responses in the allowed time interval) in reading the 14 test plate versions of one of the following Pseudoisochromatic Plate (PIP) sets: Dvorine, the original version of the AO (excludes Richmond PIP version), or Ishihara.

*Note: No other PIP versions, such as Richmond PIP, or Beck Engraving versions, or other tests for color vision, are authorized for qualification purposes. Also note that the Farnsworth Lantern (FALANT) has been dropped as an USAF qualifying test.

A4.8. Depth Perception.

A4.8.1. Initial Testing for controller duty. Failure of the Vision Test Apparatus near and distant

(VTA-DP or OVT) screening depth perception test results in a full evaluation by a competent eye care professional.

A4.8.2. Continued controller duty. New failure of the VTA-DP or OVT, when passed previously, requires evaluation by a competent eye care professional to rule out correctable causes, i. e., refractive error, anisometropia or macular disease. If the controller has previously failed the VTA-DP and passes the near stereopsis test (Verhoeff or Titmus), no further work-up is required.

A4.9. Visual Fields. Any visual field defect.

A4.10. Night Vision. Unsatisfactory night vision as determined by history for initial controller duty. In trained controllers, this history is confirmed by the appropriate electrophysiological tests requested by the Aeromedical Consultation Service ophthalmologists.

A4.11. Cardiovascular System.

A4.11.1. History of myocardial infarction, angina pectoris, or other evidence of coronary heart disease including silent ischemia.

A4.11.2. History of dysrhythmia with symptoms of hemodynamic compromise.

A4.11.3. Symptomatic valvular heart disease or asymptomatic moderate to severe valvular disease associated with hypertrophy, chamber enlargement, or ventricular dysfunction (see **Attachment 2**).

A4.11.4. Aneurysm or AV fistula of a major vessel.

A4.11.5. Hypertension, or history of hypertension on antihypertensive medication. Hypertension is evidenced by average systolic blood pressure greater than 140 mmHg or average diastolic blood pressure greater than 90 mmHg. Patients may be followed initially as in paragraph **A7.17.**

A4.11.6. Resting pulse rate greater than 110 or less than 45 beats per minute.

A4.11.7. ECG evidence of significant conduction defects, to include Wolff-Parkinson-White syndrome.

A4.12. Blood, Blood-forming Tissues, and Immune System.

A4.12.1. Anemia of any etiology.

A4.12.2. Blood donation: 8 hr restriction from controller duty following blood donation (formal flight surgeon restriction not required).

A4.13. Abdomen and Gastrointestinal System.

A4.13.1. Gastrointestinal hemorrhage or history of, regardless of cause.

A4.13.2. Peptic ulcer disease or any complication of peptic ulcer disease. An uncomplicated ulcer that has been inactive for 3 months and does not require medication (except the occasional use of antacids) is not disqualifying.

A4.13.3. Cholelithiasis.

A4.14. Genitourinary System.

A4.14.1. History of recurrent or bilateral renal calculus.

A4.14.2. Retained renal calculus, except parencymal.

A4.14.3. Cystostomy.

A4.14.4. Neurogenic bladder.

A4.14.5. Renal transplant.

A4.15. Neurological Disorders.

A4.15.1. History of any medically unexplained disturbance of consciousness or where surgical intervention was necessary to correct the precipitating cause.

A4.15.2. History of any of the following types of headaches:

A4.15.2.1. Recurrent headaches of the vascular, migraine, or cluster (Horton's cephalgia or histamine headache) type.

A4.15.2.2. A single incapacitating headache of any type (e.g.,loss of consciousness, aphasia, ataxia, vertigo or mental confusion).

A4.15.2.3. Headaches of any type which are of sufficient severity to likely interfere with controlling duties.

A4.15.2.4. Acephalgic migraines.

*Note: A waiver for migraines may be considered following one year of symptom free observation. Migrainous strokes and migraines complicated by neurological deficits other than transient visual changes are not waiverable.

A4.15.3. History of recurrent vertigo or dysequilibrium disorders.

A4.15.4. Cerebrovascular disease to include transient ischemic attack (TIA), cerebral infarction, thrombotic or embolic, or transient global amnesia.

A4.15.5. Demyelinating and autoimmune diseases.

A4.15.6. Extrapyramidal, hereditary, and degenerative diseases of the nervous system.

A4.15.7. Infections of the nervous system.

A4.16. Psychiatric Disorders.

A4.16.1. Alcohol dependence or abuse (DSM IV) or any disease the proximate cause of which is alcoholism. Waiver may be considered when all of the following conditions are met:

A4.16.1.1. The MTF Alcohol & Drug Abuse Prevention & Treatment (ADAPT) Program treatment team determines that the individual has made satisfactory progress and has maintained abstinence without the aid of medications for a period of 6 months from the date of entering treatment.

*Note: Any relapse (as determined by the treatment team) or use of medication to deter alcohol use resets the 6-month observation period for waiver consideration.

A4.16.1.2. In the opinion of the flight surgeon, privileged mental health provider, and the unit commander, and based on the ADAPT program assessment, the individual has a low potential for recidivism and can be expected to remain stable under stress.

A4.16.1.3. The individual has no medical complications or sequelae due to past alcohol abuse or dependence.

A4.16.1.4. The individual states in writing that he or she understands the waiver is valid only if total abstinence from alcohol is maintained and that a verifiable break in abstinence once the waiver period has begun is considered medically disqualifying and not waiverable. The written statement by the individual must be accomplished at the initial waiver request and reaccomplished each time a request is submitted for renewal of the waiver, and is included with the waiver request. To ensure unit commanders are aware of the need to observe individuals with past alcohol problems, new commanders are briefed on those in their units with waivers when the individual changes assignment or there has been a change of command.

A4.16.2. Unsatisfactory adaptability rating for ground based controller duties.

A4.16.3. Anxiety disorders.

*Note: Fear of controlling which does not meet the DSM III criteria of simple phobia (300.29) is handled administratively.

A4.16.4. A personality disorder that is severe enough to have repeatedly manifested itself by overt acts disqualifies the individual from controller duties, but can not be used as a medical reason for separation from active duty.

A4.16.5. History of attempted suicide or suicidal behavior.

A4.16.6. Depression disorders including major depression, dysthymia and depression not otherwise specified.

A4.16.7. All organic brain syndromes.

A4.16.8. Any personality disorder, neurosis, or mental condition that may render the individual unable to safely perform controller duties.

A4.17. Musculoskeletal, Spine, and Extremities. Any disease, condition, or deformity of the musculoskeletal system which may impair duty performance or access to control facilities, is likely to progress, or which requires frequent use of analgesic or anti-inflammatory medication for control.

A4.18. Endocrine and Metabolic.

A4.18.1. Diabetes insipidus.

A4.18.2. Hypoglycemia, whether functional or a result of pancreatic tumor.

A4.18.3. Thyroid disorders.

A4.18.4. Other endocrine or metabolic disorders which preclude satisfactory performance of controller duties.

A4.19. Miscellaneous Causes for Rejection.

A4.19.1. Use of any medication whose known actions may affect alertness, judgment, cognition, special sensory function, mood, or coordination.

A4.19.2. Air Traffic Controllers cannot perform controller duties for at least 8 hours after receiving a local or regional anesthetic agent.

A4.19.3. Exacerbation of any medical condition for which a waiver has been granted.

A4.19.4. Blood donation requires a verbal DNIC for 8 hrs and does not require flight surgeon clearance to return to duties.

A4.20. Additional Testing.

A4.20.1. HIV antibody testing is required for all applicants for initial controller duty. Record the results of cholesterol, HDL, and triglycerides in item 50, SF 88.

A4.20.2. An adaptability rating for control duty (AR-CD) and a reading aloud test (RAT) is required on all applicants for initial controller duty. Record the results in item 72, SF 88. The RAT and instructions are in AFI 36-2018, *Medical Examination of Applicants for United States Service Academies, Reserve Officer Training Corps (ROTC) Scholarship Programs, Including the AF, Army, and Navy Two and Three-Year College Scholarship Programs (CSP), and the Uniformed Services University of the Health Sciences (USUHS).*

A4.21. FAA Certificate. Civilian contract Air traffic controllers performing controller duty on

Air National Guard (ANG), Air Force Reserve on Active Duty Air Force installations shall have a

Class II FAA certifying physical examination performed by a designated civilian Aeromedical

Examiner (AME) in accordance with 14 CFR Part 67 (FAA Airman Medical Standards and

Certification). Federally-employed air traffic controllers may have Class II FAA examinations performed only by those AMEs designated by the FAA Regional Flight Surgeon to perform controller examinations. Applications for Statements of Demonstrated Ability (SODA), or waivers, will be processed through the Mike Monroney Aeronautical Center as per the Guide for

Aviation Medical Examiners.

Attachment 5

Space and Missile Operations CREW Duty (SMOC)

Conditions in Attachment 2, Medical Standards for Continued Military Service also apply. For conditions listed in Attachment 2, ensure a Medical Evaluation Board (MEB) has been performed and final disposition made prior to submission of a waiver request.

A5.1. Vision.

A5.1.1. Defective Color Vision. Color vision testing must be performed monocularly under approved and standardized illuminant (i.e.,Illuminent C). Five or more incorrect responses in either eye (including failure to make responses in the allowed time interval) in reading the **14 test plate versions** of one of the following Pseudoisochromatic Plate (PIP) sets: Dvorine, the original version of the AO (excludes Richmond PIP version), or Ishihara.

*Note: No other PIP versions, such as Richmond PIP, or Beck Engraving versions, or other tests for color vision, are authorized for qualification purposes. Also note that the Farnsworth Lantern (FALANT) has been dropped as a USAF qualifying test.

A5.1.1.1. A waiver will be considered for trained personnel who fail the above tests.

A5.1.1.2. An on-the-job color vision test is required for waiver.

A5.1.1.3. Waiver will be valid for the current system only. No waiver will be required for individuals assigned to staff positions not requiring crew duty. Reassignment to a new system will require a new on-the-job evaluation and waiver.

A5.1.2. Corrected visual acuity worse than 20/20 in the better eye near and distant.

*Note: Individuals found on routine examination to be less than 20/20 in the better eye in either near or distant, or both, but correctable to at least 20/20 near and distant in one eye may continue to perform Space and Missile Operations duties until the appropriate corrective lenses arrive. These lenses must be ordered by the most expeditious means.

A5.2. Hearing. A hearing profile less than H-2 for initial selection or less than H-3 for continued SMOC duty.

A5.3. Head and Neck.

A5.3.1. Any disease or malformation of the nose, mouth, pharynx, or larynx that might interfere with enunciation or clear voice communication as demonstrated by the reading aloud test.

A5.3.2. Symptomatic allergic rhinitis or vasomotor rhinitis not controlled by desensitization, use of topical nasal steroids, or oral antihistamines which do not cause drowsiness.

A5.3.3. Any defect that would interfere with wearing oxygen equipment, protective head gear, or other safety equipment.

A5.4. Neuropsychiatric.

A5.4.1. Any psychiatric condition which would result in a psychiatric profile of worse than S-1.

A5.4.2. History of claustrophobia.

A5.4.3. Any psychiatric condition, or history thereof, which in the opinion of the examining flight surgeon, would interfere with the performance of space and missile operations crew duty.

A5.4.4. Alcohol dependence or abuse (DSM IV) or any disease the proximate cause of which is alcoholism. Waiver may be considered when all of the following conditions are met:

A5.4.4.1. The MTF Alcohol & Drug Abuse Prevention & Treatment (ADAPT) Program treatment team determines the individual has made satisfactory progress and has maintained abstinence without the aid of medications for a period of 6 months from the date of entering treatment.

*Note: Any relapse (as determined by the treatment team) or use of medication to deter alcohol use resets the 6 month observation period for waiver consideration.

A5.4.4.2. In the opinion of the flight surgeon, privileged mental health provider, and the unit commander, and based on the ADAPT program assessment, the individual has a low potential for recidivism and can be expected to remain stable under stress.

A5.4.4.3. The individual has no medical complications or sequelae due to past alcohol abuse or dependence.

A5.4.4.4. The individual states in writing that he or she understands the waiver is valid only if total abstinence from alcohol is maintained and that a verifiable break in abstinence once the waiver period has

begun is considered medically disqualifying and not waiverable. This written statement by the individual must be accomplished at the initial waiver request and reaccomplished each time a request is submitted for renewal of the waiver, and is included with the waiver request. To ensure unit commanders are aware of the need to observe individuals with past alcohol problems, new commanders are briefed on those in their units with waivers when the individual changes assignment or there has been a change in command.

*Note: Documentation of these conditions must be submitted with waiver request.

A5.4.5. Headaches except mild, minor, non-recurrent headaches controlled by single doses of aspirin, acetaminophen, or a nonsteroidal anti-inflammatory agent.

A5.4.6. Unsatisfactory adaptability rating for space and missile operations duty.

A5.4.7. History of attempted suicide, either suicide attempt or gesture.

A5.4.8. History of seizures within the past 5 years, or usage of medications to control seizures within the past 5 years.

A5.4.9. Head injuries.

A5.4.9.1. Head injury of a mild degree (**A7.23.**) with a normal neurological examination (**Table 16.1.**) does not require waiver action.

A5.4.9.2. Head injury of a moderate or severe degree will require waiver action after normal neurological testing as delineated in **Table 16.1.**

A5.5. Medication.

A5.5.1. The following medications are approved for use in missileers and space operators. However, many of the medical conditions for which these medications may be used may be temporarily or permanently disqualifying for missile or space operations.

A5.5.2. Injectable medications.

A5.5.2.1. Crew members cannot perform crew duties for at least 8 hours after receiving a local or regional anesthetic agent.

A5.5.2.2. Injectable steroids may be used to treat inflammatory conditions or ganglion cysts. Crew members should be restricted from duties for a minimum of 8 hours following the procedure.

A5.5.3. Medications which may be used without medical consultation.

A5.5.3.1. Over the counter skin antiseptics, topical antifungals, 1 percent Hydrocortisone cream, or benzoyl peroxide for minor wounds and skin diseases which do not interfere with the performance of duties or wear of personal equipment.

A5.5.3.2. Single doses of over-the-counter aspirin, acetaminophen or ibuprofen to provide analgesia for minor self-limiting conditions.

A5.5.3.3. Antacids for mild isolated episodes of epigastric distress.

A5.5.3.4. Hemorrhoidal suppositories.

A5.5.3.5. Bismuth subsalicylate for mild afebrile cases of diarrhea.

A5.5.3.6. Psyllium hydrophilic mucilloid (Metamucil) or other bulk forming agents.

A5.5.3.7. Throat lozenges for relief of minor throat discomfort.

A5.5.3.8. Oxymetazoline or Phenylephrine nasal spray.

A5.5.3.9. Pseudoephedrine HCL 30 mg for mild isolated episodes of congestion.

A5.5.3.10. Guaifenesin cough syrup for mild isolated episodes of coughing.

A5.5.4. Medication prescribed by a flight surgeon which may be used without removal from crew duty.

A5.5.4.1. Isoniazid for prophylactic therapy of tuberculin converters who do not have active tuberculosis.

A5.5.4.2. Oral contraceptives, implantable timed release progestin, estrogen alone or with progestin as replacement therapy.

A5.5.4.3. Chloroquine phosphate, primaquine phosphate, or doxycycline for antimalarial prophylaxis.

A5.5.4.4. Pyridostigmine for chemical warfare prophylaxis.

A5.5.4.5. Topical antibiotics.

A5.5.4.6. Topical tretinoin for control of acne as long as local irritation does not interfere with wear of the life-support equipment.

A5.5.4.7. Topical benzoyl peroxide 5-10%.

A5.5.4.8. Topical steroids.

A5.5.4.9. Topical fungicides.

A5.5.4.10. Salicylic acid plaster**.**

A5.5.4.11. Topical Acyclovir.

A5.5.4.12. Oral Antibiotics.

A5.5.4.13. Vaginal creams or suppositories for treatment of vaginitis.

A5.5.4.14. Immunobiologics.

A5.5.4.15. Nicorette or transdermal nicotine.

A5.5.4.16. Resin binding agents such as cholestyramine for control of hyperlipidemia.

A5.5.4.17. Oral and topical decongestants for the temporary relief of minor flu-like symptoms.

A5.5.4.18. Benzonatate pearls or guifenesin cough syrup.

A5.5.4.19. Nasal steroids or cromolyn nasal spray for control of mild to moderate allergic rhinitis, nonallergic rhinitis, or vasomotor rhinitis. Observation for control of the rhinitis (usually 7 to 14 calendar days) is required. Claritin (loratidine) for the control of seasonal allergic rhinitis.

A5.5.4.20. Nonsteroidal anti-inflammatory agents.

A5.5.4.21. Lindane cream or lotion.

A5.5.4.22. Docusate sodium for acute constipation.

A5.5.4.23. Ophthalmic antibiotic drops for mild conjunctivitis which does not affect vision.

A5.5.4.24. Otic antibiotic drops for external otitis.

A5.5.5. Medication prescribed by a flight surgeon which may be used without removal from crew duty once the potential for idiosyncratic reaction has been excluded.

A5.5.5.1. Nonsedating antihistamines for relief of minor allergy symptoms. Should only be given if the crewmember has taken this medication in the past without drowsiness.

A5.5.5.2. Chlorothiazide or hydrochlorothiazide for control of hypertension or hypercalciuria.

A5.5.5.3. Triamterene, lisinopril, nifedipine, or diltiazem for control of hypertension.

A5.5.5.4. Probenecid for treatment of gout or hyperuricemia.

A5.5.5.5. Allopurinol for treatment of gout or hyperuricemia.

A5.5.5.6. Combination therapy of thiazide with triamterene, probenecid, allopurinol, or oral potassium supplements, to control hypertension.

A5.5.5.7. Epinephrine derivatives without added action agents, or betablockers (Timolol, Levobunolol, Betaxolol) all for topical use only, to control glaucoma.

A5.5.5.8. Synthroid for treatment of thyroid hypofunction or for thyroid suppression.

A5.5.5.9. Folic acid in the treatment of sprue.

A5.5.5.10. Sucralfate (1 gram once daily) for prevention of recurrent, uncomplicated duodenal ulcers. Minimum 7 days observation required.

A5.5.5.11. Ranitidine, omeprazole, and famotidine.

A5.5.5.12. Griseofulvin or fluconazole for treatment of fungal infections after a 4-week ground trial.

A5.5.5.13. Clomiphene citrate for treatment of infertility.

A5.5.5.14. Lovastatin, pravastatin and gemfibrozil for control of hypercholesterolemia.

A5.5.5.15. Acyclovir (oral), for treatment of HSV or suppressive therapy.

A5.5.6. All medications not listed above are disqualifying for space and missile crew duty and will require a waiver from HQ AFSPC.

A5.6. General.

A5.6.1. Any medical condition, the natural history of which is to incapacitate an individual suddenly and without warning.

A5.6.2. Confirmed presence of Human Immunodeficiency Virus (HIV) or antibody.

A5.6.3. Exacerbation of any medical condition for which a waiver has been granted.

A5.7. Continuation of Space and Missile Operations Crew Duty.

A5.7.1. When space and missile operations members report to a new base for duty or training, the flight surgeon performs an informal examination, using SF 600, *Health Record-Chronological Record of Medical Care*, only as extensive as considered necessary to ensure the individual is qualified to perform their duties. Students reporting for training must have a physical examination certified by HQ AFSPC/SGPA before entering training.

A5.7.1.1. When the flight surgeon becomes aware that a member's qualification has changed, flight medicine immediately notifies the operational unit using the AF Form 1042.

A5.7.1.2. Only a flight surgeon may make the determination as to the crew member's ability to perform crew duty. A follow up visit to the flight surgeons' office is not always needed to return a crew member to crew duty, but may be requested by the patient, flight surgeon or commander. If the flight surgeon determines that he does not need a return visit for him to return to crew duty, the 1042 must be annotated that no return is necessary.

A5.7.1.3. When a crew member receives care by a non-flight surgeon provider, the member should be seen immediately by a flight surgeon for appropriate aeromedical disposition. If a flight surgeon is not immediately available, the member should be temporarily removed from space and missile duties until seen by a flight surgeon.

A5.7.2. PES personnel complete Preventive Health Assessment (PHA) annually within the 6 month period preceding the last day of the birth month. This applies to:

A5.7.2.1. All 13SXX and 1C6XX personnel whether on crew duty or not, and any individual of another AFSC assigned to operational crew duty maintaining mission ready or equivalent status

A5.7.2.2. Students undergoing training and applicants who have been certified for training but have not yet entered training, and space and missile operators who are not assigned to crew duty.

A5.7.3. Flight surgeons should perform medical examinations for continued space and missile operations crew duty and initial training.

A5.7.4. When space operators are assigned to remote locations where no flight surgeons are available, the following exceptions apply:

A5.7.4.1. The crew member's physical examination is valid for up to 18 months. If the member continues to extend past this time, a physical exam using either AF Form 1446 or SF 88 and 93 will be accomplished using the resources available at the location. This examination will then be forwarded to AFSPC/SGPA

for review and certification. Any credentialed provider may care for the crew members while deployed to the remote site.

A5.7.4.2. If the crewmember is prescribed any medication other than the medications listed in A5.5 "Medications which may be used without medical consultation" or has any condition which has the potential to interfere with satellite controlling duties then the credentialed provider should place the individual on DNIC (Duties Not to Include Controlling) status using the AF Form 1042.

A5.7.4.3. The following procedure will be used for returning an individual to controlling duties. The credentialed provider or other designated representative shall consult a flight surgeon in theatre, at the site support Flight Surgeon's Office, or HQ AFSPC/SGPA by phone to discuss the crewmembers condition. The credentialed provider or designated representative will, upon the recommendation of the consulting flight surgeon, RTFS the crew member by signing the AF Form 1042 in the flight surgeon's block and annotating in the remarks section, the name of the flight surgeon who recommends the RTFS.

A5.8. Additional Testing.

A5.8.1. HIV antibody testing is required for all applicants for initial duty. Record the results of cholesterol, HDL, and triglycerides in item 50, SF 88.

A5.8.2. An adaptability rating for space and missile operations crew duty and a reading aloud test

(RAT) is required on all applicants for initial duty. Record the results in item 72, SF 88. The

RAT and instructions are in AFI 36-2018.

A5.9. Pregnancy:

A5.9.1. Pregnancy is not necessarily disqualifying for space and missile duties. It may be appropriate to remove an individual from crew duties if she is experiencing some side effects from her pregnancy (i.e. hyperemesis, preeclampsia). The following guidelines should be used for routine pregnancy.

A5.9.1.1. Missileers - remove from alert duty after 24 weeks gestation.

A5.9.1.2. Spacelift Operators and Space Warning Operators - remove from shift duty after 32 weeks gestation.

A5.9.1.3. Satellite Command and Control and Space Surveillance Operators - remove from shift duty after 36 weeks gestation

Attachment 6

AIR VEHICLE OPERATOR (AVO) DUTY

Conditions in Attachment 2 apply (Rated personnel in direct control of UAVs maintain Flying Class II standards in paragraph 7.5. and Attachment 2 and Attachment 7. Unrated and medically disqualified rated personnel in direct control of UAVs and sensor operators maintain Air Vehicle Operator Duty standards in Attachment 2 and Attachment 6. Unrated personnel required to perform frequent and regular aerial flights must meet Flying Class III standards in Attachment 7.) For conditions listed in Attachment 2, ensure a Medical Evaluation Board (MEB) has been performed and final disposition made prior to submission of a waiver request.

A6.1. Ear, Nose, and Throat.

A6.1.1. Symptomatic allergic rhinitis, seasonal or perennial not controlled by desensitization or use of topical nasal steroids.

A6.1.2. Any disease or malformation of the nose, mouth, pharynx or larynx that might interfere with enunciation or clear voice communication.

A6.1.3. Any disturbance of equilibrium.

A6.1.4. Obstructions of the nose from any cause which prevent nasal respiration.

A6.2. Hearing.

A6.2.1. Hearing loss greater than that specified for H-1 profile for initial selection. Hearing loss greater than that specified for H-2 profile for continued AVO duty.

A6.2.2. Use of hearing aid.

A6.3. Vision.

A6.3.1. Intraocular pressure.

A6.3.1.1. Glaucoma, as evidenced by IOP of 30 mmHg or greater, or the secondary changes in the optic disc or visual field associated with glaucoma.

A6.3.1.2. Ocular hypertension (Preglaucoma). Two or more determinations of 22 mmHg or greater but less than 30 mmHg, or a difference of 4 mmHg or greater between the two eyes.

A6.3.2. Nystagmus, except on versional end points.

A6.3.3. Contact lenses that correct near visual acuity only or that are bifocal, or that are fit with the monovision techniques.

A6.3.4. Monocularity.

A6.3.5. History of keratorefractive surgery of any type to include radial keratotomy (RK), photorefractive keratectomy (PRK), laser in situ keratomileusis (LASIK) and other similar surgical procedures accomplished to modify the refractive power of the cornea or of lamellar or penetrating keratopasty or orthokeratology.

A6.3.6. Extraocular muscle paralysis or paresis with loss of ocular motility in any direction.

A6.3.7. Diplopia and absence of conjugate alignment in any quadrant.

A6.4. Distant Vision.

A6.4.1. Corrected vision no worse than 20/20 in each eye.

A6.5. Near Vision.

A6.5.1. Uncorrected, no standard.

A6.5.2. Corrected vision worse than 20/20 in each eye.

A6.6. Heterotropias and Heterophorias.

A6.6.1. Any heterotropia including microtropia.

A6.6.2. Heterophorias. More than 1.5 prism diopter of hyperphoria, 10 prism diopters of esophoria, or six prism diopters of exophoria requires a thorough evaluation for other eye pathology to include motor and sensory abnormalities, by an ophthalmologist or optometrist and include all tests required under paragraph **A7.11.** If no other eye pathology to include is found and all other aspects of the examination are normal, a waiver can be considered.

A6.7. Color Vision. Color vision testing must be performed monocularly under approved and standardized illuminant (i.e.,Illuminant C). Five or more incorrect responses in either eye (including failure to make responses in the allowed time interval) in reading the **14 test plate versions** of one of the following Pseudoisochromatic Plate (PIP) sets: Dvorine, the original version of the AO (excludes Richmond PIP version), or Ishihara.

*Note: No other PIP versions, such as Richmond PIP, or Beck Engraving versions, or other tests for color vision, are authorized for qualification purposes. Also note that the Farnsworth Lantern (FALANT) has been dropped as an USAF qualifying test.

A6.8. Visual Fields. Any visual field defect.

A6.9. Cardiovascular System.

A6.9.1. History of myocardial infarction, angina pectoris, or other evidence of coronary heart disease.

A6.9.2. History of dysrhythmia with symptoms of hemodynamic compromise.

A6.9.3. Symptomatic valvular heart disease.

A6.9.4. Aneurysm or AV fistula of a major vessel.

A6.9.5. Hypertension, or history of hypertension on antihypertensive medication. Hypertension is evidenced by average systolic blood pressure greater than 140 mmHg or average diastolic blood pressure greater than 90 mmHg. Patients may be followed initially as in paragraph **A7.17.**

A6.9.6. Resting pulse rate greater than 100 or less than 45 beats per minute.

A6.9.7. ECG evidence of conduction defects, to include Wolff-Parkinson-White syndrome.

A6.10. Blood, Blood-forming Tissues, and Immune System.

A6.10.1. Anemia of any etiology.

A6.10.2. Blood donation: 8 hour restriction from AVO duty following blood donation (formal flight surgeon restriction not required).

A6.11. Abdomen and Gastrointestinal System.

A6.11.1. Gastrointestinal hemorrhage or history of, regardless of cause.

A6.11.2. Peptic ulcer disease or any complication of peptic ulcer disease. An uncomplicated ulcer that has been inactive for 3 months and does not require medication (except the occasional use of antacids) is not disqualifying.

A6.11.3. Cholelithiasis.

A6.12. Genitourinary System.

A6.12.1. History of recurrent or bilateral renal calculus.

A6.12.2. Retained renal calculus, except parencymal.

A6.12.3. Cystostomy.

A6.12.4. Neurogenic bladder.

A6.12.5. Renal transplant.

A6.13. Neurological Disorders.

A6.13.1. History of any medically unexplained disturbance of consciousness or where surgical intervention was necessary to correct the precipitating cause.

A6.13.2. Any recurring headaches of the vascular, migraine, or cluster (Horton's cephalgia or histamine headache) type or incapacitating tension headaches. Acephalgic migraine.

A6.13.3. History of recurrent vertigo or dysequilibrium disorders.

A6.13.4. Cerebrovascular disease to include transient ischemic attack (TIA), cerebral infarction, thrombotic or embolic, or transient global amnesia.

A6.13.5. Demyelinating and autoimmune diseases.

A6.13.6. Extrapyramidal, hereditary, and degenerative diseases of the nervous system.

A6.13.7. Infections of the nervous system.

A6.14. Psychiatric Disorders.

A6.14.1. Any psychiatric condition which would result in a psychiatric profile of less than S-1.

A6.14.2. History of claustrophobia.

A6.14.3. Any psychiatric condition, which in the opinion of the examining flight surgeon, would interfere with the performance of AVO duty.

A6.14.4. Alcohol dependence or abuse (DSM IV) or any disease the proximate cause of which is alcoholism. Waiver may be considered when all the conditions are met in Attachment **A4.16.**

A6.14.5. Unsatisfactory adaptability rating for AVO duties.

A6.14.6. Anxiety disorders.

*Note: Fear of AVO duties which does not meet the DSM IV criteria of simple phobia (300.29) is handled administratively.

A6.14.7. A personality disorder that is severe enough to have repeatedly manifested itself by overt acts disqualifies the individual from AVO duties, but can not be used as a medical reason for separation from active duty.

A6.14.8. History of attempted suicide or suicidal behavior.

A6.14.9. Depression disorders including major depression, dysthymia and depression not otherwise specified.

A6.14.10. All organic brain syndromes.

A6.14.11. Any personality disorder, neurosis, or mental condition that may render the individual unable to safely perform AVO duties.

A6.15. Musculoskeletal, Spine, and Extremities. Any disease, condition, or deformity of the musculoskeletal system which may impair duty performance or access to control facilities, is likely to progress, or which requires frequent use of analgesic or anti-inflammatory medication for control.

A6.16. Endocrine and Metabolic.

A6.16.1. Diabetes mellitus.

A6.16.2. Diabetes insipidus.

A6.16.3. Hypoglycemia, whether functional or a result of pancreatic tumor.

A6.16.4. Thyroid disorders.

A6.16.5. Other endocrine or metabolic disorders which preclude satisfactory performance of

AVO duties.

A6.17. Miscellaneous Causes for Rejection.

A6.17.1. Use of any medication whose known actions may affect alertness, judgment, cognition, special sensory function, mood, or coordination.

A6.17.2. Exacerbation of any medical condition for which a waiver has been granted.

A6.18. Medication.

A6.18.1. Any medical condition, the natural history of which is to incapacitate an individual suddenly and without warning.

A6.18.2. Exacerbation of any medical condition for which a waiver has been granted.

A6.19. Continuation of Air Vehicle Operator Duty.

A6.19.1. When AVOs report to a new base for duty or training, the flight surgeon performs an informal examination, using SF 600, Health Record-Chronological Record of Medical Care, only as extensive as considered necessary to ensure the individual is qualified to perform their duties. Students reporting for training must have a physical examination certified by HQ ACC/SGPA before entering training.

A6.19.2. When the flight surgeon becomes aware that a member's qualification has changed, flight medicine immediately notifies the operational unit.

A6.19.3. PES personnel complete AF Form 1446, *Medical Examination - Flying Personnel*, within the 6-month period preceding the last day of the birth month on all years that a member is not scheduled for a complete medical examination. This requirement applies to students undergoing training and applicants who have been certified for training but have not yet entered training.

A6.19.4. A flight surgeon should perform medical examinations for continued AVO duty and initial training. In those cases where a flight surgeon is not available the physical must be sent to the HQ ACC/SG for review and certification.

A6.20. Additional Testing.

A6.20.1. HIV antibody testing is required for all applicants for initial AVO duty. Record the results of cholesterol, HDL, and triglycerides in item 50, SF 88.

A6.20.2. An adaptability rating for AVO duty (AVO-D) and a reading aloud test (RAT) is required on all applicants for initial AVO duty. Record the results in item 72, SF 88. The RAT and instructions are in AFI 36-2018, Medical Examination of Applicants for United States Service Academies, Reserve Officer Training Corps (ROTC) Scholarship Programs, Including the AF, Army, and Navy Two and Three-Year

College Scholarship Programs (CSP), and the Uniformed Services University of the Health Sciences (USUHS).

Attachment 7

Medical Standards for Flying Duty

Conditions listed in Attachment 2, Medical Standards for Continued Military Service and Attachment 3, Appointment, Enlistment, and Induction apply. For conditions listed in Attachment 2, ensure a Medical Evaluation Board (MEB) has been performed and final disposition made prior to submission of a flying waiver request.

A7.1. Head, Face, Neck, and Scalp (Flying Classes I, IA, II, and III).

A7.1.1. Injuries to the head (See paragraph **A7.23.**).

A7.1.2. Loss or congenital absence of bone substance of the skull.

A7.1.3. Chronic arthritis, complete or partial ankylosis, or recurrent dislocation of the temporomandibular joint.

A7.1.4. Congenital cysts of branchial cleft origin or those developing from the remains of a thyroglossal duct, with or without fistulous tracts.

A7.1.5. Chronic draining fistulae of the neck, regardless of cause.

A7.1.6. Contractions of the muscles of the neck if persistent or chronic. Cicatricial contracture of the neck to the extent it interferes with function or the wear of equipment.

A7.1.7. Cervical ribs if symptomatic or symptoms can be induced by abduction, scalenus, or costoclavicular maneuvers.

A7.1.8. Any anatomic or functional anomaly of head or neck structures, which interfere with normal speech, ventilation of the middle ear, breathing, mastication, swallowing, or wear of aviation or other military equipment.

A7.2. Nose, Sinuses, Mouth, and Throat.

A7.2.1. Flying Classes II and III.

A7.2.1.1. Allergic rhinitis, unless mild in degree and considered unlikely to limit the examinee's flying activities. Waivers are considered if symptoms are controlled by desensitization or topical medication (or both).

A7.2.1.2. Chronic nonallergic or vasomotor rhinitis, unless mild, asymptomatic, and not associated with eustachian tube dysfunction. Waivers are considered if symptoms are controlled by topical medication.

A7.2.1.3. Nasal polyps.

A7.2.1.4. Deviations of the nasal septum, septal spurs, enlarged turbinates or other obstructions to nasal ventilation which result in clinical symptoms. Symptomatic atresia or stenosis of the choana.

A7.2.1.5. Epistaxis, chronic, recurrent.

A7.2.1.6. Chronic sinusitis unless mild in degree and considered unlikely to limit the examinee's flying activities.

A7.2.1.7. Recurrent calculi of the salivary glands or ducts.

A7.2.1.8. Deformities, injuries, or destructive diseases of the mouth (including teeth), nose, throat, pharynx, or larynx that interfere with ventilation of the paranasal sinuses and, or middle ear, breathing, easily understood speech, or mastication and swallowing of ordinary food.

A7.2.1.9. Atrophic rhinitis.

A7.2.1.10. Perforation of the nasal septum.

A7.2.1.11. Anosmia or parosmia.

A7.2.1.12. Salivary fistula.

A7.2.1.13. Ulcerations, perforation, or extensive loss of substance of the hard or soft palate; extensive adhesions of the soft palate to the pharynx; or complete paralysis of the soft palate. Unilateral paralysis of the soft palate which does not interfere with speech or swallowing and is otherwise asymptomatic is not disqualifying.

A7.2.1.14. Chronic pharyngitis and nasopharyngitis.

A7.2.1.15. Chronic laryngitis. Neoplasm, polyps, granuloma, or ulceration of the larynx.

A7.2.1.15.1. Aphonia or history of recurrent aphonia if the cause was such as to make subsequent attacks probable. Painful Dysphonia Plicae Ventricularis.

A7.2.1.15.2. Tracheostomy or tracheal fistula.

A7.2.1.15.3. Malformations, injuries or diseases of the esophagus, such as ulceration, diverticulum, varices, stricture, achalasia, pronounced dilation, or peptic esophagitis.

A7.2.2. Flying Classes I and IA. In addition to the above:

A7.2.2.1. A verified history of allergic, nonallergic, or vasomotor rhinitis, after age 12.

A7.2.2.2. Any surgical procedure for sinusitis, polyposis or hyperplastic tissue. Waiver may be considered if recovery is complete and individual has been asymptomatic for 1 year.

A7.3. Ears.

A7.3.1. Flying Classes II and III.

A7.3.1.1. History of surgery involving the middle ear, excluding cholesteatoma below.

A7.3.1.2. Residual of mastoid surgery.

A7.3.1.3. Inability to perform the VALSALVA maneuver.

A7.3.1.4. Perforation of the tympanic membrane. Surgery to repair perforated tympanic membrane is disqualifying until healing is complete and hearing is normal.

A7.3.1.5. Tinnitus when associated with active disease.

A7.3.1.6. Abnormal labyrinthine function.

A7.3.1.7. Recurrent episodes of vertigo with or without nausea, vomiting, tinnitus, and hearing loss.

A7.3.1.8. Any conditions that interfere with the auditory or vestibular functions.

A7.3.1.9. Cholesteatoma or history of surgical removal of cholesteatoma.

A7.3.1.10. Atresia, tuberosity, severe stenosis or tumors of the external auditory canal which prevents an adequate view of the tympanic membrane or effective therapeutic access to the entire external auditory canal.

A7.3.2. Classes I, IA, II (flight surgeon applicants) and III (initial applicants). In addition to the above:

A7.3.2.1. Applicants must demonstrate satisfactory performance of the Reading Aloud Test (RAT).

A7.3.2.2. History of radical mastoidectomy.

A7.3.2.3. History of abnormal labyrinthine function, unexplained or recurrent vertigo.

A7.3.2.4. Surgical repair of perforated tympanic membrane within the last 120 calendar days.

A7.4. Hearing, Flying Class II and III. Hearing loss greater than H-1 profile or asymmetric hearing loss requires work-up by an audiologist (audiology evaluation for initial waiver and waiver renewals must have been accomplished within 12 months of submission to waiver authority). Waivers are required for H-3 hearing loss or greater. Indefinite waivers are not authorized.

A7.4.1. H-2 profile alone does not require waiver. However, an evaluation **sufficient to rule-out conductive or retrocochlear pathology** should be conducted. This includes full audiologic evaluation and, where appropriate, referral for ENT consultation. Referral to ENT may be at the discretion of the audiologist or referring facility. Restriction from flying is not required during work-up.

A7.4.2. H-3 profile requires waiver.

A7.4.2.1. For members with new H-3 profiles (i.e., those whose hearing has recently changed to H-3, and who have not been previously worked-up), restriction from flying is appropriate.

*Note: Members with long-standing, stable H-3 not previously evaluated, require work-up and waiver, but need not be restricted from flying, unless in the opinion of the flight surgeon they represent a danger to flying safety.

A7.4.2.2. Interim waiver may be granted by MAJCOM/SG after determination of acceptable hearing proficiency (occupational aircrew hearing assessment), pending complete audiology evaluation (indefinite waivers are not authorized).

A7.4.2.3. Validate hearing proficiency in one of two ways prior to issuance of medical waiver for H-3 profile:

A7.4.2.3.1. Inflight hearing test as described in SAM TR73-29

A7.4.2.3.2. Written validation, signed by the flying squadron commander or operations officer, of the adequacy of the member's hearing to perform safely in assigned aircrew duties in the flying environment.

A7.4.2.4. Waiver is contingent upon complete audiologic and where appropriate, ENT evaluation.

*Note: The audiologist must rule out conductive and retrocochlear disease. The audiologist may defer ENT evaluation.

A7.4.2.5. The occupational aircrew hearing assessment is deferred for inactive flyers. They may receive a Flying Class IIC waiver specifying the completion of the occupational aircrew hearing assessment before return to active flying.

A7.4.3. Asymmetric hearing loss (greater than, or equal to, 25dB difference, comparing left and right ear, at any two consecutive frequencies) requires full audiological work-up with further clinical evaluation as indicated, and requires a waiver (indefinite waivers are not authorized). Restriction from flying is not required during work-up.

A7.4.4. The following tests are suggested as a complete audiologic evaluation:

A7.4.4.1. Pure tone air and bone conduction thresholds.

A7.4.4.2. Speech reception thresholds.

A7.4.4.3. Speech discrimination testing, to include high intensity discrimination.

A7.4.4.4. Immittance audiometry.

A7.4.4.5. Tympanograms.

A7.4.4.6. Ipsilateral and contralateral acoustic reflexes (levels not exceeding 110 dB HL).

A7.4.4.7. Acoustic reflex decay (500 and 1000 Hz, with levels not exceeding 110 dB HL).

A7.4.4.8. Otoacoustic emissions (transient evoked or distortion product).

A7.4.5. The following tests may be required if indicated by the above:

A7.4.5.1. Auditory brainstem response.

A7.4.5.2. MRI.

*Note: Audiology reevaluation is required for waiver renewals if a shift of greater than 10dB is noted from the “initial” audiology evaluation used for the initial waiver in any one frequency from 1,000 Hz to 4,000 Hz. Additionally, audiology evaluations submitted to the waiver authority must have been accomplished within 12 months. These rules apply to all hearing waivers.

A7.5. Dental.

A7.5.1. Flying Classes II and III.

A7.5.1.1. Personnel wearing orthodontic appliances need not have appliances removed for physical qualification. After consultation with the treating orthodontist, the local flight surgeon may qualify the individual for flying duties if there is no effect on speech or the ability to wear equipment with comfort.

A7.5.1.2. Severe malocclusion which interferes with normal mastication or requires protracted treatment.

A7.5.1.3. Diseases of the jaw or associated structures such as cysts, tumors, chronic infections, and severe periodontal conditions which could interfere with normal mastication, until adequately treated.

A7.5.1.4. Aircrew members in Dental Class III or who have a significant dental defect which may be expected to cause a dental emergency during flight will be grounded. ARC members are managed IAW paragraph **14.14.1.** of this instruction.

A7.5.2. Classes I and IA. In addition to the above:

A7.5.2.1. Dental defects such as carious teeth, malformed teeth, defective restorations, or defective prosthesis, until corrected.

A7.5.2.2. Anticipated or ongoing treatment with fixed orthodontic appliances.

A7.6. Eye, Flying Classes I, IA, II, and III.

A7.6.1. Lids/Adnexa.

A7.6.1.1. Any condition of the eyelids which impairs normal eyelid function or comfort or potentially threatens visual performance.

A7.6.1.2. Epithora, nasolacrimal duct obstruction.

A7.6.1.3. Ptosis, any, except benign etiologies which are not progressive and do not interfere with vision in any field of gaze or direction.

A7.6.1.4. Dacryocystitis, acute or chronic.

A7.6.1.4.1. Dacryostenosis

A7.6.2. Conjunctiva.

A7.6.2.1. Conjunctivitis, chronic, seasonal.

A7.6.2.2. Trachoma, unless healed without scarring.

A7.6.2.3. Xerophthalmia.

A7.6.2.4. Pterygium which encroaches on the cornea more than 1mm or interferes with vision, or is progressive, or causes refractive problems

A7.6.3. Cornea.

A7.6.3.1. Keratitis, chronic or acute, including history of.

A7.6.3.2. Corneal ulcer of any kind, including history of recurrent corneal ulcers or recurrent corneal erosions.

A7.6.3.3. Vascularization or opacification of the cornea, from any cause, when it is progressive, interferes with vision or causes refractive problems.

A7.6.3.4. History of traumatic corneal laceration unless it does not interfere with vision, nor is likely to progress.

A7.6.3.5. Corneal dystrophy of any type, including keratoconus of any degree.

*Note: UPT Applicants who demonstrate a topographical pattern suggestive of keratoconus, referred to as TPSK, but who do not have any other clinical signs of keratoconus, may be eligible for waiver. However, these members must have been processed through EFS-Medical for eligibility. Test results from outside agencies, or civilian sources do not qualify. Members identified with TPSK may be waivered into the ACS TPSK Study/Management Group, only after evaluation by the ACS. Members identified with TPSK will be informed that their participation in this study group is **mandatory** for consideration of waiverability into UFT and continued flying. Reevaluation periodically at the ACS will be required for waiver renewal.

A7.6.3.6. History of radial keratotomy (RK) or any other surgical or laser procedure, such as photorefractive keratectomy (PRK) and laser in situ keratomileusis (LASIK) accomplished to modify the refractive power of the cornea or for any other reason, such as phototherapeutic keratectomy (PTK), are not waiverable.

A7.6.3.6. Orthokeratology, active or a history of within six months of application to UFT**.**

A7.6.3.7. Lamellar or penetrating keratoplasty (corneal transplant).

A7.6.4. Uveal Tract. Acute, chronic or recurrent inflammation of the uveal tract (iris, ciliary body, or choroid), except for healed traumatic iritis.

A7.6.5. Retina/Vitreous.

A7.6.5.1. Retinal detachment and history of same.

A7.6.5.2. Degenerations and dystrophies of the retina including retinoschisis and all types of central and peripheral pigmentary degenerations.

A7.6.5.3. Degenerations and dystrophies of the macula, macular cysts, and holes.

A7.6.5.4. Retinitis, chorioretinitis, or other inflammatory conditions of the retina, unless single episode which has healed, is expected not to recur, and does not impair central or peripheral vision.

A7.6.5.5. Angiomatoses, phakomatoses, retinal cysts and other conditions which impair or may impair vision.

A7.6.5.6. Hemorrhages, exudates or other retinal vascular disturbances.

A7.6.5.7. Vitreous opacities or disturbances which may cause loss of visual acuity.

A7.6.6. Optic Nerve.

A7.6.6.1. Congenito-hereditary conditions that interfere or may interfere with central or peripheral vision.

A7.6.6.2. Optic neuritis, of any kind, including retrobulbar neuritis, papillitis, neuroretinitis, or a documented history of same.

A7.6.6.3. Papilledema.

A7.6.6.4. Optic atrophy (primary or secondary) or optic pallor.

A7.6.6.5. Optic nerve cupping greater than 0.4 or an asymmetry between the cups of greater than 0.2.

A7.6.6.6. Optic neuropathy.

A7.6.7. Lens.

A7.6.7.1. Aphakia, unilateral or bilateral.

A7.6.7.2. Dislocation of a lens, partial or complete.

A7.6.7.3. Opacities or irregularities of the lens which interfere with vision or are considered to be progressive.

A7.6.7.4. Pseudophakia (intraocular lens implant).

A7.6.7.5. Posterior capsular opacification.

A7.6.8. Other Defects and Disorders.

A7.6.8.1. Asthenopia, if severe.

A7.6.8.2. Exophthalmos, unilateral or bilateral.

A7.6.8.3. Nystagmus of any type, except on versional end points.

A7.6.8.4. Diplopia in any field of gaze, either constant or intermittent, including history of

A7.6.8.5. Visual field defects, any type, including hemianopsia.

A7.6.8.6. Abnormal pupils or loss of normal pupillary reflexes, with the exception of physiological anisocoria.

A7.6.8.7. Retained intraocular foreign body.

A7.6.8.8. Absence of an eye.

A7.6.8.9. Anophthalmos or microphthalmus.

A7.6.8.10. Any traumatic, organic, or congenital disorder of the eye or adnexa, not specified above, which threatens to intermittently or permanently impair visual function.

A7.6.8.11. Migraine or its variants, to include acephalgic migraine (See paragraph **A7.23.**).

A7.6.8.12. History of any ocular surgery to include lasers of any type.

A7.7. Vision and Refraction.

Table 1. VISION & REFRACTIVE ERROR STANDARDS

	Vision Limits for Each Eye				**Refraction Limits**			
Flying Class	**Distant Vision**		**Near Vision**		**Any Meridian**	**Astig- mat-ism**	**Aniso-metropia**	**Contact Lenses** Notes5,6, 7,13
	Uncorr	Corrected	Uncorr	Corrected				
I Notes 2,10,12,13	20/70	20/20	20/20	-	+2.00 -1.50	1.50	2.00	Note 1
IA Note 2,10,12,13	20/200	20/20	20/40	20/20	+3.00 -2.75	2.00	2.50	Note 1
II (Pilot) Note 13	20/400	20/20 Note 3,11	-	20/20 Notes:3,9	+3.50 -4.00	2.00	2.50 Note 4	
II/III Note 13	20/400	20/20 Note 3,12	-	20/20 Notes: 3, 9	+5.50 -5.50 Note 8	3.00	3.50 Note 4	

Notes:

1. Use of hard, rigid, or gas permeable (hard) contact lenses within 3 months before the examination or soft contact lenses 1 month before examination is prohibited. Document SF 88 appropriately to ensure this requirement has been met.

2. These medical standards apply for USAFA, AFROTC cadets at the time of AF commissioning physical, AF active duty members, civilian applicants for flying training, and applicants from the Reserve and Guard components during the initial flying physical.

3. Individuals found on routine examination to be 20/20 in one eye and 20/25 in the other but correctable to 20/20 in each eye may continue flying until the appropriate corrective lenses arrive. These lenses must be ordered by the most expeditious means. **Be advised that this policy should only be used if the condition does not cause acute change in stereopsis performance (i.e., failure of depth perception screening tests).**

4. Anisometropias greater than Flying Class II or III standards may be considered for waiver if the OVT (or VTA) stereopsis is normal and the aviator has no asthenopic symptoms due to poor fusional control, or diplopia.

5. Complex refractive errors that can be corrected only by contact lenses are disqualifying.

6. All aircrew members are prohibited from using contact lenses for treatment of medical conditions unless they have been specifically prescribed and issued or approved by the ACS.

7. Optional wear of contact lenses for aircrew members is outlined in **Attachment 17**.

8. Waivers may only be considered after the individual has a normal ophthalmological examination to include a dilated fundus exam and possesses plastic lens spectacles which correct them to 20/20 in each eye and meets the USAF standards for approved commercially obtained spectacles for aircrew duties (see attachment 17.7).

9. Actively flying personnel should be corrected to 20/20 at the nearest cockpit working distance.

10. The Air Force Chief of Staff retains Exception To Policy (ETP) authority for vision and refractive limits for UFT applicants.

11. Flying Class II aviators should be refracted to their best corrected visual acuity. Use of spectacles to correct to better than 20/20 is at the discretion of the crewmember.

12. For qualification purposes, cycloplegic refraction readings should be recorded for that required to read the 20/20 line in each eye. However, continue refraction to best visual acuity and report the best achievable corrected visual acuity as a clinical baseline. (Thus, acuity and refractive error numbers may not correlate). Cycloplegic refractions that cannot achieve the 20/20 line will need clinical evaluation or re-evaluation.

13. Crewmembers who wear corrective spectacles or contact lenses must carry a spare set of clear prescription spectacles on their person while performing aircrew duties, see AFI 11-206, paragraph 6.3.3. Additionally, only 15 percent (N-15) transmittance neutral density gray spectacle lenses are approved for flying duty, see AFR 167-3, para 2-4d. Consult other guidance, such as AFMOA or MAJCOM policy letters pertaining to aircrew spectacles.

A7.8. Heterophoria and Heterotropia.

A7.8.1. Flying Class III except InFlight Refuelers.

A7.8.1.1. Esophoria greater than 15 prism diopters.

A7.8.1.2. Exophoria greater than 8 prism diopters.

A7.8.1.3. Hyperphoria greater than 2 prism diopters.

A7.8.1.4. Heterotropia greater than 15 prism diopters.

A7.8.2. Flying Class I, IA, II, Inflight Refuelers and individuals required to perform scanner duties.

A7.8.2.1. Esophoria greater than 10 prism diopters.

A7.8.2.2. Exophoria greater than 6 prism diopters.

A7.8.2.3. Hyperphoria greater than 1.5 prism diopters.

A7.8.2.4. Heterotropia, including microtropias.

A7.8.2.5. Point of convergence (PC) greater than 100mm.

*Note: Accomplish and record PC measurements only at the time of initial flying class I, IA, II-Flight Surgeon, and III - Inflight Refueler applicant exams. The PC is no longer required on periodic examinations.

A7.8.2.6. History of extraocular muscle surgery is cause for complete evaluation of ocular motility by a competent eye care professional to look for residual heterophorias, heterotropias (including microtropias), and motor sensory problems.

*Note: The evaluation must include all of the motility tests listed in **A7.11.** Further processing of such cases will proceed in accordance with **A7.11.** as well.

A7.9. Near Point of Accommodation.

A7.9.1. Flying Classes II and III. No standards.

A7.9.2. Flying Classes I and IA. Near point of accommodation less than minimum for age specified in **Attachment 11**.

A7.10. Color Vision, Classes I, IA, II and III. Color vision testing must be performed monocularly under an approved and standardized illuminant (i.e., Illuminant C). Five or more incorrect responses in either eye (including failure to make responses in the allowed time interval) in reading the 14 test plates versions of one of the following Pseudoisochromatic Plate (PIP) sets is considered a failure: Dvorine, the original version of the AO (excludes Richmond PIP version), or Ishihara (record responses as correct/total).

*Note: No other PIP versions, such as the Richmond PIP, or Beck Engraving versions, or other tests for color vision are authorized for qualification purposes. Also note that the Farnsworth Lantern (FALANT) has been dropped as an USAF qualifying test.

A7.10.1. Flying Class I/IA/II/III: Must possess normal color vision as demonstrated by passing the approved PIP.

A7.10.2. Flying Class II-Flight Surgeon Applicants: Same as above.

*Note: FS applicants with mild color vision defects may be considered for a FCIIA waiver. FCIIA waiver authority is delegated to HQ AETC/SG. Controversial cases will be referred to AFMOA/SGOA. See **Attachment 10**, Certification & Waiver Authority.

A7.11. Depth Perception/Stereopsis.

A7.11.1. Flying Class III (other than Inflight Refuelers and individuals required to perform scanner duties). No standard.

A7.11.2. Flying Class I, IA, II-Flight Surgeon Applicant and III-Inflight Refueler Applicants and individuals required to perform scanner duties. Failure of the Vision Test Apparatus (VTA-DP) or its newer replacement, the Optec Vision Tester (OVT), screening depth perception test with uncorrected refractive errors should be retested with refraction correction in place, regardless of level of unaided visual acuity. Failure even with correction is disqualifying, but may be considered for waiver consideration by higher waiver authorities, only after completion of a full evaluation by an ophthalmologist or optometrist, to include **all** of the following: ductions, versions, cover test and alternate cover test in primary and 6 cardinal positions of gaze, AO Vectograph Stereopsis Test at 6 meters (4 line version), AO Suppression Test at 6 meters, Randot or Titmus Stereopsis Test, Red Lens Test, and 4 Diopter Base out Prism Test at 6 meters. These tests are designed to identify and characterize motility/alignment disorders, especially microtropias and monofixation syndrome. The results of these tests done locally are considered to be preliminary, but will be used by waiver authorities to determine whether a candidate should be permanently disqualified without any waiver consideration, to identify if there are potentially correctable causes, and to determine whether further evaluation is required.

*Note: A prospective Undergraduate Flying Training (UFT) Microtropia Study/Management Group is established at the ACS with minimally defective stereopsis secondary to monofixation syndrome or microstrabismus that are considered appropriate for waiver consideration. Potential Study Group members must meet the criteria established by the ACS to be eligible for this Study/Management Group. All potential candidates must be evaluated at the ACS Ophthalmology Branch if recommended and approved by HQ AETC/SGPS. AETC/SGPS is the waiver authority.

A7.11.3. Flying Class II and III-Inflight Refuelers and individuals required to perform scanner duties. A new failure of the VTA-DP or OVT requires evaluation by an ophthalmologist or optometrist to determine the cause of the failure and to rule out correctable causes, i.e., refractive error and anisometropia. If any new failure still is unable to pass the VTA or OVT with proper optical correction, then all of the motility tests listed above under Flying Class I in **A7.11.** must be accomplished as a prerequisite for any further waiver consideration.

A7.11.4. If the aviator has previously failed the VTA or OVT, and has previously been evaluated, and has either, normal motility or a stable previously known waivered motility disorder, and can pass another stereopsis test, such as the Verhoeff, Titmus, Randot, or Howard Dolman, no further work-up or waiver is required. However, such cases should already have been granted an initial waiver for this consideration. If not, a waiver is required.

*Note: If the local flight surgeon feels that the degree of depth perception may not be compatible with the present aircraft or duties of assignment, further work-up and waiver will be required. Consultation at the ACS is indicated for any rated aircrew member with defective, questionable or change in stereopsis or depth perception or a significant change in the level of stereopsis performance.

A7.12. Field of Vision.

A7.12.1. Flying Classes I, IA, II and III.

A7.12.1.1. Contraction of the normal visual field in either eye to within 30 degrees of fixation in any meridian.

A7.12.1.2. Central scotoma, whether active or inactive, including transitory migraine related or any other central scotoma which is due to active pathological process.

A7.12.1.3. Any peripheral scotoma, other than physiologic.

A7.13. Night Vision, Flying Classes I, IA, II, and III. Unsatisfactory night vision as determined by history for initial flying. In trained aviators, this history is confirmed by the appropriate electrophysiological tests requested by the Aeromedical Consultation Service ophthalmologists. Dark field and empty field myopia due to accommodation are normal physiologic responses.

A7.14. Red Lens Test.

A7.14.1. Flying Classes II and III (except Inflight Refuelers). No standards.

A7.14.2. Flying Classes I and IA and Inflight Refuelers and individuals required to perform scanner duties. Any diplopia or suppression during the Red Lens Test which develops within 20 inches of the center of the screen (30 degrees) is considered a failure. Complete evaluation of ocular motility/alignment by a qualified ophthalmologist or optometrist is required as a prerequisite for higher waiver authorities to determine if ACS evaluation is required.

*Note: See paragraph **A7.11.**

A7.15. Intraocular Pressure, Flying Classes I, IA, II, and III.

A7.15.1. Glaucoma. As evidenced by intraocular pressures of 30 mmHg or greater, or the secondary changes in the optic disc or visual field associated with glaucoma. Trained aircrew with glaucoma require consultation (review or evaluation) with the ACS prior to waiver consideration.

*Note: Pigmentary dispersion syndrome (PDS) is not medically disqualifying for flying (includes Initial Flying Classes) unless associated with elevated intraocular pressures above 22 mmHg. PDS with elevated IOP, referred to as Pigmentary Glaucoma Suspect, (PGS) requires local ophthalmology evaluation. A confirmed diagnosis of Pigmentary Glaucoma Suspect (PGS) is disqualifying for all initial Flying Classes. Trained aircrew with PGS require consultation (review or evaluation) with the ACS prior to waiver consideration.

A7.15.2. Ocular hypertension (Preglaucoma). Two or more determinations of 22 mmHg or greater, but less than 30 mmHg, or 4 mmHg or more difference between the two eyes. (See paragraph **16.5.**).

*Note: Abnormal pressures obtained by a noncontact (air puff) tonometer or Schiotz must be verified by applanation.

A7.16. Lungs and Chest Wall.

A7.16.1. Flying Classes II and III.

A7.16.1.1. Pulmonary tuberculosis, including tuberculous pleuritis or pleurisy of unknown etiology with positive tuberculin test.

A7.16.1.2. History of spontaneous pneumothorax. A single episode of spontaneous pneumothorax does not require waiver if PA inspiratory and expiratory chest radiograph and thin-cut CT-scan show full expansion of the lung and no demonstrable pathology which would predispose to recurrence.

A7.16.1.3. Pulmonary blebs or bullae, unless corrected by surgical treatment, recovery is complete, and pulmonary function tests are normal.

A7.16.1.4. Bronchiectasis, unless corrected by surgical treatment, recovery is complete, and pulmonary function tests are normal.

A7.16.1.5. Sarcoidosis.

A7.16.1.6. Pleural effusion.

A7.16.1.7. Empyema, residual sacculation or unhealed sinuses of the chest wall following surgery for empyema.

A7.16.1.8. Chronic bronchitis if pulmonary function is impaired to such a degree as to interfere with duty performance or to restrict activities.

A7.16.1.9. Asthma of any degree, or a history of asthma, reactive airway disease, intrinsic or extrinsic bronchial asthma, exercise-induced bronchospasm, or IgE (Immunoglobulin E) mediated asthma.

A7.16.1.10. Bullous or generalized pulmonary emphysema, demonstrated by pulmonary function tests.

A7.16.1.11. Cystic disease of the lung.

A7.16.1.12. Silicosis or extensive pulmonary fibrosis with functional impairment or abnormal pulmonary function tests.

A7.16.1.13. History of lung abscess.

A7.16.1.14. Chronic mycotic infection of the lung. Residuals of infection, including cavitation, except for scattered nodular parenchymal and hilar calcifications.

A7.16.1.15. Foreign body in the trachea, bronchus, lung, or chest wall.

A7.16.1.16. Chronic adhesive (fibrous) pleuritis of sufficient extent to interfere with pulmonary function and exercise tolerance.

A7.16.1.17. History of bi-lobectomy, lobectomy or multiple segmental resections if there is significant reduction of vital capacity, timed vital capacity, or maximum breathing capacity, or if there is residual pulmonary pathology.

A7.16.1.18. Suppurative periostitis, osteomyelitis, caries, or necrosis of the ribs, sternum, clavicle, scapulae, or vertebrae.

A7.16.1.19. Congenital malformation or acquired deformities which reduce the chest capacity or diminish respiratory or cardiac functions to a degree which interferes with vigorous physical exertion or produce disfigurement when the examinee is dressed.

A7.16.1.20. Chronic cystic mastitis.

A7.16.1.21. History of pulmonary embolus.

A7.16.1.22. Silicone implants, injections, or saline inflated implants in breasts for cosmetic purposes. See paragraph **A3.12.**

A7.16.1.23. Sleep apnea and other clinical sleep disorders.

A7.16.2. Flying Classes I and IA. In addition to the above:

A7.16.2.1. History of spontaneous pneumothorax. A single episode may be considered for waiver after 3 years if pulmonary evaluation shows complete recovery with full expansion of the lung and no demonstrable pathology that would predispose to recurrence.

A7.16.2.2. Chronic adhesive pleuritis which produces any findings except minimal blunting of the costophrenic angles.

A7.16.2.3. History of sarcoidosis.

A7.17. Cardiovascular System.

A7.17.1. Flying Classes II and III.

A7.17.1.1. History of cardiac surgery.

A7.17.1.2. Heart pump failure, regardless of cause.

A7.17.1.3. Hypertrophy or dilatation of the heart verified by echocardiogram, unless evaluation demonstrates it to be normal physiological response to athletic conditioning.

A7.17.1.4. Persistent tachycardia with a resting pulse rate of more than 100.

A7.17.1.5. Elevated blood pressure (measured in the sitting position) as follows:

A7.17.1.5.1. In applicants for flying training or initial flying duty, evidenced by average systolic pressure greater than 140 mmHg, or average diastolic pressure of greater than 90 mmHg obtained from the 5-day blood pressure check.

A7.17.1.5.2. History of elevated blood pressure requiring chronic medication for control.

A7.17.1.5.3. In trained flying personnel evidenced by:

A7.17.1.5.3.1. Average systolic blood pressure greater than 140 mmHg or average diastolic blood pressure greater than 90 mmHg.

*Note: Asymptomatic personnel with average systolic blood pressure ranging between 141 mmHg and 160 mmHg, or average diastolic blood pressure ranging between 91 mmHg and 100 mmHg, may remain on flying status for up to 6 months (from the date the elevated blood pressure was first identified) while undergoing non-pharmacological intervention to achieve acceptable values.

A7.17.1.5.3.2. Any elevation in blood pressure due to secondary metabolic or pathologic causes until the underlying cause has been corrected, provided the primary condition is not disqualifying.

A7.17.1.5.4. Orthostatic or symptomatic hypotension or recurrent vasodepressor syncope.

A7.17.1.5.5. Pericarditis, myocarditis, or endocarditis, or history of these conditions.

A7.17.1.5.6. Any significant congenital abnormalities of the heart and vessels, unless corrected by surgery without residuals or complications. A minimum recovery period of 6 months following surgery is mandatory before waiver is considered together with repeat studies including invasive testing as applicable, demonstrating functional correction. Uncomplicated dextrocardia and minor atrial and ventricular septal defects may be acceptable without surgical correction.

A7.17.1.5.7. Acute rheumatic fever; a verified history of rheumatic fever or chorea within the previous 2 years; recurrent attacks of rheumatic fever or chorea at any time; evidence of residual cardiac damage.

A7.17.1.5.8. Coronary artery disease, symptomatic or asymptomatic. History of myocardial ischemia. Coronary artery disease strongly suspected by symptoms or tests for myocardial ischemia or infarction unless ruled out by angiography (other definitive evaluation of coronary patency and function will be considered on a case-by-case basis). History of coronary artery surgery or other intervention is generally not waiverable, but will be reviewed by ACS on request of MAJCOM/ SGPA or AFMOA/SGOA.

A7.17.1.5.9. History of symptomatic major dysrhythmia. Asymptomatic major dysrhythmias require ACS review. Major dysrhythmias include supraventricular tachycardia, atrial flutter or fibrillation, ventricular tachycardia or fibrillation, and asystole.

A7.17.1.5.10. Verified history of major electrocardiographic conduction defects, such as Mobitz II second-degree A-V block, third degree A-V block, Wolff-Parkinson-White (WPW) syndrome, or Lown-Ganong-Levin (LGL) syndrome. W-P-W pattern may be waiverable if ACS evaluation reveals no dysrhythmias; either WPW or LGL syndrome may be waiverable if corrected.

A7.17.1.5.11. Left anterior and posterior fascicular block and left bundle branch block may be considered for waiver if ACS evaluation reveals no underlying disease.

A7.17.1.5.12. Right bundle branch block may be waiverable after local cardiologic evaluation.

A7.17.1.6. History of valvular heart disease to include pulmonic, mitral, and tricuspid valvular regurgitation greater than mild, aortic regurgitation greater than trace, and any degree of valvular stenosis. Mitral valve prolapse (MVP) and bicuspid aortic valve are also medically disqualifying.

A7.17.1.7. Resting ECG findings considered to be "borderline," or known to be serial changes from previous records unless a cardiac evaluation as directed by the ECG Library reveals no underlying disease. Refer to ACS “Disposition for ECG findings.”

A7.17.1.8. All electrocardiographic tracings read as abnormal. Waiver is not considered until evaluation recommended by ACS has been completed.

A7.17.1.9. Borderline or abnormal noninvasive cardiac studies.

*Note: For rated officers, copies of any study, i.e., ECG, holter monitor, thallium scan, ETT-TM, or echocardiogram video tape **MUST** be forwarded to the ECG Library, Brooks AFB TX for review.

A7.17.1.10. History of recurrent thrombophlebitis or thrombophlebitis with persistent thrombus, evidence of circulatory obstruction, or deep venous incompetence in the involved veins.

A7.17.1.11. Varicose veins with complications or if more than mild.

A7.17.1.12. Peripheral vascular disease, including Raynaud's disease, thromboangiitis obliterans, erythromelalgia, arteriosclerotic, or diabetic vascular disease.

A7.17.1.13. Aneurysm of any vessel or history of correction by surgery.

A7.17.1.14. Syphilitic heart disease.

A7.17.1.15. History of significant traumatic heart disease.

A7.17.1.16. Hypersensitive carotid sinus.

A7.17.1.17. Arteritis of any artery.

A7.17.1.18. Inadequate arterial blood supply to any extremity.

A7.17.1.19. Vasculitis.

A7.17.2. Flying Classes I and IA. **In addition to the above:**

A7.17.2.1. Wolff-Parkinson-White electrocardiographic pattern; may be waiverable for flying training if corrected.

A7.17.2.2. Any major vascular synthetic graft.

A7.17.2.3. Elevated blood pressure (see **A7.17.** above).

A7.18. Blood, Blood-Forming Tissue, and Immune System Diseases. Flying Classes I, IA, II and III:

A7.18.1. Anemia of any etiology. Hematocrit values less than 38 for men or 36 for women should be evaluated; decreasing hematocrit values, even if in the normal range, may also be an indication for workup. Waiver for trained aircrew is permissable for stable anemia not due to an otherwise disqualifying condition, as long as the hematocrit does not fall below 32 percent.

A7.18.2. Loss of 200 cc or more of blood is disqualifying for at least 72 hours. Platelet pheresis is disqualifying for 72 hours.

A7.18.3. Polycythemia; a hematocrit above 50 in men, or above 47 in women, should be evaluated. Waiver is not favorably considered if the hematocrit is above 55 percent.

A7.18.4. Hemoglobinopathies and thalassemias.

A7.18.4.1. Homozygous hemoglobin abnormalities.

A7.18.4.2. Sickle cell disease or heterozygous sickling disorders other than sickle cell trait.

A7.18.4.3. Sickle cell trait if the individual has a history of symptoms associated with a sickling disorder or symptomology attributable to intravascular sickling during decompression in an altitude chamber. Review and certification by proper authority (see **Attachment 9**) is required for all aircrew members with sickle cell trait after evaluation as outlined in paragraph **16.7.**

A7.18.5. Hemorrhagic states and thromboembolic disease:

A7.18.5.1. Coagulopathies.

A7.18.5.2. Thromboembolic disease, except for acute, non-recurrent conditions.

A7.18.5.3. Thrombocytopenia or thrombocytosis. Platelet counts less than 100,000/mm^3 or greater than 400,000 mm^3 should be evaluated. Thrombocytosis greater than 750,000/mm^3 is not waiverable.

A7.18.5.4. Platelet dysfunctions.

A7.18.6. Leukopenia (granulocytopenia). White blood cell counts should fall within the range of 3,500 to 12,000 cells/mm^3--counts in the range of 750 to 3500 cells/mm^3 should be fully evaluated. Granulocyte counts of less than 750 cells/mm^3 are not waiverable.

A7.18.7. All leukemias and other myeloproliferative disorders.

A7.18.8. All lymphomas including mycosis fungoides and Sezary syndrome.

A7.18.9. Plasma cell dyscrasias.

A7.18.9.1. Multiple myeloma.

A7.18.9.2. Macroglobulinemia.

A7.18.10. Immunodeficiency syndromes, primary or acquired. Confirmed presence of Human Immunodeficiency Virus (HIV) or antibody. AFMOA/SGOA retains waiver authority for all flying classes.

A7.18.11. Generalized lymphadenopathy or splenomegaly until the cause is corrected.

A7.19. Abdomen and Gastrointestinal System.

A7.19.1. Flying Classes II and III.

A7.19.1.1. Gastrointestinal hemorrhage or history of, regardless of cause. Waiver may be considered for any condition that is clearly attributable to a specific, nonpersistent cause.

A7.19.1.2. Peptic ulcer disease, active or refractory.

A7.19.1.3. Peptic ulcer complicated by hemorrhage, obstruction or perforation.

A7.19.1.4. Hernia other than small asymptomatic umbilical or hiatal.

A7.19.1.5. History of viral hepatitis, with carrier status, persistent transaminase elevation or evidence of chronic active or persistent hepatitis.

A7.19.1.6. Wounds, injuries, scars, or weakness of the muscles of the abdominal wall which are sufficient to interfere with function.

A7.19.1.7. Sinus or fistula of the abdominal wall.

A7.19.1.8. Chronic or recurrent esophagitis including reflux esophagitis.

A7.19.1.9. Chronic gastritis.

A7.19.1.10. Congenital abnormalities of the bowel if symptomatic or requiring surgical treatment. History of intestinal obstruction if due to any chronic or recurrent disease. Surgery to relieve childhood pyloric stenosis or intussusception is not disqualifying if there is no residual dysfunction.

A7.19.1.11. Crohn's disease (regional enteritis).

A7.19.1.12. Malabsorption syndromes (see paragraph **A7.29.**).

A7.19.1.13. Irritable bowel syndrome.

A7.19.1.14. Ulcerative colitis or proctitis or verified history of same.

A7.19.1.15. Chronic diarrhea, regardless of cause.

A7.19.1.16. Megacolon.

A7.19.1.17. Diverticulitis, symptomatic diverticulosis, or symptomatic Meckel's diverticulum.

A7.19.1.18. Any chronic liver disease whether congenital or acquired. Marked enlargement of the liver from any cause. Hepatic cysts. Congenital hyperbilirubinemias, e.g. Gilbert's disease, do not require waiver if asymptomatic.

A7.19.1.19. Chronic cholecystitis.

A7.19.1.20. Cholelithiasis.

A7.19.1.21. Sphincter of oddi dysfunction or bile duct abnormalities or strictures.

A7.19.1.22. Pancreatitis or history of same.

A7.19.1.23. Congenital anomalies, disease of the spleen. Chronic enlargement of the spleen.

A7.19.1.24. Splenectomy, for any reason except the following:

A7.19.1.24.1. Trauma to an otherwise healthy spleen.

A7.19.1.24.2. Hereditary spherocytosis.

A7.19.1.25. History of gastroenterostomy, gastrointestinal bypass, stomach stapling, or surgery for relief of intestinal adhesions.

A7.19.1.26. Symptomatic esophageal motility disorders.

A7.19.1.27. History of partial resection of the large or small intestines for chronic or recurrent disease.

A7.19.2. Flying Class I and IA. See above.

A7.20. Perianal, Rectum, and Prostate, Flying Classes I, IA, II, and III.

A7.20.1. Proctitis, chronic or symptomatic.

A7.20.2. Stricture or prolapse of the rectum.

A7.20.3. Hemorrhoids which cause marked symptoms or internal hemorrhoids which hemorrhage or protrude intermittently or constantly until surgically corrected.

A7.20.4. Fecal incontinence.

A7.20.5. Anal fistula.

A7.20.6. Ischiorectal abscess.

A7.20.7. Chronic anal fissure.

A7.20.8. Symptomatic rectocele.

A7.20.9. Pilonidal cyst if there is a history of inflammation or discharging sinus in the 2 years preceding examination. Surgery for pilonidal cyst or sinus is disqualifying until the wound is healed, there are no referable symptoms, and no further treatment or medication is required.

A7.20.10. Chronic prostatitis, prostatic hypertrophy, with urinary retention or abscess of the prostate gland.

A7.21. Genitourinary System, Flying Class I, IA, II and III.

A7.21.1. History of recurrent or bilateral renal calculus. Uncomplicated single episode of renal calculus does not require waiver, but should be evaluated.

A7.21.2. Retained renal calculus. Retained calculus located in a papillary duct or any more distal portion of the collecting system may be considered for a flying Class IIA waiver.

A7.21.3. Proteinuria under normal activity (at least 48 hours post strenuous exercise) greater than 200 mg in 24 hours. Waiver may be considered for fixed and reproducible orthostatic proteinuria when the urinary protein to urinary creatinine ratio on a randomly collected urine (not first morning void) is less than or equal to 0.2. It is not necessary to collect a 24 hour urine specimen.

A7.21.4. Persistent or recurrent hematuria.

A7.21.5. Cylindruria, hemoglobinuria, or other findings indicative of significant renal disease.

A7.21.6. Chronic nephritis.

A7.21.7. Stricture of the urethra.

A7.21.8. Urinary fistula.

A7.21.9. Urinary incontinence.

A7.21.10. Absence of one kidney. Functional impairment of either or both kidneys.

A7.21.11. Horseshoe kidney.

A7.21.12. Chronic pyelitis or pyelonephritis.

A7.21.13. Renal ptosis (floating kidney) causing impaired renal drainage, hypertension or pain.

A7.21.14. Hydronephrosis or pyonephrosis.

A7.21.15. Polycystic kidney disease.

A7.21.16. Chronic cystitis.

A7.21.17. Amputation of the penis.

A7.21.18. Hermaphroditism.

A7.21.19. Epispadias or hypospadias with unsatisfactory surgical correction.

A7.21.20. Hydrocele, unless small and asymptomatic

A7.21.21. Large or painful left varicocele. Any right varicocele unless significant underlying pathology has been excluded.

A7.21.22. Undescended testicle. Absence of both testicles.

A7.21.23. Chronic orchitis or epididymitis.

A7.21.24. Urinary diversion.

A7.21.25. Major abnormalities and defects of the genitalia such as a change of sex, a history thereof, or complications (such as adhesions or disfiguring scars) residual to surgical correction of these conditions.

A7.22. Pelvic.

A7.22.1. Flying Classes II and III.

A7.22.1.1. Pregnancy or other symptomatic enlargement of the uterus due to any cause. Pregnancy waivers for trained flying personnel may be requested under the following guidelines: the request is voluntary and must be initiated by the crewmember with concurrence by the squadron commander, flight surgeon, and obstetrician. Physiological training is waived during pregnancy; flying is restricted to pressurized multi-crew, multi-engine, non-ejection seat aircraft; and crewmembers are released from all mobility commitments. The waiver is valid for the 13th through 24th week of gestation.

*Note: Refer to AFRCI 48-101 for further guidance on unit assigned reservists.

A7.22.1.2. Chronic symptomatic vaginitis.

A7.22.1.3. Chronic salpingitis or oophoritis.

A7.22.1.4. Symptomatic uterine fibroids.

A7.22.1.5. Ovarian cysts.

A7.22.1.6. All symptomatic congenital abnormalities of the reproductive system.

A7.22.1.7. Dysmenorrhea, if incapacitating to a degree which necessitates recurrent absences of more than a few hours from routine duty.

A7.22.1.8. Gross irregularity of the menstrual cycle. Menorrhagia, metrorrhagia, polymenorrhea, or amenorrhea.

A7.22.1.9. Menopausal syndrome, either physiologic or surgical, if manifested by more than mild constitutional or psychological symptoms.

A7.22.1.10. Endometriosis, if symptomatic or controlled medically.

A7.22.1.11. Malposition of the uterus, if symptomatic.

A7.22.1.12. Vulvitis, chronic.

A7.22.2. Flying Class I and IA. In addition to above, history of endometriosis.

A7.23. Neurological Disorders.

A7.23.1. Flying Classes II and III.

A7.23.1.1. Infections of the CNS.

A7.23.1.2. Seizure of any type (grand mal, petit mal, focal, etc.).

A7.23.1.3. Disturbances of consciousness (not due to head injury).

A7.23.1.3.1. An isolated episode of neurocardiogenic syncope associated with venipunture or prolonged standing in the sun (or similar benign precipitating event) which is less than 1 minute in duration, without loss of continence, and followed by rapid and complete recovery without sequelae does not require waiver if thorough neurological and cardiovascular evaluation by a flight surgeon reveals no abnormalities.

A7.23.1.3.2. Physiological loss of consciousness (LOC) caused by reduced oxygen tension, general anesthesia, or other medically induced LOC (excluding vasovagal syncope) does not require waiver provided there is full recovery without sequelae.

A7.23.1.3.3. High G loss of consciousness (G-LOC) during a centrifuge run does not require waiver for continued flying duty unless there are neurologic sequelae or evidence that the G-LOC occurrence is associated with coexistant disease or anatomic abnormality. Inflight G-LOC caused by an improperly performed anti-G straining maneuver or a disconnect of the anti-G protective gear is not disqualifying and is managed as a physiological incident. The local flight surgeon completes appropriate post-incident medical evaluation and reports the incident according to applicable directives.

A7.23.1.3.4. All other loss or disturbance of consciousness. For rated personnel, waivers are considered by AFMOA/SGOA only after evaluation at ACS. For non-rated personnel, waiver is at MAJCOM discretion.

*Note: Flying training applicants and students with a history of syncope evaluated according to **Table 16.1.** and certified acceptable for Flying Class I or IA by HQ AETC/SG do not require a waiver for flying Class II for the same history of syncope.

A7.23.1.4. History of any of the following types of headaches:

A7.23.1.4.1. Recurrent headaches of the vascular, migraine, or cluster (Horton's cephalgia or histamine headache) type.

A7.23.1.4.2. A single incapacitating headache of any type (e.g.,loss of consciousness, aphasia, ataxia, vertigo or mental confusion).

A7.23.1.4.3. Headache of any type which are of sufficient severity to likely interfere with flying duties.

A7.23.1.4.4. Acephalgic migraines.

*Note: A waiver for migraines may be considered following one year of symptom free observation. Migrainous strokes and migraines complicated by neurological deficits other than transient visual changes are not waiverable.

A7.23.1.5. Electroencephalographic abnormalities.

A7.23.1.5.1. Truly epileptiform abnormalities to include generalized, lateralized, or focal spikes, sharp waves, spike-wave complexes, and sharp and slow wave complexes during alertness, drowsiness, or sleep are disqualifying. Benign transients such as Small Sharp Spikes (SSS) or Benign Epileptiform Transients of Sleep (BETS), wicket spikes, 6 Hertz (Hz) (phantom) spike and wave, rhythmic temporal theta of drowsiness (psychomotor variant), and 14 and 6Hz positive spikes are not disqualifying.

A7.23.1.5.2. Generalized, lateralized, or focal continuous polymorphic delta activity or intermittent rhythmic delta activity (FIRDA or OIRDA) during the alert state is disqualifying unless the etiology of the abnormality has been identified and determined not to be a disqualifying disorder.

A7.23.1.6. History of head injury.

A7.23.1.6.1. Head injury associated with any of the following are not waiverable:

A7.23.1.6.1.1. Post-traumatic seizures. (Exception: seizures at the time of injury)

A7.23.1.6.1.2. Persistent neurological deficits indicative of significant parenchymal CNS injury, such as hemiparesis or hemianopsia.

A7.23.1.6.1.3. Evidence of impairment of higher intellectual functions or alterations of personality as a result of injury.

A7.23.1.6.1.4. Cerebrospinal fluid shunts.

A7.23.1.6.2. Severe head injury. Head trauma associated with any of the complications listed below may be considered for Flying Class II and III waiver in 5 years (see **Table 16.1.**).

A7.23.1.6.2.1. Unconsciousness or amnesia or the combination of the two equal to or exceeding 24 hours duration.

*Note: In cases which are defined as severe only due to the duration of loss of consciousness or amnesia and are otherwise minimal, mild, or moderate, a waiver at 2 years may be considered if the evaluation requirements in **Table 16.1.** are met.

A7.23.1.6.2.2. Radiographic evidence of retained metallic or bony fragments.

A7.23.1.6.2.3. Leptomeningeal cysts, aerocele, brain abscess, or arteriovenous fistula.

A7.23.1.6.2.4. Depressed skull fracture (the inner table indented by more than the thickness of the skull) with or without dural penetration.

A7.23.1.6.2.5. Traumatic or surgical laceration or contusion of the dura mater or the brain, or a history of penetrating brain injury.

A7.23.1.6.2.6. Focal neurological signs.

A7.23.1.6.2.7. Epidural, subdural, subarachnoid, or intracerebral hematoma.

*Note: A small epidural collection of blood found only on CT-scan or magnetic resonance imaging (MRI) and without evidence of parenchymal injury either on the imaging study or on neurological examination, followed to resolution without surgery, may be considered for flying class II or III waiver at two years as in the moderate head injury group.

A7.23.1.6.2.8. CNS infection such as abscess or meningitis within 6 months of head injury.

A7.23.1.6.2.9. Cerebrospinal fluid rhinorrhea or otorrhea persisting more than 7 calendar days.

A7.23.1.6.3. Moderate head injury. Head trauma associated with the below criteria may be considered for Flying Class II or III waiver in 2 years (see **Table 16.1.**).

A7.23.1.6.3.1. Unconsciousness for a period of 30 minutes or greater, but less than 24 hours.

A7.23.1.6.3.2. Amnesia for a period of 1 hour or greater but less than 24 hours. (Waiver contingent on a completely normal neurological and neuropsychological evaluation to include computerized tomography (CT) scan.)

*Exception: Waiver may be considered after 6 months of observation if a normal CT-scan was obtained within 2 calendar days of injury.

*Note: In cases which are defined as moderate only due to the duration of loss of consciousness or amnesia and are otherwise minimal, mild, a waiver at 6 months may be considered if the evaluation requirements in **Table 16.1.** are met.

A7.23.1.6.4. Mild head injury. Head trauma which does not meet criteria for more severe injury may be considered for waiver after l month (see **Table 16.1.**).

A7.23.1.6.5. Head trauma with no loss of consciousness, amnesia, or abnormal findings on examination, does not require waiver.

A7.23.1.7. Persistent post-traumatic sequelae, as manifested by headache, vomiting, disorientation, spatial disequilibruim, personality changes, impaired memory, poor mental concentration, shortened attention span, dizziness, altered sleep patterns, or any findings consistent with organic brain syndrome are disqualifying, but may be considered for waiver when full recovery has been confirmed by complete neurological and neuropsychological evaluation.

A7.23.1.8. Craniotomy and skull defects.

A7.23.1.9. Neurosyphilis in any form (meningovascular, tabes dorsalis, or general paresis).

A7.23.1.10. Narcolepsy, cataplexy, and similar states.

A7.23.1.11. Injury of one or more peripheral nerves unless it is not expected to interfere with normal function in any practical manner.

A7.23.1.12. History of subarachnoid hemorrhage, embolism, vascular insufficiency, thrombosis, hemorrhage, arteriosclerosis, arteriovenous malformation, or aneurysm involving the CNS.

A7.23.1.13. History of tumor involving the brain or its coverings.

A7.23.1.14. Personal or family history of hereditary disturbances such as multiple neurofibromatosis, Huntington's chorea, hepatolenticular degeneration, acute intermittent porphyria, spinocerebellar ataxia, peroneal muscular atrophy, muscular dystrophy, and familial periodic paralysis.

A7.23.1.15. Probable evidence or history of degenerative or demyelinating process such as multiple sclerosis, dementia, basal ganglia disease, or Friedreich's ataxia.

A7.23.1.16. History or evidence of such defects as basilar invagination, hydrocephalus, premature closure of the cranial sutures, meningocele, and cerebral or cerebellar agenesis if there is evidence of impairment of normal functions or if the process is expected to be progressive.

A7.23.1.17. Verified history of neuritis, neuralgia, neuropathy, or radiculopathy, whatever the etiology, unless:

A7.23.1.17.1. The condition has completely subsided and the cause is determined to be of no future concern.

A7.23.1.17.2. There is no residual which could be deemed detrimental to normal function in any practical manner.

A7.23.1.18. Polyneuritis, whatever the etiology, unless:

A7.23.1.18.1. Limited to a single episode.

A7.23.1.18.2. The acute state subsided at least 1 year before examination.

A7.23.1.18.3. There is no residual which could be expected to interfere with normal function in any practical manner.

A7.23.1.19. History or evidence of chronic or recurrent diseases, such as myasthenia gravis, polymyositis, or myotonia disorder.

A7.23.1.20. Evidence or history of involvement of the nervous system by a toxic, metabolic or disease process if there is any indication such involvement is likely to interfere with prolonged normal function in any practical manner or is progressive or recurrent, or if there is a significant neurological residual which would interfere with aviation duties.

A7.23.1.21. Tremors, chorea, dystonia or other movement disorders which could interfere with aviation or normal function.

A7.23.2. Flying Classes I and IA. In addition to the above, paroxysmal convulsive disorders. Seizures associated with febrile illness before 5 years of age may be acceptable with waiver if recent neurological evaluation, MRI, and electroencephalogram (EEG) including awake and sleep samples are normal.

A7.23.2.1. History of severe head injury is usually not waiverable and may not be considered until at least 10 years post injury.

A7.24. Psychiatric Disorders (Reference Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) Fourth Edition, American Psychiatric Association).

A7.24.1. Flying Classes II and III.

A7.24.1.1. Eating Disorders.

A7.24.1.2. Gender Identity Disorders.

A7.24.1.3. Mental Disorders due to a General Medical Condition.

A7.24.1.4. Delirium, Dementia, and Amnestic Disorders, and Other Cognitive Disorders.

A7.24.1.5. Alcohol Dependence or Abuse (DSM IV) or any disease the proximate cause of which is alcoholism. These conditions may be waived by MAJCOM/SG if the following conditions have been met:

A7.24.1.5.1. The MTF Alcohol & Drug Abuse Prevention & Treatment (ADAPT) Program treatment team determines that the individual has made satisfactory progress and has maintained abstinence without the aid of medications for a period of 6 months from the date of entering treatment.

*Note: Any relapse (as determined by the treatment team) or use of medication to deter alcohol use resets the 6-month observation period for waiver consideration.

A7.24.1.5.2. In the opinion of the flight surgeon, privileged mental health provider, and flying unit commander, and based on the ADAPT program assessment, the individual has a low potential for recidivism and can be expected to remain stable under stress.

A7.24.1.5.3. The individual has no medical complications or sequelae due to past alcohol abuse or dependence.

A7.24.1.5.4. The individual states in writing that he or she understands the waiver is valid only if total abstinence from alcohol is maintained and that a verifiable break in abstinence once the waiver period has begun is considered medically disqualifying and not waiverable. This written statement by the individual must be accomplished at the initial waiver request and reaccomplished each time a request is submitted for renewal of the waiver, and is included with the waiver request. To ensure flying unit commanders are aware of the need to observe individuals with past alcohol problems, new commanders are briefed on those in their units with waivers for this condition when the individual changes assignment or there has been a change in command.

A7.24.1.5.5. All other drug abuse or use. These conditions are not waiverable.

A7.24.1.6. Schizophrenia and other Psychotic Disorders.

A7.24.1.7. Mood Disorders.

A7.24.1.7.1. Depressive disorders including major depression, dysthymia, cyclothymia, and depression not otherwise specified.

A7.24.1.7.2. Bipolar disorder.

A7.24.1.8. Anxiety Disorders. Non-phobic fear of flying is considered an administrative not medical problem.

A7.24.1.9. Somatoform Disorders.

A7.24.1.10. Dissociative Disorders.

A7.24.1.11. Sexual paraphilias are not medically disqualifying; however, individuals meeting diagnostic criteria are dealt with administratively.

A7.24.1.12. Sexual dysfunctions and sexual disorders not otherwise specified are not medically disqualifying unless in association with another Axis I disorder.

A7.24.1.13. Sleep disorders if of such magnitude to warrant somatic treatment greater than 30 days duration, or if associated with an Axis I disorder other than an adjustment disorder.

A7.24.1.14. Factitious Disorders.

A7.24.1.15. Impulse Control Disorders Not Elsewhere Classified.

A7.24.1.16. Adjustment Disorders of more than 60 days duration.

A7.24.1.17. Unsatisfactory adaptability rating for military aviation (ARMA) if maladaptive personality traits (not meeting diagnostic criteria for a personality disorder) or a pattern of maladaptive behavior is present that significantly interferes with safety of flight, crew coordination, or mission completion. Motivational issues are referred to administrative channels.

A7.24.1.18. Psychological Factors Affecting Medical Condition.

A7.24.1.19. Personality disorders are not medically disqualifying; however, if social and occupational, administrative or legal ramifications are operant, a psychiatric evaluation may be warranted to clarify suitability for future flying or other duty.

A7.24.1.20. History of attempted suicide or suicidal behavior.

A7.24.2. Flying Classes I and IA. In addition to the above:

A7.24.2.1. History of any of the above diagnoses excluding verifiable simple adjustment disorders not requiring hospitalization.

A7.24.2.2. History of schizophrenia or bipolar disorder in both parents.

A7.24.2.3. Unsatisfactory adaptability rating for military aviation.

A7.24.2.4. History of persistent learning disorder.

A7.24.2.5. Evidence of any condition causing serious chronic impairment of educational goals or chronic behavioral difficulties requiring hospitalization or prolonged treatment.

A7.25. Extremities, Flying Classes I, IA, II, and III.

A7.25.1. General Conditions.

A7.25.1.1. Arthritis of any type of more than minimal degree, which interferes with the ability to follow a physically active lifestyle, or may reasonably be expected to preclude the satisfactory performance of flying duties.

A7.25.1.2. Documented history or findings of rheumatoid arthritis.

A7.25.1.3. Active osteomyelitis or a verified history of osteomyelitis, unless inactive with no recurrence during the 2 years before examination, and without residual deformity sufficient to interfere with function.

A7.25.1.4. Osteoporosis.

A7.25.1.5. Osteochondromatosis or multiple cartilaginous exostoses.

A7.25.1.6. Disease or injury, or congenital anomaly of any bone or joint, with residual deformity, instability, pain, rigidity, or limitation of motion if function is impaired to such a degree it interferes with training, physically active lifestyle, or flying duties.

A7.25.1.7. Unreduced dislocation; substantiated history of recurrent dislocations or subluxations of a major joint if not satisfactorily corrected.

A7.25.1.8. Instability of a major joint if symptomatic and more than mild, or if subsequent to surgery there is evidence of instability, weakness, or significant atrophy.

A7.25.1.9. Malunited fractures which interfere significantly with function.

A7.25.1.10. Symptomatic nonunion of fractures.

A7.25.1.11. Any retained orthopedic fixation device, that interferes with function or easily subject to trauma.

A7.25.1.12. Muscular paralysis, paresis, contracture, or atrophy if progressive or of sufficient degree to interfere with the performance of flying duties.

A7.25.1.13. Demonstrable loose body in any joint (includes osteocartilaginous or metallic foreign objects).

A7.25.1.14. Synovitis with persistent swelling or limitation of motion.

A7.25.1.15. Osteonecrosis.

A7.25.1.16. Chondromalacia, if symptomatic or there is verified history of joint effusion, interference with function, or residuals from surgery.

A7.25.1.17. Joint replacement.

A7.25.1.18. Myotonia congenita.

A7.25.1.19. Scars, extensive, deep or adherent to the skin and soft tissues or neuromas of an extremity which are painful, interfere with movement, preclude the wearing of equipment, or show a tendency to breakdown.

A7.25.1.20. Symptomatic amputation stump (neuroma, bone spur, adherent scar or ulceration).

A7.25.2. Upper Extremity.

A7.25.2.1. Absence of any segment of the hand or digits.

A7.25.2.2. Resection of a joint other than that of a finger.

A7.25.2.3. Hyperdactylia.

A7.25.2.4. Scars and deformities of the fingers or hand which impair circulation, are symptomatic, or impair normal function to such a degree as to interfere with the satisfactory performance of flying duties.

A7.25.2.5. Healed disease or injury of the wrist, elbow or shoulder with residual weakness or symptoms of such a degree as to interfere with the satisfactory performance of flying duty. Grip strength of less than 75 percent of predicted normal when compared with the normal hand (non-dominant is 80 percent of dominant grip).

A7.25.2.6. Limitation of motion. Same as **A3.27.**

A7.25.3. Lower Extremity.

A7.25.3.1. Amputation or absence of any portion of the foot or lower extremity in excess of 1 of the 2nd through 5th toes.

A7.25.3.2. Clubfoot of any degree.

A7.25.3.3. Rigid or spastic flatfoot, Flatfoot, tarsal coalition.

A7.25.3.4. Weak foot with demonstrable eversion of the foot, valgus of the heel, or marked bulging of the inner border due to inward rotation of the talus regardless of the presence or absence of symptoms.

A7.25.3.5. Elevation of the longitudinal arch (pes cavus) if of enough degree to cause subluxation of the metatarsal heads and clawing of the toes. Obliteration of the transverse arch associated with permanent flexion of the small toes.

A7.25.3.6. Any condition, disease, or injury to feet or toes which results in disabling pain, distracting discomfort, inability to satisfactorily perform military aviation, or precludes wear of proper military footgear.

A7.25.3.7. Verified history of congenital dislocation of the hip, osteochondritis of the hip (Legg-Perthes disease), or slipped femoral epiphysis of the hip with X-ray evidence of residual deformity or degenerative changes.

A7.25.3.8. Verified history of hip dislocation within 2 years of examination or degenerative changes on X-ray from old hip dislocation.

A7.25.3.9. Difference in leg length of more than 2.5. cm (from anterior superior iliac spine to the distal tip of the medial malleolus).

A7.25.3.10. Weak Knee. Dislocation of semilunar cartilages or loose foreign bodies within the knee joint; residual instability of the knee ligaments; or significant atrophy or weakness of the thigh musculature in comparison with the normal side; or range of motion less than specified in **A3.27.**; or other symptoms of internal derangement or a condition which would interfere with the performance of flying duties.

A7.25.3.11. Osteochondritis dessicans of the knee or ankle if there are X-ray changes.

A7.25.3.12. Osteochondritis of the tibial tuberosity (Osgood-Schlatter disease) if symptomatic or with obvious prominence of the part and X-ray evidence of separated bone fragments.

A7.25.3.13. Limitation of motion same as **A3.27.**

A7.25.3.14. Toes-stiffness which interferes with walking, marching, running, or jumping.

A7.26. Spine and Other Musculoskeletal.

A7.26.1. Flying Classes I and IA: Same as Attachment **A3.29.** and the following:

A7.26.1.1. Flying Classes II and III.

A7.26.1.1.1. History of disease or injury of the spine or sacroiliac joints, either with or without objective signs, which has prevented the examinee from successfully following a physically active lifestyle.

A7.26.1.1.2. Arthritis of the spine, all types.

A7.26.1.1.3. Granulomatous disease of the spine, active or healed.

A7.26.1.1.4. Lumbar scoliosis of more than 20 degrees or thoracic scoliosis of more than 25 degrees as measured by the Cobb method

A7.26.1.1.5. Abnormal curvature of the spine of any degree in which there is a noticeable deformity when the examinee is dressed, in which pain or interference with function is present, or which is progressive.

A7.26.1.1.6. Symptomatic spondylolisthesis or spondylolysis.

A7.26.1.1.7. History of frank herniated nucleus pulposus or history of surgery or chemonucleolysis for that condition.

A7.26.1.1.8. Fractures or dislocations of the vertebrae. Compression fractures more than 25 percent or of more than a single vertebra may be considered for categorical IIB waiver. History of fractures of the transverse processes is not disqualifying if asymptomatic.

A7.26.1.1.9. Spina bifida when more than one vertebra is involved, if there is dimpling of the overlying skin, or a history of surgical repair for spina bifida.

A7.26.1.1.10. Juvenile epiphysitis with any degree of residual change indicated by x-ray or kyphosis.

A7.26.1.1.11. Weak or painful back requiring external support.

A7.26.1.1.12. Recurrent disabling low back pain due to any cause.

A7.26.1.1.13. Any surgical fusion.

A7.27. Skin.

A7.27.1. Flying Classes II and III.

A7.27.1.1. Any chronic skin disorder which is severe enough to cause recurrent grounding from flying duties, or is aggravated by or interferes with the wearing of military equipment.

A7.27.1.2. Extensive, deep, or adherent scars which interfere with muscular movements, with the wearing of military equipment, or show a tendency to breakdown.

A7.27.1.3. Atopic dermatitis with active or residual lesions in characteristic areas or a verified history.

A7.27.1.4. Dermatitis herpetiformis.

A7.27.1.5. Eczema which is chronic and resistant to treatment.

A7.27.1.6. Fungus infections of the skin, systemic or superficial, that interfere with duty performance or the wear of life support equipment.

A7.27.1.7. Furunculosis which is extensive, recurrent or chronic.

A7.27.1.8. Hyperhidrosis if chronic or severe.

A7.27.1.9. Leukemia cutis; mycosis fungoides; Hodgkin's disease.

A7.27.1.10. Lichen planus.

A7.27.1.11. Neurofibromatosis.

A7.27.1.12. Photodermatosis unless due to medication.

A7.27.1.13. Psoriasis.

A7.27.1.14. Scleroderma.

A7.27.1.15. Xanthoma if symptomatic or accompanied by hypercholesterolemia or hyperlipoproteinemia.

A7.27.1.16. Chronic urticaria.

A7.27.2. Flying Classes I and IA. In addition to above, psoriasis or verified history of same.

A7.28. Endocrine and Metabolic.

A7.28.1. Flying Classes II and III.

A7.28.1.1. Adiposogenital dystrophy (Frohlich's syndrome).

A7.28.1.2. Adrenal dysfunction of any degree, including pheochromocytoma.

A7.28.1.3. Cretinism.

A7.28.1.4. Diabetes insipidus.

A7.28.1.5. Diabetes mellitus, see note at **A3.32.**

A7.28.1.6. Gigantism or acromegaly.

A7.28.1.7. Thyroid disorders.

A7.28.1.7.1. Goiter if associated with pressure symptoms, or if enlargement is of such degree as to interfere with wearing of a military uniform or military equipment.

A7.28.1.7.2. Hyperthyroidism or thyrotoxicosis.

A7.28.1.7.3. Thyroiditis, acute and subacute.

A7.28.1.7.4. Hypothyroidism.

A7.28.1.8. Gout

A7.28.1.9. Hyperinsulinism, confirmed, symptomatic.

A7.28.1.10. Parathyroid dysfunction.

A7.28.1.11. Hypopituitarism.

A7.28.1.12. Myxedema, spontaneous or postoperative, with clinical manifestations.

A7.28.1.13. Nutritional deficiency diseases (including sprue, beriberi, pellagra, and scurvy) which are more than mild and not readily amenable to therapy or in which permanent pathological changes have been established.

A7.28.1.14. Other endocrine or metabolic disorders which obviously preclude satisfactory performance of military service or which require frequent or prolonged treatment.

A7.28.1.15. Hypercholesterolemia controlled by medication other than resin binders.

A7.28.1.16. Osteopenia.

A7.28.1.17. Hypoglycemia from any endogenous source.

A7.28.2. Flying Classes I and IA. In addition to the above:

A7.28.2.1. Diabetes mellitus (see Note in **A3.32.**). Persistent glucosuria from any cause including fasting renal glucosuria is disqualifying. Glucosuria post-prandially or during glucose loading challenge is not disqualifying in the absence of any renal disease or history of recurrent genitourinary infections. However, this finding requires evaluation.

A7.28.2.2. Any confirmed (repeated) serum cholesterol in excess of 230 mg/dl with one or both of the following criteria present:

A7.28.2.2.1. HDL cholesterol equal to or less than 15 percent of total cholesterol.

A7.28.2.2.2. LDL cholesterol greater than 170 mg/dl.

A7.29. Height and Weight.

A7.29.1. Flying Class III.

A7.29.1.1. Height.

A7.29.1.1.1. Height less than 64 inches or more than 77 inches. Waivers should be considered when appropriate based on crew position. Note: Combat Control and Pararescue have no standard. The minimum height requirement for air battle managers is 60 inches.

A7.29.1.2. Weight.

A7.29.1.2.1. For initial qualification a weight in relation to height applies. Body fat standards are considered for individuals who exceed their maximum allowable weight. (See **Attachment 15**.)

A7.29.1.2.2. For trained personnel refer to **Attachment 16**.

A7.29.2. Flying Class II.

A7.29.2.1. Height.

A7.29.2.1.1. Height less than 64 inches or more than 77 inches.

A7.29.2.2. Weight.

A7.29.2.2.1. For trained personnel, refer to **Attachment 16**. Additional weight restrictions may apply in certain ejection systems. Note: Refer overweight personnel to their unit commanders by letter for appropriate action under appropriate directives.

A7.29.3. Flying Class I.

A7.29.3.1. Height.

A7.29.3.1.1. Height less than 64 inches or more than 77 inches.

A7.29.3.1.2. Sitting height greater than 40 inches or less than 34 inches. (See AFPAM 48-133 for method of measurement).

A7.29.3.1.2.1. Buttock to knee measurement no greater than 27 inches. (See AFPAM 481-133 for method of measurement).

A7.29.3.2. Weight.

A7.29.3.2.1. Weight in relation to height applies and body weight may not exceed 232 pounds. Body fat standards are considered for individuals who exceed their maximum allowable weight. (See **Attachment 16**).

A7.29.4. Flying Classes IA and Initial II (Flight Surgeon).

A7.29.4.1. Height.

A7.29.4.1.1. Height less than 64 inches or more than 77. Waivers may be considered by weapons system.

A7.29.4.1.2. Sitting height greater than 40 inches or less than 33 inches. (See AFPAM 48-133 for method of measurement).

A7.29.4.2. Weight.

A7.29.4.2.1. Weight in relation to height applies and body weight may not exceed 232 pounds. Body fat standards are considered for individuals who exceed their maximum allowable weight. (See **Attachment 16**).

A7.30. Systemic and Miscellaneous Causes for Rejection.

A7.30.1. Flying Classes II and III.

A7.30.1.1. Recurrent decompression sickness (DCS). A single episode of DCS does not require waiver. All episodes of DCS require a minimum of 72 hours DNIF. Consultation with USAFSAM/AFIC (Hyperbaric Medicine) and concurrence of MAJCOM/SG is required before RTFS. In cases of DCS with neurological manifestations, a normal examination by a neurologist is required before RTFS.

A7.30.1.2. Malignancies. History or presence of malignant tumor, cyst or cancer of any sort. Basal cell and squamous cell carcinomas and carcinoma-in-situ of the cervix which have been adequately excised (as evidenced by pathology report, or basal cell carcinoma which have been treated by electrodessication and curretage by a dermatologist credentialed to perform this procedure), are exempted from tumor board action, but are report to tumor registry and are not disqualifying. Childhood malignancy considered cured may be considered for waiver on a case-by-case basis.

A7.30.1.3. Benign tumors which interfere with function or the wear of equipment and tumors which are likely to enlarge or be subjected to trauma during military service or show malignant potential.

A7.30.1.4. Following bleomyocin chemotherapy, AFMOA/SGOA may consider granting a

FCIIC waiver with the following restrictions:

A7.30.1.4.1. “No assignment to aircraft requiring routine use of oxygen equipment. Waiver from altitude chamber exposure. Ground training without supplemental oxygen is acceptable.” These restrictions must be annotated in the remarks section of the AF Form 1042.

A7.30.1.5. Bone marrow donation. DNIF the person until their hematocrit and hemoglobin return to their own pre-donation level and all symptoms referable to the donation have been resolved.

A7.30.1.6. Airsickness in flying personnel is not cause for medical disqualification unless there is medical evidence of organic or psychiatric pathology. If airsickness is of such chronicity or severity as to interfere with the performance of flying duties by a rated officer, his or her potential for further use in rated duties are addressed by a Flying Evaluation Board. Copies of these cases are sent through medical channels to AFMOA/SGOA for review before convening a board. Airsickness experienced by nonrated personnel (other than UPT or UNT students) while enrolled in flying courses is medically disqualifying if it is of such severity or chronicity as to interfere with the performance of flying duties. Final determination of medical qualification in these cases are made by the MAJCOM/SG.

A7.30.1.7. Any allergic condition which requires desensitization therapy. Waivers are considered if symptoms are controlled by desensitization or topical medication (or both).

A7.30.1.8. Eosinophilic granuloma.

A7.30.1.9. Gaucher's disease.

A7.30.1.10. Schuller-Christian disease.

A7.30.1.11. Letterer-Siwe's disease.

A7.30.1.12. Chronic metallic poisoning.

A7.30.1.13. Residual of cold injury, such as deep-seated ache, paresthesia, hyperhidrosis, easily traumatized skin, cyanosis, ankylosis, amputation of any digit, or cold urticaria.

A7.30.1.14. Heat pyrexia (heat stroke or heat exhaustion) if a reliable history indicates an abnormally lowered heat tolerance threshold.

A7.30.1.15. History of malignant hyperthermia.

A7.30.1.16. Syphilis, congenital or acquired. A history of primary or secondary syphilis is not disqualifying provided:

A7.30.1.16.1. The examinee has no symptoms of disease.

A7.30.1.16.2. There are no signs of active disease and no residual thereof.

A7.30.1.16.3. Serologic VDRL testing rules out reinfection.

A7.30.1.16.4. There is a verified history of adequate treatment.

A7.30.1.16.5. There is no evidence or history of CNS involvement.

A7.30.1.17. Parasitic infestation, all types until adequately treated.

A7.30.1.18. History of sensitivity or a demonstrated sensitivity of sufficient severity to require permanent exemption from any immunization required by appropriate directives.

A7.30.1.19. History of food-induced anaphylaxis.

A7.30.1.20. Other congenital or acquired abnormalities, defects or diseases which preclude satisfactory performance of flying duty.

A7.30.1.21. Miscellaneous conditions such as porphyria, hemochromatosis, amyloidosis.

A7.30.1.22. Inflammatory idiopathic diseases of connective tissue.

A7.30.1.23. Lupus erythematosus (acute, subacute, or chronic).

A7.30.1.24. Active tuberculosis in any form or location, or substantiated history of active tuberculosis within the previous 2 years.

A7.30.1.25. Sarcoidosis.

A7.30.1.26. History of malignancy.

A7.30.2. Flying Classes I and IA. In addition to the above:

A7.30.2.1. Motion sickness experienced in aircraft, automobiles, or water craft after the age of 12 with any significant frequency. Any history of motion sickness is completely explored.

A7.31. Medication. Use of any medication, except as described below is cause for medical disqualification for flying duty until the grounding condition has been resolved, the medication is no longer required and the effects of the drugs have dissipated.

A7.31.1. Aircrew members cannot fly for at least 8 hours after receiving a local or regional anesthetic agent.

A7.31.2. Aircrew and individuals on the sensitive duty program are not cleared for a minimum of 3 weeks following the use of Ketamine.

A7.31.3. Medications which may be used without medical consultation.

A7.31.3.1. Skin antiseptics, topical antifungals, 1 percent Hydrocortisone cream (more potent topical steroids require waivers), or benzoyl peroxide for minor wounds and skin diseases which do not interfere with the performance of flying duties or wear of personal equipment.

A7.31.3.2. Single doses of over-the-counter aspirin, acetaminophen or ibuprofen to provide analgesia for minor self-limiting conditions.

A7.31.3.3. Antacids for mild isolated episodes of epigastric distress.

A7.31.3.4. Hemorrhoidal suppositories.

A7.31.3.5. Bismuth subsalicylate for mild afebrile cases of diarrhea.

A7.31.3.6. Oxymetazoline or phenylephrine nasal sprays may be used by aircrew as "get me downs" should unexpected ear or sinus block occur during flight. These should not be used to treat symptoms of head congestion existing prior to flight.

A7.31.3.7. Multivitamin, no more than one per day.

A7.31.3.8. Dietary, herbal, and nutritional supplements can only be used with the approval of a flight surgeon. The flight surgeon should consider aeromedical implications of the supplement as well as the probability the supplement will actually enhance performance.

A7.31.4. Medication prescribed by a flight surgeon which may be used without removal from flying duty once the potential for idiosyncratic reaction has been excluded.

A7.31.4.1. Isoniazid for prophylactic therapy of tuberculin converters who do not have active tuberculosis. Minimum of 7 days ground trial.

A7.31.4.2. Oral contraceptives, implantable timed release progestin, injectable sustained duration progestin (for contraception only), estrogen alone or with progestin, as replacement therapy. Minimum of 28 days ground trial is required. Changes of dosage or brand requires an additional 28-day observation period.

A7.31.4.3. Chloroquine phosphate, primaquine phosphate, or doxycycline (100 mg daily) for antimalarial prophylaxis. Single dose ground trial is advised.

A7.31.4.4. Pyridostigmine for chemical warfare prophylaxis. Single dose ground trial is advised.

A7.31.4.5. Scopolamine alone or in combination with dextroamphetamine or ephedrine for airsickness in formal flying training programs. Not authorized for solo flight.

A7.31.4.6. Doxycycline (100mg) administered twice a day for 5 days may be used to treat mild diarrhea. Doxycycline may also be used for prophylaxis against diarrhea in deployed personnel. One hundred milligrams should be administered daily during the period of exposure and for at least 2 days following exposure, with the total period of use not to exceed 2 weeks.

A7.31.4.7. Topical antibiotics for control of acne.

A7.31.4.8. Topical tretinoin for control of acne as long as local irritation does not interfere with wear of the life-support equipment.

A7.31.4.9. Topical acyclovir.

A7.31.4.10. Completion of a course of oral penicillin, oxacillin, dicloxacillin, amoxicillin, erythromycin, sulfamethoxazole-trimethoprim, tetracycline, ampicillin, doxycycline, or cephalexin, once the acute infectious process is asymptomatic.

A7.31.4.11. Vaginal creams or suppositories for treatment of vaginitis once asymptomatic.

A7.31.4.12. Temazepam, or zolpidem if such use is essential for the safe performance of mission, and only after MAJCOM/SG coordination and approval. MAJCOM/SG may delegate this approval to wing and detachment level if unit mission so warrants. Single dose ground trial is required for use.

A7.31.4.13. Dextroamphetamine use may be allowed for certain missions. Check with MAJCOM/SG prior to prescribing. Single dose grounding trial is required.

A7.31.4.14. Immunobiologics.

A7.31.4.15. Nicorette or transdermal nicotine. Minimum of 72 hours ground trial.

A7.31.4.16. Resin binding agents such as cholestyramine for control of hyperlipidemia. Note: Niacin is not approved for use by flyers.

A7.31.5. Maintenance medication requiring waiver. Those medications for conditions listed below may be waived by the MAJCOM surgeon. The use of other medications, singly or in combination requires review by AFMOA/SGOA for rated officers and by the MAJCOM surgeon for non-rated flying personnel.

A7.31.5.1. Chlorothiazide or hydrochlorothiazide for control of hypertension or hypercalciuria.

A7.31.5.2. Triamterene for control of hypertension.

A7.31.5.3. Lisinopril for treatment of hypertension (ACS review or evaluation may be required for Flying Class II, refer to current ACS policy). Flying Class II waiver requires a medically monitored centrifuge evaluation. If a medically monitored centrifuge evaluation has not been performed, rated individuals will be considered for a categorical Flying Class IIC waiver (Member must undergo a medically monitored centrifuge evaluation required prior to return to assignment to Fighter, Attack, Reconnaissance (FAR), or trainer aircraft (except T-1).

A7.31.5.4. Probenecid for treatment of gout or hyperuricemia.

A7.31.5.5. Allopurinol for treatment of gout or hyperuricemia.

A7.31.5.6. Combination therapy of thiazide with triamterene, probenecid, allopurinol, or oral potassium supplements.

A7.31.5.7. Epinephrine derivatives without added action agents, or betablockers (Timolol, Levobunolol, Betaxolol) all for topical use only, to control glaucoma.

A7.31.5.8. Synthroid for treatment of thyroid hypofunction or for thyroid suppression.

A7.31.5.9. Tetracycline, erythromycin, doxycycline in standard doses for acne management.

A7.31.5.10. Sulfamethoxazole-trimethoprim, tetracycline, ampicillin, doxycycline for chronic genitourinary infectious or prostatitis once asymptomatic.

A7.31.5.11. Folic acid in the treatment of sprue.

A7.31.5.12. Sucralfate (1 gram once daily) for prevention of recurrent, uncomplicated duodenal ulcers. Minimum 7 days observation required.

A7.31.5.13. Ranitidine.

*Note: Prior requirement for a FCIIA waiver is removed.

A7.31.5.14. Pravachol (Note: May not be delegated locally).

A7.31.5.15. Omeprazole (Note: Prior requirement for a FCIIA waiver is removed).

A7.31.5.16. Nasal steroids or cromolyn nasal spray for control of mild to moderate allergic rhinitis, non-allergic rhinitis, or vasomotor rhinitis. Observation for control of the rhinitis (usually 7 to 14 calendar days) is required. Claritin (loratidine) for the control of seasonal allergic rhinitis.

A7.31.5.17. Griseofulvin for treatment of fungal infections may be granted a one year non-renewable waiver after a 4 week ground trial.

A7.31.5.18. Clomiphene citrate for treatment of infertility.

A7.31.5.19. Lovastatin or pravastatin for treatment of hypercholesterolemia.

A7.31.5.20. Gemfibrozil may be considered for categorical IIA waiver by MAJCOM/SG.

A7.31.5.21. Acyclovir (oral), for treatment of HSV or suppressive therapy.

Attachment 8

Medical Standards for Miscellaneous Categories

A8.1. Attendance at Service Schools. Applicants for all types of training courses must be free of any abnormal physical or mental condition which is likely to interfere with successful completion of the course. Certain technical training courses and AF specialty classifications impose additional requirements.

A8.2. Parachute Duty. The medical standards for applicants for parachute duty training and subsequent parachute duty are the same as those for Flying Class III, and those requirements in this attachment (see A8.10).

A8.3. Marine Diving Duty (Required for Pararescue and Combat Control Duty). The medical standards are those for Flying Class III plus those here and those listed in **A8.10.** Failure to meet standards is cause to reject an examinee for initial Marine Diving duty and for continued duty unless a waiver is granted. Acute medical problems, injuries, or their appropriate therapy may be cause for withholding certification for initial training or temporarily restricting from duty until the problem is resolved.

A8.3.1. Any disease or condition that causes chronic or recurrent disability, sudden incapacitation, or has the potential of being exacerbated by the hyperbaric environment.

A8.3.2. History of injury or procedure involving entrance into thoracic, pericardial, or abdominal cavities in the previous 6 months, or the cranial cavity at any time.

A8.3.3. Ear, Nose, and Throat.

A8.3.3.1. Any history of inner ear pathology.

A8.3.3.2. Any history of inner or middle ear surgery except PE tubes before age 10.

A8.3.3.3. Inability to equalize middle ear pressure.

A8.3.4. Eyes.

A8.3.4.1. Night vision impairments.

A8.3.4.2. Vision worse than 20/70, each eye, near and distant, without correction.

A8.3.4.3. Vision that does not correct to 20/20, each eye, near and distant.

A8.3.5. Pulmonary.

*Note: Inspiratory and expiratory Chest X-ray is accomplished within 1 year of entering training.

A8.3.5.1. Congenital and acquired defects which may restrict pulmonary function, cause air-trapping, or affect the ventilation-perfusion balance.

A8.3.5.2. Chronic obstructive or restrictive pulmonary disease of any type.

A8.3.5.3. Pneumothorax.

A8.3.6. Gastrointestinal. History of irritable bowel syndrome.

A8.3.7. Skin and Cellular Tissues. Acute or chronic diseases that are exacerbated by the hyperbaric or marine environment.

A8.3.8. Dental.

*Note: Dentist signs the SF 88 for initial Pararescue or Combat Control duty.

A8.3.8.1. All divers should be class I or II before assuming diving duty. Divers who are class III for acute conditions should be temporarily disqualified from diving duty until the acute condition is corrected. Divers who are class III because of a chronic condition (e.g. periodontal disease) receive ongoing dental care for the condition if they are to be considered qualified for diving duty. Divers are restricted from diving duty for 48 hours following operative dental procedures.

A8.3.8.2. Acute infectious diseases of the soft tissues of the oral cavity, until treatment is completed.

A8.3.8.3. Any defect of the oral cavity or associated structures which interfere with effective use of self-contained underwater breathing apparatus (SCUBA).

A8.3.8.4. Dental corrections are corrected and documented in item #44 of the SF 88 prior to entry into initial Pararescue or Combat Control training.

A8.3.9. Blood and Blood-Forming Tissues. Any significant anemia or hemolytic disease.

A8.3.10. Neurologic. Unexplained or recurrent syncope.

A8.3.11. Psychiatric.

A8.3.11.1. Personality disorders, neurosis, immaturity, instability, asocial traits, or psychosis.

A8.3.11.2. Stammering or stuttering.

A8.3.11.3. Alcoholism except those who have successfully completed a recognized rehabilitation and aftercare program. Any relapse is cause for disqualification.

A8.3.11.4. History of claustrophobia.

A8.3.12. Musculoskeletal. Intervertebral disc disease with neurological deficit.

A8.3.13. Height and Weight. Weight in excess of that specified in **Attachment 18**.

A8.3.14. Systemic/Miscellaneous. History of recurrent decompression sickness or single episode of air embolism.

A8.4. Physiological Training and Physiological Training Personnel/Operational Support Flying Duty (ASC 9C).

A8.4.1. The standards listed in **Attachment 3** and this section are disqualifying for physiologic training and operational support flying personnel.

A8.4.2. Clearance to complete physiologic training:

A8.4.2.1. Military personnel on flying status have a current class I, IA, II, or III physical on record (or PHA if applicable).

A8.4.2.2. Military personnel requiring passenger training or who perform aviation duties in ASC 9C, and physiological training personnel are required to have a normal examination of tympanic membranes, lungs and chest, heart, abdomen, neurologic, hemoglobin, weight, blood pressure and pulse documented in the health record.. This examination is valid until the end of the birth month of the next year from the date accomplished.

*Note: AF Form 1042 , *Medical Recommendation for Flying or Special Operational Duty*, is issued as satisfactory evidence of completion of the requirements outlined above.

A8.4.2.3. AF, Army, or Navy ROTC cadets will present evidence of satisfactory completion of SF 88, *Report of Medical Examination* or DD Form 2351, *DOD Medical Examination Review Board (DOD-MERB) Report of Medical Examination*, accomplished within 36 months of the scheduled physiological training.

*Note: Before scheduling cadets for training, the ROTC detachment must send the Aerospace Physiology Unit copies of the SF88 , and SF93, *Report of Medical History* , or DD Form 2351, with DD Form 2492, *Report of Medical History* . The Aerospace Physiology Unit will have the local flight surgeon's office

review these forms and stamp these documents "Qualified to Participate in Altitude Chamber Training" for all cadets physically qualified. AF Form 1042, is not required for this group of trainees, but any current medical problems must be cleared by the local flight surgeon.

A8.4.3. Civilians undergoing physiological training are required to present a current FAA medical certificate or the forms listed in the paragraph above or a valid AF Form 1042.

A8.4.4. The following conditions are disqualifying for physiological training or operational support flying:

A8.4.4.1. Inability to valsalva.

A8.4.4.2. Current or chronic obstructive ear, nose, throat, sinus or pulmonary disease.

A8.4.4.3. Loss of 200 cc or more blood is disqualifying for at least 72 hours following the loss.

A8.4.4.4. Sickle cell disease or heterozygous sickling disorders other than sickle cell trait.

A8.4.4.5. Sickle cell trait if there is a history of symptoms associated with sickling disorder. Symptomology attributable to intravascular sickling during decompression in an altitude chamber is also disqualifying.

A8.4.4.6. History of migraine, claustrophobia, organic heart disease, or symptomatic hiatal hernia.

A8.4.4.7. Inguinal hernia.

A8.4.4.8. Pregnancy.

A8.4.4.9. Use of medications which may impair mission performance.

A8.4.4.10. Any disease, which in the judgment of the flight surgeon, is likely to limit the performance of duty or place the individual at increased health risk.

A8.4.4.11. Individuals cleared for flying after bleomycin chemotherapy are not to have altitude chamber exposure. Ground training without supplemental oxygen is acceptable. These restrictions must be annotated in the remarks section of AF Form 1042. For further details concerning this unique condition, see AFI 11-403, Aerospace Physiological Training Program.

A8.5. Survival Training Instructor Duty-Selection and Retention. The Survival Training Instructor course is physically demanding and requires the ability to withstand daily running up to 5 miles, 50 push-ups, mountain climbing, heat and cold exposure, hiking and backpacking with a weight up to 70 pounds. A medical examination recorded on SFs 88 and 93 specifically for survival instructor duty is required at

the time of application. The MMPI, MCMI, and Shipley-Hartford Institute of Living Scale psychological tests are required as part of the application examination.

A8.5.1. Selection. The causes for rejection are:

A8.5.1.1. Any condition listed in **Attachment 3**.

A8.5.1.2. Profile less than P-1, U-1, L-1, H-2, E-2, S-1, except the uncorrected distant vision is not worse than 20/00 each eye corrected to 20/0.

A8.5.1.3. Speech impediment which interferes with clear enunciation.

A8.5.1.4. History of recurrent or chronic back pain.

A8.5.1.5. Scoliosis over 25 degrees measured by the Cobb method. Any other abnormal curvature of the spine of any degree in which there is a noticeable deformity, or in which there is pain, or interference with function, or which is progressive.

A8.5.1.6. Spondylolysis or spondylolisthesis, if symptomatic.

A8.5.1.7. History of recurrent knee pain or chondromalacia of the patella. A history of knee surgery requires an orthopedic evaluation and a demonstrated ability of at least 1 year of strenuous physical activity not requiring a brace.

A8.5.1.8. History of recurrent shin splints.

A8.5.1.9. History of recurrent ankle sprains.

A8.5.1.10. History of foot pain.

A8.5.1.11. History of stress fractures.

A8.5.1.12. History of any vertebral fractures, except that history of a healed, asymptomatic fracture of the transverse process is not disqualifying.

A8.5.1.13. History of surgery involving a major joint requires an orthopedic evaluation.

A8.5.1.14. History of frost bite or heat exhaustion.

A8.5.1.15. History of asthma, reactive airway disease or exercise induced breathing difficulties.

A8.5.1.16. Allergy to stinging insects, pollen, trees, grasses, or dust unless desensitized and controlled on maintenance dosage.

A8.5.1.17. Deficient night or color vision. Color vision is acceptable if the individual can properly identify the colors on a military topographic map.

A8.5.1.18. Food aversions, insect or snake phobias.

A8.5.1.19. Character and behavior disorders.

A8.5.1.20. History of alcohol or drug abuse.

A8.5.1.21. History of suicidal gesture or attempt.

A8.5.1.22. Intolerance to close or confined spaces.

A8.5.1.23. Mental health condition that indicates the applicant is unable to accept constructive criticism or unable to function in a high stress environment.

A8.5.2. Retention. A trained and experienced survival instructor is considered using these standards as a guide, but continued duty is dependent upon the member's demonstrated ability and performance.

A8.5.3. Certification and Waiver Authority. HQ AETC/SGPS is the medical certification and waiver authority for selection and retention of survival instructors and trainees.

A8.6. Military Training Instructor (MTI) Duty. MTIs have the primary responsibility for conducting basic military training. They instruct, supervise, counsel, and inspect indoors and outdoors under all kinds of environmental situations.

A8.6.1. The MPF refers each MTI applicant to the PES section for:

A8.6.1.1. Health records review.

A8.6.1.2. Physician interview and examination. Additionally, an interview and recommendation by a military psychiatrist or psychologist specifically for MTI duty is mandatory. The results of the interview and examination are recorded in the applicant's outpatient health record on SF 600, Chronological Record of Medical Care.

A8.6.1.3. Current physical profile assessment is recorded on AF Form 422, *Physical Profile Serial Report*, with the statement indicating the applicant was interviewed and examined by a physician and psychiatrist or psychologist.

A8.6.2. Specific causes for rejection are:

A8.6.2.1. Physical profile less than 121221.

A8.6.2.2. Speech impediment which interferes with clear enunciation.

A8.6.2.3. History of injury to, or defects of, the spinal column, major bones, or joints which have caused recurring symptoms.

A8.6.2.4. History of symptomatic defects of the foot including pes planus, bunions, hallux valgus, hammer toes, plantar warts, recurring ingrown toenails, and pes cavus.

A8.6.2.5. History, or recurrent evidence, of a psychiatric condition.

A8.6.2.6. Personality disorder which precludes the applicant from accepting criticism, supervising large groups of students, or functioning effectively in a high stress situation.

A8.6.2.7. Asthma, recurrent bronchospasm, reactive airway disease or emphysema.

A8.6.2.8. Weight which does not meet the requirements of **Attachment 16**.

A8.6.2.9. Any other medical or psychiatric condition which, in the opinion of the examiner, contraindicates duty in a physically and psychologically demanding environment.

A8.6.2.10. Annually, a mental health provider interviews MTIs and reviews their health records to insure their medical fitness for continuation as an MTI. An AF Form 422 serves as the annual medical certification for continued duty.

A8.6.2.11. HQ AETC/SG is the medical certification and waiver authority in the MTI selection and retention process.

A8.7. Duty Requiring Use of Night Vision Goggles (NVG).

A8.7.1. Aircrew members and special operational duty personnel who wear NVGs in the performance of their duties are required to meet no additional vision standards over and above already required for their duty AFSC (exceptions to these are discussed below). The corrected visual acuity standards for each flying class normally yield a visual acuity of at least 20/50 while wearing NVG. The flight surgeon screens the health records of personnel required to wear NVGs initially and periodically thereafter to confirm that the member has passed the most recent annual vision screening. Aircrew who fail this screening, complain of visual problems with or without NVGs, or fail to achieve 20/50 visual acuity in the NVG

pre-flight test lane should be referred for a routine clinical eye examination. The flight surgeon should refer to AL-SR-1992-0002, *Night Vision Manual for Flight Surgeons*, for additional guidance.

A8.7.2. Each aircrew or special operational duty member who requires corrective lenses in order to meet the visual acuity standards for flying, and who is required to wear NVGs in the performance of flying duties, should wear soft contact lenses (SCL) with appropriate correction. Members who cannot, or do not wish to, wear SCLs are to wear industrial safety lenses (polycarbonate or 3.0 mm thick CR-39 plastic) when using NVG. Two pairs of aircrew spectacles with safety lenses ground to the appropriate correction can be obtained in the following manner:

A8.7.2.1. If the individual has not had a refraction done within the past year, obtain a current refraction.

A8.7.2.2. Send the current prescription written on a DD Form 771, *Eyewear Prescription*, with verification of NVG duties written in the "Special Lenses or Frame" block to Optical Research Unit USAFSAM/AFCO, 2507 Kennedy Circle, Brooks AFB TX 78235-5117.

A8.7.2.3. Dispense the glasses to the individual with instructions to wear them only when using NVG and to protect the lenses from marring or scratching.

A8.7.2.4. Individuals who still use the old unmodified version (full faceplate) of the AN/PVS-5a NVG, and who are also required to wear spectacles in the performance of their duties, must meet the following additional vision requirements:

A8.7.2.5. Refractive error of no more than plus 2.00 or minus 6.00 diopters in any meridian.

A8.7.2.6. Astigmatism requiring no more than 2.00 diopters of cylinder.

A8.7.2.7. If unable to meet either of the above two requirements, the individual must be able to wear MAG-1 combat spectacles with the full faceplate NVG. MAG-1 combat spectacles with plastic or polycarbonate lenses can be ordered from the Optical Research Unit using the procedures outlined above. Specify MAG-1 combat spectacles on the DD Form 771.

A8.8. Remote or Isolated Duty.

A8.8.1. Verification of Medical Acceptability. All personnel alerted for overseas assignment or assignment to a geographically separated unit (GSU) are sent to the PES section for verification of medical acceptability for assignment. This verification consists of the following:

A8.8.1.1. Thorough health record review in order to determine if the individual has any significant medical problems which might be exacerbated by his or her pending assignment or would be difficult to manage medically at the projected gaining base. This review is accomplished by an experienced Aeromedical journeyman/craftsman. Any questionable conditions will be referred to the profile officer for proper disposition to include coordination with the gaining MAJCOM/SG and HQ AFPC if appropriate.

A8.8.1.2. Completion of AF Form 422 showing that the individual is qualified for worldwide, Remote or Isolated duty.

A8.8.1.3. Annotate the SF 600 that the review and appropriate actions have been accomplished.

A8.8.2. If the individual is going to a base that does not have a USAF medical treatment facility with a PES section, complete a Preventive Health Assessment (PHA) or periodic medical examination as required, if the exam is due during the tour. Air traffic controllers assigned to remote sites where required interval medical examinations are not available are authorized no more than a 6 month deferral period to allow mission completion. This deferred period is effective only while assigned to the remote site. Members must ensure currency once assigned to medical facilities capable of performing examinations. Also complete an audiometric examination if the individual is on the hearing conservation program.

*Note: Personnel qualified for worldwide duty in accordance with **Attachment 2** may not be acceptable for remote or isolated duty assignments. Individuals in need of specialized and recurrent medical or dental care are not acceptable. Known conditions which could produce catastrophic or life threatening illness should not be assigned to remote or isolated duty. Assume the independent duty medical technicians are the only level of medical care immediately available to the individual.

A8.8.3. If qualification for worldwide duty is questionable, PES prepares an AF Form 422 according to this instruction and the form is reviewed by the DBMS or designated senior profile officer before sending it to the MPF.

A8.9. Hyperbaric Chamber Training or Duty. The medical standards listed in **Attachment 3** and this section are cause to reject an examinee for initial hyperbaric chamber training duty and for continued duty unless a waiver is granted. Acute medical problems, injuries or their appropriate therapy may be cause for withholding certification for initial training or temporarily restricting from duty until the problem is resolved. The scope of the medical examination is the same as the scope in paragraph. **A8.4.** for Physiological Training duty personnel, ASC: 9C.

A8.9.1. Any disease or condition that causes chronic or recurrent disability, sudden incapacitation or has the potential of being exacerbated by the hyperbaric environment.

A8.9.2. History of injury or procedure involving entrance in to thoracic, pericardial or abdominal cavities in the previous 6 months, or the cranial cavity at any time.

A8.9.3. Ear, Nose Throat.

A8.9.3.1. Any history of inner ear pathology

A8.9.3.2. Any history of inner or middle ear surgery except PE tubes before age 10.

A8.9.3.3. Inability to equalize middle ear pressure.

A8.9.4. Pulmonary.

A8.9.4.1. Abnormal inspiratory or expiratory chest x-ray abnormal.

A8.9.4.2. Chronic obstructive or restrictive pulmonary disease of any type.

A8.9.4.3. History of spontaneous pneumothorax.

A8.9.5. Dental-Class III.

A8.9.6. Anemia, significant chronic or nonreversible.

A8.9.7. Gastrointestinal - tendency to excessive flatulence.

A8.9.8. Neurological - unexplained or recurrent syncope.

A8.9.9. Neurosis, or psychosis.

A8.9.10. History of claustrophobia

A8.10. Medical Certification and Waiver Requirements for Combat Control (1C2X1) and Pararescue (1T2X1) Duty.

A8.10.1. Initial Flying Class III examinations for 1C2X1 duty applicants must meet the requirements in AFI 48-123 attachments for Marine Diving Duty. In order to meet Army and Navy requirements, the following additional test must be documented on the SF 88 (Note: HQ AETC/SGPS retains sole certification and waiver authority):

A8.10.1.1. Item No 32 - Digital rectal and prostate examination, stool for occult blood

A8.10.1.2. Item No 41 - Neurological evaluation by the flight surgeon: each specific item must be addressed (i.e., serial 7’s-normal; deltoid 5/5).

A8.10.1.2.1. Cranial nerves.

A8.10.1.2.2. Serial 7s.

A8.10.1.2.3. Heel-toe.

A8.10.1.2.4. Gait.

A8.10.1.2.5. Muscle strength.

A8.10.1.2.5.1. Deltoid.

A8.10.1.2.5.2. Bicep.

A8.10.1.2.5.3. Tricep.

A8.10.1.2.5.4. Grip.

A8.10.1.2.6. Toe raises.

A8.10.1.2.7. Heel raises.

A8.10.1.2.8. Knee flex.

A8.10.1.2.9. DTRs.

A8.10.1.2.9.1. Bicep.

A8.10.1.2.9.2. Tricep.

A8.10.1.2.9.3. Patellar.

A8.10.1.2.9.4. Achilles.

A8.10.1.2.9.5. Heel-shin slide.

A8.10.1.3. Item No 44 - must read “Type II/Class 1 qualified.” Include bite-wing x-rays with package.

A8.10.1.4. Item No 46 - Chest x-ray (inspiratory and expiratory).

A8.10.1.5. Item No 47 – RPR.

A8.10.1.6. Item No 48 - ECG tracing must be reviewed/signed by a physician.

A8.10.1.7. Item No 50 - Must include complete CBS results.

A8.10.1.8. Item No 72 - Reading aloud test (RAT), adaptability rating-diving duty (AR-Diving Duty), adaptability rating for military aviation (ARMA).

A8.10.1.9. Item No. 73 - Must state: “applicant possesses no fear of heights, depths, dark, or confined places. Applicant possesses the ability to hold breath for 60 seconds subsequent to deep breathing.”

A8.10.1.10. Item No. 77 - Must state: “(is) initial Flying Class III/Airborne/Combat Control/Pararescue/ Marine Diving Duty.”

A8.10.1.11. Item No. 79-82. - Must contain all signatures.

A8.10.2. Trained personnel attending the U.S. Army military free fall, free fall jump master, special forces combat diver, dive supervisor, dive medical technician, or the survival, evasion, resistance and escape course will also need to have their most current physical certified by HQ AETC/SGPS prior to attending training. The same special requirements must be met. (Any personnel attending any Army special school will need to meet these requirements also).

A8.10.3. Only original medical documents will be used for certification by HQ AETC/SGPS. Faxes are unacceptable. Forward the appropriate number of required documents as outline in AFI 48-123, Chapter 8.2.

A8.11. Incentive and Orientation Flights.

A8.11.1. All orientation flight candidates will be referred to the flight medicine clinic for a medical clearance prior to the flight. A flight surgeon will accomplish a medical records review and a physical examination (Scope of examination is determined locally). In lieu of medical record review, civilians should provide a statement of health from their physician to include a summary of medical problems and medications. All individuals (military and civilian) identified for incentive or orientation flights must be able to safely eject without endangering life or limb. Communicate medical clearance and recommendations/ restrictions to the flying unit on AF Form 1042. The following guidelines apply:

A8.11.1.1. Individuals considered for any aircraft in the Air Force inventory on line prior to 1967 will use the following as “disqualifiers:”

A8.11.1.2. Standing height greater than 77 inches, with sitting height measurement greater than 40 inches.

A8.11.1.3. Standing height less than 64 inches, with sitting height measurement less than 34 inches.

A8.11.1.4. Buttock to knee measurement no greater than 27.5 inches.

A8.11.1.5. The qualified body weight (nude weight) ranges for USAF ejection seats are as follows:

A8.11.1.5.1. T-37, U-2, B-52: 132 to 201 pounds.

A8.11.1.5.2. A-10, B-1, B-2, F-15, F-16, F-22, F-117, T-38: 140 to 211 pounds.

A8.11.1.5.3. T-6A (JPATS): 103 to 245 pounds.

A8.11.2. Individuals considered for the F-15, F16 or any aircraft utilizing the ACES II ejection system will use the following as "disqualifiers:"

A8.11.2.1. Standing and sitting height (same as above).

A8.11.2.2. Weight less than 130 lbs.

*Note: As some individuals may seem suspect, even if within standards, the examining flight surgeon may require a buttock to knee measurement. However, care should be taken not to use the "buttock to knee" measurement in-lieu of the standards. Individuals who do not meet standards will be referred to the flying unit for disposition as the final authority, as the examining flight surgeon and MAJCOM/SG do not have waiver authority for indoctrination and incentive flights.

A8.12. Fire Fighters. Firefighters must meet the medical monitoring protocol of the National Fire Protection Association (NFPA) standard 1582, *Medical Requirements for Fire Fighters*, 1997 Edition. There is no waiver authority for the provisions of this standard. Military firefighters with Category A conditions and Category B conditions for which a direct fitness for duty issue is raised should be evaluated in accordance with the MEB procedures in **Chapter 10**.

Attachment 9

PERIODIC MEDICAL EXAMINATION

Scope Criteria	**Periodic Medical Examinations**	
Category	**Frequency**	**Qualification**
All officers and airmen on flying status or special operational duty as defined by this instruction; includes Aviation Service Code (ASC) ending with "K."	Annually, within 3 months (maximum of 6 months) preceding the last day of the birth month.	Flying Class II or III or special operational duty as defined by this instruction. Type of examination: PHA with the periodic flying physical as an occupational subcomponent. ARC members: Flying Long physical every 3 years with a Periodic Flying (short) in the 2 intervening years.
All officers and airmen not on flying status or special operational duty and inactive flyers (ASC: 6J, 7J, 8J, or 9J) as defined by this instruction.	Annually ARC members: see notes below.	Worldwide duty Type of examination: Preventive Health Assessment (PHA), active duty only. ARC members: Periodic non-flying examination (SF 88).

Scope Criteria	Periodic Medical Examinations	
Category	**Frequency**	**Qualification**
General officers	Annually, within 3 months of the last day of the birth month (see note 2).	Flying Class II, III, or worldwide duty as appropriate. Type of Examination: PHA with provider visit. ARC members: Annual periodic examination.
Operational Support Flying Physiological Training Personnel to include members requiring chamber training. Hyperbaric Medicine Personnel. Aviation Service Code 9C Personnel.	Annually (This examination is valid until the end of the birth month of the next year).	Type of examination: PHA with occupational physical as specified in **A8.4.**
Ground Based Controllers (non-flying).	Annually.	Ground based controller duties. Type of examination: PHA with occupational physical sufficient to ensure **Attachment 4** Standards are met. Controllers must be seen by a flight surgeon annually. ARC members: SF 88 every 5th year in the scope specified in **Attachment 4**. Periodic Flying (long) every 5th year. Periodic Flying (short) in the intervening years.
Space and Missile Operations Crew Duty.	Annually.	Type of examination: PHA with appropriate occupational examination. ARC members: SF 88 every 5th year in the scope specified in **Attachment 5**. Periodic Flying (long) every 5th year. Periodic Flying (short) in the intervening years.
Air Vehicle Operator Duty.	Annually.	Type of examination: PHA with appropriate occupational examination. Must be seen by Flight Surgeon annually.

Notes:

1. Complete AF Form 1446, *Medical Examination-Flying Personnel*, each year a complete examination (SF 88) is not required.

2. For ARC general officers on flying status, the AF Form 1446 (on alternate years) is optional at the member's discretion, otherwise a complete exam is required.

3. ANG officers being considered for promotion to general or promotion within the general officer ranks must undergo a medical examination within 6 months of the recognition board. Forward a copy of the promotion medical examination to: ANG/SGPS, 3500 Fetchet Avenue, Andrews AFB, MD 20762-5157.

4. The frequency of periodic exams on ARC members in this category will be every 5th year from date of last exam. Exams may be accomplished 6 months prior to expiration .

5. Papanicolau smear is required on all periodic physical exams accomplished on female ARC members. Members may use results from their private health care provider provided it was accomplished within the last 11 months. The name and address of the member's provider, date accomplished, and results must be recorded on SF88.

6. A mammogram is required at age 40 and with each subsequent periodic examination on female ARC members. Members may use results from their private health care provider provided it was accomplished within the last 11 months. The name and address of the member's provider, date accomplished, and results must be recorded on SF88.

Attachment 10

Certification & Waiver Authority

Table 2. Certification & Waiver Authority.

Category	**Certification Authority** (Notes 8, 11, 12)	**Waiver Authority** (Notes, 1, 2, 8, 11, 10)
Flying Class 1, 1A, Initial II	AETC/SG (Note 6)	AETC/SG
Flying Class II (Notes 3,4,5,10)	-	MAJCOM/SG (Note 17)
Flying Class III (Note 7) **- Initial (Active duty) - Initial (ARC members) - Continued flying**	MAJCOM/SG Appropriate ARC/SG (Note 12) -	AETC/SG Appropriate ARC/SG (Note 12,17) MAJCOM/SG (Note 17)
Special Operational Duty - Initial - Continued Special Operational Duty	MAJCOM/SG Appropriate ARC/SG (Note 17)	AETC/SG MAJCOM/SG Appropriate ARC/SG (Note 17)
Physiological Training/Operational Support Duty (ASC 9C)	Local/Chief, Flight Medicine	Local/Chief, Flight Medicine
Space & Missile Operations Duty - Active Duty - ARC	AETC/SG (Note 14) Appropriate ARC/SG (Note 17)	AFSPC/SG AFSPC/SG

Category	**Certification Authority** (Notes 8, 11, 12)	**Waiver Authority** (Notes, 1, 2, 8, 11, 10)
Initial Commission - Extended Active Duty - Air Reserve Components - US Air Force Academy	AETC/SG Appropriate ARC/SG (Note 17) AFA/SG	AETC/SG Appropriate ARC/SG AFA/SG
Change in Commission Status Without Break in Service - Active Duty Members	Note 14	AFPC/DPAMM
Change in Commission Status Entry into: - ANG - IMA Program - Reserve Unit Program	State Air Surgeon (ANG) ARPC/SG Gaining Reserve Medical Squadron Senior Flight Surgeon Note 13	ANG/SG ARPC/SG AFRC/SG
Officer Program Applicants - USAFA - ROTC - USUHS - HPSP - Special Officer Procurement	DODMERB DODMERB DODMERB AETC/SG AETC/SG	AFA/SG AETC/SG SEC DEF /HA AETC/SG AETC/SG
AF Initial Enlistment - Active Duty - ARC	MEPS MEPS/ARC Medical Squadron	AETC/SG Appropriate ARC/SG
Continued military duty - Active duty - ARC	AFPC/DPAMM ARC/SG	- -
Recall to Active Duty ARC	-	AFPC/DPAMM
PALACE CHASE or FRONT	Gaining ARC Medical Squadron	Appropriate ARC/SG
ARC Members Voluntarily Entering EAD	Appropriate ARC/SG (Note 17)	AETC/SG

Notes:

1. For cases in which AFMOA/SGOA is waiver authority, interim waiver authority by subordinate commands is specifically denied.

2. HQ USAF/SG is the ultimate waiver authority for all medical waivers.

3. Authority to grant categorical Flying Class II with suffixes A, B, or C is retained by AFMOA/SGOA, unless delegated in this AFI or policy letter.

3.1. Exceptions.

3.1.1. Flying Class IIA. MAJCOM/SG may grant the following FCIIA waivers:

3.1.1.1. Initial and renewal for use of Gemfibrozil for control of hyperlipidemia.

3.1.1.2. Initial and renewal for asymptomatic moderate Aortic Insufficiency (AI) or with otherwise non-disqualifying ventricular dysrhythmias which are considered possibly related to AI (no evidence of left ventricular enlargement or dysfunction) for members seen or case reviewed at the ACS.

3.1.1.3. Initial and renewal for Minimal Coronary Artery Disease (MCAD) for members seen or case reviewed at the ACS.

3.1.1.4. Initial waiver for Aerospace Medicine Primary (AMP) course applicants who possess mild sub-standard color vision is delegated to HQ AETC/SG. FCIIA restriction will include authorization for a T-37 flight to complete the AMP course.

3.1.2. Flying Class IIB. MAJCOM/SG may grant **renewals only** for waivers initially granted by AFMOA/SGOA.

3.1.3. Flying Class IIC. MAJCOM/SG may grant initial waiver (and renewal) for the following:

3.1.3.1. Asymptomatic mild AI (no evidence of left ventricular enlargement or dysfunction and no significant associated ventricular dysrhythmias) for members seen or case reviewed at the ACS. Members who did not undergo centrifuge evaluation. FCIIC restriction is as follows: “Medically monitored centrifuge evaluation required prior to assignment to Fighter, Attack, Reconnaissance (FAR) or Trainer Aircraft (except T-1).”

3.1.3.2. Mitral valve prolapse (MVP) for members seen or case reviewed at the ACS who did not undergo centrifuge evaluation. See above restriction.

3.1.3.3. Hypertension controlled with Lisinopril for members seen or case reviewed at the ACS. Members who did not undergo centrifuge evaluation. See above restriction.

3.1.3.4. H-3 Profile (inactive flyers). The following restriction applies: “An occupational cockpit hearing evaluation/assessment is required prior to reassignment to active flying.”

3.1.4. Other. MAJCOM/SG may grant initial and renewal waivers for all routine ACS clinical management group evaluations. Controversial cases will be forwarded to AFMOA/SGOA. MAJCOM/SG will forward a copy of **all** FCIIA/B/C actions (memorandum cover letter) as follows: FCIIA, B, or C: forward copy to HQ AFPC/DPAOY1, 550 C Street West, Suite 31, Randolph AFB, TX 78150-4733. Colonel (0-6) forward copy to: HQ AF/DPOA, 1040 AF Pentagon, Washington, DC 20330. All FCIIC waiver actions delegated to MAJCOM/SG, the memorandum cover letter by MAJCOM/SG will be forwarded to AFMOA/SGOA, 110 Luke Avenue, Room 400, Bolling AFB, DC 20330-7050 and HQ USAF/XOOT, 1480 AF Pentagon Washington, DC 20330-1480, to include FCIIC waiver renewals. Ensure the restrictions are contained in the memorandum.

4. Certification and waiver authority for USAF flying personnel while assigned to the National Aeronautics and Space Administration (NASA) is NASA.

5. HQ AFMC/SG has waiver authority on USAF Test Pilot School applicants except for conditions listed in Chapter **8.1.3.**

6. ARC/SG is the certification authority for assigned reserve personnel who apply for the AMP course.

7. Non-rated applicants for flying duty (Class III) and Flight Nurse applicants, who are currently medically qualified and performing flying duty, do not require additional review and certification or reexamination prior to retraining unless the individual is applying for Inflight Refueling Duty, Combat Control Duty, Pararescue Duty, or the individual is on a medical waiver.

Enlisted members applying for commissioning and flight nurse duty may use their most current periodic flying (long) medical examination (appropriately supplemented) if not more than 24 months old, in lieu of accomplishing another physical for the specific purpose of commissioning.

8. The MAJCOM or appropriate ARC/SG for ANG is ANG/SG; for unit-assigned reservists is HQ AFRC/SG; and for IMAs and Retired Reserve members is HQ ARPC/SG.

9. HQ AETC/SG is the certification authority for those individuals undergoing Basic Military Training School (BMTS). For ARC members undergoing BMTS, HQ AETC/SG will coordinate medical disposition with the appropriate ARC/SG.

10. HQ USAF/SG (AFMOA/SGOA) no longer serves as MAJCOM for Direct Reporting Units (DRUs). This responsibility has been delegated as follows: Air Force District of Washington (AFDW), Pentagon is delegated to HQ AMC/SGPA. Others: Air Force Element (AFELM), Defense Intelligence Agency (DIA), Air Force Operational Test and Evaluation Center (AFOTEC), and others, if not otherwise specified in the table or notes above will be the medical facilities MAJCOM/SG that submits the aeromedical waiver examination package. Waiver authority for HQ AFIA is delegated to HQ AFIA/SG when that position is filled by a senior flight surgeon. Waiver authority for personnel assigned to HQ USSOCOM is delegated to HQ AFSOC.

11. HQ AIA/SG no longer serves as MAJCOM with regards to certification and waiver authority. Authority has been delegated to the MAJCOM to which the member is assigned for duty (e.g., member's MAJCOM is AIA, but he/she is assigned PCS to USAFE, PACAF, etc., for duty, that MAJCOM becomes the certification and waiver authority in accordance with the above table).

12. HQ AETC/SG is sole certification and waiver authority for applicants applying for the Combat Control or Pararescue Duty career fields.

13. Applicants who previously held a commission for 6 months or more in any service component and who are within 36 months of nonmedical separation, will not require their physical exam to be reviewed or certified by HQ AFRC/SG prior to being commissioned in the unit assigned reserve program, unless the applicant does not meet the medical requirements IAW **Attachment 3**.

14. Local Base Certification/Waiver Authority (active duty only). Flight surgeons (AFSC 48G4/3 or 48A4X), normally the Aerospace Medicine Squadron/Flight Commander or the senior SME flight surgeon (tenants only) as specifically identified by the parent MAJCOM, retain this authority. This authority will not be delegated further**.** At locations with flight surgeons who do not meet this criteria, the certification/waiver authority reverts to the MAJCOM of assignment. Non-flight surgeons are not authorized to sign, or certify medical examinations. Flight surgeons granted this authority by their MAJCOM may not certify/waiver ARC aircrew members.

15. Active duty non-aircrew members transitioning into ARC flying positions must have their medical examinations certified by the appropriate ARC Surgeon.

16. The final review authority on Flying Training examinations is the Aerospace Medicine Squadron/ Flight Commander. The final review authority on all other examinations requiring this signature is the senior flight surgeon assigned

17. State certification/waiver authority (ANG only). State Air Surgeons that are current, certified, and trained as specifically identified by ANG/SGP retain this authority. This authority will not be delegated further. At locations where State Air Surgeons are not assigned or are not trained, the certification/waiver authority reverts to ANG/SGP.

Attachment 11

HEARING PROFILE

A11.1. H-1 Profile. The H-1 profile qualifies applicants for Flying Classes I and IA, initial Flying Class II and III, AF Academy, special operational duty, and selected career fields as noted in AFI 36-2108, *Airman Classification.* See note 2.

A11.1.1. Definition: Unaided hearing loss in either ear with no single value greater than:

Hz:	500	1000	2000	3000	4000	6000
dB:	25	25	25	35	45	45

A11.2. H-2 Profile. The H-2 profile qualifies for AF enlistment, commission, initial Space and Missile Operations duty, and continued special operational duty, but requires evaluation for continued flying (See **A7.4.**).

A11.2.1. Definition: Unaided hearing loss in either ear with no single value greater than:

Hz:	500	1000	2000	3000	4000	6000
dB:		35	35	35	45	55

A11.3. H-3 Profile. The H-3 profile requires evaluation and MAJCOM review for continued flying, and audiology evaluation for fitness for continued active duty.

A11.3.1. Definition: An H-3 profile is any loss that exceeds the values noted above in the definition of an H-2 profile.

A11.4. H-4 Profile. The H-4 profile requires a Medical Evaluation Board.

A11.4.1. Definition: Hearing loss sufficient to preclude safe and effective performance of duty, regardless of level of pure tone hearing loss and despite use of hearing aids.

Notes:

1. All personnel working in hazardous noise areas will be enrolled in the Hearing Conservation Program. The Air Force Hearing Conservation Program directive (see appropriate AFOSH Standard) should be consulted. Standard threshold shifts should be appropriately recorded and addressed whenever a significant shift in measured hearing threshold is noted. Such a shift may not result in a profile change.

2. For the purpose of this instruction, ISO 1964 and ANSI S3.6 values are identical.

3. Exceeding the definition/standard for H-1 or H-2 automatically places the individual in the next highest category.

4. The hearing profiles, like other aspects of the Air Force profile system, typically do not apply to civilian personnel. That is, profiles greater than H-1 apply only to active duty personnel.

Attachment 13

PHYSICAL PROFILE SERIAL CHART

P. Physical Condition

P-1. Free of any identified organic defect or systemic disease.

P-2. Presence of minimally significant organic defect(s) or systemic diseases(s).

P-3. Significant defect(s) or disease(s) under good control, not requiring regular and close

medical support. Capable of all basic work commensurate with grade and position.

P-4. Severe organic defect(s) systemic and infectious disease(s), all conditions disqualifying by **Attachment 2** (e.g. diabetes, seizure etc.). See note.

U. Upper Extremities

U-1. Bones, joints, and muscles normal. Able to do hand-to-hand fighting.

U-2. Slightly limited mobility of joints, mild muscular weakness or other musculoskeletal defects which do not prevent hand-to-hand fighting and are compatible with prolonged effort.

U-3. Defect(s) causing moderate interference with function, yet capable of strong effort for short periods.

U-4. Strength, range of motion, and general efficiency of hand, arm, shoulder girdle, and back, including cervical and thoracic spine severely compromised or disqualifying by A2.13. or **A2.13.** See note.

L. Lower Extremities

L-1. Bones, muscles, and joints normal. Capable of performing long marches, continuous standing, running, climbing, and digging without limitation.

L-2. Slightly limited mobility of joints, mild muscular weakness, or other musculoskeletal defects which do not prevent moderate marching, climbing, running, digging, or prolonged effort.

L-3. Defect(s) causing moderate interference with function, yet capable of strong effort for short periods.

L-4. Strength, range of movement, and efficiency of feet, legs, pelvic girdle, lower back, and

lumbar vertebrae severely compromised or disqualifying by A2.13. or **A2.13.**. See note.

H. Hearing (Ears)

See **Attachment 11** for hearing profile.

E. Vision (Eyes)

E-1. Minimum vision of 20/200 correctable to 20/20 in each eye.

E-2. Vision correctable to 20/40 in one eye and 20/70 in the other, or 20/30 in one eye and

20/200 in the other eye, or 20/20 in one eye and 20/400 in the other eye.

E-3. Vision which is worse than E-2 profile but better than E-4.

E-4. Visual defects disqualifying by **A2.5.** See note.

S. Psychiatric

S-1. No psychiatric disorder.

S-2. Mild transient psychoneurosis.

S-3. Mild chronic psychoneurosis, moderate transient psychoneurotic reaction.

S-4. All psychosis and the psychoneuroses which are persistent or recurrent, requiring

hospitalization or the need for continuing psychiatric care or disqualifying by **A2.12.** See note.

*Note: Individuals with a 4 profile are not qualified for world-wide duty. Ensure these members have met an MEB (if required), consult **Attachment 2**, Medical Standards for Continued Military Service, and **Chapter 10** of this instruction. Members on temporary 4 profiles (4T) should be followed per **Chapter 10** if an MEB has not been accomplished.

Attachment 18

DEPLOYMENT CRITERIA

A18.1. General Considerations. For the purposes of this instruction a deployment is defined as any temporary duty period outside the United States and its dependencies, or during which an individual has no ready access to a permanent fixed military medical treatment facility. Conditions which may seriously compromise the near-term well being if an individual were to deploy are disqualifying for deployment duty. This may involve dependence on certain medications appliances, severe dietary restrictions, frequent special treatments, or a requirement for frequent clinical monitoring.

A18.1.1. Individuals returned to duty as “fit” by Physical Evaluation Boards (PEB) may not meet deployment standards. Such individuals, if they are retained, must have profiles restricting them from deployment duties. They may be assignable to locations with large, fixed military medical treatment facilities.

A18.1.2. The following standards are to be applied after an individual has met either a Medical Evaluation Board (MEB) or a Physical Evaluation Board (PEB).

A18.1.3. ARC members should have Deployment Criteria addressed in the Narrative Summary submitted in the Worldwide Duty medical Evaluation package for the purpose of enabling the ARC/SG to make a valid deployability determination.

A18.2. Standards. To be able to deploy, an individual must be able to:

A18.2.1. Perform duties for a prolonged period (12 hours or more).

A18.2.2. Subsist on field rations for prolonged periods.

A18.2.3. Be free of medical conditions which require special appliances, special treatments, and frequent clinical follow-up.

A18.2.4. Wear or use all required items of uniform or personal protective equipment which includes flak vest, helmet, and the Chemical Warfare Defense Ensemble (CWDE).

A18.2.5. Perform heavy physical work over at least short periods of time.

A18.2.6. Have sufficient unaided hearing to safely perform duty.

A18.2.7. Have sufficient night vision to travel unassisted at night.

A18.2.8. Have sufficient corrected visual acuity to safely perform duty.

A18.2.9. Have normal tolerance to heat and cold.

A18.2.10. Have no increased predisposition to sudden incapacitation.

A18.2.11. Travel by either air or sea.

Attachment 19

Preventive Health Assessment (PHA)

A19.1. Introduction. The Preventive Health Assessment (PHA) implements a vastly improved method of applying physical standards to our active duty force and is a significant link in the Put Prevention Into Practice (PPIP) initiative. It has evolved from the periodic physical examination program, focused physical examination and Preventive Health Physical (PHP) initiatives. Currently the PHA program applies only to active duty Air Force members and AGR members of the ANG.

A19.1.1. PHA. PHA is accomplished by focusing on the member's age, sex, health risk factors, medical history and occupation to determine the scope of the assessment. PHA allows each MTF to determine the scheduling method to be utilized for performing PHAs on nonflying personnel. Flying personnel and special operational duty members will continue to be scheduled utilizing their birth month. MTFs should do everything possible to ensure the member does not have to return two or three times to complete their annual medical requirements (multiple visits should be the exception, not the norm).

***Note:** Consult Air Force Pamphlet 48-134, entitled The Air Force Preventive Health Assessment Program.

Attachment 21

IC 2000-2 TO AFI 48-123, MEDICAL EXAMINATIONS AND STANDARDS

14 NOVEMBER 2000

SUMMARY OF REVISIONS

This change appropriately aligns the hearing loss data values in paragraph A11.2.1. A bar (|) indicates revision from the previous edition.

Attachment 11

HEARING PROFILE

A11.1. H-1 Profile. The H-1 profile qualifies applicants for Flying Classes I and IA, initial Flying Class II and III, AF Academy, special operational duty, and selected career fields as noted in AFI 36-2108, *Airman Classification.* See note 2.

A11.1.1. Definition: Unaided hearing loss in either ear with no single value greater than:

Hz:500100020003000400060 00

dB:25252535 4545

A11.2. H-2 Profile. The H-2 profile qualifies for AF enlistment, commission, initial Space and Missile Operations duty, and continued special operational duty, but requires evaluation for continued flying (See A7.4).

A11.2.1. Definition: Unaided hearing loss in either ear with no single value greater than:

Hz: 500100020003000400060 00

dB: 3535354555------

A11.3. H-3 Profile. The H-3 profile requires evaluation and MAJCOM review for continued flying, and audiology evaluation for fitness for continued active duty.

A11.3.1. Definition: An H-3 profile is any loss that exceeds the values noted above in the definition of an H-2 profile.

A11.4. H-4 Profile. The H-4 profile requires a Medical Evaluation Board.

A11.4.1. Definition: Hearing loss sufficient to preclude safe and effective performance of duty, regardless of level of pure tone hearing loss and despite use of hearing aids.

Notes:

1. All personnel working in hazardous noise areas will be enrolled in the Hearing Conservation Program. The Air Force Hearing Conservation Program directive (see appropriate AFOSH Standard) should be consulted. Standard threshold shifts should be appropriately recorded and addressed whenever a significant shift in measured hearing threshold is noted. Such a shift may not result in a profile change.

2. For the purpose of this instruction, ISO 1964 and ANSI S3.6 values are identical.

3. Exceeding the definition/standard for H-1 or H-2 automatically places the individual in the next highest category.

4. The hearing profiles, like other aspects of the Air Force profile system, typically do not apply to civilian personnel. That is, profiles greater than H-1 apply only to active duty personnel.

Attachment 22

IC 2001-1 TO AFI 48-123, MEDICAL EXAMINATIONS AND STANDARDS

22 MAY 2001

SUMMARY OF REVISIONS

This revision incorporates Interim Change IC 2001-3. This change incorporates new weight for ejection system standards. A bar (|) indicates revision from the previous edition.

Attachment 7

MEDICAL STANDARDS FOR FLYING DUTY

Conditions listed in **Attachment 2**, Medical Standards for Continued Military Service and **Attachment 3**, Appointment, Enlistment, and Induction apply. For conditions listed in **Attachment 2**, ensure a Medical Evaluation Board (MEB) has been performed and final disposition made prior to submission of a flying waiver request.

A7.1. Head, Face, Neck, and Scalp (Flying Classes I, IA, II, and III).

A7.1.1. Injuries to the head (See paragraph **A7.23.**).

A7.1.2. Loss or congenital absence of bone substance of the skull.

A7.1.3. Chronic arthritis, complete or partial ankylosis, or recurrent dislocation of the temporomandibular joint.

A7.1.4. Congenital cysts of branchial cleft origin or those developing from the remains of a thyroglossal duct, with or without fistulous tracts.

A7.1.5. Chronic draining fistulae of the neck, regardless of cause.

A7.1.6. Contractions of the muscles of the neck if persistent or chronic. Cicatricial contracture of the neck to the extent it interferes with function or the wear of equipment.

A7.1.7. Cervical ribs if symptomatic or symptoms can be induced by abduction, scalenus, or costoclavicular maneuvers.

A7.1.8. Any anatomic or functional anomaly of head or neck structures, which interfere with normal speech, ventilation of the middle ear, breathing, mastication, swallowing, or wear of aviation or other military equipment.

A7.2. Nose, Sinuses, Mouth, and Throat.

A7.2.1. Flying Classes II and III.

A7.2.1.1. Allergic rhinitis, unless mild in degree and considered unlikely to limit the examinee's flying activities. Waivers are considered if symptoms are controlled by desensitization or topical medication (or both).

A7.2.1.2. Chronic nonallergic or vasomotor rhinitis, unless mild, asymptomatic, and not associated with eustachian tube dysfunction. Waivers are considered if symptoms are controlled by topical medication.

A7.2.1.3. Nasal polyps.

A7.2.1.4. Deviations of the nasal septum, septal spurs, enlarged turbinates or other obstructions to nasal ventilation which result in clinical symptoms. Symptomatic atresia or stenosis of the choana.

A7.2.1.5. Epistaxis, chronic, recurrent.

A7.2.1.6. Chronic sinusitis unless mild in degree and considered unlikely to limit the examinee's flying activities.

A7.2.1.7. Recurrent calculi of the salivary glands or ducts.

A7.2.1.8. Deformities, injuries, or destructive diseases of the mouth (including teeth), nose, throat, pharynx, or larynx that interfere with ventilation of the paranasal sinuses and, or middle ear, breathing, easily understood speech, or mastication and swallowing of ordinary food.

A7.2.1.9. Atrophic rhinitis.

A7.2.1.10. Perforation of the nasal septum.

A7.2.1.11. Anosmia or parosmia.

A7.2.1.12. Salivary fistula.

A7.2.1.13. Ulcerations, perforation, or extensive loss of substance of the hard or soft palate; extensive adhesions of the soft palate to the pharynx; or complete paralysis of the soft palate. Unilateral paralysis of the soft palate which does not interfere with speech or swallowing and is otherwise asymptomatic is not disqualifying.

A7.2.1.14. Chronic pharyngitis and nasopharyngitis.

A7.2.1.15. Chronic laryngitis. Neoplasm, polyps, granuloma, or ulceration of the larynx.

A7.2.1.15.1. Aphonia or history of recurrent aphonia if the cause was such as to make subsequent attacks probable. Painful Dysphonia Plicae Ventricularis.

A7.2.1.15.2. Tracheostomy or tracheal fistula.

A7.2.1.15.3. Malformations, injuries or diseases of the esophagus, such as ulceration, diverticulum, varices, stricture, achalasia, pronounced dilation, or peptic esophagitis.

A7.2.2. Flying Classes I and IA. In addition to the above:

A7.2.2.1. A verified history of allergic, nonallergic, or vasomotor rhinitis, after age 12.

A7.2.2.2. Any surgical procedure for sinusitis, polyposis or hyperplastic tissue. Waiver may be considered if recovery is complete and individual has been asymptomatic for 1 year.

A7.3. Ears.

A7.3.1. Flying Classes II and III.

A7.3.1.1. History of surgery involving the middle ear, excluding cholesteatoma below.

A7.3.1.2. Residual of mastoid surgery.

A7.3.1.3. Inability to perform the VALSALVA maneuver.

A7.3.1.4. Perforation of the tympanic membrane. Surgery to repair perforated tympanic membrane is disqualifying until healing is complete and hearing is normal.

A7.3.1.5. Tinnitus when associated with active disease.

A7.3.1.6. Abnormal labyrinthine function.

A7.3.1.7. Recurrent episodes of vertigo with or without nausea, vomiting, tinnitus, and hearing loss.

A7.3.1.8. Any conditions that interfere with the auditory or vestibular functions.

A7.3.1.9. Cholesteatoma or history of surgical removal of cholesteatoma.

A7.3.1.10. Atresia, tuberosity, severe stenosis or tumors of the external auditory canal which prevents an adequate view of the tympanic membrane or effective therapeutic access to the entire external auditory canal.

A7.3.2. Classes I, IA, II (flight surgeon applicants) and III (initial applicants). In addition to the above:

A7.3.2.1. Applicants must demonstrate satisfactory performance of the Reading Aloud Test (RAT).

A7.3.2.2. History of radical mastoidectomy.

A7.3.2.3. History of abnormal labyrinthine function, unexplained or recurrent vertigo.

A7.3.2.4. Surgical repair of perforated tympanic membrane within the last 120 calendar days.

A7.4. Hearing, Flying Class II and III. Hearing loss greater than H-1 profile or asymmetric hearing loss requires work-up by an audiologist (audiology evaluation for initial waiver and waiver renewals must have been accomplished within 12 months of submission to waiver authority). Waivers are required for H-3 hearing loss or greater. Indefinite waivers are not authorized.

A7.4.1. H-2 profile alone does not require waiver. However, an evaluation **sufficient to rule-out conductive or retrocochlear pathology** should be conducted. This includes full audiologic evaluation and, where appropriate, referral for ENT consultation. Referral to ENT may be at the discretion of the audiologist or referring facility. Restriction from flying is not required during work-up.

A7.4.2. H-3 profile requires waiver.

A7.4.2.1. For members with new H-3 profiles (i.e., those whose hearing has recently changed to H-3, and who have not been previously worked-up), restriction from flying is appropriate.

*Note: Members with long-standing, stable H-3 not previously evaluated, require work-up and waiver, but need not be restricted from flying, unless in the opinion of the flight surgeon they represent a danger to flying safety.

A7.4.2.2. Interim waiver may be granted by MAJCOM/SG after determination of acceptable hearing proficiency (occupational aircrew hearing assessment), pending complete audiology evaluation (indefinite waivers are not authorized).

A7.4.2.3. Validate hearing proficiency in one of two ways prior to issuance of medical waiver for H-3 profile:

A7.4.2.3.1. Inflight hearing test as described in SAM TR73-29

A7.4.2.3.2. Written validation, signed by the flying squadron commander or operations officer, of the adequacy of the member's hearing to perform safely in assigned aircrew duties in the flying environment.

A7.4.2.4. Waiver is contingent upon complete audiologic and where appropriate, ENT evaluation.

*Note: The audiologist must rule out conductive and retrocochlear disease. The audiologist may defer ENT evaluation.

A7.4.2.5. The occupational aircrew hearing assessment is deferred for inactive flyers. They may receive a Flying Class IIC waiver specifying the completion of the occupational aircrew hearing assessment before return to active flying.

A7.4.3. Asymmetric hearing loss (greater than, or equal to, 25dB difference, comparing left and right ear, at any two consecutive frequencies) requires full audiological work-up with further clinical evaluation as indicated, and requires a waiver (indefinite waivers are not authorized). Restriction from flying is not required during work-up.

A7.4.4. The following tests are suggested as a complete audiologic evaluation:

A7.4.4.1. Pure tone air and bone conduction thresholds.

A7.4.4.2. Speech reception thresholds.

A7.4.4.3. Speech discrimination testing, to include high intensity discrimination.

A7.4.4.4. Immittance audiometry.

A7.4.4.5. Tympanograms.

A7.4.4.6. Ipsilateral and contralateral acoustic reflexes (levels not exceeding 110 dB HL).

A7.4.4.7. Acoustic reflex decay (500 and 1000 Hz, with levels not exceeding 110 dB HL).

A7.4.4.8. Otoacoustic emissions (transient evoked or distortion product).

A7.4.5. The following tests may be required if indicated by the above:

A7.4.5.1. Auditory brainstem response.

A7.4.5.2. MRI.

*Note: Audiology reevaluation is required for waiver renewals if a shift of greater than 10dB is noted from the "initial" audiology evaluation used for the initial waiver in any one frequency from 1,000 Hz to 4,000 Hz. Additionally, audiology evaluations submitted to the waiver authority must have been accomplished within 12 months. These rules apply to all hearing waivers.

A7.5. Dental.

A7.5.1. Flying Classes II and III.

A7.5.1.1. Personnel wearing orthodontic appliances need not have appliances removed for physical qualification. After consultation with the treating orthodontist, the local flight surgeon may qualify the individual for flying duties if there is no effect on speech or the ability to wear equipment with comfort.

A7.5.1.2. Severe malocclusion which interferes with normal mastication or requires protracted treatment.

A7.5.1.3. Diseases of the jaw or associated structures such as cysts, tumors, chronic infections, and severe periodontal conditions which could interfere with normal mastication, until adequately treated.

A7.5.1.4. Aircrew members in Dental Class III or who have a significant dental defect which may be expected to cause a dental emergency during flight will be grounded. ARC members are managed IAW paragraph **14.14.1.** of this instruction.

A7.5.2. Classes I and IA. In addition to the above:

A7.5.2.1. Dental defects such as carious teeth, malformed teeth, defective restorations, or defective prosthesis, until corrected.

A7.5.2.2. Anticipated or ongoing treatment with fixed orthodontic appliances.

A7.6. Eye, Flying Classes I, IA, II, and III.

A7.6.1. Lids/Adnexa.

A7.6.1.1. Any condition of the eyelids which impairs normal eyelid function or comfort or potentially threatens visual performance.

A7.6.1.2. Epithora, nasolacrimal duct obstruction.

A7.6.1.3. Ptosis, any, except benign etiologies which are not progressive and do not interfere with vision in any field of gaze or direction.

A7.6.1.4. Dacryocystitis, acute or chronic.

A7.6.1.4.1. Dacryostenosis

A7.6.2. Conjunctiva.

A7.6.2.1. Conjunctivitis, chronic, seasonal.

A7.6.2.2. Trachoma, unless healed without scarring.

A7.6.2.3. Xerophthalmia.

A7.6.2.4. Pterygium which encroaches on the cornea more than 1mm or interferes with vision, or is progressive, or causes refractive problems

A7.6.3. Cornea.

A7.6.3.1. Keratitis, chronic or acute, including history of.

A7.6.3.2. Corneal ulcer of any kind, including history of recurrent corneal ulcers or recurrent corneal erosions.

A7.6.3.3. Vascularization or opacification of the cornea, from any cause, when it is progressive, interferes with vision or causes refractive problems.

A7.6.3.4. History of traumatic corneal laceration unless it does not interfere with vision, nor is likely to progress.

A7.6.3.5. Corneal dystrophy of any type, including keratoconus of any degree.

*Note: UPT Applicants who demonstrate a topographical pattern suggestive of keratoconus, referred to as TPSK, but who do not have any other clinical signs of keratoconus, may be eligible for waiver. However, these members must have been processed through EFS-Medical for eligibility. Test results from outside

agencies, or civilian sources do not qualify. Members identified with TPSK may be waivered into the ACS TPSK Study/Management Group, only after evaluation by the ACS. Members identified with TPSK will be informed that their participation in this study group is **mandatory** for consideration of waiverability into UFT and continued flying. Reevaluation periodically at the ACS will be required for waiver renewal.

A7.6.3.6. History of radial keratotomy (RK) or any other surgical or laser procedure, such as photorefractive keratectomy (PRK) and laser in situ keratomileusis (LASIK) accomplished to modify the refractive power of the cornea or for any other reason, such as phototherapeutic keratectomy (PTK), are not waiverable.

A7.6.3.7. Orthokeratology, active or a history of within six months of application to UFT**.**

A7.6.3.8. Lamellar or penetrating keratoplasty (corneal transplant).

A7.6.4. Uveal Tract. Acute, chronic or recurrent inflammation of the uveal tract (iris, ciliary body, or choroid), except for healed traumatic iritis.

A7.6.5. Retina/Vitreous.

A7.6.5.1. Retinal detachment and history of same.

A7.6.5.2. Degenerations and dystrophies of the retina including retinoschisis and all types of central and peripheral pigmentary degenerations.

A7.6.5.3. Degenerations and dystrophies of the macula, macular cysts, and holes.

A7.6.5.4. Retinitis, chorioretinitis, or other inflammatory conditions of the retina, unless single episode which has healed, is expected not to recur, and does not impair central or peripheral vision.

A7.6.5.5. Angiomatoses, phakomatoses, retinal cysts and other conditions which impair or may impair vision.

A7.6.5.6. Hemorrhages, exudates or other retinal vascular disturbances.

A7.6.5.7. Vitreous opacities or disturbances which may cause loss of visual acuity.

A7.6.6. Optic Nerve.

A7.6.6.1. Congenito-hereditary conditions that interfere or may interfere with central or peripheral vision.

A7.6.6.2. Optic neuritis, of any kind, including retrobulbar neuritis, papillitis, neuroretinitis, or a documented history of same.

A7.6.6.3. Papilledema.

A7.6.6.4. Optic atrophy (primary or secondary) or optic pallor.

A7.6.6.5. Optic nerve cupping greater than 0.4 or an asymmetry between the cups of greater than 0.2.

A7.6.6.6. Optic neuropathy.

A7.6.7. Lens.

A7.6.7.1. Aphakia, unilateral or bilateral.

A7.6.7.2. Dislocation of a lens, partial or complete.

A7.6.7.3. Opacities or irregularities of the lens which interfere with vision or are considered to be progressive.

A7.6.7.4. Pseudophakia (intraocular lens implant).

A7.6.7.5. Posterior capsular opacification.

A7.6.8. Other Defects and Disorders.

A7.6.8.1. Asthenopia, if severe.

A7.6.8.2. Exophthalmos, unilateral or bilateral.

A7.6.8.3. Nystagmus of any type, except on versional end points.

A7.6.8.4. Diplopia in any field of gaze, either constant or intermittent, including history of

A7.6.8.5. Visual field defects, any type, including hemianopsia.

A7.6.8.6. Abnormal pupils or loss of normal pupillary reflexes, with the exception of physiological anisocoria.

A7.6.8.7. Retained intraocular foreign body.

A7.6.8.8. Absence of an eye.

A7.6.8.9. Anophthalmos or microphthalmus.

A7.6.8.10. Any traumatic, organic, or congenital disorder of the eye or adnexa, not specified above, which threatens to intermittently or permanently impair visual function.

A7.6.8.11. Migraine or its variants, to include acephalgic migraine (See paragraph **A7.23.**).

A7.6.8.12. History of any ocular surgery to include lasers of any type.

A7.7. Vision and Refraction.

Table A7.1. Vision and Refractive Error Standards.

	Vision Limits for Each Eye				**Refraction Limits**			
Flying Class	**Distant Vision**		**Near Vision**		**Any Meridian**	**Astig-matism**	**Aniso-metropia**	**Contact Lenses** Notes5,6,7,13
	Uncorr	Corrected	Uncorr	Corrected				
I Notes 2,10,12,13	20/70	20/20	20/20	-	+2.00 -1.50	1.50	2.00	Note 1
IA Note 2,10,12,13	20/200	20/20	20/40	20/20	+3.00 -2.75	2.00	2.50	Note 1
II (Pilot) Note 13	20/400	20/20 Note 3,11	-	20/20 Notes:3,9	+3.50 -4.00	2.00	2.50 Note 4	
II/III Note 13	20/400	20/20 Note 3,12	-	20/20 Notes: 3, 9	+5.50 -5.50 Note 8	3.00	3.50 Note 4	

NOTES:

1. Use of hard, rigid, or gas permeable (hard) contact lenses within 3 months before the examination or soft contact lenses 1 month before examination is prohibited. Document SF 88 appropriately to ensure this requirement has been met.

2. These medical standards apply for USAFA, AFROTC cadets at the time of AF commissioning physical, AF active duty members, civilian applicants for flying training, and applicants from the Reserve and Guard components during the initial flying physical.

3. Individuals found on routine examination to be 20/20 in one eye and 20/25 in the other but correctable to 20/20 in each eye may continue flying until the appropriate corrective lenses arrive. These lenses must be ordered by the most expeditious means. **Be advised that this policy should only be used if the condition does not cause acute change in stereopsis performance (i.e., failure of depth perception screening tests).**

4. Anisometropias greater than Flying Class II or III standards may be considered for waiver if the OVT (or VTA) stereopsis is normal and the aviator has no asthenopic symptoms due to poor fusional control, or diplopia.

5. Complex refractive errors that can be corrected only by contact lenses are disqualifying.

6. All aircrew members are prohibited from using contact lenses for treatment of medical conditions unless they have been specifically prescribed and issued or approved by the ACS.

7. Optional wear of contact lenses for aircrew members is outlined in **Attachment 17**.

8. Waivers may only be considered after the individual has a normal ophthalmological examination to include a dilated fundus exam and possesses plastic lens spectacles which correct them to 20/20 in each eye and meets the USAF standards for approved commercially obtained spectacles for aircrew duties (see **Attachment 17**.7).

9. Actively flying personnel should be corrected to 20/20 at the nearest cockpit working distance.

10. The Air Force Chief of Staff retains Exception To Policy (ETP) authority for vision and refractive limits for UFT applicants.

11. Flying Class II aviators should be refracted to their best corrected visual acuity. Use of spectacles to correct to better than 20/20 is at the discretion of the crewmember.

12. For qualification purposes, cycloplegic refraction readings should be recorded for that required to read the 20/20 line in each eye. However, continue refraction to best visual acuity and report the best achievable corrected visual acuity as a clinical baseline. (Thus, acuity and refractive error numbers may not correlate). Cycloplegic refractions that cannot achieve the 20/20 line will need clinical evaluation or re-evaluation.

13. Crewmembers who wear corrective spectacles or contact lenses must carry a spare set of clear prescription spectacles on their person while performing aircrew duties, see AFI 11-206, paragraph 6.3.3. Additionally, only 15 percent (N-15) transmittance neutral density gray spectacle lenses are approved for flying duty, see AFR 167-3, para 2-4d. Consult other guidance, such as AFMOA or MAJCOM policy letters pertaining to aircrew spectacles.

A7.8. Heterophoria and Heterotropia.

A7.8.1. Flying Class III except InFlight Refuelers.

A7.8.1.1. Esophoria greater than 15 prism diopters.

A7.8.1.2. Exophoria greater than 8 prism diopters.

A7.8.1.3. Hyperphoria greater than 2 prism diopters.

A7.8.1.4. Heterotropia greater than 15 prism diopters.

A7.8.2. Flying Class I, IA, II, Inflight Refuelers and individuals required to perform scanner duties.

A7.8.2.1. Esophoria greater than 10 prism diopters.

A7.8.2.2. Exophoria greater than 6 prism diopters.

A7.8.2.3. Hyperphoria greater than 1.5 prism diopters.

A7.8.2.4. Heterotropia, including microtropias.

A7.8.2.5. Point of convergence (PC) greater than 100mm.

*Note: Accomplish and record PC measurements only at the time of initial flying class I, IA, II-Flight Surgeon, and III - Inflight Refueler applicant exams. The PC is no longer required on periodic examinations.

A7.8.2.6. History of extraocular muscle surgery is cause for complete evaluation of ocular motility by a competent eye care professional to look for residual heterophorias, heterotropias (including microtropias), and motor sensory problems.

*Note: The evaluation must include all of the motility tests listed in **A7.11.** Further processing of such cases will proceed in accordance with **A7.11.** as well.

A7.9. Near Point of Accommodation.

A7.9.1. Flying Classes II and III. No standards.

A7.9.2. Flying Classes I and IA. Near point of accommodation less than minimum for age specified in **Attachment 11**.

A7.10. Color Vision, Classes I, IA, II and III. Color vision testing must be performed monocularly under an approved and standardized illuminant (i.e., Illuminant C). Five or more incorrect responses in either eye (including failure to make responses in the allowed time interval) in reading the 14 test plates versions of one of the following Pseudoisochromatic Plate (PIP) sets is considered a failure: Dvorine, the original version of the AO (excludes Richmond PIP version), or Ishihara (record responses as correct/ total).

*Note: No other PIP versions, such as the Richmond PIP, or Beck Engraving versions, or other tests for color vision are authorized for qualification purposes. Also note that the Farnsworth Lantern (FALANT) has been dropped as an USAF qualifying test.

A7.10.1. Flying Class I/IA/II/III: Must possess normal color vision as demonstrated by passing the approved PIP.

A7.10.2. Flying Class II-Flight Surgeon Applicants: Same as above.

*Note: FS applicants with mild color vision defects may be considered for a FCIIA waiver. FCIIA waiver authority is delegated to HQ AETC/SG. Controversial cases will be referred to AFMOA/SGOA. See **Attachment 10**, Certification & Waiver Authority.

A7.11. Depth Perception/Stereopsis.

A7.11.1. Flying Class III (other than Inflight Refuelers and individuals required to perform scanner duties). No standard.

A7.11.2. Flying Class I, IA, II-Flight Surgeon Applicant and III-Inflight Refueler Applicants and individuals required to perform scanner duties. Failure of the Vision Test Apparatus (VTA-DP) or its newer replacement, the Optec Vision Tester (OVT), screening depth perception test with uncorrected refractive errors should be retested with refraction correction in place, regardless of level of unaided visual acuity. Failure even with correction is disqualifying, but may be considered for waiver consideration by higher waiver authorities, only after completion of a full evaluation by an ophthalmologist or optometrist, to include **all** of the following: ductions, versions, cover test and alternate cover test in primary and 6 cardinal positions of gaze, AO Vectograph Stereopsis Test at 6 meters (4 line version), AO Suppression Test at 6 meters, Randot or Titmus Stereopsis Test, Red Lens Test, and 4 Diopter Base out Prism Test at 6 meters. These tests are designed to identify and characterize motility/alignment disorders, especially microtropias and monofixation syndrome. The results of these tests done locally are considered to be preliminary, but will be used by waiver authorities to determine whether a candidate should be permanently disqualified without any waiver consideration, to identify if there are potentially correctable causes, and to determine whether further evaluation is required.

*Note: A prospective Undergraduate Flying Training (UFT) Microtropia Study/Management Group is established at the ACS with minimally defective stereopsis secondary to monofixation syndrome or microstrabismus that are considered appropriate for waiver consideration. Potential Study Group members must meet the criteria established by the ACS to be eligible for this Study/Management Group. All

potential candidates must be evaluated at the ACS Ophthalmology Branch if recommended and approved by HQ AETC/SGPS. AETC/SGPS is the waiver authority.

A7.11.3. Flying Class II and III-Inflight Refuelers and individuals required to perform scanner duties. A new failure of the VTA-DP or OVT requires evaluation by an ophthalmologist or optometrist to determine the cause of the failure and to rule out correctable causes, i.e., refractive error and anisometropia. If any new failure still is unable to pass the VTA or OVT with proper optical correction, then all of the motility tests listed above under Flying Class I in **A7.11.** must be accomplished as a prerequisite for any further waiver consideration.

A7.11.4. If the aviator has previously failed the VTA or OVT, and has previously been evaluated, and has either, normal motility or a stable previously known waivered motility disorder, and can pass another stereopsis test, such as the Verhoeff, Titmus, Randot, or Howard Dolman, no further work-up or waiver is required. However, such cases should already have been granted an initial waiver for this consideration. If not, a waiver is required.

*Note: If the local flight surgeon feels that the degree of depth perception may not be compatible with the present aircraft or duties of assignment, further work-up and waiver will be required. Consultation at the ACS is indicated for any rated aircrew member with defective, questionable or change in stereopsis or depth perception or a significant change in the level of stereopsis performance.

A7.12. Field of Vision.

A7.12.1. Flying Classes I, IA, II and III.

A7.12.1.1. Contraction of the normal visual field in either eye to within 30 degrees of fixation in any meridian.

A7.12.1.2. Central scotoma, whether active or inactive, including transitory migraine related or any other central scotoma which is due to active pathological process.

A7.12.1.3. Any peripheral scotoma, other than physiologic.

A7.13. Night Vision, Flying Classes I, IA, II, and III. Unsatisfactory night vision as determined by history for initial flying. In trained aviators, this history is confirmed by the appropriate electrophysiological tests requested by the Aeromedical Consultation Service ophthalmologists. Dark field and empty field myopia due to accommodation are normal physiologic responses.

A7.14. Red Lens Test.

A7.14.1. Flying Classes II and III (except Inflight Refuelers). No standards.

A7.14.2. Flying Classes I and IA and Inflight Refuelers and individuals required to perform scanner duties. Any diplopia or suppression during the Red Lens Test which develops within 20 inches of the center of the screen (30 degrees) is considered a failure. Complete evaluation of ocular motility/alignment by a qualified ophthalmologist or optometrist is required as a prerequisite for higher waiver authorities to determine if ACS evaluation is required.

*Note: See paragraph **A7.11.**

A7.15. Intraocular Pressure, Flying Classes I, IA, II, and III.

A7.15.1. Glaucoma. As evidenced by intraocular pressures of 30 mmHg or greater, or the secondary changes in the optic disc or visual field associated with glaucoma. Trained aircrew with glaucoma require consultation (review or evaluation) with the ACS prior to waiver consideration.

*Note: Pigmentary dispersion syndrome (PDS) is not medically disqualifying for flying (includes Initial Flying Classes) unless associated with elevated intraocular pressures above 22 mmHg. PDS with elevated IOP, referred to as Pigmentary Glaucoma Suspect, (PGS) requires local ophthalmology evaluation. A confirmed diagnosis of Pigmentary Glaucoma Suspect (PGS) is disqualifying for all initial Flying Classes. Trained aircrew with PGS require consultation (review or evaluation) with the ACS prior to waiver consideration.

A7.15.2. Ocular hypertension (Preglaucoma). Two or more determinations of 22 mmHg or greater, but less than 30 mmHg, or 4 mmHg or more difference between the two eyes. (See paragraph **16.5.**).

*Note: Abnormal pressures obtained by a noncontact (air puff) tonometer or Schiotz must be verified by applanation.

A7.16. Lungs and Chest Wall.

A7.16.1. Flying Classes II and III.

A7.16.1.1. Pulmonary tuberculosis, including tuberculous pleuritis or pleurisy of unknown etiology with positive tuberculin test.

A7.16.1.2. History of spontaneous pneumothorax. A single episode of spontaneous pneumothorax does not require waiver if PA inspiratory and expiratory chest radiograph and thin-cut CT-scan show full expansion of the lung and no demonstrable pathology which would predispose to recurrence.

A7.16.1.3. Pulmonary blebs or bullae, unless corrected by surgical treatment, recovery is complete, and pulmonary function tests are normal.

A7.16.1.4. Bronchiectasis, unless corrected by surgical treatment, recovery is complete, and pulmonary function tests are normal.

A7.16.1.5. Sarcoidosis.

A7.16.1.6. Pleural effusion.

A7.16.1.7. Empyema, residual sacculation or unhealed sinuses of the chest wall following surgery for empyema.

A7.16.1.8. Chronic bronchitis if pulmonary function is impaired to such a degree as to interfere with duty performance or to restrict activities.

A7.16.1.9. Asthma of any degree, or a history of asthma, reactive airway disease, intrinsic or extrinsic bronchial asthma, exercise-induced bronchospasm, or IgE (Immunoglobulin E) mediated asthma.

A7.16.1.10. Bullous or generalized pulmonary emphysema, demonstrated by pulmonary function tests.

A7.16.1.11. Cystic disease of the lung.

A7.16.1.12. Silicosis or extensive pulmonary fibrosis with functional impairment or abnormal pulmonary function tests.

A7.16.1.13. History of lung abscess.

A7.16.1.14. Chronic mycotic infection of the lung. Residuals of infection, including cavitation, except for scattered nodular parenchymal and hilar calcifications.

A7.16.1.15. Foreign body in the trachea, bronchus, lung, or chest wall.

A7.16.1.16. Chronic adhesive (fibrous) pleuritis of sufficient extent to interfere with pulmonary function and exercise tolerance.

A7.16.1.17. History of bi-lobectomy, lobectomy or multiple segmental resections if there is significant reduction of vital capacity, timed vital capacity, or maximum breathing capacity, or if there is residual pulmonary pathology.

A7.16.1.18. Suppurative periostitis, osteomyelitis, caries, or necrosis of the ribs, sternum, clavicle, scapulae, or vertebrae.

A7.16.1.19. Congenital malformation or acquired deformities which reduce the chest capacity or diminish respiratory or cardiac functions to a degree which interferes with vigorous physical exertion or produce disfigurement when the examinee is dressed.

A7.16.1.20. Chronic cystic mastitis.

A7.16.1.21. History of pulmonary embolus.

A7.16.1.22. Silicone implants, injections, or saline inflated implants in breasts for cosmetic purposes. See paragraph **A3.12.**

A7.16.1.23. Sleep apnea and other clinical sleep disorders.

A7.16.2. Flying Classes I and IA. In addition to the above:

A7.16.2.1. History of spontaneous pneumothorax. A single episode may be considered for waiver after 3 years if pulmonary evaluation shows complete recovery with full expansion of the lung and no demonstrable pathology that would predispose to recurrence.

A7.16.2.2. Chronic adhesive pleuritis which produces any findings except minimal blunting of the costophrenic angles.

A7.16.2.3. History of sarcoidosis.

A7.17. Cardiovascular System.

A7.17.1. Flying Classes II and III.

A7.17.1.1. History of cardiac surgery.

A7.17.1.2. Heart pump failure, regardless of cause.

A7.17.1.3. Hypertrophy or dilatation of the heart verified by echocardiogram, unless evaluation demonstrates it to be normal physiological response to athletic conditioning.

A7.17.1.4. Persistent tachycardia with a resting pulse rate of more than 100.

A7.17.1.5. Elevated blood pressure (measured in the sitting position) as follows:

A7.17.1.5.1. In applicants for flying training or initial flying duty, evidenced by average systolic pressure greater than 140 mmHg, or average diastolic pressure of greater than 90 mmHg obtained from the 5-day blood pressure check.

A7.17.1.5.2. History of elevated blood pressure requiring chronic medication for control.

A7.17.1.5.3. In trained flying personnel evidenced by:

A7.17.1.5.3.1. Average systolic blood pressure greater than 140 mmHg or average diastolic blood pressure greater than 90 mmHg.

*Note: Asymptomatic personnel with average systolic blood pressure ranging between 141 mmHg and 160 mmHg, or average diastolic blood pressure ranging between 91 mmHg and 100 mmHg, may remain on flying status for up to 6 months (from the date the elevated blood pressure was first identified) while undergoing non-pharmacological intervention to achieve acceptable values.

A7.17.1.5.3.2. Any elevation in blood pressure due to secondary metabolic or pathologic causes until the underlying cause has been corrected, provided the primary condition is not disqualifying.

A7.17.1.5.4. Orthostatic or symptomatic hypotension or recurrent vasodepressor syncope.

A7.17.1.5.5. Pericarditis, myocarditis, or endocarditis, or history of these conditions.

A7.17.1.5.6. Any significant congenital abnormalities of the heart and vessels, unless corrected by surgery without residuals or complications. A minimum recovery period of 6 months following surgery is mandatory before waiver is considered together with repeat studies including invasive testing as applicable, demonstrating functional correction. Uncomplicated dextrocardia and minor atrial and ventricular septal defects may be acceptable without surgical correction.

A7.17.1.5.7. Acute rheumatic fever; a verified history of rheumatic fever or chorea within the previous 2 years; recurrent attacks of rheumatic fever or chorea at any time; evidence of residual cardiac damage.

A7.17.1.5.8. Coronary artery disease, symptomatic or asymptomatic. History of myocardial ischemia. Coronary artery disease strongly suspected by symptoms or tests for myocardial ischemia or infarction unless ruled out by angiography (other definitive evaluation of coronary patency and function will be considered on a case-by-case basis). History of coronary artery surgery or other intervention is generally not waiverable, but will be reviewed by ACS on request of MAJCOM/ SGPA or AFMOA/SGOA.

A7.17.1.5.9. History of symptomatic major dysrhythmia. Asymptomatic major dysrhythmias require ACS review. Major dysrhythmias include supraventricular tachycardia, atrial flutter or fibrillation, ventricular tachycardia or fibrillation, and asystole.

A7.17.1.5.10. Verified history of major electrocardiographic conduction defects, such as Mobitz II second-degree A-V block, third degree A-V block, Wolff-Parkinson-White (WPW) syndrome, or Lown-Ganong-Levin (LGL) syndrome. W-P-W pattern may be waiverable if ACS evaluation reveals no dysrhythmias; either WPW or LGL syndrome may be waiverable if corrected.

A7.17.1.5.11. Left anterior and posterior fascicular block and left bundle branch block may be considered for waiver if ACS evaluation reveals no underlying disease.

A7.17.1.5.12. Right bundle branch block may be waiverable after local cardiologic evaluation.

A7.17.1.6. History of valvular heart disease to include pulmonic, mitral, and tricuspid valvular regurgitation greater than mild, aortic regurgitation greater than trace, and any degree of valvular stenosis. Mitral valve prolapse (MVP) and bicuspid aortic valve are also medically disqualifying.

A7.17.1.7. Resting ECG findings considered to be "borderline," or known to be serial changes from previous records unless a cardiac evaluation as directed by the ECG Library reveals no underlying disease. Refer to ACS “Disposition for ECG findings.”

A7.17.1.8. All electrocardiographic tracings read as abnormal. Waiver is not considered until evaluation recommended by ACS has been completed.

A7.17.1.9. Borderline or abnormal noninvasive cardiac studies.

*Note: For rated officers, copies of any study, i.e., ECG, holter monitor, thallium scan, ETT-TM, or echocardiogram video tape **MUST** be forwarded to the ECG Library, Brooks AFB TX for review.

A7.17.1.10. History of recurrent thrombophlebitis or thrombophlebitis with persistent thrombus, evidence of circulatory obstruction, or deep venous incompetence in the involved veins.

A7.17.1.11. Varicose veins with complications or if more than mild.

A7.17.1.12. Peripheral vascular disease, including Raynaud's disease, thromboangiitis obliterans, erythromelalgia, arteriosclerotic, or diabetic vascular disease.

A7.17.1.13. Aneurysm of any vessel or history of correction by surgery.

A7.17.1.14. Syphilitic heart disease.

A7.17.1.15. History of significant traumatic heart disease.

A7.17.1.16. Hypersensitive carotid sinus.

A7.17.1.17. Arteritis of any artery.

A7.17.1.18. Inadequate arterial blood supply to any extremity.

A7.17.1.19. Vasculitis.

A7.17.2. Flying Classes I and IA. **In addition to the above:**

A7.17.2.1. Wolff-Parkinson-White electrocardiographic pattern; may be waiverable for flying training if corrected.

A7.17.2.2. Any major vascular synthetic graft.

A7.17.2.3. Elevated blood pressure (see **A7.17.** above).

A7.18. Blood, Blood-Forming Tissue, and Immune System Diseases. Flying Classes I, IA, II and III:

A7.18.1. Anemia of any etiology. Hematocrit values less than 38 for men or 36 for women should be evaluated; decreasing hematocrit values, even if in the normal range, may also be an indication for workup. Waiver for trained aircrew is permissable for stable anemia not due to an otherwise disqualifying condition, as long as the hematocrit does not fall below 32 percent.

A7.18.2. Loss of 200 cc or more of blood is disqualifying for at least 72 hours. Platelet pheresis is disqualifying for 72 hours.

A7.18.3. Polycythemia; a hematocrit above 50 in men, or above 47 in women, should be evaluated. Waiver is not favorably considered if the hematocrit is above 55 percent.

A7.18.4. Hemoglobinopathies and thalassemias.

A7.18.4.1. Homozygous hemoglobin abnormalities.

A7.18.4.2. Sickle cell disease or heterozygous sickling disorders other than sickle cell trait.

A7.18.4.3. Sickle cell trait if the individual has a history of symptoms associated with a sickling disorder or symptomology attributable to intravascular sickling during decompression in an altitude chamber. Review and certification by proper authority (see **Attachment 9**) is required for all aircrew members with sickle cell trait after evaluation as outlined in paragraph **16.7.**

A7.18.5. Hemorrhagic states and thromboembolic disease:

A7.18.5.1. Coagulopathies.

A7.18.5.2. Thromboembolic disease, except for acute, non-recurrent conditions.

A7.18.5.3. Thrombocytopenia or thrombocytosis. Platelet counts less than 100,000/mm^3 or greater than 400,000 mm^3 should be evaluated. Thrombocytosis greater than 750,000/mm^3 is not waiverable.

A7.18.5.4. Platelet dysfunctions.

A7.18.6. Leukopenia (granulocytopenia). White blood cell counts should fall within the range of 3,500 to 12,000 cells/mm^3--counts in the range of 750 to 3500 cells/mm^3 should be fully evaluated. Granulocyte counts of less than 750 cells/mm^3 are not waiverable.

A7.18.7. All leukemias and other myeloproliferative disorders.

A7.18.8. All lymphomas including mycosis fungoides and Sezary syndrome.

A7.18.9. Plasma cell dyscrasias.

A7.18.9.1. Multiple myeloma.

A7.18.9.2. Macroglobulinemia.

A7.18.10. Immunodeficiency syndromes, primary or acquired. Confirmed presence of Human Immunodeficiency Virus (HIV) or antibody. AFMOA/SGOA retains waiver authority for all flying classes.

A7.18.11. Generalized lymphadenopathy or splenomegaly until the cause is corrected.

A7.19. Abdomen and Gastrointestinal System.

A7.19.1. Flying Classes II and III.

A7.19.1.1. Gastrointestinal hemorrhage or history of, regardless of cause. Waiver may be considered for any condition that is clearly attributable to a specific, nonpersistent cause.

A7.19.1.2. Peptic ulcer disease, active or refractory.

A7.19.1.3. Peptic ulcer complicated by hemorrhage, obstruction or perforation.

A7.19.1.4. Hernia other than small asymptomatic umbilical or hiatal.

A7.19.1.5. History of viral hepatitis, with carrier status, persistent transaminase elevation or evidence of chronic active or persistent hepatitis.

A7.19.1.6. Wounds, injuries, scars, or weakness of the muscles of the abdominal wall which are sufficient to interfere with function.

A7.19.1.7. Sinus or fistula of the abdominal wall.

A7.19.1.8. Chronic or recurrent esophagitis including reflux esophagitis.

A7.19.1.9. Chronic gastritis.

A7.19.1.10. Congenital abnormalities of the bowel if symptomatic or requiring surgical treatment. History of intestinal obstruction if due to any chronic or recurrent disease. Surgery to relieve childhood pyloric stenosis or intussusception is not disqualifying if there is no residual dysfunction.

A7.19.1.11. Crohn's disease (regional enteritis).

A7.19.1.12. Malabsorption syndromes (see paragraph **A7.29.**).

A7.19.1.13. Irritable bowel syndrome.

A7.19.1.14. Ulcerative colitis or proctitis or verified history of same.

A7.19.1.15. Chronic diarrhea, regardless of cause.

A7.19.1.16. Megacolon.

A7.19.1.17. Diverticulitis, symptomatic diverticulosis, or symptomatic Meckel's diverticulum.

A7.19.1.18. Any chronic liver disease whether congenital or acquired. Marked enlargement of the liver from any cause. Hepatic cysts. Congenital hyperbilirubinemias, e.g. Gilbert's disease, do not require waiver if asymptomatic.

A7.19.1.19. Chronic cholecystitis.

A7.19.1.20. Cholelithiasis.

A7.19.1.21. Sphincter of oddi dysfunction or bile duct abnormalities or strictures.

A7.19.1.22. Pancreatitis or history of same.

A7.19.1.23. Congenital anomalies, disease of the spleen. Chronic enlargement of the spleen.

A7.19.1.24. Splenectomy, for any reason except the following:

A7.19.1.24.1. Trauma to an otherwise healthy spleen.

A7.19.1.24.2. Hereditary spherocytosis.

A7.19.1.25. History of gastroenterostomy, gastrointestinal bypass, stomach stapling, or surgery for relief of intestinal adhesions.

A7.19.1.26. Symptomatic esophageal motility disorders.

A7.19.1.27. History of partial resection of the large or small intestines for chronic or recurrent disease.

A7.19.2. Flying Class I and IA. See above.

A7.20. Perianal, Rectum, and Prostate, Flying Classes I, IA, II, and III.

A7.20.1. Proctitis, chronic or symptomatic.

A7.20.2. Stricture or prolapse of the rectum.

A7.20.3. Hemorrhoids which cause marked symptoms or internal hemorrhoids which hemorrhage or protrude intermittently or constantly until surgically corrected.

A7.20.4. Fecal incontinence.

A7.20.5. Anal fistula.

A7.20.6. Ischiorectal abscess.

A7.20.7. Chronic anal fissure.

A7.20.8. Symptomatic rectocele.

A7.20.9. Pilonidal cyst if there is a history of inflammation or discharging sinus in the 2 years preceding examination. Surgery for pilonidal cyst or sinus is disqualifying until the wound is healed, there are no referable symptoms, and no further treatment or medication is required.

A7.20.10. Chronic prostatitis, prostatic hypertrophy, with urinary retention or abscess of the prostate gland.

A7.21. Genitourinary System, Flying Class I, IA, II and III.

A7.21.1. History of recurrent or bilateral renal calculus. Uncomplicated single episode of renal calculus does not require waiver, but should be evaluated.

A7.21.2. Retained renal calculus. Retained calculus located in a papillary duct or any more distal portion of the collecting system may be considered for a flying Class IIA waiver.

A7.21.3. Proteinuria under normal activity (at least 48 hours post strenuous exercise) greater than 200 mg in 24 hours. Waiver may be considered for fixed and reproducible orthostatic proteinuria when the urinary protein to urinary creatinine ratio on a randomly collected urine (not first morning void) is less than or equal to 0.2. It is not necessary to collect a 24 hour urine specimen.

A7.21.4. Persistent or recurrent hematuria.

A7.21.5. Cylindruria, hemoglobinuria, or other findings indicative of significant renal disease.

A7.21.6. Chronic nephritis.

A7.21.7. Stricture of the urethra.

A7.21.8. Urinary fistula.

A7.21.9. Urinary incontinence.

A7.21.10. Absence of one kidney. Functional impairment of either or both kidneys.

A7.21.11. Horseshoe kidney.

A7.21.12. Chronic pyelitis or pyelonephritis.

A7.21.13. Renal ptosis (floating kidney) causing impaired renal drainage, hypertension or pain.

A7.21.14. Hydronephrosis or pyonephrosis.

A7.21.15. Polycystic kidney disease.

A7.21.16. Chronic cystitis.

A7.21.17. Amputation of the penis.

A7.21.18. Hermaphroditism.

A7.21.19. Epispadias or hypospadias with unsatisfactory surgical correction.

A7.21.20. Hydrocele, unless small and asymptomatic

A7.21.21. Large or painful left varicocele. Any right varicocele unless significant underlying pathology has been excluded.

A7.21.22. Undescended testicle. Absence of both testicles.

A7.21.23. Chronic orchitis or epididymitis.

A7.21.24. Urinary diversion.

A7.21.25. Major abnormalities and defects of the genitalia such as a change of sex, a history thereof, or complications (such as adhesions or disfiguring scars) residual to surgical correction of these conditions.

A7.22. Pelvic.

A7.22.1. Flying Classes II and III.

A7.22.1.1. Pregnancy or other symptomatic enlargement of the uterus due to any cause. Pregnancy waivers for trained flying personnel may be requested under the following guidelines: the request is voluntary and must be initiated by the crewmember with concurrence by the squadron commander, flight surgeon, and obstetrician. Physiological training is waived during pregnancy; flying is restricted to pressurized multi-crew, multi-engine, non-ejection seat aircraft; and crewmembers are released from all mobility commitments. The waiver is valid for the 13th through 24th week of gestation.

*Note: Refer to AFRCI 48-101 for further guidance on unit assigned reservists.

A7.22.1.2. Chronic symptomatic vaginitis.

A7.22.1.3. Chronic salpingitis or oophoritis.

A7.22.1.4. Symptomatic uterine fibroids.

A7.22.1.5. Ovarian cysts.

A7.22.1.6. All symptomatic congenital abnormalities of the reproductive system.

A7.22.1.7. Dysmenorrhea, if incapacitating to a degree which necessitates recurrent absences of more than a few hours from routine duty.

A7.22.1.8. Gross irregularity of the menstrual cycle. Menorrhagia, metrorrhagia, polymenorrhea, or amenorrhea.

A7.22.1.9. Menopausal syndrome, either physiologic or surgical, if manifested by more than mild constitutional or psychological symptoms.

A7.22.1.10. Endometriosis, if symptomatic or controlled medically.

A7.22.1.11. Malposition of the uterus, if symptomatic.

A7.22.1.12. Vulvitis, chronic.

A7.22.2. Flying Class I and IA. In addition to above, history of endometriosis.

A7.23. Neurological Disorders.

A7.23.1. Flying Classes II and III.

A7.23.1.1. Infections of the CNS.

A7.23.1.2. Seizure of any type (grand mal, petit mal, focal, etc.).

A7.23.1.3. Disturbances of consciousness (not due to head injury).

A7.23.1.3.1. An isolated episode of neurocardiogenic syncope associated with venipunture or prolonged standing in the sun (or similar benign precipitating event) which is less than 1 minute in duration, without loss of continence, and followed by rapid and complete recovery without sequelae does not require waiver if thorough neurological and cardiovascular evaluation by a flight surgeon reveals no abnormalities.

A7.23.1.3.2. Physiological loss of consciousness (LOC) caused by reduced oxygen tension, general anesthesia, or other medically induced LOC (excluding vasovagal syncope) does not require waiver provided there is full recovery without sequelae.

A7.23.1.3.3. High G loss of consciousness (G-LOC) during a centrifuge run does not require waiver for continued flying duty unless there are neurologic sequelae or evidence that the G-LOC occurrence is associated with coexistant disease or anatomic abnormality. Inflight G-LOC caused by an improperly performed anti-G straining maneuver or a disconnect of the anti-G protective gear is not disqualifying and is managed as a physiological incident. The local flight surgeon completes appropriate post-incident medical evaluation and reports the incident according to applicable directives.

A7.23.1.3.4. All other loss or disturbance of consciousness. For rated personnel, waivers are considered by AFMOA/SGOA only after evaluation at ACS. For non-rated personnel, waiver is at MAJCOM discretion.

*Note: Flying training applicants and students with a history of syncope evaluated according to **Table 16.1.** and certified acceptable for Flying Class I or IA by HQ AETC/SG do not require a waiver for flying Class II for the same history of syncope.

A7.23.1.4. History of any of the following types of headaches:

A7.23.1.4.1. Recurrent headaches of the vascular, migraine, or cluster (Horton's cephalgia or histamine headache) type.

A7.23.1.4.2. A single incapacitating headache of any type (e.g.,loss of consciousness, aphasia, ataxia, vertigo or mental confusion).

A7.23.1.4.3. Headache of any type which are of sufficient severity to likely interfere with flying duties.

A7.23.1.4.4. Acephalgic migraines.

*Note: A waiver for migraines may be considered following one year of symptom free observation. Migrainous strokes and migraines complicated by neurological deficits other than transient visual changes are not waiverable.

A7.23.1.5. Electroencephalographic abnormalities.

A7.23.1.5.1. Truly epileptiform abnormalities to include generalized, lateralized, or focal spikes, sharp waves, spike-wave complexes, and sharp and slow wave complexes during alertness, drowsiness, or sleep are disqualifying. Benign transients such as Small Sharp Spikes (SSS) or Benign Epileptiform Transients of Sleep (BETS), wicket spikes, 6 Hertz (Hz) (phantom) spike and wave, rhythmic temporal theta of drowsiness (psychomotor variant), and 14 and 6Hz positive spikes are not disqualifying.

A7.23.1.5.2. Generalized, lateralized, or focal continuous polymorphic delta activity or intermittent rhythmic delta activity (FIRDA or OIRDA) during the alert state is disqualifying unless the etiology of the abnormality has been identified and determined not to be a disqualifying disorder.

A7.23.1.6. History of head injury.

A7.23.1.6.1. Head injury associated with any of the following are not waiverable:

A7.23.1.6.1.1. Post-traumatic seizures. (Exception: seizures at the time of injury)

A7.23.1.6.1.2. Persistent neurological deficits indicative of significant parenchymal CNS injury, such as hemiparesis or hemianopsia.

A7.23.1.6.1.3. Evidence of impairment of higher intellectual functions or alterations of personality as a result of injury.

A7.23.1.6.1.4. Cerebrospinal fluid shunts.

A7.23.1.6.2. Severe head injury. Head trauma associated with any of the complications listed below may be considered for Flying Class II and III waiver in 5 years (see **Table 16.1.**).

A7.23.1.6.2.1. Unconsciousness or amnesia or the combination of the two equal to or exceeding 24 hours duration.

*Note: In cases which are defined as severe only due to the duration of loss of consciousness or amnesia and are otherwise minimal, mild, or moderate, a waiver at 2 years may be considered if the evaluation requirements in **Table 16.1.** are met.

A7.23.1.6.2.2. Radiographic evidence of retained metallic or bony fragments.

A7.23.1.6.2.3. Leptomeningeal cysts, aerocele, brain abscess, or arteriovenous fistula.

A7.23.1.6.2.4. Depressed skull fracture (the inner table indented by more than the thickness of the skull) with or without dural penetration.

A7.23.1.6.2.5. Traumatic or surgical laceration or contusion of the dura mater or the brain, or a history of penetrating brain injury.

A7.23.1.6.2.6. Focal neurological signs.

A7.23.1.6.2.7. Epidural, subdural, subarachnoid, or intracerebral hematoma.

*Note: A small epidural collection of blood found only on CT-scan or magnetic resonance imaging (MRI) and without evidence of parenchymal injury either on the imaging study or on neurological examination, followed to resolution without surgery, may be considered for flying class II or III waiver at two years as in the moderate head injury group.

A7.23.1.6.2.8. CNS infection such as abscess or meningitis within 6 months of head injury.

A7.23.1.6.2.9. Cerebrospinal fluid rhinorrhea or otorrhea persisting more than 7 calendar days.

A7.23.1.6.3. Moderate head injury. Head trauma associated with the below criteria may be considered for Flying Class II or III waiver in 2 years (see **Table 16.1.**).

A7.23.1.6.3.1. Unconsciousness for a period of 30 minutes or greater, but less than 24 hours.

A7.23.1.6.3.2. Amnesia for a period of 1 hour or greater but less than 24 hours. (Waiver contingent on a completely normal neurological and neuropsychological evaluation to include computerized tomography (CT) scan.)

*Exception: Waiver may be considered after 6 months of observation if a normal CT-scan was obtained within 2 calendar days of injury.

*Note: In cases which are defined as moderate only due to the duration of loss of consciousness or amnesia and are otherwise minimal, mild, a waiver at 6 months may be considered if the evaluation requirements in **Table 16.1.** are met.

A7.23.1.6.4. Mild head injury. Head trauma which does not meet criteria for more severe injury may be considered for waiver after l month (see **Table 16.1.**).

A7.23.1.6.5. Head trauma with no loss of consciousness, amnesia, or abnormal findings on examination, does not require waiver.

A7.23.1.7. Persistent post-traumatic sequelae, as manifested by headache, vomiting, disorientation, spatial disequilibruim, personality changes, impaired memory, poor mental concentration, shortened attention span, dizziness, altered sleep patterns, or any findings consistent with organic brain syndrome are disqualifying, but may be considered for waiver when full recovery has been confirmed by complete neurological and neuropsychological evaluation.

A7.23.1.8. Craniotomy and skull defects.

A7.23.1.9. Neurosyphilis in any form (meningovascular, tabes dorsalis, or general paresis).

A7.23.1.10. Narcolepsy, cataplexy, and similar states.

A7.23.1.11. Injury of one or more peripheral nerves unless it is not expected to interfere with normal function in any practical manner.

A7.23.1.12. History of subarachnoid hemorrhage, embolism, vascular insufficiency, thrombosis, hemorrhage, arteriosclerosis, arteriovenous malformation, or aneurysm involving the CNS.

A7.23.1.13. History of tumor involving the brain or its coverings.

A7.23.1.14. Personal or family history of hereditary disturbances such as multiple neurofibromatosis, Huntington's chorea, hepatolenticular degeneration, acute intermittent porphyria, spinocerebellar ataxia, peroneal muscular atrophy, muscular dystrophy, and familial periodic paralysis.

A7.23.1.15. Probable evidence or history of degenerative or demyelinating process such as multiple sclerosis, dementia, basal ganglia disease, or Friedreich's ataxia.

A7.23.1.16. History or evidence of such defects as basilar invagination, hydrocephalus, premature closure of the cranial sutures, meningocele, and cerebral or cerebellar agenesis if there is evidence of impairment of normal functions or if the process is expected to be progressive.

A7.23.1.17. Verified history of neuritis, neuralgia, neuropathy, or radiculopathy, whatever the etiology, unless:

A7.23.1.17.1. The condition has completely subsided and the cause is determined to be of no future concern.

A7.23.1.17.2. There is no residual which could be deemed detrimental to normal function in any practical manner.

A7.23.1.18. Polyneuritis, whatever the etiology, unless:

A7.23.1.18.1. Limited to a single episode.

A7.23.1.18.2. The acute state subsided at least 1 year before examination.

A7.23.1.18.3. There is no residual which could be expected to interfere with normal function in any practical manner.

A7.23.1.19. History or evidence of chronic or recurrent diseases, such as myasthenia gravis, polymyositis, or myotonia disorder.

A7.23.1.20. Evidence or history of involvement of the nervous system by a toxic, metabolic or disease process if there is any indication such involvement is likely to interfere with prolonged normal function in any practical manner or is progressive or recurrent, or if there is a significant neurological residual which would interfere with aviation duties.

A7.23.1.21. Tremors, chorea, dystonia or other movement disorders which could interfere with aviation or normal function.

A7.23.2. Flying Classes I and IA. In addition to the above, paroxysmal convulsive disorders. Seizures associated with febrile illness before 5 years of age may be acceptable with waiver if recent neurological evaluation, MRI, and electroencephalogram (EEG) including awake and sleep samples are normal.

A7.23.2.1. History of severe head injury is usually not waiverable and may not be considered until at least 10 years post injury.

A7.24. Psychiatric Disorders (Reference Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) Fourth Edition, American Psychiatric Association).

A7.24.1. Flying Classes II and III.

A7.24.1.1. Eating Disorders.

A7.24.1.2. Gender Identity Disorders.

A7.24.1.3. Mental Disorders due to a General Medical Condition.

A7.24.1.4. Delirium, Dementia, and Amnestic Disorders, and Other Cognitive Disorders.

A7.24.1.5. Alcohol Dependence or Abuse (DSM IV) or any disease the proximate cause of which is alcoholism. These conditions may be waived by MAJCOM/SG if the following conditions have been met:

A7.24.1.5.1. The MTF Alcohol & Drug Abuse Prevention & Treatment (ADAPT) Program treatment team determines that the individual has made satisfactory progress and has maintained abstinence without the aid of medications for a period of 6 months from the date of entering treatment.

*Note: Any relapse (as determined by the treatment team) or use of medication to deter alcohol use resets the 6-month observation period for waiver consideration.

A7.24.1.5.2. In the opinion of the flight surgeon, privileged mental health provider, and flying unit commander, and based on the ADAPT program assessment, the individual has a low potential for recidivism and can be expected to remain stable under stress.

A7.24.1.5.3. The individual has no medical complications or sequelae due to past alcohol abuse or dependence.

A7.24.1.5.4. The individual states in writing that he or she understands the waiver is valid only if total abstinence from alcohol is maintained and that a verifiable break in abstinence once the waiver period has begun is considered medically disqualifying and not waiverable. This written statement by the individual must be accomplished at the initial waiver request and reaccomplished each time a request is submitted for renewal of the waiver, and is included with the waiver request. To ensure flying unit commanders are aware of the need to observe individuals with past alcohol problems, new commanders are briefed on those in their units with waivers for this condition when the individual changes assignment or there has been a change in command.

A7.24.1.5.5. All other drug abuse or use. These conditions are not waiverable.

A7.24.1.6. Schizophrenia and other Psychotic Disorders.

A7.24.1.7. Mood Disorders.

A7.24.1.7.1. Depressive disorders including major depression, dysthymia, cyclothymia, and depression not otherwise specified.

A7.24.1.7.2. Bipolar disorder.

A7.24.1.8. Anxiety Disorders. Non-phobic fear of flying is considered an administrative not medical problem.

A7.24.1.9. Somatoform Disorders.

A7.24.1.10. Dissociative Disorders.

A7.24.1.11. Sexual paraphilias are not medically disqualifying; however, individuals meeting diagnostic criteria are dealt with administratively.

A7.24.1.12. Sexual dysfunctions and sexual disorders not otherwise specified are not medically disqualifying unless in association with another Axis I disorder.

A7.24.1.13. Sleep disorders if of such magnitude to warrant somatic treatment greater than 30 days duration, or if associated with an Axis I disorder other than an adjustment disorder.

A7.24.1.14. Factitious Disorders.

A7.24.1.15. Impulse Control Disorders Not Elsewhere Classified.

A7.24.1.16. Adjustment Disorders of more than 60 days duration.

A7.24.1.17. Unsatisfactory adaptability rating for military aviation (ARMA) if maladaptive personality traits (not meeting diagnostic criteria for a personality disorder) or a pattern of maladaptive behavior is present that significantly interferes with safety of flight, crew coordination, or mission completion. Motivational issues are referred to administrative channels.

A7.24.1.18. Psychological Factors Affecting Medical Condition.

A7.24.1.19. Personality disorders are not medically disqualifying; however, if social and occupational, administrative or legal ramifications are operant, a psychiatric evaluation may be warranted to clarify suitability for future flying or other duty.

A7.24.1.20. History of attempted suicide or suicidal behavior.

A7.24.2. Flying Classes I and IA. In addition to the above:

A7.24.2.1. History of any of the above diagnoses excluding verifiable simple adjustment disorders not requiring hospitalization.

A7.24.2.2. History of schizophrenia or bipolar disorder in both parents.

A7.24.2.3. Unsatisfactory adaptability rating for military aviation.

A7.24.2.4. History of persistent learning disorder.

A7.24.2.5. Evidence of any condition causing serious chronic impairment of educational goals or chronic behavioral difficulties requiring hospitalization or prolonged treatment.

A7.25. Extremities, Flying Classes I, IA, II, and III.

A7.25.1. General Conditions.

A7.25.1.1. Arthritis of any type of more than minimal degree, which interferes with the ability to follow a physically active lifestyle, or may reasonably be expected to preclude the satisfactory performance of flying duties.

A7.25.1.2. Documented history or findings of rheumatoid arthritis.

A7.25.1.3. Active osteomyelitis or a verified history of osteomyelitis, unless inactive with no recurrence during the 2 years before examination, and without residual deformity sufficient to interfere with function.

A7.25.1.4. Osteoporosis.

A7.25.1.5. Osteochondromatosis or multiple cartilaginous exostoses.

A7.25.1.6. Disease or injury, or congenital anomaly of any bone or joint, with residual deformity, instability, pain, rigidity, or limitation of motion if function is impaired to such a degree it interferes with training, physically active lifestyle, or flying duties.

A7.25.1.7. Unreduced dislocation; substantiated history of recurrent dislocations or subluxations of a major joint if not satisfactorily corrected.

A7.25.1.8. Instability of a major joint if symptomatic and more than mild, or if subsequent to surgery there is evidence of instability, weakness, or significant atrophy.

A7.25.1.9. Malunited fractures which interfere significantly with function.

A7.25.1.10. Symptomatic nonunion of fractures.

A7.25.1.11. Any retained orthopedic fixation device, that interferes with function or easily subject to trauma.

A7.25.1.12. Muscular paralysis, paresis, contracture, or atrophy if progressive or of sufficient degree to interfere with the performance of flying duties.

A7.25.1.13. Demonstrable loose body in any joint (includes osteocartilaginous or metallic foreign objects).

A7.25.1.14. Synovitis with persistent swelling or limitation of motion.

A7.25.1.15. Osteonecrosis.

A7.25.1.16. Chondromalacia, if symptomatic or there is verified history of joint effusion, interference with function, or residuals from surgery.

A7.25.1.17. Joint replacement.

A7.25.1.18. Myotonia congenita.

A7.25.1.19. Scars, extensive, deep or adherent to the skin and soft tissues or neuromas of an extremity which are painful, interfere with movement, preclude the wearing of equipment, or show a tendency to breakdown.

A7.25.1.20. Symptomatic amputation stump (neuroma, bone spur, adherent scar or ulceration).

A7.25.2. Upper Extremity.

A7.25.2.1. Absence of any segment of the hand or digits.

A7.25.2.2. Resection of a joint other than that of a finger.

A7.25.2.3. Hyperdactylia.

A7.25.2.4. Scars and deformities of the fingers or hand which impair circulation, are symptomatic, or impair normal function to such a degree as to interfere with the satisfactory performance of flying duties.

A7.25.2.5. Healed disease or injury of the wrist, elbow or shoulder with residual weakness or symptoms of such a degree as to interfere with the satisfactory performance of flying duty. Grip strength of less than 75 percent of predicted normal when compared with the normal hand (non-dominant is 80 percent of dominant grip).

A7.25.2.6. Limitation of motion. Same as **A3.27.**

A7.25.3. Lower Extremity.

A7.25.3.1. Amputation or absence of any portion of the foot or lower extremity in excess of 1 of the 2nd through 5th toes.

A7.25.3.2. Clubfoot of any degree.

A7.25.3.3. Rigid or spastic flatfoot, Flatfoot, tarsal coalition.

A7.25.3.4. Weak foot with demonstrable eversion of the foot, valgus of the heel, or marked bulging of the inner border due to inward rotation of the talus regardless of the presence or absence of symptoms.

A7.25.3.5. Elevation of the longitudinal arch (pes cavus) if of enough degree to cause subluxation of the metatarsal heads and clawing of the toes. Obliteration of the transverse arch associated with permanent flexion of the small toes.

A7.25.3.6. Any condition, disease, or injury to feet or toes which results in disabling pain, distracting discomfort, inability to satisfactorily perform military aviation, or precludes wear of proper military footgear.

A7.25.3.7. Verified history of congenital dislocation of the hip, osteochondritis of the hip (Legg-Perthes disease), or slipped femoral epiphysis of the hip with X-ray evidence of residual deformity or degenerative changes.

A7.25.3.8. Verified history of hip dislocation within 2 years of examination or degenerative changes on X-ray from old hip dislocation.

A7.25.3.9. Difference in leg length of more than 2.5. cm (from anterior superior iliac spine to the distal tip of the medial malleolus).

A7.25.3.10. Weak Knee. Dislocation of semilunar cartilages or loose foreign bodies within the knee joint; residual instability of the knee ligaments; or significant atrophy or weakness of the thigh musculature in comparison with the normal side; or range of motion less than specified in **A3.27.**; or other symptoms of internal derangement or a condition which would interfere with the performance of flying duties.

A7.25.3.11. Osteochondritis dessicans of the knee or ankle if there are X-ray changes.

A7.25.3.12. Osteochondritis of the tibial tuberosity (Osgood-Schlatter disease) if symptomatic or with obvious prominence of the part and X-ray evidence of separated bone fragments.

A7.25.3.13. Limitation of motion same as **A3.27.**

A7.25.3.14. Toes-stiffness which interferes with walking, marching, running, or jumping.

A7.26. Spine and Other Musculoskeletal.

A7.26.1. Flying Classes I and IA: Same as Attachment **A3.29.** and the following:

A7.26.1.1. Flying Classes II and III.

A7.26.1.1.1. History of disease or injury of the spine or sacroiliac joints, either with or without objective signs, which has prevented the examinee from successfully following a physically active lifestyle.

A7.26.1.1.2. Arthritis of the spine, all types.

A7.26.1.1.3. Granulomatous disease of the spine, active or healed.

A7.26.1.1.4. Lumbar scoliosis of more than 20 degrees or thoracic scoliosis of more than 25 degrees as measured by the Cobb method

A7.26.1.1.5. Abnormal curvature of the spine of any degree in which there is a noticeable deformity when the examinee is dressed, in which pain or interference with function is present, or which is progressive.

A7.26.1.1.6. Symptomatic spondylolisthesis or spondylolysis.

A7.26.1.1.7. History of frank herniated nucleus pulposus or history of surgery or chemonucleolysis for that condition.

A7.26.1.1.8. Fractures or dislocations of the vertebrae. Compression fractures more than 25 percent or of more than a single vertebra may be considered for categorical IIB waiver. History of fractures of the transverse processes is not disqualifying if asymptomatic.

A7.26.1.1.9. Spina bifida when more than one vertebra is involved, if there is dimpling of the overlying skin, or a history of surgical repair for spina bifida.

A7.26.1.1.10. Juvenile epiphysitis with any degree of residual change indicated by x-ray or kyphosis.

A7.26.1.1.11. Weak or painful back requiring external support.

A7.26.1.1.12. Recurrent disabling low back pain due to any cause.

A7.26.1.1.13. Any surgical fusion.

A7.27. Skin.

A7.27.1. Flying Classes II and III.

A7.27.1.1. Any chronic skin disorder which is severe enough to cause recurrent grounding from flying duties, or is aggravated by or interferes with the wearing of military equipment.

A7.27.1.2. Extensive, deep, or adherent scars which interfere with muscular movements, with the wearing of military equipment, or show a tendency to breakdown.

A7.27.1.3. Atopic dermatitis with active or residual lesions in characteristic areas or a verified history.

A7.27.1.4. Dermatitis herpetiformis.

A7.27.1.5. Eczema which is chronic and resistant to treatment.

A7.27.1.6. Fungus infections of the skin, systemic or superficial, that interfere with duty performance or the wear of life support equipment.

A7.27.1.7. Furunculosis which is extensive, recurrent or chronic.

A7.27.1.8. Hyperhidrosis if chronic or severe.

A7.27.1.9. Leukemia cutis; mycosis fungoides; Hodgkin's disease.

A7.27.1.10. Lichen planus.

A7.27.1.11. Neurofibromatosis.

A7.27.1.12. Photodermatosis unless due to medication.

A7.27.1.13. Psoriasis.

A7.27.1.14. Scleroderma.

A7.27.1.15. Xanthoma if symptomatic or accompanied by hypercholesterolemia or hyperlipoproteinemia.

A7.27.1.16. Chronic urticaria.

A7.27.2. Flying Classes I and IA. In addition to above, psoriasis or verified history of same.

A7.28. Endocrine and Metabolic.

A7.28.1. Flying Classes II and III.

A7.28.1.1. Adiposogenital dystrophy (Frohlich's syndrome).

A7.28.1.2. Adrenal dysfunction of any degree, including pheochromocytoma.

A7.28.1.3. Cretinism.

A7.28.1.4. Diabetes insipidus.

A7.28.1.5. Diabetes mellitus, see note at **A3.32.**

A7.28.1.6. Gigantism or acromegaly.

A7.28.1.7. Thyroid disorders.

A7.28.1.7.1. Goiter if associated with pressure symptoms, or if enlargement is of such degree as to interfere with wearing of a military uniform or military equipment.

A7.28.1.7.2. Hyperthyroidism or thyrotoxicosis.

A7.28.1.7.3. Thyroiditis, acute and subacute.

A7.28.1.7.4. Hypothyroidism.

A7.28.1.8. Gout

A7.28.1.9. Hyperinsulinism, confirmed, symptomatic.

A7.28.1.10. Parathyroid dysfunction.

A7.28.1.11. Hypopituitarism.

A7.28.1.12. Myxedema, spontaneous or postoperative, with clinical manifestations.

A7.28.1.13. Nutritional deficiency diseases (including sprue, beriberi, pellagra, and scurvy) which are more than mild and not readily amenable to therapy or in which permanent pathological changes have been established.

A7.28.1.14. Other endocrine or metabolic disorders which obviously preclude satisfactory performance of military service or which require frequent or prolonged treatment.

A7.28.1.15. Hypercholesterolemia controlled by medication other than resin binders.

A7.28.1.16. Osteopenia.

A7.28.1.17. Hypoglycemia from any endogenous source.

A7.28.2. Flying Classes I and IA. In addition to the above:

A7.28.2.1. Diabetes mellitus (see Note in **A3.32.**). Persistent glucosuria from any cause including fasting renal glucosuria is disqualifying. Glucosuria post-prandially or during glucose loading challenge is not disqualifying in the absence of any renal disease or history of recurrent genitourinary infections. However, this finding requires evaluation.

A7.28.2.2. Any confirmed (repeated) serum cholesterol in excess of 230 mg/dl with one or both of the following criteria present:

A7.28.2.2.1. HDL cholesterol equal to or less than 15 percent of total cholesterol.

A7.28.2.2.2. LDL cholesterol greater than 170 mg/dl.

A7.29. Height and Weight

A7.29.1. Flying Class III

A7.29.1.1. Weight

A7.29.1.1.1. For initial qualification weight in relation to height applies (refer to **Attachment 16**). Additional standard applies for duties in ejection seat aircraft; in no case may weight be less than 103# or greater than 240# for T-38 and 245# for all other ejection seat aircraft.

A7.29.1.1.2. For trained personnel refer to **Attachment 16**. Additional standard applies for duties in ejection seat aircraft; in no case may weight be less than 103# or greater than 240# for T-38 and 245# for all other ejection seat aircraft.

A7.29.2. Flying Class II

A7.29.2.1 Weight

A7.29.2.1.1. For trained personnel refer to **Attachment 16**. Additional standard applies for duties in ejection seat aircraft; in no case may weight be less than 103# or greater than 240# for T-38 and 245# for all other ejection seat aircraft.

A7.29.3. Flying Class I

A7.29.3.1 Weight

A7.29.3.1.1. Weight in relation to height applies (refer to **Attachment 16**). Additional standard applies for Undergraduate Pilot Training; in no case may weight be less than 103# or greater than 240#.

A7.29.4. Flying Classes IA and Initial II (Flight Surgeon)

A7.29.4.1 Weight

A7.29.4.1.1. Weight in relation to height applies (refer to **Attachment 16**). Additional standard applies for training/duties in ejection seat aircraft; in no case may weight be less than 103# or greater than 240# for T-38 and 245# for all other ejection seat aircraft.

NOTE:

1. For UPT students, fighter-track UNT students and trained ejection seat aircrew identified outside of the weight for ejection seat standard, notify Squadron/CC via AF Form 1042 action.

2. IAW AF/XO message R 252140Z APR 01 “Aircrew Weight and Ejection Seats”, on 1 May 2002 any aircrew member assigned to ejection seat aircraft who has failed to attain/maintain weight within the ejection seat standard will be cross-flowed to non-ejection seat aircraft. Accordingly:

a. Prior to 1 May 2002, DNIF is not required for these individuals identified outside of the weight for ejection seat standard. The individual’s current weight and the requirement to attain/maintain the ejection seat standard NLT 1 May 2002 will be noted in the comments section of the AF Form 1042.

b. On 1 May 2002, those individuals identified outside of the weight for ejection seat standard will be placed DNIF and referred to the Squadron/CC for cross-flow into non-ejection seat aircraft IAW XO message (R 252140Z APR 01 “Aircrew Weight and Ejection Seats”)

A7.30. Systemic and Miscellaneous Causes for Rejection.

A7.30.1. Flying Classes II and III.

A7.30.1.1. Recurrent decompression sickness (DCS). A single episode of DCS does not require waiver. All episodes of DCS require a minimum of 72 hours DNIF. Consultation with USAFSAM/AFIC (Hyperbaric Medicine) and concurrence of MAJCOM/SG is required before RTFS. In cases of DCS with neurological manifestations, a normal examination by a neurologist is required before RTFS.

A7.30.1.2. Malignancies. History or presence of malignant tumor, cyst or cancer of any sort. Basal cell and squamous cell carcinomas and carcinoma-in-situ of the cervix which have been adequately excised (as evidenced by pathology report, or basal cell carcinoma which have been treated by electrodessication and curretage by a dermatologist credentialed to perform this procedure), are exempted from tumor board action, but are report to tumor registry and are not disqualifying. Childhood malignancy considered cured may be considered for waiver on a case-by-case basis.

A7.30.1.3. Benign tumors which interfere with function or the wear of equipment and tumors which are likely to enlarge or be subjected to trauma during military service or show malignant potential.

A7.30.1.4. Following bleomyocin chemotherapy, AFMOA/SGOA may consider granting a

FCIIC waiver with the following restrictions:

A7.30.1.4.1. “No assignment to aircraft requiring routine use of oxygen equipment. Waiver from altitude chamber exposure. Ground training without supplemental oxygen is acceptable.” These restrictions must be annotated in the remarks section of the AF Form 1042.

A7.30.1.5. Bone marrow donation. DNIF the person until their hematocrit and hemoglobin return to their own pre-donation level and all symptoms referable to the donation have been resolved.

A7.30.1.6. Airsickness in flying personnel is not cause for medical disqualification unless there is medical evidence of organic or psychiatric pathology. If airsickness is of such chronicity or severity as to interfere with the performance of flying duties by a rated officer, his or her potential for further use in rated duties are addressed by a Flying Evaluation Board. Copies of these cases are sent through medical channels to AFMOA/SGOA for review before convening a board. Airsickness experienced by nonrated personnel (other than UPT or UNT students) while enrolled in flying courses is medically disqualifying if it is of such severity or chronicity as to interfere with the performance of flying duties. Final determination of medical qualification in these cases are made by the MAJCOM/SG.

A7.30.1.7. Any allergic condition which requires desensitization therapy. Waivers are considered if symptoms are controlled by desensitization or topical medication (or both).

A7.30.1.8. Eosinophilic granuloma.

A7.30.1.9. Gaucher's disease.

A7.30.1.10. Schuller-Christian disease.

A7.30.1.11. Letterer-Siwe's disease.

A7.30.1.12. Chronic metallic poisoning.

A7.30.1.13. Residual of cold injury, such as deep-seated ache, paresthesia, hyperhidrosis, easily traumatized skin, cyanosis, ankylosis, amputation of any digit, or cold urticaria.

A7.30.1.14. Heat pyrexia (heat stroke or heat exhaustion) if a reliable history indicates an abnormally lowered heat tolerance threshold.

A7.30.1.15. History of malignant hyperthermia.

A7.30.1.16. Syphilis, congenital or acquired. A history of primary or secondary syphilis is not disqualifying provided:

A7.30.1.16.1. The examinee has no symptoms of disease.

A7.30.1.16.2. There are no signs of active disease and no residual thereof.

A7.30.1.16.3. Serologic VDRL testing rules out reinfection.

A7.30.1.16.4. There is a verified history of adequate treatment.

A7.30.1.16.5. There is no evidence or history of CNS involvement.

A7.30.1.17. Parasitic infestation, all types until adequately treated.

A7.30.1.18. History of sensitivity or a demonstrated sensitivity of sufficient severity to require permanent exemption from any immunization required by appropriate directives.

A7.30.1.19. History of food-induced anaphylaxis.

A7.30.1.20. Other congenital or acquired abnormalities, defects or diseases which preclude satisfactory performance of flying duty.

A7.30.1.21. Miscellaneous conditions such as porphyria, hemochromatosis, amyloidosis.

A7.30.1.22. Inflammatory idiopathic diseases of connective tissue.

A7.30.1.23. Lupus erythematosus (acute, subacute, or chronic).

A7.30.1.24. Active tuberculosis in any form or location, or substantiated history of active tuberculosis within the previous 2 years.

A7.30.1.25. Sarcoidosis.

A7.30.1.26. History of malignancy.

A7.30.2. Flying Classes I and IA. In addition to the above:

A7.30.2.1. Motion sickness experienced in aircraft, automobiles, or water craft after the age of 12 with any significant frequency. Any history of motion sickness is completely explored.

A7.31. Medication. Use of any medication, except as described below is cause for medical disqualification for flying duty until the grounding condition has been resolved, the medication is no longer required and the effects of the drugs have dissipated.

A7.31.1. Aircrew members cannot fly for at least 8 hours after receiving a local or regional anesthetic agent.

A7.31.2. Aircrew and individuals on the sensitive duty program are not cleared for a minimum of 3 weeks following the use of Ketamine.

A7.31.3. Medications which may be used without medical consultation.

A7.31.3.1. Skin antiseptics, topical antifungals, 1 percent Hydrocortisone cream (more potent topical steroids require waivers), or benzoyl peroxide for minor wounds and skin diseases which do not interfere with the performance of flying duties or wear of personal equipment.

A7.31.3.2. Single doses of over-the-counter aspirin, acetaminophen or ibuprofen to provide analgesia for minor self-limiting conditions.

A7.31.3.3. Antacids for mild isolated episodes of epigastric distress.

A7.31.3.4. Hemorrhoidal suppositories.

A7.31.3.5. Bismuth subsalicylate for mild afebrile cases of diarrhea.

A7.31.3.6. Oxymetazoline or phenylephrine nasal sprays may be used by aircrew as "get me downs" should unexpected ear or sinus block occur during flight. These should not be used to treat symptoms of head congestion existing prior to flight.

A7.31.3.7. Multivitamin, no more than one per day.

A7.31.3.8. Dietary, herbal, and nutritional supplements can only be used with the approval of a flight surgeon. The flight surgeon should consider aeromedical implications of the supplement as well as the probability the supplement will actually enhance performance.

A7.31.4. Medication prescribed by a flight surgeon which may be used without removal from flying duty once the potential for idiosyncratic reaction has been excluded.

A7.31.4.1. Isoniazid for prophylactic therapy of tuberculin converters who do not have active tuberculosis. Minimum of 7 days ground trial.

A7.31.4.2. Oral contraceptives, implantable timed release progestin, injectable sustained duration progestin (for contraception only), estrogen alone or with progestin, as replacement therapy. Minimum of 28 days ground trial is required. Changes of dosage or brand requires an additional 28-day observation period.

A7.31.4.3. Chloroquine phosphate, primaquine phosphate, or doxycycline (100 mg daily) for antimalarial prophylaxis. Single dose ground trial is advised.

A7.31.4.4. Pyridostigmine for chemical warfare prophylaxis. Single dose ground trial is advised.

A7.31.4.5. Scopolamine alone or in combination with dextroamphetamine or ephedrine for airsickness in formal flying training programs. Not authorized for solo flight.

A7.31.4.6. Doxycycline (100mg) administered twice a day for 5 days may be used to treat mild diarrhea. Doxycycline may also be used for prophylaxis against diarrhea in deployed personnel. One hundred milligrams should be administered daily during the period of exposure and for at least 2 days following exposure, with the total period of use not to exceed 2 weeks.

A7.31.4.7. Topical antibiotics for control of acne.

A7.31.4.8. Topical tretinoin for control of acne as long as local irritation does not interfere with wear of the life-support equipment.

A7.31.4.9. Topical acyclovir.

A7.31.4.10. Completion of a course of oral penicillin, oxacillin, dicloxacillin, amoxicillin, erythromycin, sulfamethoxazole-trimethoprim, tetracycline, ampicillin, doxycycline, or cephalexin, once the acute infectious process is asymptomatic.

A7.31.4.11. Vaginal creams or suppositories for treatment of vaginitis once asymptomatic.

A7.31.4.12. Temazepam, or zolpidem if such use is essential for the safe performance of mission, and only after MAJCOM/SG coordination and approval. MAJCOM/SG may delegate this approval to wing and detachment level if unit mission so warrants. Single dose ground trial is required for use.

A7.31.4.13. Dextroamphetamine use may be allowed for certain missions. Check with MAJCOM/SG prior to prescribing. Single dose grounding trial is required.

A7.31.4.14. Immunobiologics.

A7.31.4.15. Nicorette or transdermal nicotine. Minimum of 72 hours ground trial.

A7.31.4.16. Resin binding agents such as cholestyramine for control of hyperlipidemia. Note: Niacin is not approved for use by flyers.

A7.31.5. Maintenance medication requiring waiver. Those medications for conditions listed below may be waived by the MAJCOM surgeon. The use of other medications, singly or in combination requires review by AFMOA/SGOA for rated officers and by the MAJCOM surgeon for non-rated flying personnel.

A7.31.5.1. Chlorothiazide or hydrochlorothiazide for control of hypertension or hypercalciuria.

A7.31.5.2. Triamterene for control of hypertension.

A7.31.5.3. Lisinopril for treatment of hypertension (ACS review or evaluation may be required for Flying Class II, refer to current ACS policy). Flying Class II waiver requires a medically monitored centrifuge evaluation. If a medically monitored centrifuge evaluation has not been performed, rated individuals will be considered for a categorical Flying Class IIC waiver (Member must undergo a medically monitored centrifuge evaluation required prior to return to assignment to Fighter, Attack, Reconnaissance (FAR), or trainer aircraft (except T-1).

A7.31.5.4. Probenecid for treatment of gout or hyperuricemia.

A7.31.5.5. Allopurinol for treatment of gout or hyperuricemia.

A7.31.5.6. Combination therapy of thiazide with triamterene, probenecid, allopurinol, or oral potassium supplements.

A7.31.5.7. Epinephrine derivatives without added action agents, or betablockers (Timolol, Levobunolol, Betaxolol) all for topical use only, to control glaucoma.

A7.31.5.8. Synthroid for treatment of thyroid hypofunction or for thyroid suppression.

A7.31.5.9. Tetracycline, erythromycin, doxycycline in standard doses for acne management.

A7.31.5.10. Sulfamethoxazole-trimethoprim, tetracycline, ampicillin, doxycycline for chronic genitourinary infectious or prostatitis once asymptomatic.

A7.31.5.11. Folic acid in the treatment of sprue.

A7.31.5.12. Sucralfate (1 gram once daily) for prevention of recurrent, uncomplicated duodenal ulcers. Minimum 7 days observation required.

A7.31.5.13. Ranitidine.

*Note: Prior requirement for a FCIIA waiver is removed.

A7.31.5.14. Pravachol (Note: May not be delegated locally).

A7.31.5.15. Omeprazole (Note: Prior requirement for a FCIIA waiver is removed).

A7.31.5.16. Nasal steroids or cromolyn nasal spray for control of mild to moderate allergic rhinitis, non-allergic rhinitis, or vasomotor rhinitis. Observation for control of the rhinitis (usually 7 to 14 calendar days) is required. Claritin (loratidine) for the control of seasonal allergic rhinitis.

A7.31.5.17. Griseofulvin for treatment of fungal infections may be granted a one year non-renewable waiver after a 4 week ground trial.

A7.31.5.18. Clomiphene citrate for treatment of infertility.

A7.31.5.19. Lovastatin or pravastatin for treatment of hypercholesterolemia.

A7.31.5.20. Gemfibrozil may be considered for categorical IIA waiver by MAJCOM/SG.

A7.31.5.21. Acyclovir (oral), for treatment of HSV or suppressive therapy.