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Medical Services

Standards of Medical Fitness

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SUMMARY of CHANGE

AR 40-501

Standards of Medical Fitness

This revision--

- o Revises the list of authorities who approve waivers for the medical fitness standards contained in chapters 2, 3, 4, or 5 (para 1-6).
- o Revises the medical accession standards in compliance with DOD Directive 6130.3, "Physical Standards for Appointment, Enlistment, or Induction," December 15, 2000, and DOD Instruction 6130.4, "Criteria and Procedure Requirements for Physical Standards for Appointment, Enlistment, or Induction in the Armed Forces," December 14, 2000 (chap 2).
- o Adds the International Classification of Disease codes for medical conditions causing rejection for appointment, enlistment, and induction (chap 2).
- o Revises the medical retention standards, including new standards on asthma (chap 3).
- o Adds metabolic equivalent testing to functional classifications of patients with cardiovascular disease (table 3-1).
- o Revises the aviation chapters (chap 4 and chap 6).
- o Reduces the number of physician signatures on permanent 3 or 4 profiles (chap 7) and updates the description of profile codes (table 7-1).
- o Adds occupational history requirements to the pregnancy profile (chap 7).
- o Replaces SF 93 (Report of Medical History) and SF 88 (Report of Medical Examination) with two new forms, DD Form 2807-1 (Report of Medical History) and DD Form 2808 (Report of Medical Examination) (chap 8 and table 8-1).
- o Revises the Cardiovascular Screening program requirements (chap 8).
- o Adds policies for medical examinations and physical standards for the Army National Guard (chap 10).
- o Rescinds DA Form 4970 and DA Form 4970-E (Medical Screening Summary--Over 40 Physical Fitness Program).

Effective 29 April 2002

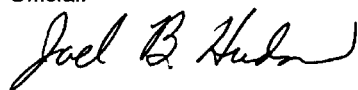
Medical Services

Standards of Medical Fitness

By Order of the Secretary of the Army:

ERIC K. SHINSEKI
General, United States Army
Chief of Staff

Official:



JOEL B. HUDSON
Administrative Assistant to the
Secretary of the Army

History. This printing publishes a revision of AR 40-501. Because the publication has been extensively revised, the changed portions have not been highlighted.

Summary. This regulation provides information on medical fitness standards for induction, enlistment, appointment, retention, and related policies and procedures. This publication implements DOD Directive 6130.3, Physical Standards for Appointment, Enlistment, and Induction,

December 15, 2000, and DOD Instruction 6130.4, Criteria and Procedure Requirements for Physical Standards for Appointment, Enlistment, or Induction in the Armed Forces, December 14, 2000.

Applicability. This regulation applies to candidates for military service and to Active Army personnel. It also applies to the Army National Guard of the United States and the U.S. Army Reserve. This publication is applicable during mobilization.

Proponent and exception authority. The proponent of this regulation is the Office of the Surgeon General. The proponent has the authority to approve exceptions to this regulation that are consistent with controlling law and regulation. Proponents may delegate the approval authority, in writing, to a division chief within the proponent agency in the grade of colonel or the civilian equivalent.

Army management control process. This regulation contains management control provisions, but it does not identify key management controls that must be evaluated.

Supplementation. Supplementation of

this regulation and establishment of command or local forms are prohibited without prior approval from HQDA (DASG-HS-AS), 5109 Leesburg Pike, Falls Church, VA 22041-3258.

Suggested Improvements. Users are invited to send comments and suggested improvements on DA Form 2028 (Recommended Changes to Publications and Blank Forms) directly to HQDA (DASG-HS-AS), 5109 Leesburg Pike, Falls Church, VA 22041-3258.

Distribution. This publication is available in electronic media only (EMO), and is intended for command level A for medical activities only of the Active Army, the Army National Guard, and the U.S. Army Reserve.

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*This regulation supersedes AR 40-501, 30 August 1995. It also rescinds DA Form 4970 and DA Form 4970-E, April 1981.

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Glossary

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Chapter 1

General Provisions

1–1. Purpose

This regulation governs—

- a.* Medical fitness standards for enlistment, induction, and appointment, including officer procurement programs.
- b.* Medical fitness standards for retention and separation, including retirement.
- c.* Medical fitness standards for diving, Special Forces, Airborne, Ranger, free fall parachute training and duty, and certain enlisted military occupational specialties (MOSs) and officer assignments.
- d.* Medical standards and policies for aviation.
- e.* Physical profiles.
- f.* Medical examinations.

1–2. References

Required and related publications and prescribed and referenced forms are listed in appendix A.

1–3. Explanation of abbreviations and terms

Abbreviations and special terms used in this regulation are explained in the glossary.

1–4. Responsibilities

a. The Surgeon General (TSG) will develop, revise, interpret, and disseminate current Army medical fitness standards and ensure Army compliance with Department of Defense (DOD) directives pertaining to those standards. TSG has the authority to issue exceptions to policies that are contained in this regulation.

b. Director, Department of Defense Medical Examination Review Board (DODMERB); Director, Army National Guard (ARNGUS); Chief, U.S. Army Reserve (USAR); Superintendent, U.S. Military Academy (USMA), Director, Uniformed Services University of the Health Sciences (USUHS), and commanders of the U.S. Military Entrance Processing Command (MEPCOM), U.S. Army Recruiting Command (USAREC), U.S. Training and Doctrine Command, U.S. Army Medical Command (USAMEDCOM), U.S. Army Reserve Personnel Command (AR–PERSCOM), State Adjutants General, and all Army military treatment facilities (MTFs) worldwide, will implement policies prescribed in this regulation applicable to all Active Army and Reserve Component (RC) personnel and applicants for appointment (including all officer procurement programs), enlistment, and induction.

c. Commanders and military personnel officers at all levels of command will implement administrative and command provisions of chapters 5, 7, 8, 9, and 10.

1–5. Medical classification

Individuals evaluated under the medical fitness standards contained in this regulation will be reported as indicated below.

a. Medically acceptable. Medical examiners will report as “medically acceptable” all individuals who meet the medical fitness standards established for the particular purpose for which examined. No individual will be accepted on a provisional basis subject to the successful treatment or correction of a disqualifying defect.

b. Medically unacceptable.

(1) Medical examiners will report as “medically unacceptable” by reason of medical unfitness all individuals who possess any one or more of the medical conditions or physical defects listed in this regulation as a cause for rejection for the specific purpose for which examined, except as noted in (2) below.

(2) Medical examiners will report as “Medically unacceptable—prior administrative waiver granted” all individuals who do not meet the medical fitness standards established for the particular purpose for which examined when a waiver has been previously granted and the applicable provisions of paragraph 1–6 apply.

1–6. Review authorities and waivers

a. Medical fitness standards cannot be waived by medical examiners or by the examinee.

b. Examinees initially reported as medically unacceptable by reason of medical unfitness when the medical fitness standards in chapter 2, 3, 4, or 5 apply, may request a waiver of the medical fitness standards in accordance with the basic administrative directive governing the personnel action. Upon such request, the designated administrative authority or his or her designees for the purpose may grant such a waiver in accordance with current directives. The Office of the Surgeon General (OTSG) provides guidance when necessary to the review and waiver authorities on the interpretation of the medical standards and appropriateness of medical waivers. The Secretary of the Army is the waiver authority for accession. That authority is delegated down through the Deputy Chief of Staff for Personnel to the authorities listed in paragraphs *c* through *i* below.

c. The DODMERB, U.S. Air Force Academy, Colorado Springs, CO 80840–6518 is the review authority for reports of examinations given applicants for entrance into the Reserve Officers’ Training Corps (ROTC) Scholarship Program

and the USMA. (See AR 40–29/AFR 160–13/NAVMEDCOMINST 6120.2/CG COMDTINST M6120.8.) The waiver authority for ROTC is the Commanding General, ROTC Command. The waiver authority for USMA is the Superintendent, USMA.

d. Military Entrance Processing Stations (MEPS), under the purview of MEPCOM, are the review authorities for enlistment and nonscholarship ROTC program examinations accomplished in their facilities. The Commanding General, USAREC, is the waiver authority for original enlistment. The Director, ARNGUS is the waiver authority for the ARNGUS.

e. U.S. Army Medical Center (MEDCEN) or medical department activity (MEDDAC) Commanders are the review authorities for entry into nonscholarship ROTC programs (unless accomplished at the MEPS), retention in all ROTC programs, and appointment as commissioned officers from the ROTC program. In ROTC programs when personnel are examined by other Government medical facilities or by civilian facilities, reviews will be made by the MEDDAC or MEDCEN commander in the area where the examined person's college or university is located.

f. Waiver authority for applicants for U.S. Army Medical Department (AMEDD) personnel procurement programs (except USUHS) is USAREC. This waiver authority may be changed by TSG after appropriate coordination with the Office of the Deputy Chief of Staff for Personnel (ODCSPER). The waiver authority for students already enrolled in AMEDD procurement programs is TSG (ATTN: DASG–HS–AS). The waiver authority for applicants for USUHS is the Assistant Secretary of Defense (Health Affairs) (ASD(HA)).

g. Review and waiver authority for other direct appointment programs (for example, Chaplain Corps) is USAREC. The waiver authority for initial selection for the Judge Advocate General Corps is AR–PERSCOM.

h. Waiver authority for Special Forces training, Special Forces Assessment and Selection (SFAS), survival, evasion, resistance, escape (SERE) training, Military Freefall (MFF), and Special Forces Combat Diving Qualification Course (CDQC) is the Commandant, U.S. Army John F. Kennedy Special Warfare Center and School (USAJFKSWCS). Waiver authority for the Airborne School is the Commandant, U.S. Army Infantry School in coordination with U.S. Total Army Personnel Command (PERSCOM).

i. Waivers for initial enlistment or appointment, including entrance and retention in officer procurement programs, will not be granted if the applicant does not meet the retention standards of chapter 3. Requests from waiver authorities for exception to this policy will only be made under extraordinary circumstances and only with the approval of TSG (Headquarters, Department of the Army, (HQDA) (DASG–HS–AS)).

j. Waivers of medical fitness standards that have been previously granted apply automatically to subsequent medical actions pertinent to the program or purpose for which granted without the necessity of confirmation or termination when—

(1) The duration of the waiver was not limited at the time it was granted and the medical condition or physical defect has not interfered with the individual's successful performance of military duty.

(2) The medical condition or physical defect waived was below retention medical fitness standards applicable to the particular program involved and the medical condition or physical defect has remained essentially unchanged.

(3) The medical condition or physical defect waived was below procurement medical fitness standards applicable to the particular program involved and the medical condition or physical defect, although worse, is within the retention medical fitness standards prescribed for the program or purpose involved.

Chapter 2

Physical Standards for Enlistment, Appointment, and Induction

2–1. General

This chapter implements DOD Directive 6130.3, Physical Standards for Appointment, Enlistment, and Induction, December 15, 2000, and DOD Instruction 6130.4, Criteria and Procedure Requirements for Physical Standards for Appointment, Enlistment, or Induction in the Armed Forces, December 14, 2000.

2–2. Application and responsibilities

a. Purpose. The purpose of the standards contained in this chapter is to ensure that individuals medically qualified are—

(1) Free of contagious diseases that would likely endanger the health of other personnel.

(2) Free of medical conditions or physical defects that would require excessive time lost from duty for necessary treatment or hospitalization or would likely result in separation from the Army for medical unfitness.

(3) Medically capable of satisfactorily completing required training.

(4) Medically adaptable to the military environment without the necessity of geographical area limitations.

(5) Medically capable of performing duties without aggravation of existing physical defects or medical conditions.

b. Application. This chapter prescribes the medical conditions and physical defects that are causes for rejection for appointment, enlistment, and induction into military service. Other standards may be prescribed by DOD in the event

of mobilization or a national emergency. Those individuals found medically qualified based on the medical standards of chapter 2 that were in effect prior to this publication will not be disqualified solely on the basis of the new standards. The designated waiver authorities may grant waivers for selection or continuation in the programs described below, provided the individual meets the retention standards of chapter 3. However, the standard in paragraph 2–35/ will not be waived regardless of whether chapter 2 or chapter 3 standards are applied.

c. Scope. The standards of chapter 2 apply to—

(1) Applicants for appointment as commissioned or warrant officers in the Active Army and RCs, including appointment as a soldier in the USAR or the Army National Guard of the United States (ARNGUS). This includes enlisted soldier applicants for appointment as commissioned or warrant officers. (However, for officers of the ARNGUS or USAR who apply for appointment in the Active Army, the standards of chap 3 are applicable.)

(2) Applicants for enlistment in the Regular Army. For medical conditions or physical defects predating original enlistment, these standards are applicable for enlistees' first 6 months of active duty. (However, for enlisted soldiers of the ARNGUS or USAR who apply for enlistment in the Regular Army or who re-enter active duty for training (ADT) under the “split-training” option, the standards of chap 3 are applicable.)

(a) Enlisted soldiers identified within the first 6 months of active duty with a condition that existed prior to service that does not meet the standards of chapter 2 may be separated (or receive a waiver to remain on active duty) following an evaluation by an Entrance Physical Standards Board, in accordance with AR 635–200, chapter 5, with the exception as noted in (b) below.

(b) Enlisted soldiers identified within the first 6 months of active duty with a condition that existed prior to service that does not meet the standards of chapter 2 or chapter 3 must be evaluated by a medical evaluation board (MEB). The soldier will then be referred to a physical evaluation board (PEB) unless the soldier waives his or her right to the PEB in accordance with AR 635–40.

(3) Applicants for enlistment in the RC and federally recognized units or organizations of the ARNGUS. For medical conditions or physical defects predating original enlistment, these standards are applicable during the enlistees' initial period of ADT until their return to RC units.

(4) Applicants for reenlistment in Active Army, RC, and federally recognized units or organizations of the ARNGUS after a period of more than 6 months has elapsed since discharge.

(5) Applicants (civilian applicants or enlisted soldier applicants) for the USMA, Scholarship or Advanced Course ROTC, USUHS, Health Professions Scholarship Program (HPSP), Officer Candidate School (OCS), Warrant Officer Candidate School, and all other Army special officer personnel procurement programs. (See chap 3 for retention of students in HPSP and USUHS programs.)

(6) Retention of cadets and midshipmen at the United States Armed Forces academies and students enrolled in ROTC. (However, the Commander, ROTC Cadet Command or the Superintendent, USMA has the authority to grant medical waivers for continuation in these programs, provided the cadet meets the retention standards of chap 3.)

(7) All individuals being inducted into the Army.

d. Responsibilities. The Secretary of the Army shall—

(1) Revise Army policies to conform with the standards contained in DOD Directive 6130.3 and DOD Instruction 6130.4.

(2) Ensure uniformity of application and implementation of DOD Instruction 6130.4.

(3) Have authority to grant a waiver of the standards in individual cases for applicable reasons and ensure uniformity of waiver determinations. Delegated waiver authorities are noted in chapter 1.

(4) Have authority to change Army-specific visual standards (particularly for officer-accession programs) and establish other standards for special programs. Notification of any proposed changes in standards will be provided to the ASD(HA) 60 days before their implementation.

(5) Ensure that accurate International Classification of Disease (ICD) Codes are assigned to all medical conditions resulting in a personnel action such as medical waiver or medical separation.

(6) Eliminate inconsistencies and inequities based on race, sex, or examination location in the application of the standards.

e. Medical conditions. The disqualifying medical conditions are listed in paragraphs 2–3 through 2–37 below. (The ICD codes are listed in parentheses following each standard in chap 2.)

2–3. Abdominal organs and gastrointestinal system

The causes for rejection for appointment, enlistment, and induction are an authenticated history of:

a. Esophagus. Ulceration, varices, fistula, achalasia, or other dysmotility disorders; chronic or recurrent esophagitis if confirmed by appropriate x-ray or endoscopic examination (530).

b. Stomach and duodenum.

(1) Gastritis. Chronic hypertrophic, or severe (535).

(2) Active ulcer of the stomach or duodenum confirmed by x-ray or endoscopy (533).

(3) Congenital abnormalities of the stomach or duodenum causing symptoms or requiring surgical treatment (751), except a history of surgical correction of hypertrophic pyloric stenosis of infancy.

c. Small and large intestine.

(1) Inflammatory bowel disease. Regional enteritis (555), ulcerative colitis (556), ulcerative proctitis (556).

(2) Duodenal diverticula with symptoms or sequelae (hemorrhage, perforation, etc.) (562.02).

(3) Intestinal malabsorption syndromes, including postsurgical and idiopathic (579).

(4) Congenital (751). Condition, to include Meckel's diverticulum or functional (564) abnormalities, persisting or symptomatic within the past 2 years.

d. Gastrointestinal bleeding. History of, unless the cause has been corrected, and is not otherwise disqualifying (578).

e. Hepato-pancreatic-biliary tract.

(1) Viral hepatitis (070), or unspecified hepatitis (570), within the preceding 6 months or persistence of symptoms after 6 months, or objective evidence of impairment of liver function, chronic hepatitis, and hepatitis B carriers (070). (Individuals who are known to have tested positive for hepatitis C virus (HCV) infection require confirmatory testing. If positive, individuals should be clinically evaluated for objective evidence of liver function impairment. If evaluation reveals no signs or symptoms of disease, the applicant meets the standards.)

(2) Cirrhosis (571), hepatic cysts and abscess (572), and sequelae of chronic liver disease (572).

(3) Cholecystitis, acute or chronic, with or without cholelithiasis (574), and other disorders of the gallbladder including post-cholecystectomy syndrome (575), and biliary system (576).

Note. Cholecystectomy is not disqualifying 60 days postsurgery (or 30 days post-laparoscopic surgery), providing there are no disqualifying residuals from treatment.

(4) Pancreatitis. Acute (577.0) and chronic (577.1).

f. Anorectal.

(1) Anal fissure if persistent, or anal fistula (565).

(2) Anal or rectal polyp (569.0), prolapse (569.1), stricture (569.2), or incontinence (787.6).

(3) Hemorrhoids, internal or external, when large, symptomatic, or history of bleeding (455).

g. Spleen.

(1) Splenomegaly, if persistent (789.2).

(2) Splenectomy (P41.5), except when accomplished for trauma, or conditions unrelated to the spleen, or for hereditary spherocytosis (282.0).

h. Abdominal wall.

(1) Hernia, including inguinal (550), and other abdominal (553), except for small, asymptomatic umbilical or asymptomatic hiatal.

(2) History of abdominal surgery within the preceding 60 days (P54), except that individuals post-laparoscopic cholecystectomy may be qualified after 30 days.

i. Other.

(1) Gastrointestinal bypass (P43) or stomach stapling (P44) for control of obesity.

(2) Persons with artificial openings (V44).

2-4. Blood and blood-forming tissue diseases

The causes for rejection for appointment, enlistment, and induction are an authenticated history of:

a. Anemia. Any hereditary (282), acquired (283), aplastic (284), or unspecified (285) anemia that has not permanently corrected with therapy.

b. Hemorrhagic disorders. Any congenital (286) or acquired (287) tendency to bleed due to a platelet or coagulation disorder.

c. Leukopenia. Chronic or recurrent (288), based upon available norms for ethnic background.

d. Immunodeficiency (279).

2-5. Dental

The causes for rejection are for appointment, enlistment, and induction are:

a. Diseases of the jaw or associated tissues which are not easily remediable, and will incapacitate the individual or otherwise prevent the satisfactory performance of duty. This includes temporomandibular disorders (524.6) and/or myofascial pain dysfunction that is not easily corrected or has the potential for significant future problems with pain and function.

b. Severe malocclusion (524) that interferes with normal mastication or requires early and protracted treatment; or relationship between mandible and maxilla that prevents satisfactory future prosthodontic replacement.

c. Insufficient natural healthy teeth (521) 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 world-wide duty. Dental implants systems must be successfully osseointegrated and completed.

d. Orthodontic appliances for continued treatment (V53.4) (attached or removable). Retainer appliances are permissible, provided all active orthodontic treatment has been satisfactorily completed.

2-6. Ears

The causes for rejection for appointment, enlistment, and induction are:

a. External ear. Atresia or severe microtia (744), acquired stenosis (380.5), severe chronic or acute otitis externa (380.2), or severe traumatic deformity (738.7).

b. Mastoids. Mastoiditis (383), residual of mastoid operation with fistula (383.81), or marked external deformity that prevents or interferes with wearing a protective mask or helmet (383.3).

c. Meniere's Syndrome. Or other diseases of the vestibular system (386).

d. Middle and inner ear. Acute or chronic otitis media (382), cholesteatoma (385.3), or history of any inner (P20) or middle (P19) ear surgery excluding myringotomy or successful tympanoplasty.

e. Tympanic membrane. Any perforation of the tympanic membrane (384), or surgery to correct perforation within 120 days of examination (P19).

2-7. Hearing

The cause for rejection for appointment, enlistment, and induction is a hearing threshold level greater than that described in paragraph c below.

a. Audiometers, calibrated to standards of the International Standards Organization (ISO 1964) or the American National Standards Institute (ANSI 1996), will be used to test the hearing of all applicants.

b. All audiometric tracings or audiometric readings recorded on reports of medical examination or other medical records will be clearly identified.

c. Acceptable audiometric hearing levels (both ears) are:

(1) Pure tone at 500, 1000, and 2000 cycles per second of not more than 30 decibels (dB) on the average (each ear), with no individual level greater than 35dB at these frequencies.

(2) 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.

2-8. Endocrine and metabolic disorders

The causes for rejection for appointment, enlistment, and induction are an authenticated history of:

a. Adrenal dysfunction (255) of any degree.

b. Diabetes mellitus (250) of any type.

c. Glycosuria. Persistent, when associated with impaired glucose tolerance (250) or renal tubular defects (271.4).

d. Acromegaly. Gigantism or other disorder of pituitary function (253).

e. Gout (274).

f. Hyperinsulinism (251.1).

g. Hyperparathyroidism (252.0) and hypoparathyroidism (252.1).

h. Thyroid disorders.

(1) Goiter, persistent or untreated (240).

(2) Hypothyroidism, uncontrolled by medication (244).

(3) Cretinism (243).

(4) Hyperthyroidism (242).

(5) Thyroiditis (245).

i. Nutritional deficiency diseases. Such diseases include beriberi (265), pellagra (265.2), and scurvy (267).

j. Other endocrine or metabolic disorders such as cystic fibrosis (277), porphyria (277.1), and amyloidosis (277.3) that obviously prevent satisfactory performance of duty or require frequent or prolonged treatment.

2-9. Upper extremities

(See also para 2-11.) The causes for rejection for appointment, enlistment, and induction are:

a. 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 appear in TC 8-640.

(1) Shoulder (726.1):

(a) Forward elevation to 90 degrees.

(b) Abduction to 90 degrees.

(2) Elbow (726.3):

(a) Flexion to 100 degrees.

- (b) Extension to 15 degrees.
- (3) Wrist (726.4): a total range of 60 degrees (extension plus flexion) or radial and ulnar deviation combined arc 30 degrees.
- (4) Hand (726.4):
 - (a) Pronation to 45 degrees.
 - (b) Supination to 45 degrees.
- (5) Fingers and thumb (726.4): inability to clench fist, pick up a pin, grasp an object, or touch tips of at least three fingers with thumb.
 - b. Hand and fingers.
 - (1) Absence of the distal phalanx of either thumb (885).
 - (2) Absence of distal and middle phalanx of an index, middle, or ring finger of either hand, irrespective of the absence or loss of little finger (886).
 - (3) Absence of more than the distal phalanx of any two of the following fingers: index, middle finger, or ring finger of either hand (886).
 - (4) Absence of hand or any portion thereof (887) except for fingers as noted above.
 - (5) Polydactyly (755).
 - (6) Scars and deformities of the fingers or hand (905.2) that are symptomatic or that impair normal function to such a degree as to interfere with the satisfactory performance of military duty.
 - (7) Intrinsic paralysis or weakness, including nerve palsy (354) sufficient to produce physical findings in the hand such as muscle atrophy or weakness.
 - (8) Wrist, forearm, elbow, arm, or shoulder. Recovery from disease or injury with residual weakness or symptoms such as to preclude satisfactory performance of duty (905.2), or grip strength of less than 75 percent of predicted normal when injured hand is compared with the normal hand (non-dominant is 80 percent of dominant grip).

2-10. Lower extremities

(See also para 2-11.) The causes for rejection for appointment, enlistment, and induction are:

- a. 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 appear in TC 8-640.
 - (1) Hip (due to disease (726.5), injury (905.2)):
 - (a) Flexion to 90 degrees.
 - (b) No demonstrable flexion contracture.
 - (c) Extension to 10 degrees (beyond 0 degrees).
 - (d) Abduction to 45 degrees.
 - (e) Rotation of 60 degrees (internal and external combined).
 - (2) Knee (due to disease (726.6), injury (905.4)):
 - (a) Full extension compared with contralateral.
 - (b) Flexion to 90 degrees.
 - (3) Ankle (due to disease (726.7), injury (905.4)):
 - (a) Dorsiflexion to 10 degrees.
 - (b) Planter flexion to 30 degrees.
 - (4) Subtalar (due to disease (726.7) or injury (905.4)): eversion and inversion (total to 5 degrees).
- b. Foot and ankle.
 - (1) Absences of one or more small toes (895) if function of the foot is poor or running or jumping is prevented; absence of a foot (896) or any portion thereof except for toes.
 - (2) Absence of great toe(s) (895); loss of dorsal/plantar flexion if function of the foot is impaired (905.4).
 - (3) Deformities of the toes, either acquired (735) or congenital (755.66), including polydactyly (755.02), that prevent wearing military footwear or impair walking, marching, running, or jumping. This includes hallux valgus (735).
 - (4) Clubfoot or Pes Cavus (754.5), if stiffness or deformity prevents foot function or wearing military footwear.
 - (5) Symptomatic pes planus, acquired (734) or congenital (754.6) or pronounced cases, with absence of subtalar motion.
 - (6) Ingrown toenails (703), if severe.
 - (7) Planter fasciitis (728.7), persistent.
 - (8) Neuroma (355.6), confirmed condition and refractory to medical treatment or will impair function of the foot.
- c. Leg, knee, thigh, and hip.
 - (1) Loose or foreign bodies within the knee joint (717.6).
 - (2) Physical findings of an unstable or internally deranged joint (717.9). History of anterior (717.83) or posterior (717.84) cruciate ligament injury.
 - (3) Surgical correction of any knee ligaments if symptomatic or unstable (P81).

(4) History of congenital dislocation of the hip (754.3), osteochondritis of the hip (Legg-Perthes disease) (732.1), or slipped femoral epiphysis of the hip (732.2).

(5) Hip dislocation (835) within 2 years before examination.

(6) Osteochondritis of the tibial tuberosity (Osgood-Schlatter disease) (732.4), if symptomatic.

d. General.

(1) Deformities (905.4), disease or chronic pain (719.4) 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 walking, running, or weight bearing, or the satisfactory completion of prescribed training or military duty.

(2) Shortening of a lower extremity (736.81) resulting in a noticeable limp or scoliosis.

2-11. Miscellaneous conditions of the extremities

(See also paras 2-9 and 2-10.) The causes for rejection for appointment, enlistment, and induction are an authenticated history of:

a. Arthritis.

(1) Active, subacute, or chronic arthritis (716).

(2) Chronic osteoarthritis (715.3) or traumatic arthritis (716.1) of isolated joints of more than a minimal degree, which has interfered with the following of a physically active vocation in civilian life or that prevents the satisfactory performance of military duty.

b. Chronic Retro Patellar Knee Pain Syndrome with or without confirmatory arthroscopic evaluation (717.7).

c. Dislocation if unreduced, or recurrent dislocations of any major joint such as shoulder (831), hip (835), elbow (832), or knee (836); or instability of any major joint such as shoulder (718.1), elbow (718.3), or hip (718.5).

d. Fractures.

(1) Malunion or non-union of any fracture (733.8), except ulnar styloid process.

(2) Orthopedic hardware (733.99), including plates, pins, rods, wires, or screws used for fixation and left in place; except that a pin, wire, or screw not subject to easy trauma is not disqualifying.

e. Injury of a bone or joint of more than a minor nature, with or without fracture or dislocation, that occurred within the preceding 6 weeks: upper extremity (923), lower extremity (924), ribs and clavicle (922).

f. Joint replacement (V43.6).

g. Muscular paralysis, contracture, or atrophy (728), if progressive or of sufficient degree to interfere with military service and muscular dystrophies (359).

h. Osteochondritis dessicans (732.7).

i. Osteochondromatosis or Multiple Cartilaginous Exostoses (727.82).

j. Osteoporosis (733).

k. Osteomyelitis (730), active or recurrent.

l. Scars (709.2), extensive, deep, or adherent to the skin and soft tissues that interfere with muscular movements.

m. Implants, silastic or other devices implanted to correct orthopedic abnormalities (V43).

2-12. Eyes

The causes for rejection for appointment, enlistment, and induction are:

a. Lids.

(1) Blepharitis (373), chronic, of more than mild degree.

(2) Blepharospasm (333.81).

(3) Dacryocystitis, acute or chronic (375.3).

(4) Deformity of the lids (374.4), complete or extensive, sufficient to interfere with vision or impair protection of the eye from exposure.

b. Conjunctiva.

(1) Conjunctivitis, chronic (372.1), including trachoma (076) and allergic conjunctivitis (372.13).

(2) Pterygium, (372.4), if encroaching on the cornea in excess of 3 millimeters (mm), interfering with vision, progressive (372.42), or recurring after two operative procedures (372.45).

(3) Xerophthalmia (372.53).

c. Cornea.

(1) Dystrophy, corneal, of any type (371.5), including keratoconus (371.6) of any degree.

(2) Keratorefractive surgery, history of lamellar (P11.7) and/or penetrating keratoplasty (P11.6). Laser surgery or appliance utilized to reconfigure the cornea is also disqualifying.

(3) Keratitis (370), acute or chronic, which includes recurrent corneal ulcers, erosions (abrasions), or herpetic ulcers (054.42).

(4) Vascularization (370.6) or opacification (371) of the cornea from any cause that is progressive or reduces vision below the standards prescribed in paragraph 2–13 below.

d. Uveitis (364) or iridocyclitis.

e. Retina.

(1) Angiomas (759.6), or other congenitohereditary retinal dystrophy (362.7) that impairs visual function.

(2) Chorioretinitis or inflammation of the retina (363), including histoplasmosis, toxoplasmosis, or vascular conditions of the eye to include Coats' disease, Eales' disease, and retinitis proliferans, unless a single episode of known cause that has healed and does not interfere with vision.

(3) Congenital or degenerative changes of any part of the retina (362).

(4) Detachment of the retina (361), history of surgery for same, or peripheral retinal injury or degeneration that may cause retinal detachment.

f. Optic nerve.

(1) Optic neuritis (377.3), neuroretinitis, secondary optic atrophy, or documented history of attacks of retrobulbar neuritis.

(2) Optic atrophy (377.1), or cortical blindness (377.7).

(3) Papilledema (377.0).

g. Lens.

(1) Aphakia (379.3), lens implant, or dislocation of a lens.

(2) Opacities of the lens (366) that interfere with vision or that are considered to be progressive.

h. Ocular mobility and motility.

(1) Diplopia (386.2), documented, constant or intermittent.

(2) Nystagmus (379.5).

(3) Strabismus (378), uncorrectable by lenses to less than 40 diopters or accompanied by diplopia.

(4) Strabismus, surgery (P15) for the correction of, within the preceding 6 months.

(5) For entrance into the USMA or ROTC programs, the following conditions are also disqualifying: esotropia of over 15 prism diopters; exotropia of over 10 prism diopters; hypertropia of over 5 prism diopters.

i. Miscellaneous defects and conditions.

(1) Abnormal visual fields due to disease of the eye or central nervous system (368.4), or trauma (368.9). Meridian-specific visual field minimums are as follows:

(*a*) Temporal, 85 degrees.

(*b*) Superior-temporal, 55 degrees.

(*c*) Superior, 45 degrees.

(*d*) Superior nasal, 55 degrees.

(*e*) Nasal, 60 degrees.

(*f*) Inferior nasal, 50 degrees.

(*g*) Inferior, 65 degrees.

(*h*) Inferior-temporal, 85 degrees.

(2) Absence of an eye, congenital (743) or acquired (360.8).

(3) Asthenopia (368.13), severe.

(4) Exophthalmos (376), unilateral or bilateral, non-familial.

(5) Glaucoma (365), primary, or secondary, or pre-glaucoma as evidenced by intraocular pressure above 21 millimeters of mercury (mmHg), or the secondary changes in the optic disc or visual field loss associated with glaucoma.

(6) Loss of normal pupillary reflex reactions to accommodation (367.5) or light (379.4), including Adie's syndrome.

(7) Night blindness (368.6).

(8) Retained intraocular foreign body (360).

(9) Growth or tumors of the eyelid, other than small basal cell tumors which can be cured by treatment, and small nonprogressive asymptomatic benign lesions.

(10) Any organic disease of the eye (360) or adnexa (376) not specified above, that threatens vision or visual function.

2–13. Vision

The causes for rejection for appointment, enlistment, and induction are:

a. Distant visual acuity of any degree that does not correct with spectacle lenses to at least one of the following (367):

(1) 20/40 in one eye and 20/70 in the other eye.

(2) 20/30 in one eye and 20/100 in the other eye.

(3) 20/20 in one eye and 20/400 in the other eye. However, for entrance into USMA, distant visual acuity that does

not correct to 20/20 in each eye is disqualifying. For entrance into ROTC programs and OCS, distant visual acuity that does not correct to 20/20 in one eye and 20/100 in the other eye is disqualifying.

b. Near visual acuity (367) of any degree that does not correct to 20/40 in the better eye.

c. Refractive error (hyperopia (367.0), myopia (367.1), astigmatism (367.2)), in any spherical equivalent of worse than -8.00 or + 8.00 diopters; if ordinary spectacles cause discomfort by reason of ghost images or prismatic displacement; or if corrected by orthokeratology or keratorefractive surgery. However, for entrance into USMA or Army ROTC programs, the following conditions are disqualifying:

- (1) Astigmatism, all types over 3 diopters.
- (2) Hyperopia over 8.00 diopters spherical equivalent.
- (3) Myopia over 6.75 diopters spherical equivalent.
- (4) Refractive error corrected by orthokeratology or keratorefractive surgery.

d. Contact lenses. Complicated cases requiring contact lenses for adequate correction of vision, such as corneal scars (371) and irregular astigmatism (367.2).

e. Color vision (368.5). Although there is no standard, color vision will be tested because adequate color vision is a prerequisite for entry into many military specialties. However, for entrance into the USMA or Army ROTC or OCS programs, the inability to distinguish and identify without confusion the color of an object, substance, material, or light that is uniformly colored a vivid red or vivid green is disqualifying.

2-14. Genitalia

The causes for rejection for appointment, enlistment, and induction are:

a. Female genitalia.

- (1) Abnormal uterine bleeding (626.2), including menorrhagia, metrorrhagia, or polymenorrhea.
- (2) Amenorrhea (626.0), unexplained.
- (3) Dysmenorrhea (625.3), incapacitating to a degree recurrently necessitating absences of more than a few hours from routine activities.
- (4) Endometriosis (617).
- (5) Hermaphroditism (752.7).
- (6) Menopausal syndrome (627), if manifested by more than mild constitutional or mental symptoms, or artificial menopause if less than 1 year's duration.
- (7) Ovarian cysts (620), persistent, clinically significant.
- (8) Pelvic inflammatory disease (614), acute or chronic.
- (9) Pregnancy (V22).
- (10) Uterus, congenital absence of (752.3), or enlargement due to any cause (621.2).
- (11) Vulvar or vaginal ulceration (616.5), including herpes genitalia (054.11) and condyloma acuminatum (078.11), acute or chronic, not amenable to treatment. Such treatment must be given and demonstrated effective prior to accession.
- (12) Abnormal Pap smear (795) graded LGSIL or higher severity, or any smear in which the descriptive terms carcinoma-in-situ, invasive cancer, condyloma acuminatum, human papilloma virus, or dysplasia are used.
- (13) Major abnormalities and defects of the genitalia such as a change of sex (P64.5). A history thereof, or dysfunctional residuals from surgical correction of these conditions.

b. Male genitalia.

- (1) Absence of both testicles, either congenital (752.8), or acquired (878.2), or unexplained absence of a testicle.
- (2) Epispadias or Hypospadias (752.6), when accompanied by evidence of infection of the urinary tract, or if clothing is soiled when voiding.
- (3) Undiagnosed enlargement or mass of testicle or epididymis (608.9).
- (4) Undescended testicle(s) (752.5).
- (5) Orchitis (604), acute or chronic epididymitis.
- (6) Penis, amputation of (878), if the resulting stump is insufficient to permit normal micturition.
- (7) Penile infectious lesions, including herpes genitalis (054.1) and condyloma acuminata (078.11), acute or chronic, not amenable to treatment. Such treatment must be given and demonstrated effective prior to accession.
- (8) Prostatitis (601), acute or chronic.
- (9) Hydrocele (603.9). Left varicocele, if painful, or any right varicocele (456.4).

c. Major abnormalities and defects of the genitalia, such as a change of sex (P64.5), a history thereof, or dysfunctional residuals from surgical correction of these conditions.

2-15. Urinary system

(See para 2-8.) The causes for rejection for appointment, enlistment, and induction are:

a. Cystitis (595).

- b. Urethritis (597).
- c. Enuresis (788.3) or incontinence of urine beyond age 12. (See also para 2–29.)
- d. Hematuria, pyuria, or other findings indicative of renal tract disease (599).
- e. Urethral stricture (598) or fistula (599.1).
- f. Kidney.
 - (1) Absence of one kidney, congenital (753.0) or acquired (593.89).
 - (2) Infections, acute or chronic (590).
 - (3) Polycystic kidney (753.1), confirmed history of.
 - (4) Horseshoe kidney (753.3).
 - (5) Hydronephrosis (591).
 - (6) Nephritis, acute (580) or chronic (582).
- g. Proteinuria (791) under normal activity (at least 48 hours after strenuous exercise) greater than 200 milligrams (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.
- h. Renal calculus (592) within the previous 12 months, recurrent calculus, nephrocalcinosis, or bilateral renal calculi at any time.

2–16. Head

The causes for rejection for appointment, enlistment, and induction are:

- a. Injuries, including severe contusions and other wounds of the scalp (920) and cerebral concussion (850), until a period of 3 months has elapsed. (See para 2–26.)
- b. Deformities of the skull, face, or jaw (754.0) of a degree that would prevent the individual from wearing a protective mask or military headgear.
- c. Defects (756.0), loss or congenital absence of the bony substance of the skull not successfully corrected by reconstructive materials, or leaving residual defect in excess of 1 square inch (6.45 centimeter (cm)²) or the size of a 25 cent piece.

2–17. Neck

The causes for rejection for appointment, enlistment, and induction are:

- a. Cervical ribs (756.2), if symptomatic or so obvious that they are found on routine physical examination. (Detection based primarily on x-rays is not considered to meet this criterion.)
- b. Congenital cysts (744.4) of branchial cleft origin or those developing from remnants of the thyroglossal duct, with or without fistulous tracts.
- c. Contraction (723.8) of the muscles of the neck, spastic or non-spastic, or cicatricial contracture of the neck to the extent that it interferes with wearing a uniform or military equipment or is so disfiguring as to impair military bearing.

2–18. Heart

The causes for rejection for appointment, enlistment, and induction are:

- a. All valvular heart diseases, congenital (746) or acquired (394), 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.
- b. Coronary heart disease (410).
- c. Symptomatic arrhythmia (or electrocardiographic evidence of arrhythmia), history of.
 - (1) Supraventricular tachycardia (427.0), or any dysrhythmia originating from the atrium or sinoatrial node, such as atrial flutter, and atrial fibrillation, unless there has been no recurrence during the preceding 2 years while off all medications. Premature atrial or ventricular contractions are disqualifying when sufficiently symptomatic to require treatment or result in physical or psychological impairment.
 - (2) Ventricular arrhythmias (427.1), including ventricular fibrillation, tachycardia, and multi focal premature ventricular contractions. Occasional asymptomatic premature ventricular contractions are not disqualifying.
 - (3) Ventricular conduction disorders, left bundle branch block (426.2), Mobitz type II second degree atrioventricular (AV) block (426.12), and third degree AV block (426.0). Wolff-Parkinson-White Syndrome (426.7) and Lown-Ganong-Levine-Syndrome (426.81) associated with an arrhythmia are also disqualifying.
 - (4) Conduction disturbances such as first degree AV block (426.11), left anterior hemiblock (426.2), right bundle branch block (426.4), or Mobitz type I second degree AV block (426.13) are disqualifying when symptomatic or associated with underlying cardiovascular disease.
- d. Hypertrophy or dilatation of the heart (429.3).
- e. Cardiomyopathy (425), including myocarditis (422), or history of congestive heart failure (428) even though currently compensated.
- f. Pericarditis (420).

- g.* Persistent tachycardia (785) (resting pulse rate of 100 or greater).
- h.* Congenital anomalies of heart and great vessels (746), except for corrected patent ductus arteriosus.

2–19. Vascular system

The causes for rejection for appointment, enlistment, and induction are:

- a.* Abnormalities of the arteries and blood vessels (447), including aneurysms (442), even if repaired, atherosclerosis (440), or arteritis (446).
- b.* Hypertensive vascular disease (401), evidenced by the average of three consecutive diastolic blood pressure measurements greater than 90 mmHg or three consecutive systolic pressure measurements greater than 140 mmHg. High blood pressure requiring medication or a history of treatment including dietary restriction.
- c.* Pulmonary (415) or systemic embolization (444).
- d.* Peripheral vascular disease, including Raynaud's phenomenon (443).
- e.* Vein diseases, recurrent thrombophlebitis (451), thrombophlebitis during the preceding year, or any evidence of venous incompetence, such as large or symptomatic varicose veins, edema, or skin ulceration (454).

2–20. Height

The causes for rejection for appointment, enlistment, and induction are:

- a.* Men: Height below 60 inches or over 80 inches.
- b.* Women: Height below 58 inches or over 80 inches.

2–21. Weight

a. Army applicants for initial appointment as commissioned officers (to include appointment as commissioned warrant officers) must meet the standards of AR 600–9. Body fat composition is used as the final determinant in evaluating an applicant's acceptability when the weight exceeds the weight tables.

b. All other applicants must meet the standards of tables 2–1 and 2–2. Body fat composition is used as the final determinant in evaluating an applicant's acceptability when the weight exceeds the weight tables.

2–22. Body build

The cause for rejection for appointment, enlistment, and induction is deficient muscular development that would interfere with the completion of required training.

2–23. Lungs, chest wall, pleura, and mediastinum

The causes for rejection for appointment, enlistment, and induction are:

- a.* Abnormal elevation of the diaphragm (793.2), either side.
- b.* Abscess of the lung (513).
- c.* Acute infectious processes of the lung (518), until cured.
- d.* Asthma (493), including reactive airway disease, exercise induced bronchospasm or asthmatic bronchitis, reliably diagnosed at any age. Reliable diagnostic criteria should consist of any of the following elements:
 - (1) Substantiated history of cough, wheeze, and/or dyspnea that persists or recurs over a prolonged period of time, generally more than 6 months.
 - (2) If the diagnosis of asthma is in doubt, a test for reversible airflow obstruction (greater than a 15 percent increase in forced expiratory volume in 1 second (FEV1) following administration of an inhaled bronchodilator) or airway hyperactivity (exaggerated decrease in airflow induced by standard bronchoprovocation challenge such as methacholine inhalation or a demonstration of exercise-induced bronchospasm) must be performed.
- e.* Bronchitis (490), chronic, symptoms over 3 months occurring at least twice a year.
- f.* Bronchiectasis (494).
- g.* Bronchopleural fistula (510).
- h.* Bullous or generalized pulmonary emphysema (492).
- i.* Chronic mycotic diseases (117) of the lung including coccidioidomycosis.
- j.* Chest wall malformation (754) or fracture (807) that interferes with vigorous physical exertion.
- k.* Empyema (510), including residual pleural effusion (511.9) or unhealed sinuses of chest wall (510).
- l.* Extensive pulmonary fibrosis (515).
- m.* Foreign body in lung, trachea, or bronchus (934).
- n.* Lobectomy, with residual pulmonary disease or removal of more than one lobe (P32.4).
- o.* Pleurisy with effusion (511.9), within the previous 2 years if known or unknown origin.
- p.* Pneumothorax (512) during the year preceding examination if due to a simple trauma or surgery; during the 3 years preceding examination from spontaneous origin. Recurrent spontaneous pneumothorax after surgical correction or pleural sclerosis.
- q.* Sarcoidosis (135). (See para 2–34.)

r. Silicone breast implants, encapsulated (85.53) if less than 9 months since surgery or with symptomatic complications.

s. Tuberculous lesions. (See para 2–34.)

2–24. Mouth

The causes for rejection for appointment, enlistment, and induction are:

a. Cleft lip or palate defects (749), unless satisfactorily repaired by surgery.

b. Leukoplakia (528.6).

2–25. Nose, sinuses, and larynx

The causes for rejection for appointment, enlistment, and induction are:

a. Allergic manifestations.

(1) Allergic or vasomotor rhinitis (477), if moderate or severe and not controlled by oral medications, desensitization, or topical corticosteroid medication.

(2) Atrophic rhinitis (472).

(3) Vocal cord paralysis (478.3), or symptomatic disease of the larynx (478.7).

b. Anosmia or parosmia (352).

c. Epistaxis (784.7), recurrent.

d. Nasal polyps (471), unless surgery was performed at least 1 year before examination.

e. Perforation of nasal septum (478.1), if symptomatic or progressive.

f. Sinusitis (461), acute.

g. Sinusitis, chronic (473), when evidenced by chronic purulent nasal discharge, hyperplastic changes of the nasal tissue, symptoms requiring frequent medical attention, or x-ray findings.

h. Larynx ulceration, polyps, granulated tissue, or chronic laryngitis (476).

i. Tracheostomy (V44) or tracheal fistula.

j. Deformities or conditions (750.9) of the mouth, tongue, palate throat, pharynx, larynx, and nose that interfere with chewing, swallowing, speech, or breathing.

k. Pharyngitis (462) and nasopharyngitis (472.2), chronic.

2–26. Neurological disorders

The causes for rejection for appointment, enlistment, and induction are:

a. Cerebrovascular conditions, any history of subarachnoid (430) or intracerebral (431) hemorrhage, vascular insufficiency, aneurysm, or arteriovenous malformation (437).

b. Congenital malformations (742), if associated with neurological manifestations or if known to be progressive; meningocele (741), even if uncomplicated.

c. Degenerative and hereditodegenerative disorders affecting the cerebrum (330), basal ganglia (333), cerebellum (334), spinal cord (335), and peripheral nerves, or muscles (337).

d. Recurrent headaches (784) of all types if they are of sufficient severity or frequency to interfere with normal function within 3 years.

e. Head injury (854).

(1) Applicants with a history of head injury with—

(a) Late post-traumatic epilepsy (occurring more than 1 week after injury).

(b) Permanent motor or sensory deficits.

(c) Impairment of intellectual function.

(d) Alteration of personality.

(e) Central nervous system shunt.

(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 neurophysical evaluation shows no residual dysfunction or complications. Applicants with a history of severe penetrating head injury are unfit for a period of at least 10 years after the injury. After 10 years they may be considered fit if complete neurological and neuropsychological evaluation shows no residuals dysfunction or complications. Severe head injuries are defined by one or more of the following:

(a) Unconsciousness or amnesia, alone or in combination, of 24 hours duration or longer.

(b) Depressed skull fracture.

(c) Laceration or contusion of dura or brain.

(d) Epidural, subdural, subarachnoid, or intracerebral hematoma.

(e) Associated abscess or meningitis.

(f) Cerebrospinal fluid rhinorrhea or otorrhea persisting more than 7 days.

(g) Focal neurologic signs.

- (h) Radiographic evidence of retained metallic or bony fragments.
 - (i) Leptomeningeal cysts or arteriovenous fistula.
 - (j) Early post-traumatic seizure(s) occurring within 1 week of injury but more than 30 minutes after injury.
- (3) Applicants with a history of moderate head injury are unfit for a period of at least 2 years after injury, after which they may be considered fit if complete neurological evaluation shows no residual dysfunction or complications. Moderate head injuries are defined by unconsciousness or amnesia, alone or in combination of 1 to 24 hours duration or linear skull fracture.
- (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 injury; after which they may be acceptable if neurological evaluation shows no residual dysfunction or complications.
- (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.
- f. Infectious diseases.
 - (1) Meningitis (322), encephalitis (323), or poliomyelitis (045) within 1 year before examination, or if there are residual neurological defects.
 - (2) Neurosyphilis (094) of any form, general paresis, tabes dorsalis meningovascular syphilis.
 - g. Narcolepsy (347), sleep apnea syndrome (780.57).
 - h. Paralysis, weakness, lack of coordination, pain, sensory disturbance (344).
 - i. Epilepsy (345), beyond the age of 5 unless the applicant has been free of seizures for a period of 5 years while taking no medication for seizure control, and has a normal electroencephalogram (EEG). All such applicants will have a current neurology consultation with current EEG results. EEG may be requested by the reviewing authority.
 - j. Chronic disorders such as myasthenia gravis (358) and multiple sclerosis (340).
 - k. Central nervous system shunts of all kinds (V45.2).

2–27. Disorders with psychotic features

The causes for rejection for appointment, enlistment, and induction are disorders with psychotic features (295).

2–28. Neurotic, anxiety, mood, somatoform, dissociative, or factitious disorders

The causes for rejection for appointment, enlistment, and induction are a history of such disorders (300) resulting in any or all of the below:

- a. Admission to a hospital or residential facility.
- b. Care by a physician or other mental health professional for more than 6 months.
- c. Symptoms or behavior of a repeated nature that impaired social, school, or work efficiency.

2–29. Personality, conduct, and behavior disorders

The causes for rejection for appointment, enlistment, and induction are:

- a. Personality (301), conduct (312), or behavior disorders (313) 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 capacity to adapt to military service.
- b. Personality (301), conduct (312), or behavior (313) 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 Army as demonstrated by repeated inability to maintain reasonable adjustment in school, with employers and fellow workers, and with other social groups.
- c. Other behavior disorders including but not limited to conditions such as authenticated evidence of functional enuresis (307.6) or encopresis (307.7), sleepwalking (307.6), or eating disorders that are habitual or persistent (307.1 or 307.5) occurring beyond age 12, or stammering (307.0) of such a degree that the individual is normally unable to express himself or herself clearly or to repeat commands.
- d. Specific academic skills defects, chronic history of academic skills (314) or perceptual defects (315), 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. Suicide, history of attempted or suicidal behavior (300.9).

2–30. Psychosexual conditions

The causes for rejection for appointment, enlistment, and induction are transsexualism, exhibitionism, transvestitism, voyeurism, and other paraphilias (302).

2-31. Substance misuse

The causes for rejection for appointment, enlistment, and induction are:

- a. Alcohol dependence (303).
- b. Drug dependence (304).
- c. Non-dependent use of drugs characterized by—
 - (1) The evidence of use of any controlled hallucinogenic, or other intoxicating substance at time of examination (305), when the use cannot be accounted for as the result of a prescription of a physician.
 - (2) Documented misuse or abuse of any controlled substance (including cannabinoids or anabolic steroids) requiring professional care (305).
 - (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 (305).
- d. The use of LSD (305.3) within a 2-year period of the examination.
- e. Alcohol abuse (305), use of alcoholic beverages that 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.

2-32. Skin and cellular tissues

The causes for rejection for appointment, enlistment, and induction are:

- a. Acne (706), 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 would not be amenable to treatment. Patients under treatment with isotretinoin (Accutane) are medically unacceptable until 8 weeks after completion of course of therapy.
- b. Atopic dermatitis (691) or eczema (692), with active or residual lesions in characteristic areas (face, neck, antecubital, and or/popliteal fossae, occasionally wrists and hands), or documented history thereof after the age of 8.
- c. Contact dermatitis (692.4), especially involving rubber or other materials used in any type of required protective equipment.
- d. Cysts.
 - (1) Cysts (706.2), other than pilonidal, of such a size or location as to interfere with the normal wearing of military equipment.
 - (2) Pilonidal cysts (685), if evidenced by the presence of a tumor mass or a discharging sinus. History of pilonidal cystectomy within 6 months before examination is disqualifying.
- e. Dermatitis factitia (698.4).
- f. Bullous dermatoses (694), such as Dermatitis Herpetiformis, pemphigus, and epidermolysis bullosa.
- g. Chronic Lymphedema (457).
- h. Fungus infections (117), systemic or superficial types, if extensive and not amenable to treatment.
- i. Furunculosis (680), extensive recurrent, or chronic.
- j. Hyperhidrosis of hands or feet (780.8), chronic or severe.
- k. Ichthyosis, or other congenital (757) or acquired (216) anomalies of the skin such as nevi or vascular tumors that interfere with function or are exposed to constant irritation.
- l. Keloid formation (701.4), if the tendency is marked or interferes with the wearing of military equipment.
- m. Leprosy (030.9), any type.
- n. Lichen planus (697.0).
- o. Neurofibromatosis (von Recklinghausen's disease) (237.7).
- p. Photosensitivity (692.72), any primary sun-sensitive condition, such as polymorphous light eruption or solar urticaria; any dermatosis aggravated by sunlight such as lupus erythematosus.
- q. Psoriasis (696.1), unless mild by degree, not involving nail pitting, and not interfering with wearing military equipment or clothing.
- r. Radiodermatitis (692.82).
- s. Scars (709.2) that are so 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 the area is susceptible to trauma.
- t. Scleroderma (710.1).
- u. Tattoos (709.9) that will significantly limit effective performance of military service or that are otherwise prohibited under AR 670-1.
- v. Urticaria (708.8), chronic.
- w. Warts, plantar (078.19), symptomatic.
- x. Xanthoma (272.2), if disabling or accompanied by hyperlipemia.

y. Any other chronic skin disorder of a degree or nature, such as Dysplastic Nevi Syndrome (448.1), which requires frequent outpatient treatment or hospitalization, or interferes with the satisfactory performance of duty.

2-33. Spine and sacroiliac joints

(See also para 2-11.) The causes for rejection for appointment, enlistment, and induction are:

- a. Arthritis (720). (See para 2-11a.)
- b. 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 (724) or that is associated with pain referred to the lower extremities, muscular spasm, postural deformities, or limitation of motion.
- c. Deviation or curvature of spine (737) from normal alignment, structure, or function if—
 - (1) It prevents the individual from following a physically active vocation in civilian life.
 - (2) It interferes with wearing a uniform or military equipment.
 - (3) It is symptomatic and associated with positive physical finding(s) and demonstrable by x-ray.
 - (4) 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.
- d. Fusion, congenital (756.15), involving more than two vertebrae. Any surgical fusion (81.0P) is disqualifying.
- e. Healed fractures or dislocations of the vertebrae (805). 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.
- f. Juvenile epiphysitis (732.6) with any degree of residual change indicated by x-ray or kyphosis.
- g. Ruptured nucleus pulposus (722), herniation of intervertebral disk or history of operation for this condition.
- h. Spina bifida (741) when symptomatic or if there is more than one vertebra involved, dimpling of the overlying skin, or a history of surgical repair.
- i. Spondylolysis (756.1) and spondylolisthesis (738.4).
- j. Weak or painful back (724) requiring external support such as a corset or brace; recurrent sprains or strains requiring limitation of physical activity or frequent treatment.

2-34. Systemic diseases

The causes for rejection for appointment, enlistment, and induction are:

- a. Amyloidosis (277.3).
- b. Ankylosing spondylitis (720).
- c. Eosinophilic granuloma (277.8) 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.
- d. Lupus erythematosus (710) and mixed connective tissue disease.
- e. Polymyositis/dermatomyositis complex (710).
- f. Progressive Systemic Sclerosis (710), including CRST (calcinosis, Raynaud's phenomenon, sclerodactyly, and telangiectasis) variant. A single plaque of localized scleroderma (morphea) that has been stable for at least 2 years is not disqualifying.
- g. Reiter's Disease (099.3).
- h. Rheumatoid arthritis (714).
- i. Rhabdomyolysis (728.9).
- j. Sarcoidosis (135), unless there is substantiated evidence of a complete spontaneous remission of at least 2 years duration.
- k. Sjogren's Syndrome (710.2).
- l. Tuberculosis (010).
 - (1) Active tuberculosis in any form or location, or history of active tuberculosis within the previous 2 years.
 - (2) One or more reactivations.
 - (3) Residual physical or mental defects from past tuberculosis that would preclude the satisfactory performance of duty.
 - (4) Individuals with a past history of active tuberculosis MORE than 2 years prior to enlistment, induction and appointment are QUALIFIED IF they have received a complete course of standard chemotherapy for tuberculosis. In addition, individuals with a tuberculin reaction 10 mm or greater and without evidence of residual disease are qualified once they have been treated with chemoprophylaxis.
 - (5) Vasculitis (446) such as Bechet's, Wegener's granulomatosis, polyarteritis nodosa.

2-35. General and miscellaneous conditions and defects

The causes for rejection for appointment, enlistment, and induction are:

- a.* Allergic manifestations (995.0). A reliable history of anaphylaxis to stinging insects. Reliable history of a moderate to severe reaction to common foods, spices, or food additives.
- b.* Any acute pathological condition, including acute communicable diseases, until recovery has occurred without sequelae.
- c.* Chronic metallic poisoning with lead, arsenic, or silver (985), or beryllium or manganese (985).
- d.* Cold injury (991), 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.
- e.* Cold urticaria (708.2) and angioedema, hereditary angioedema (277.6).
- f.* Filariasis (125), trypanosomiasis (086), schistosomiasis (120), uncinariasis (126.9), or other parasitic conditions, if symptomatic or carrier states.
- g.* Heat pyrexia, heatstroke, or sunstroke (992). Documented evidence of a predisposition (including disorders of sweat mechanism and a previous serious episode), recurrent episodes requiring medical attention, or residual injury (especially cardiac, cerebral, hepatic, and renal); malignant hyperthermia (995.89).
- h.* Industrial solvent and other chemical intoxication (982).
- i.* Motion sickness (994.6). An authenticated history of frequent incapacitating motion sickness after the 12th birthday.
- j.* Mycotic (114) infection of internal organs.
- k.* Organ transplant recipient (V42).
- l.* Presence of human immunodeficiency virus (HIV-I) or antibody (042). Presence is confirmed by repeatedly reactive enzyme-linked immunoassay serological test and positive immunoelectrophoresis (Western Blot) test, or other DOD-approved confirmatory test.
- m.* Reactive tests for syphilis (093) such as the rapid plasma reagin (RPR) test 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 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.
- n.* Residual of tropical fevers, such as malaria (084) and various parasitic or protozoal infestations that prevent the satisfactory performance of military duty.
- o.* Rheumatic fever (390) during the previous 2 years, or any history of recurrent attacks; Sydenham's chorea at any age.
- p.* Sleep apnea (780.57).

2-36. Tumors and malignant diseases

The causes for rejection for appointment, enlistment, and induction are:

- a.* Benign tumors (M8000) that interfere with function, prevent wearing the uniform or protective equipment, would require frequent specialized attention, or have a high malignant potential.
- b.* Malignant tumors (V10), exception for basal cell carcinoma, removed with no residual. In addition, the following cases should be qualified if on careful review they meet the following criteria: individuals who have a history of childhood cancer who have not received any surgical or medical cancer therapy for 5 years and are free of cancer; individuals with a history of Wilm's tumor and germ cell tumors of the testis treated surgically and/or with chemotherapy after a 2-year disease-free interval off all treatment; individuals with a history of Hodgkin's disease treated with radiation therapy and/or chemotherapy and disease free off treatment for 5 years; individuals with a history of large cell lymphoma after a 2-year disease-free interval off all therapy.

2-37. Miscellaneous

Any condition that in the opinion of the examining medical officer will significantly interfere with the successful performance of military duty or training (796) may be a cause for rejection for appointment, enlistment, and induction.

Table 2-1
Military acceptable weight (in pounds) as related to age and height for males—Initial Army procurement^{1, 2}

Height (inches)	Minimum weight any age	Maximum weight by years of age			
		17-20	21-27	28-39	40 and over
60	100	139	141	143	146
61	102	144	146	148	151
62	103	148	150	153	156
63	104	153	155	158	161
64	105	158	160	163	166
65	106	163	165	168	171
66	107	168	170	173	177
67	111	174	176	179	182
68	115	179	181	184	187
69	119	184	186	189	193
70	123	189	192	195	199
71	127	194	197	201	204
72	131	200	203	206	210
73	135	205	208	212	216
74	139	211	214	218	222
75	143	217	220	224	228
76	147	223	226	230	234
77	151	229	232	236	240
78	153	235	238	242	247
79	159	241	244	248	253
80	166	247	250	255	259
		Maximum body fat by years of age			
		17-20	21-27	28-39	40 and over
		24%	26%	28%	30%

Notes:

¹ If a male exceeds these weights, percent body fat will be measured by the method described in AR 600-9.

² If a male also exceeds this body fat, he will be rejected for service.

Table 2-2
Military acceptable weight (in pounds) as related to age and height for females—Initial Army procurement^{1, 2}

Height (inches)	Minimum weight any age	Maximum weight by years of age			
		17-20	21-27	28-39	40 and over
58	90	112	115	119	122
59	92	116	119	123	126
60	94	120	123	127	130
61	96	124	127	131	135
62	98	129	132	137	139
63	100	133	137	141	144
64	102	137	141	145	148
65	104	141	145	149	153
66	106	146	150	154	158
67	109	149	154	159	162
68	112	154	159	164	167
69	115	158	163	168	172
70	118	163	168	173	177
71	122	167	172	177	182

Table 2-2
Military acceptable weight (in pounds) as related to age and height for females—Initial Army procurement¹, ²—Continued

Height (inches)	Minimum weight any age	Maximum weight by years of age			
		17-20	21-27	28-39	40 and over
72	125	172	177	183	188
73	128	177	182	188	193
74	130	183	189	194	198
75	133	188	194	200	204
76	136	194	200	206	209
77	139	199	205	211	215
78	141	204	210	216	220
79	144	209	215	222	226
80	147	214	220	227	232
		Maximum body fat by years of age			
		17-20	21-27	28-39	40 and over
		30%	32%	34%	36%

Notes:

¹ If a female exceeds these weights, percent body fat will be measured by the method described in AR 600-9.

² If a female also exceeds this body fat, she will be rejected for service.

Chapter 3 Medical Fitness Standards for Retention and Separation, Including Retirement

3-1. General

This chapter gives the various medical conditions and physical defects which may render a soldier unfit for further military service and which fall below the standards required for the individuals in paragraph 3-2 below.

3-2. Application

These standards apply to the following individuals (see chaps 4 and 5 for other standards that apply to specific specialties):

- a. All commissioned and warrant officers of the Active Army, ARNGUS, and USAR.
- b. All enlisted soldiers of the Active Army, ARNGUS, and USAR.
- c. Students already enrolled in the HPSP and USUHS programs.
- d. Enlisted soldiers of the ARNGUS or USAR who apply for enlistment in the regular Army.
- e. Commissioned and warrant officers of the ARNGUS or USAR who apply for appointment in the Active Army.
- f. Soldiers of the ARNGUS or USAR who re-enter active duty under the “split-training option.” (However, the weight standards of tables 2-1 and 2-2 apply to split option trainees.)
- g. Retired soldiers recalled to active duty.

3-3. Disposition

Soldiers with conditions listed in this chapter who do not meet the required medical standards will be evaluated by an MEB as defined in AR 40-400 and will be referred to a PEB as defined in AR 635-40 with the following caveats:

- a. USAR or ARNGUS soldiers not on active duty, whose medical condition was not incurred or aggravated during an active duty period, will be processed in accordance with chapter 9 and chapter 10 of this regulation.
- b. Soldiers pending separation in accordance with provisions of AR 635-200 or AR 600-8-24 authorizing separation under other than honorable conditions who do not meet medical retention standards will be referred to an MEB. In the case of enlisted soldiers, the physical disability processing and the administrative separation processing will be conducted in accordance with the provisions of AR 635-200 and AR 635-40. In the case of commissioned or warrant officers, the physical disability processing and the administrative separation processing will be conducted in accordance with the provisions of AR 600-8-24 and AR 635-40.
- c. A soldier will not be referred to an MEB or a PEB because of impairments that were known to exist at the time of acceptance in the Army and that have remained essentially the same in degree of severity and have not interfered with successful performance of duty.
- d. Physicians who identify soldiers with medical conditions listed in this chapter should initiate an MEB at the time

of identification. Physicians should not defer initiating the MEB until the soldier is being processed for nondisability retirement. Many of the conditions listed in this chapter (for example, arthritis in para 3–14*b*) fall below retention standards only if the condition has precluded or prevented successful performance of duty. In those cases, when it is clear the condition is long standing and has not prevented the soldier from reaching retirement eligibility, then the soldier meets retention standards and an MEB is not required.

e. Soldiers who have previously been found unfit for duty by a PEB, but were continued on active duty (COAD) under the provisions of AR 635–40, chapter 6, will be referred to a PEB prior to retirement or separation processing.

f. If the Secretary of Defense prescribes less stringent standards during partial or full mobilization, individuals who meet the less stringent standards but do not meet the standards of this chapter will not be referred for an MEB or a PEB, until the termination of the mobilization or as directed by the Secretary of the Army.

3–4. General policy

Possession of one or more of the conditions listed in this chapter does not mean automatic retirement or separation from the Service. Physicians are responsible for referring soldiers with conditions listed below to an MEB. It is critical that MEBs are complete and reflect all of the soldier’s medical problems and physical limitations. The PEB will make the determination of fitness or unfitness. The PEB, under the authority of the U.S. Army Physical Disability Agency, will consider the results of the MEB, as well as the requirements of the soldier’s MOS, in determining fitness. See chapter 9 and chapter 10 of this regulation for processing of RC soldiers.

3–5. Abdominal and gastrointestinal defects and diseases

The causes for referral to an MEB are as follows:

a. Achalasia (cardiospasm) with dysphagia not controlled by dilatation or surgery, continuous discomfort, or inability to maintain weight.

b. Amoebic abscess with persistent abnormal liver function tests and failure to maintain weight and vigor after appropriate treatment.

c. Biliary dyskinesia with frequent abdominal pain not relieved by simple medication, or with periodic jaundice.

d. Cirrhosis of the liver with recurrent jaundice, ascites, or demonstrable esophageal varices or history of bleeding therefrom.

e. Gastritis, if severe, chronic hypertrophic gastritis with repeated symptomatology and hospitalization, confirmed by gastroscopic examination.

f. Hepatitis, chronic, when, after a reasonable time (1 or 2 years) following the acute stage, symptoms persist, and there is objective evidence of impairment of liver function.

g. Hernia, including inguinal, and other abdominal, except for small asymptomatic umbilical, with severe symptoms not relieved by dietary or medical therapy, or recurrent bleeding in spite of prescribed treatment or other hernias if symptomatic and if operative repair is contraindicated for medical reasons or when not amenable to surgical repair.

h. Crohn’s Disease/Ileitis, regional, except when responding well to treatment.

i. Pancreatitis, chronic, with frequent abdominal pain of a severe nature; steatorrhea or disturbance of glucose metabolism requiring hypoglycemic agents.

j. Peritoneal adhesions with recurring episodes of intestinal obstruction characterized by abdominal colicky pain, vomiting, and intractable constipation requiring frequent admissions to the hospital.

k. Proctitis, chronic, with moderate to severe symptoms of bleeding, painful defecation, tenesmus, and diarrhea, and repeated admissions to the hospital.

l. Ulcer, duodenal, or gastric with repeated hospitalization, or “sick in quarters” because of frequent recurrence of symptoms (pain, vomiting, or bleeding) in spite of good medical management and supported by endoscopic evidence of activity.

m. Ulcerative colitis, except when responding well to treatment.

n. Rectum, stricture of with severe symptoms of obstruction characterized by intractable constipation, pain on defecation, or difficult bowel movements, requiring the regular use of laxatives or enemas, or requiring repeated hospitalization.

3–6. Gastrointestinal and abdominal surgery

The causes for referral to an MEB are as follows:

a. Colectomy, partial, when more than mild symptoms of diarrhea remain or if complicated by colostomy.

b. Colostomy, when permanent.

c. Enterostomy, when permanent.

d. Gastrectomy, total.

e. Gastrectomy, subtotal, with or without vagotomy, or gastrojejunostomy, with or without vagotomy, when, in spite

of good medical management, the individual develops “dumping syndrome” which persists for 6 months postoperatively; or develops frequent episodes of epigastric distress with characteristic circulatory symptoms or diarrhea persisting 6 months postoperatively; or continues to demonstrate appreciable weight loss 6 months postoperatively.

- f.* Gastrostomy, when permanent.
- g.* Ileostomy, when permanent.
- h.* Pancreatectomy.
- i.* Pancreaticoduodenostomy, pancreaticogastrostomy, or pancreaticojejunostomy, followed by more than mild symptoms of digestive disturbance, or requiring insulin.
- j.* Proctectomy.
- k.* Proctopexy, proctoplasty, proctorrhaphy, or proctotomy, if fecal incontinence remains after an appropriate treatment period.

3–7. Blood and blood-forming tissue diseases

The causes for referral to an MEB are as follows:

- a.* Anemia, hereditary, acquired, aplastic, or unspecified, when response to therapy is unsatisfactory, or when therapy is such as to require prolonged, intensive medical supervision.
- b.* Hemolytic crisis, chronic and symptomatic.
- c.* Leukopenia, chronic, when response to therapy is unsatisfactory, or when therapy is such as to require prolonged, intensive medical supervision.
- d.* Hypogammaglobulinemia with objective evidence of function deficiency and severe symptoms not controlled with treatment.
- e.* Purpura and other bleeding diseases, when response to therapy is unsatisfactory, or when therapy is such as to require prolonged, intensive medical supervision.
- f.* Thromboembolic disease when response to therapy is unsatisfactory, or when therapy is such as to require prolonged, intensive medical supervision.
- g.* Splenomegaly, chronic.
- h.* HIV confirmed antibody positivity, with the presence of progressive clinical illness or immunological deficiency.

For regular Army soldiers and RC soldiers on active duty for more than 30 days (except for evaluation under the Walter Reed Staging System or for training under 10 USC 10148), an MEB must be accomplished and, if appropriate, the soldier must be referred to a PEB under AR 635–40. For RC soldiers not on active duty for more than 30 days or on ADT under 10 USC 10148, referral to a PEB will be determined under AR 635–40. Records of official diagnoses provided by private physicians (that is, civilian doctors providing evaluations under contract with Department of the Army (DA) or DOD, or civilian public health officials) concerning the presence of progressive clinical illness or immunological deficiency in RC soldiers may be used as a basis for administrative action under, for example, AR 135–133, AR 135–175, AR 135–178, or AR 140–10, as appropriate. See AR 600–110 for HIV policies, including testing requirements.

3–8. Dental diseases and abnormalities of the jaws

The causes for referral to an MEB are diseases of the jaws, periodontium, or associated tissues when, following restorative surgery, there are residuals that are incapacitating or interfere with the individual’s satisfactory performance of military duty.

3–9. Ears

The causes for referral to an MEB are as follows:

- a.* Infections of the external auditory canal when chronic and severe, resulting in thickening and excoriation of the canal or chronic secondary infection requiring frequent and prolonged medical treatment and hospitalization.
- b.* Malfunction of the acoustic nerve. (Evaluate functional impairment of hearing under para 3–10.)
- c.* Mastoiditis, chronic, with constant drainage from the mastoid cavity, requiring frequent and prolonged medical care.
- d.* Mastoiditis, chronic, following mastoidectomy, with constant drainage from the mastoid cavity, requiring frequent and prolonged medical care or hospitalization.
- e.* Meniere’s syndrome or any peripheral imbalance, syndrome or labyrinthine disorder with recurrent attacks of sufficient frequency and severity as to interfere with the satisfactory performance of duty or requiring frequent or prolonged medical care or hospitalization.
- f.* Otitis media, moderate, chronic, suppurative, resistant to treatment, and necessitating frequent and prolonged medical care or hospitalization.

3–10. Hearing

Trained and experienced personnel will not be categorically disqualified if they are capable of effective performance of duty with a hearing aid. Most soldiers having a hearing defect can be returned to duty with appropriate assignment

limitations. Soldiers incapable of performing duty with a hearing aid will be referred for MEB/PEB processing. See paragraph 8–26.

3–11. Endocrine and metabolic disorders

The causes for referral to an MEB are as follows:

- a.* Acromegaly with severe function impairment.
- b.* Adrenal dysfunction that does not respond to therapy satisfactorily or where replacement therapy presents serious problems in management.
- c.* Diabetes insipidus unless mild and the patient shows good response to treatment.
- d.* Diabetes mellitus when proven to require insulin or oral medications for control.
- e.* Goiter causing breathing obstruction.
- f.* Gout in advanced cases with frequent acute exacerbations and severe bone, joint, or kidney damage.
- g.* Hyperinsulinism when caused by a tumor or when the condition is not readily controlled.
- h.* Hyperparathyroidism when residuals or complications of surgical correction such as renal disease or bony deformities preclude the reasonable performance of military duty.
- i.* Hypofunction, adrenal cortex requiring medication for control.
- j.* Osteomalacia with residuals after therapy of such nature or degree as to preclude the satisfactory performance of duty.

3–12. Upper extremities

(See also para 3–14.) The causes for referral to an MEB are as follows:

- a.* Amputation of part or parts of an upper extremity equal to or greater than—
 - (1) A thumb proximal to the interphalangeal joint.
 - (2) Two fingers of one hand, other than the little finger, at the proximal interphalangeal joints.
 - (3) One finger, other than the little finger, at the metacarpophalangeal joint and the thumb of the same hand at the interphalangeal joint.
- b.* Joint ranges of motion which do not equal or exceed the measurements listed below. Measurements must be made with a goniometer and conform to the methods illustrated and described in TC 8–640.
 - (1) Shoulder—forward elevation to 90 degrees, or abduction to 90 degrees.
 - (2) Elbow—flexion to 100 degrees, or extension to 60 degrees.
 - (3) Wrist—a total range extension plus flexion of 15 degrees.
 - (4) Hand (for this purpose, combined joint motion is the arithmetic sum of the motion at each of the three finger joints (TC 8–640))—an active flexor value of combined joint motions of 135 degrees in each of two or more fingers of the same hand, or an active extensor value of combined joint motions of 75 degrees in each of the same two or more fingers, or limitation of motion of the thumb that precludes opposition to at least two finger tips.
- c.* Recurrent dislocations of the shoulder, when not repairable or surgery is contraindicated.

3–13. Lower extremities

(See also para 3–14.) The causes for referral to an MEB are as follows:

- a.* Amputations.
 - (1) Loss of toes that precludes the abilities to run or walk without a perceptible limp and to engage in fairly strenuous jobs.
 - (2) Any loss greater than that specified above to include foot, ankle, below the knee, above the knee, femur, hip.
- b.* Feet.
 - (1) Hallux valgus when moderately severe, with exostosis or rigidity and pronounced symptoms; or severe with arthritic changes.
 - (2) Pes planus, when symptomatic, more than moderate, with pronation on weight bearing which prevents the wearing of military footwear, or when associated with vascular changes.
 - (3) Pes cavus when moderately severe, with moderate discomfort on prolonged standing and walking, metatarsalgia, and which prevents the wearing of military footwear.
 - (4) Neuroma that is refractory to medical treatment, refractory to surgical treatment, and interferes with the satisfactory performance of military duties.
 - (5) Plantar fasciitis or heel spur syndrome that is refractory to medical or surgical treatment, interferes with the satisfactory performance of military duties, or prevents the wearing of military footwear.
 - (6) Hammertoes, severe, that precludes the wearing of appropriate military footwear, refractory to surgery, or interferes with satisfactory performance of duty.
 - (7) Hallux limitus, hallux rigidus.
- c.* Internal derangement of the knee.

- (1) Residual instability following remedial measures, if more than moderate in degree.
- (2) If complicated by arthritis, see paragraph 3-14a.
- d. Joint ranges of motion. Motion that does not equal or exceed the measurements listed below. Measurements must be made with a goniometer and conform to the methods illustrated and described in TC 8-640.
 - (1) Hip—flexion to 90 degrees or extension to 0 degree.
 - (2) Knee—flexion to 90 degrees or extension to 15 degrees.
 - (3) Ankle—dorsiflexion to 10 degrees or planter flexion to 10 degrees.
- e. Shortening of an extremity that exceeds 2 inches.
- f. Recurrent dislocations of the patella.

3-14. Miscellaneous conditions of the extremities

(See also paras 3-12 and 3-13.) The causes for referral to an MEB are as follows:

- a. Arthritis due to infection, associated with persistent pain and marked loss of function with objective x-ray evidence and documented history of recurrent incapacity for prolonged periods. For arthritis due to gonococcal or tuberculous infection, see paragraphs 3-40j and 3-45b.
- b. Arthritis due to trauma, when surgical treatment fails or is contraindicated and there is functional impairment of the involved joints so as to preclude the satisfactory performance of duty.
- c. Osteoarthritis, with severe symptoms associated with impairment of function, supported by x-ray evidence and documented history of recurrent incapacity for prolonged periods.
- d. Avascular necrosis of bone when severe enough to prevent successful performance of duty.
- e. Chondromalacia or osteochondritis dissecans, severe, manifested by frequent joint effusion, more than moderate interference with function, or with severe residuals from surgery.
- f. Fractures.
 - (1) Malunion of fractures, when, after appropriate treatment, there is more than moderate malunion with marked deformity and more than moderate loss of function.
 - (2) Nonunion of fractures, when, after an appropriate healing period, the nonunion precludes satisfactory performance of duty.
 - (3) Bone fusion defect, when manifested by more than moderate pain and loss of function.
 - (4) Callus, excessive, following fracture, when functional impairment precludes satisfactory performance of duty and the callus does not respond to adequate treatment.
- g. Joints.
 - (1) Arthroplasty with severe pain, limitation of motion, and of function.
 - (2) Bony or fibrous ankylosis, with severe pain involving major joints or spinal segments in an unfavorable position, and with marked loss of function.
 - (3) Contracture of joint, with marked loss of function and the condition is not remediable by surgery.
 - (4) Loose bodies within a joint, with marked functional impairment and complicated by arthritis to such a degree as to preclude favorable results of treatment or not remediable by surgery.
 - (5) Prosthetic replacement of major joints if there is resultant loss of function or pain that precludes satisfactory performance of duty.
- h. Muscles.
 - (1) Flaccid paralysis of one or more muscles with loss of function that precludes satisfactory performance of duty following surgical correction or if not remediable by surgery.
 - (2) Spastic paralysis of one or more muscles with loss of function that precludes the satisfactory performance of military duty.
- i. Myotonia congenita.
- j. Osteitis deformans (Paget's disease) with involvement of single or multiple bones with resultant deformities or symptoms severely interfering with function.
- k. Osteoarthropathy, hypertrophic, secondary with moderately severe to severe pain present, with joint effusion occurring intermittently in one or multiple joints, and with at least moderate loss of function.
- l. Osteomyelitis, chronic, with recurrent episodes not responsive to treatment and involving the bone to a degree that interferes with stability and function.
- m. Tendon transplant with fair or poor restoration of function with weakness that seriously interferes with the function of the affected part.

3-15. Eyes

The causes for referral to an MEB are as follows:

- a. Active eye disease or any progressive organic disease or degeneration, regardless of the stage of activity, that is

resistant to treatment and affects the distant visual acuity or visual fields so that distant visual acuity does not meet the standard stated in paragraph 3–16e or the diameter of the field of vision in the better eye is less than 20 degrees.

b. Aphakia, bilateral.

c. Atrophy of the optic nerve due to disease.

d. Glaucoma, if resistant to treatment or affecting visual fields as in a above, or if side effects of required medication are functionally incapacitating.

e. Degenerations, when vision does not meet the standards of paragraph 3–16e, or when vision is correctable only by the use of contact lenses or other special corrective devices (telescopic lenses, etc.).

f. Diseases and infections of the eye, when chronic, more than mildly symptomatic, progressive, and resistant to treatment after a reasonable period. This includes intractable allergic conjunctivitis inadequately controlled by medications and immunotherapy.

g. Residuals or complications of injury or disease, when progressive or when reduced visual acuity does not meet the criteria stated in paragraph 3–16e.

h. Unilateral detachment of retina if any of the following exists:

(1) Visual acuity does not meet the standard stated in paragraph 3–16e.

(2) The visual field in the better eye is constricted to less than 20 degrees.

(3) Uncorrectable diplopia exists.

(4) Detachment results from organic progressive disease or new growth, regardless of the condition of the better eye.

i. Bilateral detachment of retina, regardless of etiology or results of corrective surgery.

3–16. Vision

The causes for referral to an MEB are as follows:

a. Aniseikonia, with subjective eye discomfort, neurologic symptoms, sensations of motion sickness and other gastrointestinal disturbances, functional disturbances and difficulties in form sense, and not corrected by iseikonica lenses.

b. Binocular diplopia, not correctable by surgery, that is severe, constant, and in a zone less than 20 degrees from the primary position.

c. Hemianopsia, of any type if bilateral, permanent, and based on an organic defect. Those due to a functional neurosis and those due to transitory conditions, such as periodic migraine, are not considered to fall below required standards.

d. Night blindness, of such a degree that the soldier requires assistance in any travel at night.

e. Visual acuity.

(1) Vision that cannot be corrected with ordinary spectacle lenses (contact lenses or other special corrective devices (telescopic lenses, etc.) are unacceptable) to at least: 20/60 in one eye and 20/60 in the other eye, or 20/50 in one eye and 20/80 in the other eye, or 20/40 in one eye and 20/100 in the other eye, or 20/20 in one eye and 20/800 in the other eye; or

(2) An eye has been enucleated.

f. Visual field with bilateral concentric constriction to less than 20 degrees.

3–17. Genitourinary system

The causes for referral to an MEB are as follows:

a. Cystitis, when complications or residuals of treatment themselves preclude satisfactory performance of duty.

b. Dysmenorrhea, when symptomatic, irregular cycle, not amenable to treatment, and of such severity as to necessitate recurrent absences of more than 1 day.

c. Endometriosis, symptomatic and incapacitating to a degree that necessitates recurrent absences of more than 1 day.

d. Hypospadias, when accompanied by evidence of chronic infection of the genitourinary tract or instances where the urine is voided in such a manner as to soil clothes or surroundings and the condition is not amenable to treatment.

e. Incontinence of urine, due to disease or defect not amenable to treatment and of such severity as to necessitate recurrent absence from duty.

f. Kidney.

(1) Calculus in kidney, when bilateral, resulting in frequent or recurring infections, or when there is evidence of obstructive uropathy not responding to medical or surgical treatment.

(2) Congenital anomaly, when bilateral, resulting in frequent or recurring infections, or when there is evidence of obstructive uropathy not responding to medical or surgical treatment.

(3) Cystic kidney (polycystic kidney), when symptomatic and renal function is impaired or is the focus of frequent infection.

(4) Glomerulonephritis, when chronic.

- (5) Hydronephrosis, when more than mild, bilateral, and causing continuous or frequent symptoms.
- (6) Hypoplasia of the kidney, when symptomatic and associated with elevated blood pressure or frequent infections and not controlled by surgery.
- (7) Nephritis, when chronic.
- (8) Nephrosis.
- (9) Perirenal abscess, with residuals of a degree that precludes the satisfactory performance of duty.
- (10) Pyelonephritis or pyelitis, when chronic, that has not responded to medical or surgical treatment, with evidence of hypertension, eye-ground changes, cardiac abnormalities.
- (11) Pyonephrosis, when not responding to treatment.
 - g.* Menopausal syndrome, physiologic or artificial, when symptoms are not amenable to treatment and preclude successful performance of duty.
 - h.* Chronic pelvic pain with or without demonstrative pathology that has not responded to medical or surgical treatment and of such severity to necessitate recurrent absence from duty.
 - i.* Strictures of the urethra or ureter, when severe and not amenable to treatment.
 - j.* Urethritis, chronic, when not responsive to treatment and necessitating frequent absences from duty.

3–18. Genitourinary and gynecological surgery

The causes for referral to an MEB are as follows:

- a.* Cystectomy.
- b.* Cystoplasty, if reconstruction is unsatisfactory or if residual urine persists in excess of 50 cubic centimeters (cc) or if refractory symptomatic infection persists.
- c.* Hysterectomy, when residual symptoms or complications preclude the satisfactory performance of duty.
- d.* Nephrectomy, when after treatment, there is infection or pathology in the remaining kidney.
- e.* Nephrostomy, if drainage persists.
- f.* Oophorectomy, when complications or residual symptoms are not amenable to treatment and preclude successful performance of duty.
 - g.* Pyelostomy, if drainage persists.
 - h.* Ureterocolostomy.
 - i.* Ureterocystostomy, when both ureters are markedly dilated with irreversible changes.
 - j.* Ureteroileostomy cutaneous.
 - k.* Ureteroplasty.
 - (1) When unilateral procedure is unsuccessful and nephrectomy is necessary, consider it on the basis of the standard for a nephrectomy; or
 - (2) When bilateral, evaluate residual obstruction or hydronephrosis and consider it on the basis of the residuals involved.
 - l.* Ureterosigmoidostomy.
 - m.* Ureterostomy, external or cutaneous.
 - n.* Urethroostomy, if there is complete amputation of the penis or when a satisfactory urethra cannot be restored.
 - o.* Kidney transplant recipient.

3–19. Head

(See also para 3–29.) The causes for referral to an MEB are loss of substance of the skull with or without prosthetic replacement when accompanied by moderate residual signs and symptoms such as described in paragraph 3–30. A skull defect that poses a danger to the soldier or interferes with the wearing of protective headgear is cause for referral to an MEB/PEB.

3–20. Neck

(See also para 3–11.) The causes for referral to an MEB are torticollis (wry neck); severe fixed deformity with cervical scoliosis, flattening of the head and face, and loss of cervical mobility.

3–21. Heart

The causes for referral to an MEB are as follows (see table 3–1 for functional classifications and for metabolic equivalents (METS) ratings to be included in the MEB):

- a.* Coronary heart disease associated with—
 - (1) Myocardial infarction, angina pectoris, or congestive heart failure due to fixed obstructive coronary artery disease or coronary artery spasm. The policies for trial of duty, profiling, and referral to an MEB and a PEB (as outlined in para 3–25) apply. The trial of duty will be for 120 days.
 - (2) Myocardial infarction with normal coronary artery anatomy. The policies for trial of duty, profiling, and referral to an MEB and a PEB (as outlined in para 3–25) apply. The trial of duty will be for 120 days.

(3) Angina pectoris in association with objective evidence of myocardial ischemia in the presence of normal coronary artery anatomy.

(4) Fixed obstructive coronary artery disease, asymptomatic but with objective evidence of myocardial ischemia. The policies for trial of duty, profiling, and referral to an MEB and a PEB (as outlined in para 3–25) apply. The trial of duty will be for 120 days.

b. Supraventricular tachyarrhythmias, when life threatening or symptomatic enough to interfere with performance of duty and when not adequately controlled. This includes atrial fibrillation, atrial flutter, paroxysmal supraventricular tachycardia, and others.

c. Endocarditis with any residual abnormality or if associated with valvular, congenital, or hypertrophic myocardial disease.

d. Heart block (second degree or third degree AV block) and symptomatic bradyarrhythmias, even in the absence of organic heart disease or syncope. Wenckebach second degree heart block occurring in healthy asymptomatic individuals without evidence of organic heart disease is not a cause for referral to a PEB. None of these conditions is cause for MEB/PEB when associated with recognizable temporary precipitating conditions: for example, perioperative period, hypoxia, electrolyte disturbance, drug toxicity, acute illness.

e. Myocardial disease, New York Heart Association or Canadian Cardiovascular Society Functional Class II or worse. (See table 3–1.)

f. Ventricular flutter and fibrillation, ventricular tachycardia when potentially life threatening (for example, when associated with forms of heart disease that are recognized to predispose to increased risk of death and when there is no definitive therapy available to reduce this risk) or when symptomatic enough to interfere with the performance of duty. None of these ventricular arrhythmias are a cause for medical board referral to a PEB when associated with recognizable temporary precipitating conditions: for example, perioperative period, hypoxia, electrolyte disturbance, drug toxicity, or acute illness.

g. Sudden cardiac death, when an individual survives sudden cardiac death that is not associated with a temporary or treatable cause, and when there is no definitive therapy available to reduce the risk of recurrent sudden cardiac death.

h. Hypertrophic cardiomyopathy when of sufficient degree to restrict activity.

i. Pericarditis as follows:

(1) Chronic constrictive pericarditis unless successful remedial surgery has been performed.

(2) Chronic serous pericarditis.

j. Valvular heart disease with cardiac insufficiency at functional capacity of Class II or worse as defined by the New York Heart Association. (See table 3–1.)

k. Ventricular premature contractions with frequent or continuous attacks, whether or not associated with organic heart disease, accompanied by discomfort or fear of such a degree as to interfere with the satisfactory performance of duty.

l. Recurrent syncope or near syncope of cardiovascular etiology that is not controlled or when it interferes with the performance of duty, even if the etiology is unknown.

m. Any cardiovascular disorder requiring chronic drug therapy in order to prevent the occurrence of potentially fatal or severely symptomatic events that would interfere with duty performance.

3–22. Vascular system

The causes for referral to an MEB are as follows:

a. Arteriosclerosis obliterans when any of the following pertain:

(1) Intermittent claudication of sufficient severity to produce discomfort and inability to complete a walk of 200 yards or less on level ground at 112 steps per minute without a rest.

(2) Objective evidence of arterial disease with symptoms of claudication, ischemic rest pain, or with gangrenous or ulcerative skin changes of a permanent degree in the distal extremity.

(3) Involvement of more than one organ, system, or anatomic region (the lower extremities comprise one region for this purpose) with symptoms of arterial insufficiency.

b. Major cardiovascular anomalies including coarctation of the aorta, unless satisfactorily treated by surgical correction or other newly developed techniques, and without any residual abnormalities or complications.

c. Aneurysm of any vessel not correctable by surgery and aneurysm corrected by surgery after a period of up to 90 days trial of duty that results in the individual's inability to perform satisfactory duty. The policies for trial of duty, profiling, and referral to an MEB and a PEB (as outlined in para 3–25) apply.

d. Periarthritis nodosa with definite evidence of functional impairment.

e. Chronic venous insufficiency (postphlebotic syndrome) when more than mild and symptomatic despite elastic support.

f. Raynaud's phenomenon manifested by trophic changes of the involved parts characterized by scarring of the skin or ulceration.

- g.* Thromboangiitis obliterans with intermittent claudication of sufficient severity to produce discomfort and inability to complete a walk of 200 yards or less on level ground at 112 steps per minute without rest, or other complications.
- h.* Thrombophlebitis when repeated attacks requiring treatment are of such frequency as to interfere with the satisfactory performance of duty.
- i.* Varicose veins that are severe and symptomatic despite therapy.
- j.* Cold injury. See paragraph 3–47.

3–23. Miscellaneous cardiovascular conditions

The causes for referral to an MEB are as follows:

- a.* Hypertensive cardiovascular disease and hypertensive vascular disease. Diastolic pressure consistently more than 110 mmHg following an adequate period of therapy in an ambulatory status.
- b.* Rheumatic fever, active, with heart damage. Recurrent attacks.

3–24. Surgery and other invasive procedures involving the heart, pericardium, or vascular system

These procedures include newly developed techniques or prostheses not otherwise covered in this paragraph. The causes for referral to an MEB are as follows:

- a.* Permanent prosthetic valve implantation.
- b.* Implantation of permanent pacemakers, antitachycardia and defibrillator devices, and similar newly developed devices.
- c.* Reconstructive cardiovascular surgery employing exogenous grafting material.
- d.* Vascular reconstruction, after a period of 90 days trial of duty when medically advisable, that results in the individual's inability to perform satisfactory duty. The policies for trial of duty, profiling, and referral to an MEB and a PEB (as outlined in para 3–25) apply.
- e.* Coronary artery revascularization, with the option of a 120-day trial of duty based upon physician recommendation when the individual is asymptomatic, without objective evidence of myocardial ischemia, and when other functional assessment (such as exercise testing and newly developed techniques) indicates that it is medically advisable. Any individual undergoing median sternotomy for surgery will be restricted from lifting 25 pounds or more, performing pullups and pushups, or as otherwise prescribed by a physician for a period of 90 days from the date of surgery on DA Form 3349 (Physical Profile). The policies for trial of duty, profiling, and referral to an MEB and a PEB (as outlined in para 3–25) apply.
- f.* Heart or heart-lung transplantation.
- g.* Coronary or valvular angioplasty procedures, with the option of a 180-day trial of duty based upon physician recommendation when the individual is asymptomatic, without objective evidence of myocardial ischemia, and when other functional assessment (such as cardiac catheterization, exercise testing, and newly developed techniques) indicates that it is medically advisable. The policies for trial of duty, profiling, and referral to an MEB and a PEB (as outlined in para 3–25) apply.
- h.* Cardiac arrhythmia ablation procedures, with the option of a 180-day trial of duty based upon physician recommendation when asymptomatic, and no evidence of any unfitting arrhythmia as noted in paragraph 3–21. The policies for trial of duty, MEB, and physical profile (as outlined in para 3–25) apply.

3–25. Trial of duty and profiling for cardiovascular conditions

a. Trial of duty will be based upon physician recommendation when the individual is asymptomatic without objective evidence of myocardial ischemia, and when other functional assessment (such as coronary angiography, exercise testing, and newly developed techniques) indicates it is medically advisable.

b. Prior to commencing the trial of duty period, an MEB will be accomplished in all cases (including evaluation by a cardiologist or internist) and a physical activity prescription on DA Form 3349 will be provided by a physician. Upon completion of the trial of duty period, the results will be incorporated into the MEB. The results of the trial of duty will include the individual's interim history, present condition, prognosis, and the final recommendations. A detailed report from the commander or supervisor clearly describing the individual's ability to accomplish assigned duties and to perform physical activity will be incorporated into the MEB record. The results of the MEB and an updated DA Form 3349 will then be forwarded to a PEB in all cases except for the following: If the soldier successfully completes the trial of duty, is considered a New York Heart Association Functional Class I, AND there are no physical or assignments restrictions, the soldier may be returned to duty without referral to a PEB. If the soldier's condition becomes worse at a later date, a new MEB will be accomplished and the soldier will be referred to a PEB. For RC soldiers not on active duty, the trial of duty may consider performance in the soldier's civilian position, as well as any military duty that may have been performed in the interim.

c. The following profile guidelines supplement chapter 7. Individuals returning to a trial of duty will be given a temporary P–3 profile with specific written limitations and instructions for physical and cardiovascular rehabilitation on DA Form 3349. The completed MEB will include a permanent numerical designator in the "P" factor of the physical profile that is based on functional assessment as follows:

(1) Numerical designator “1.” Individuals who are asymptomatic, without objective evidence of myocardial ischemia or other cardiovascular functional abnormality (New York Heart Association Functional Class I).

(2) Numerical designator “2.” Individuals with minor physical activity limitations or who require frequent medical follow-up.

(3) Numerical Designator “3.” Individuals who are asymptomatic but with objective evidence of myocardial ischemia or other cardiovascular functional abnormality. Those requiring assignment limitations.

(4) Numerical designator “4.” Individuals who are symptomatic (New York Heart Association Functional Class II or worse).

3–26. Tuberculosis, pulmonary

The cause for referral to an MEB for pulmonary tuberculosis—

a. If an expiration of service will occur before completion of the period of hospitalization. (Career soldiers who express a desire to reenlist after treatment may extend their enlistment to cover the period of hospitalization.)

b. When a member of the USAR or ARNGUS not on active duty has active disease that will probably require treatment for more than 12 to 15 months including an appropriate period of convalescence before he or she can perform full-time military duty. Individuals who are retained in the USAR or ARNGUS while undergoing treatment may not be called or ordered to active duty (including mobilization), ADT, or inactive duty training (IDT) during the period of treatment and convalescence.

3–27. Miscellaneous respiratory disorders

The causes for referral to an MEB are as follows:

a. Asthma. This includes reactive airway disease, exercise-induced bronchospasm, asthmatic bronchospasm, or asthmatic bronchitis within the criteria outlined in paragraphs (1) through (4) below.

(1) Definitions/diagnostic criteria are as follows.

(a) Asthma is a clinical syndrome characterized by cough, wheeze, or dyspnea and physiologic evidence of reversible airflow obstruction or airway hyperactivity that persists over a prolonged period of time (generally more than 6 to 12 months).

(b) Reversible airflow obstruction is defined as more than 15 percent increase in FEV1 following the administration of an inhaled bronchodilator or prolonged corticosteroid therapy.

(c) Increased bronchial responsiveness is the presence of an exaggerated decrease in airflow induced by a standard bronchoprovocation challenge such as methacholine inhalation (PD20 FEV1 less than or equal to 4mg/ml). Demonstration of exercise induced bronchospasm (15 percent decline in FEV1) is also diagnostic of increased bronchial responsiveness; however, failure to induce bronchospasm with exercise does not rule out the diagnosis of asthma. Bronchoprovocation or exercise testing should be performed by a credentialed provider privileged to perform the procedures.

(d) Soldiers who are diagnosed as having asthma may be placed on a temporary profile under the “P” factor of the physical profile for up to 12 months trial of duty, when medically advisable. If at the end of that period, the soldier is unable to perform all military training and duty as cited below, the soldier will be referred to MEB/PEB.

(e) Acute, self limited, reversible airflow obstruction and airway hyperactivity can be caused by upper respiratory infections and inhalation of irritant gases or pollutants. This should not be permanently diagnosed as asthma unless significant symptoms or airflow abnormalities persist for more than 12 months.

(2) Chronic asthma is cause for a permanent P–3 or P–4 profile and MEB/PEB referral if it—

(a) Results in repetitive hospitalizations, repetitive emergency room visits or excessive time lost from duty.

(b) Requires repetitive use of oral corticosteroids to enable the soldier to perform all military training and duties.

(c) Results in inability to run outdoors at a pace that meets the standards for the timed 2-mile run despite medications. (The P–3 for the inability to perform the run refers to the inability due to asthma and should not be confused with giving an L2 or L3 based on an underlying orthopedic condition that requires an alternate Army Physical Fitness Test (APFT).)

(d) Prevents the soldier from wearing a protective mask.

(3) All soldiers meeting an MEB for asthma should receive a consultation from an internist, pulmonologist, or allergist.

(4) Chronic asthma meets retention standards, but is a cause for a permanent P–2 profile if it—

(a) Requires regular medications including low dose inhaled corticosteroids and/or oral or inhaled bronchodilators; but

(b) Does not prevent the soldier from otherwise performing all military training and duties including the 2 mile run within time standards.

(5) Soldiers with a diagnosis of asthma who require no medications or activity limitations require no profiling action.

b. Atelectasis, or massive collapse of the lung. Moderately symptomatic with paroxysmal cough at frequent intervals

throughout the day or with moderate emphysema or with residuals or complications that require repeated hospitalization.

c. Bronchiectasis or bronchiolectasis. Cylindrical or saccular type that is moderately symptomatic, with paroxysmal cough at frequent intervals throughout the day or with moderate emphysema with a moderate amount of bronchiectatic sputum or with recurrent pneumonia or with residuals or complications that require repeated hospitalization.

d. Bronchitis. Chronic, severe, persistent cough, with considerable expectoration or with dyspnea at rest or on slight exertion or with residuals or complications that require repeated hospitalization.

e. Cystic disease of the lung, congenital disease involving more than one lobe of a lung.

f. Diaphragm, congenital defect. Symptomatic.

g. Hemopneumothorax, hemothorax, or pyopneumothorax. More than moderate pleuritic residuals with persistent underweight or marked restriction of respiratory excursions and chest deformity or marked weakness and fatigue on slight exertion.

h. Histoplasmosis. Chronic and not responding to treatment.

i. Pleurisy, chronic, or pleural adhesions. Severe dyspnea or pain on mild exertion associated with definite evidence of pleural adhesions and demonstrable moderate reduction of pulmonary function.

j. Pneumothorax, spontaneous. Recurrent episodes of pneumothorax not corrected by surgery or pleural sclerosis.

k. Pneumoconiosis. Severe, with dyspnea on mild exertion.

l. Pulmonary calcification. Multiple calcifications associated with significant respiratory embarrassment or active disease not responsive to treatment.

m. Pulmonary emphysema. Marked emphysema with dyspnea on mild exertion and demonstrable moderate reduction in pulmonary function.

n. Pulmonary fibrosis. Linear fibrosis or fibrocalcific residuals of such a degree as to cause dyspnea on mild exertion and demonstrable moderate reduction in pulmonary function.

o. Pulmonary sarcoidosis. If not responding to therapy and complicated by demonstrable moderate reduction in pulmonary function.

p. Stenosis, bronchus. Severe stenosis associated with repeated attacks of bronchopulmonary infections requiring hospitalization of such frequency as to interfere with the satisfactory performance of duty.

3–28. Surgery of the lungs

The cause for referral to an MEB is a complete lobectomy, if pulmonary function (ventilatory tests) is impaired to a moderate degree or more.

3–29. Mouth, esophagus, nose, pharynx, larynx, and trachea

The causes for referral to an MEB are as follows:

a. Esophagus.

(1) Achalasia, unless controlled by medical therapy.

(2) Esophagitis, persistent and severe.

(3) Diverticulum of the esophagus of such a degree as to cause frequent regurgitation, obstruction, and weight loss that does not respond to treatment.

(4) Stricture of the esophagus of such a degree as to almost restrict diet to liquids, require frequent dilatation and hospitalization, and cause difficulty in maintaining weight and nutrition.

b. Larynx.

(1) Paralysis of the larynx characterized by bilateral vocal cord paralysis seriously interfering with speech and adequate airway.

(2) Stenosis of the larynx of a degree causing respiratory embarrassment upon more than minimal exertion.

c. Obstructive edema of glottis. If chronic, not amenable to treatment, and requires a tracheotomy.

d. Rhinitis. Atrophic rhinitis characterized by bilateral atrophy of nasal mucous membrane with severe crusting, concomitant severe headaches, and foul, fetid odor.

e. Sinusitis. Severe, chronic sinusitis that is suppurative, complicated by chronic or recurrent polyps, and that does not respond to treatment.

f. Trachea. Stenosis of trachea.

3–30. Neurological disorders

The causes for referral to an MEB are as follows:

a. Amyotrophic lateral sclerosis and all other forms of progressive neurogenic muscular atrophy.

b. All primary muscle disorders including facioscapulohumeral dystrophy, limb girdle atrophy, and myotonia dystrophy characterized by progressive weakness and atrophy.

c. Myasthenia gravis unless clinically restricted to the extraocular muscles.

- d. Progressive degenerative disorders of the basal ganglia and cerebellum including Parkinson's disease, Huntington's chorea, hepatolenticular degeneration, and variants of Friedreich's ataxia.
- e. Multiple sclerosis, optic neuritis, transverse myelitis, and similar demyelinating disorders.
- f. Stroke, including both the effects of ischemia and hemorrhage, when residuals affect performance.
- g. Migraine, tension, or cluster headaches, when manifested by frequent incapacitating attacks.
- h. Narcolepsy, sleep apnea syndrome, or similar disorders. (See para 3–41.)
- i. Seizure disorders and epilepsy. Seizures by themselves are not disqualifying unless they are manifestations of epilepsy. However, they may be considered along with other disabilities in judging fitness. In general, epilepsy is disqualifying unless the soldier can be maintained free of clinical seizures of all types by nontoxic doses of medications. The following guidance applies when determining whether a soldier will be referred to an MEB/PEB.

(1) All active duty soldiers with suspected epilepsy must be evaluated by a neurologist who will determine whether epilepsy exists and whether the soldier should be given a trial of therapy on active duty or referred directly to an MEB for referral to a PEB. In making the determination, the neurologist may consider the underlying cause, EEG findings, type of seizure, duration of epilepsy, family history, soldier's likelihood of compliance with therapeutic program, absence of substance abuse, or any other clinical factor influencing the probability of control or the soldier's ability to perform duty during the trial of treatment.

(2) If a trial of duty on treatment is elected by the neurologist, the soldier will be given a temporary P–3 profile with as few restrictions as possible.

(3) Once the soldier has been seizure free for 1 year, the profile may be reduced to a P–2 profile with restrictions specifying no assignment to an area where medical treatment is not available.

(4) If seizures recur beyond 6 months after the initiation of treatment, the soldier will be referred to an MEB.

(5) Should seizures recur during a later attempt to withdraw medications or during transient illness, referral to a PEB is at the discretion of the physician or MEB.

(6) If the soldier has remained seizure free for 36 months, he or she may be removed from profile restrictions.

(7) Recurrent pseudoseizures are disqualifying under the same rules as epilepsy.

j. Any other neurologic conditions, regardless of etiology, when after adequate treatment there remains residual symptoms and impairments such as persistent severe headaches, uncontrolled seizures, weakness, paralysis, or atrophy of important muscle groups, deformity, uncoordination, tremor, pain, or sensory disturbance, alteration of consciousness, speech, personality, or mental function of such a degree as to significantly interfere with performance of duty.

Note. Diagnostic concepts and terms used in paragraphs 3–31 through 3–37 are in consonance with the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM–IV). The minimum psychiatric evaluation will include Axis I, II, and III.

3–31. Disorders with psychotic features

The causes for referral to an MEB are mental disorders not secondary to intoxication, infectious, toxic, or other organic causes, with gross impairment in reality testing, resulting in interference with duty or social adjustment.

3–32. Mood disorders

The causes for referral to an MEB are as follows:

- a. Persistence or recurrence of symptoms sufficient to require extended or recurrent hospitalization; or
- b. Persistence or recurrence of symptoms necessitating limitations of duty or duty in protected environment; or
- c. Persistence or recurrence of symptoms resulting in interference with effective military performance.

3–33. Anxiety, somatoform, or dissociative disorders

The causes for referral to an MEB are as follows:

- a. Persistence or recurrence of symptoms sufficient to require extended or recurrent hospitalization; or
- b. Persistence or recurrence of symptoms necessitating limitations of duty or duty in protected environment; or
- c. Persistence or recurrence of symptoms resulting in interference with effective military performance.

3–34. Dementia and other cognitive disorders due to general medical condition

The causes for referral to an MEB include persistence of symptoms or associated personality change sufficient to interfere with the performance of duty or social adjustment.

3–35. Personality, sexual and gender identity, or factitious disorders; disorders of impulse control not elsewhere classified; substance-related disorders

The conditions may render an individual administratively unfit rather than unfit because of physical disability. Interference with performance of effective duty in association with these conditions will be dealt with through administrative channels.

3–36. Adjustment disorders

Situational maladjustments due to acute or chronic situational stress do not render an individual unfit because of physical disability, but may be the basis for administrative separation if recurrent and causing interference with military duty.

3–37. Eating disorders

The causes for referral to an MEB are eating disorders that are unresponsive to treatment or that interfere with the satisfactory performance of duty.

3–38. Skin and cellular tissues

The causes for referral to an MEB are as follows:

- a. Acne. Severe, unresponsive to treatment, and interfering with the satisfactory performance of duty or wearing of the uniform or other military equipment.
- b. Atopic dermatitis. More than moderate and after hospitalization interfering with performance of duty.
- c. Amyloidosis. Generalized.
- d. Cysts and tumors. (See paras 3–42 and 3–43.)
- e. Dermatitis herpetiformis. Not responsive to therapy.
- f. Dermatomyositis.
- g. Dermographism. Interfering with the performance of duty.
- h. Eczema, chronic. Regardless of type, when there is more than minimal involvement and the condition is unresponsive to treatment and interferes with the satisfactory performance of duty.
- i. Elephantiasis or chronic lymphedema. Not responsive to treatment.
- j. Epidermolysis bullosa.
- k. Erythema multiforme. More than moderate and recurrent or chronic.
- l. Exfoliative dermatitis. Chronic.
- m. Fungus infections, superficial or systemic types. If not responsive to therapy and interfering with the satisfactory performance of duty.
- n. Hidradenitis suppurative and/or folliculitis decalvans (dissecting cellulitis of the scalp).
- o. Hyperhidrosis. On the hands or feet, when severe or complicated by a dermatitis or infection, either fungal or bacterial and not amenable to treatment.
- p. Leukemia cutis or mycosis fungoides or cutaneous T-Cell lymphoma. (See also para 3–42.)
- q. Lichen planus. Generalized and not responsive to treatment.
- r. Lupus erythematosus. Cutaneous or mucous membranes involvement that is unresponsive to therapy and interferes with the satisfactory performance of duty.
- s. Neurofibromatosis. When interfering with the satisfactory performance of duty.
- t. Panniculitis. Relapsing, febrile, nodular.
- u. Parapsoriasis. Extensive and not controlled by treatment.
- v. Pemphigus. Not responsive to treatment and with moderate constitutional or systemic symptoms, or interfering with the satisfactory performance of duty.
- w. Psoriasis. Extensive and not controllable by treatment.
- x. Radiodermatitis. If resulting in malignant degeneration at a site not amenable to treatment.
- y. Scars and keloids. So extensive or adherent that they seriously interfere with the function of an extremity or interfere with the performance of duty.
- z. Scleroderma. Generalized or of the linear type that seriously interferes with the function of an extremity.
- aa. Tuberculosis of the skin. See paragraph 3–40.
- ab. Ulcers of the skin. Not responsive to treatment after an appropriate period of time if interfering with the satisfactory performance of duty.
- ac. Urticaria/Angioedema. Chronic, severe, and not responsive to treatment.
- ad. Xanthoma. Regardless of type, but only when interfering with the satisfactory performance of duty.
- ae. Intractable plantar keratosis, chronic. Requires frequent medical/surgical care or that interferes with the satisfactory performance of duty.
- af. Other skin disorders. If chronic or of a nature that requires frequent medical care, or interferes with the satisfactory performance of military duty.

3–39. Spine, scapulae, ribs, and sacroiliac joints

(See also para 3–14.) The causes for referral to an MEB are as follows:

- a. Dislocation. Congenital, of hip.
- b. Spina bifida. Demonstrable signs and moderate symptoms of root or cord involvement.

- c. Spondylolysis or spondylolisthesis. More than mild symptoms resulting in repeated outpatient visits, or repeated hospitalization or limitations effecting performance of duty.
- d. Coxa vara. More than moderate with pain, deformity, and arthritic changes.
- e. Herniation of nucleus pulposus. More than mild symptoms following appropriate treatment or remedial measures, with sufficient objective findings to demonstrate interference with the satisfactory performance of duty.
- f. Kyphosis. More than moderate, interfering with military duties.
- g. Scoliosis. Severe deformity with over 2 inches deviation of tips of spinous process from the midline, or of lesser degree if recurrently symptomatic and interfering with military duties.
- h. Nonradicular pain involving the cervical, thoracic, lumbosacral, or coccygeal spine, whether idiopathic or secondary to degenerative disc or joint disease, that fails to respond to adequate conservative treatment and necessitates significant limitation of physical activity.

3–40. Systemic diseases

The causes for referral to an MEB are as follows:

- a. Amyloidosis.
- b. Blastomycosis.
- c. Brucellosis. Chronic with substantiated, recurring febrile episodes, severe fatigue, lassitude, depression, or general malaise.
- d. Leprosy. Any type that seriously interferes with performance of duty or is not completely responsive to appropriate treatment.
- e. Myasthenia gravis.
- f. Mycosis. Active, not responsive to therapy or requiring prolonged treatment, or when complicated by residuals that themselves are unfitting.
- g. Panniculitis. Relapsing, febrile, nodular.
- h. Porphyria, cutanea tarda.
- i. Sarcoidosis. Progressive with severe or multiple organ involvement and not responsive to therapy.
- j. Tuberculosis.
 - (1) Meningitis, tuberculous.
 - (2) Pulmonary tuberculosis (see para 3–26), tuberculous empyema, and tuberculous pleurisy.
 - (3) Tuberculosis of the male genitalia. Involvement of the prostate or seminal vesicles and other instances not corrected by surgical excision, or when residuals are more than minimal, or are symptomatic.
 - (4) Tuberculosis of the female genitalia.
 - (5) Tuberculosis of the kidney.
 - (6) Tuberculosis of the larynx.
 - (7) Tuberculosis of the lymph nodes, skin, bone, joints, eyes, intestines, and peritoneum or mesentery. These will be evaluated on an individual basis, considering the associated involvement, residuals, and complications.
- k. Rheumatoid arthritis that interferes with successful performance of duty or requires geographic assignment limitations or requires medication for control that requires frequent monitoring by a physician due to debilitating or serious side effects.
- l. Spondyloarthropathies. Chronic or recurring episodes of arthritis causing functional impairment interfering with successful performance of duty supported by objective, subjective, and radiographic findings, or requires medication for control that requires frequent monitoring by a physician due to debilitating or serious side effects.
 - (1) Ankylosingpondylitis.
 - (2) Reiter’s syndrome.
 - (3) Psoriatic arthritis.
 - (4) Arthritis associated with inflammatory bowel disease.
 - (5) Whipple’s disease.
- m. Systemic lupus erythematosus that interferes with successful performance of duty or requires geographic assignment limitations or requires medication for control that requires frequent monitoring by a physician due to debilitating or serious side effects.
- n. Sjogren’s syndrome. When chronic, more than mildly symptomatic and resistant to treatment after a reasonable period of time.
- o. Progressive systemic sclerosis, diffuse and limited disease that interferes with successful performance of duty or requires geographic assignment limitations or requires medication for control that requires frequent monitoring by a physician due to debilitating or serious side effects.
- p. Myopathy, to include inflammatory, metabolic or inherited, that interferes with successful performance of duty or requires geographic assignment limitations or requires medication for control that requires frequent monitoring by a physician due to debilitating or serious side effects.

q. Systemic vasculitis involving major organ systems, chronic, that interferes with successful performance of duty or requires geographic assignment limitations or requires medication for control that requires frequent monitoring by a physician due to debilitating or serious side effects.

r. Hypersensitivity angitis when chronic or having recurring episodes that are more than mildly symptomatic or show definite evidence of functional impairment which is resistant to treatment after a reasonable period of time.

s. Behcet's syndrome that interferes with successful performance of duty or requires geographic assignment limitations or requires medication for control that requires frequent monitoring by a physician due to debilitating or serious side effects.

t. Adult onset Still's disease that interferes with successful performance of duty or requires geographic assignment limitations or requires medication for control that requires frequent monitoring by a physician due to debilitating or serious side effects.

u. Mixed connective tissue disease and other overlap syndromes that interfere with successful performance of duty or require geographic assignment limitations or require medication for control that requires frequent monitoring by a physician due to debilitating or serious side effects.

v. Any chronic or recurrent systemic inflammatory disease or arthritis not listed above that interferes with successful performance of duty or requires geographic assignment limitations, or requires medication for control that requires frequent monitoring by a physician due to debilitating or serious side effects.

3-41. General and miscellaneous conditions and defects

The causes for referral to an MEB are as follows:

a. Allergic manifestations.

(1) Allergic rhinitis, chronic, severe, and not responsive to treatment. (See also paras 3-29*d* and 3-29*e*.)

(2) Asthma. (See para 3-27*a*.)

(3) Allergic dermatoses. (See para 3-38.)

b. Cold injury/heat injury. (See paras 3-45 and 3-46.)

c. Sleep apnea. Obstructive sleep apnea or sleep-disordered breathing that causes daytime hypersomnolence or snoring that interferes with the sleep of others and that cannot be corrected with medical therapy, surgery, or oral prosthesis. The diagnosis must be based upon a nocturnal polysomnogram and the evaluation of a pulmonologist, neurologist, or a provider with expertise in sleep medicine. A 12-month trial of therapy with nasal continuous positive air pressure may be attempted to assist in weight reduction or other interventions, during which time the individual will be profiled as T3. Long-term therapy with nasal continuous positive air pressure requires referral to an MEB.

d. Fibromyalgia, when severe enough to prevent successful performance of duty. Diagnosis will include evaluation by a rheumatologist.

e. Miscellaneous conditions and defects. Conditions and defects not mentioned elsewhere in this chapter are causes for referral to an MEB, if—

(1) The conditions (individually or in combination) result in interference with satisfactory performance of duty as substantiated by the individual's commander or supervisor.

(2) The individual's health or well-being would be compromised if he or she were to remain in the military service.

(3) In view of the soldier's condition, his or her retention in the military service would prejudice the best interests of the Government (for example, a carrier of communicable disease who poses a health threat to others). Questionable cases, including those involving latent impairment, will be referred to PEBs.

3-42. Malignant neoplasms

The causes for referral to an MEB are as follows:

a. Malignant neoplasms that are unresponsive to therapy, or when the residuals of treatment are in themselves unfitting under other provisions of this chapter.

b. Neoplastic conditions of the lymphoid and blood-forming tissues that are unresponsive to therapy, or when the residuals of treatment are in themselves unfitting under other provisions of this chapter.

c. Malignant neoplasms, when on evaluation for administrative separation or retirement, the observation period subsequent to treatment is deemed inadequate in accordance with accepted medical principles.

d. The above definitions of malignancy or malignant disease exclude basal cell carcinoma of the skin.

3-43. Benign neoplasms

The causes for referral to an MEB are as follows:

a. Benign tumors if their condition precludes the satisfactory performance of military duty.

b. Ganglioneuroma.

c. Meningeal fibroblastoma, when the brain is involved.

d. Pigmented villonodular synovitis when severe enough to prevent successful performance of duty.

3-44. Sexually transmitted diseases

The causes for referral to an MEB are as follows:

- a. Symptomatic neurosyphilis in any form.
- b. Complications or residuals of a sexually transmitted disease of such chronicity or degree that the individual is incapable of performing useful duty.

3-45. Heat illness and injury

The causes for referral to an MEB are as follows:

- a. Heat exhaustion.
 - (1) Heat exhaustion is defined as collapse, including syncope, occurring during or immediately following exercise-heat stress without evidence of organ damage or systemic inflammatory activation.
 - (2) Individual episodes of heat exhaustion are not cause for MEB referral. However, soldiers suffering from recurrent episodes of heat exhaustion (three or more in less than 24 months) should be referred for complete medical evaluation for contributing factors.
 - (3) If no remediable factor causing recurrent heat exhaustion is identified, then the soldier will be referred to an MEB.
- b. Heat stroke.
 - (1) The definitions of heat stroke are as follows.
 - (a) Heat stroke: A syndrome of hyperpyrexia, collapse, and encephalopathy with evidence of organ damage and/or systemic inflammatory activation occurring in the setting of environmental heat stress.
 - (b) Exertional rhabdomyolysis: Rhabdomyolysis with myoglobinuria occurring with exercise-heat stress but without the encephalopathy of heat stroke.
 - (2) Soldiers will be referred to an MEB after an episode of heat stroke or exertional rhabdomyolysis. If the soldier has had full clinical recovery, and particularly if a circumstantial contributing factor to the episode can be identified, the MEB may recommend a trial of duty with a P-3 (T) profile. The profile will restrict the soldier from performing vigorous physical exercise for periods longer than 15 minutes. Maximal efforts, such as the APFT 2-mile run are not permitted. If, after 3 months, the soldier has not manifested any heat intolerance, the profile may be modified to P-2 (T) and normal unrestricted work permitted. Maximal exertion and significant heat exposure (such as wearing Mission Oriented Protective Posture (MOPP) IV) are still restricted. If the soldier manifests no heat intolerance, including a season of significant environmental heat stress, normal activities can be resumed and the soldier may be returned to duty without a PEB. Any evidence of significant heat intolerance, either during the period of the profile or subsequently, requires a referral to a PEB. (A description of the heat intolerance should be included in the MEB narrative summary.)

3-46. Cold injury

The causes for referral to an MEB are as follows:

- a. Frostbite (freezing cold injury).
 - (1) The definition of frostbite is the consequence of freezing of tissue. First degree frostbite is manifested by superficial injury without blistering. Second degree frostbite is manifested by superficial injury with clear blisters with only epidermal tissue loss. Third degree and fourth degree frostbite are manifested by significant subepidermal tissue loss.
 - (2) Soldiers with first degree frostbite after clinical healing will be given a permanent P-2 profile permitting the use of extra cold weather protective clothing, including nonregulation items, to be worn under authorized outer garments.
 - (3) Soldiers with frostbite more than first degree will be given a P-3 profile, renewed as appropriate, for the duration of the cold season restricting them from any exposure to temperatures below 0 degrees C (32 degrees F) and from any activities limited by the remainder of the season. After the cold season, soldiers will be reevaluated and, if appropriate, given the P-2 profile described in (2) above.
 - (4) Soldiers will be referred to an MEB for recurrent cold injury, recurrent or persistent cold sensitivity despite the P-2 profile, vascular or neuropathic symptoms, or disability due to tissue lost from cold injury.
- b. Trench foot (nonfreezing cold injury).
 - (1) The definition of trench foot is the consequence of prolonged cold immersion of an extremity. It is manifested by maceration of tissue and neurovascular injury.
 - (2) Soldiers with residual symptoms or significant tissue loss after healing will be referred to an MEB.
- c. Accidental hypothermia.
 - (1) The definition of accidental hypothermia is clinically significant depression of body temperature due to environmental cold exposure.
 - (2) Soldiers with significant symptoms of cold intolerance or a recurrence of hypothermia after an episode of accidental hypothermia will be referred to an MEB.

**Table 3–1
Methods of assessing cardiovascular disability**

Class	New York Heart Association Functional Classification	Canadian Cardiovascular Society Functional Classification	Specific activity scale (Goldstein et al: Circulation 64:1227, 1981)	New York Heart Association Functional Classification (Revised)
I.	Patient with cardiac disease but without resulting limitations of physical activity. Ordinary physical activity does not cause undue fatigue, palpitations, dyspnea, or anginal pain.	Ordinary physical activity, such as walking and climbing, stairs, does not cause angina. Angina with strenuous or rapid or prolonged exertion at work or recreation.	Patients can perform to completion any activity requiring 7 metabolic equivalents: for example, can carry 24 lbs up eight steps, carry objects that weigh 80 lbs, do outdoor work. (shovel snow, spade soil), do recreational activities (skiing, basketball, handball, jog, and walk 5 mph).	Cardiac status uncompromised.
II.	Patients with cardiac disease resulting in slight limitation of physical activity. They are comfortable at rest. Ordinary physical activity results in fatigue, palpitation, dyspnea, or anginal pain	Slight limitations of ordinary activity. Walking or climbing stairs rapidly, walking uphill, walking or stair climbing after meals, in cold, in wind, or when under emotional stress, or only during the few hours after awakening. Walking more than 2 blocks on the level and climbing more than one flight of ordinary stairs at a normal pace and in normal conditions.	Patient can perform to completion any activity requiring ≥ 5 metabolic equivalents, but cannot and does not perform to completion activities requiring metabolic equivalents: for example, have sexual intercourse without stopping, garden, rake, weed, roller skate, dance fox trot, walk at 4 mph on level ground.	Slightly compromised.
III.	Patients with cardiac disease resulting in marked limitation of physical activity. They are comfortable at rest. Less than ordinary physical activity causes fatigue, palpitation, dyspnea, or anginal pain.	Marked limitation of ordinary physical activity. Walking one to two blocks on the level and climbing more than one flight in normal conditions.	Patient can perform to completion any activity requiring ≥ 2 metabolic equivalents but cannot and does not perform to completion activities requiring ≥ 5 metabolic equivalents: for example, shower without stopping, strip and make bed, clean windows, walk 2.5 mph, bowl, play golf, dress without stopping.	Moderately compromised.
IV.	Patient with cardiac disease resulting in inability to carry on any physical activity without discomfort. Symptoms of cardiac insufficiency or of the anginal syndrome may be present even at rest. If any physical activity is undertaken, discomfort is increased.	Inability to carry on any physical activity without discomfort—anginal syndrome may be present at rest.	Patient cannot or does not perform to completion activities requiring ≥ 2 metabolic equivalents. Cannot carry activities listed above (specify activity scale, Class III).	Severely compromised.

New York Heart Association Therapeutic Classification

Therapeutic Classification	Revised classification (prognosis)
Class A— Patients with cardiac disease whose physical activity need not be restricted	Class I—Good.
Class B— Patients with cardiac disease whose ordinary activity need not be restricted, but who should be advised against severe or competitive physical efforts.	Class II—Good with therapy.
Class C— Patients with cardiac disease whose ordinary physical activity should be moderately restricted, and whose more strenuous efforts should be discontinued.	Class III—Fair with therapy.
Class D— Patients with cardiac disease who should be at complete rest, confined to bed or chair.	Class IV—Guarded despite therapy.

METS Equivalents (Required for PEB adjudication)

Class I=8 METS or greater
 Class II=5–8 METS
 Class III=3–5 METS
 Class IV=Less than 3 METS

Chapter 4 Medical Fitness Standards For Flying Duty

4-1. General

a. In this regulation, the term “flying duty” is synonymous with “flight status” and “aviation service.” The term “aircrew” or “aircrew member” applies to rated and non-rated personnel in aviation service and air traffic control. All provisions apply to the USAR and the ARNGUS.

b. The Aviation Medicine Consultant (AMC) to TSG will recommend to the Commander, USAMEDCOM, a senior specialist in Aerospace Medicine to be placed on orders for designation as the Aviation Medicine Approving Authority. Responsibilities will include all administrative actions and medical fitness standards for flying duty for all active and RC Army aviators. The Aviation Medicine Approving Authority is located at Building 301, Dustoff Avenue, Fort Rucker, AL 36362-5333.

c. Provisions in this chapter are subject to NATO Standardization Agreement (STANAG) 3526, which applies to allied nation aircrews serving with U.S. Forces or attending U.S. Army training programs, and to U.S. aircrews serving with foreign forces.

d. This chapter lists medical conditions and physical defects that are causes for rejection in selection, training, and retention of—

- (1) Army aviators.
- (2) DA civilian (DAC) pilots and contract civilian pilots who are employed by firms under contract to DA.
- (3) Aeroscout observers (MOS 93B) and aerial fire support observers (MOS 13F).
- (4) Flight surgeons (FSs) (MOS 61N) and aeromedical physician assistants (APAs).
- (5) Military, DAC, and DA contract air traffic controllers (ATCs).
- (6) Individuals ordered by competent authority to participate in regular flights as nonrated aircrew.
- (7) Applicants for special flight training programs directed by DA or National Guard Bureau (NGB), such as Army ROTC or USMA flight training programs.
- (8) Aircrew of allied host nations or U.S. Government agencies other than DA who are flying Army aircraft, unless superseded by agreements with that nation or agency.

e. A failure to meet medical standards for flying duties remains disqualifying for flying duties until reviewed by the Aviation Medicine Approving Authority. The Aviation Medicine Approving Authority may recommend qualified for information only, qualified with waiver, or medical termination from aviation service. The Aviation Medicine Approving Authority issues Aeromedical Policy Letters (APLs) and Aeromedical Technical Bulletins (ATBs) that provide detailed recommendations for specific, common disqualifications. Refer all questionable cases to the Aviation Medicine Approving Authority, Fort Rucker, AL 36362-5333.

4-2. Classes of medical standards for flying and applicability

The classes of medical fitness standards for flying duties are as follows:

- a. Class 1 (warrant officer candidate) or Class 1A (commissioned officer or cadet) standards apply to—
- (1) Applicants for aviator training. (See also AR 611-85 and AR 611-110.)
 - (2) Applicants for special flight training programs directed by DA or NGB, such as Army ROTC or USMA flight training programs.
 - (3) Other non-U.S. Army personnel selected for training until the beginning of training at aircraft controls, or as determined by Chief, Army Aviation Branch.
- b. Class 2 standards apply to—
- (1) Student aviators after beginning training at aircraft controls or as determined by Chief, Army Aviation Branch.
 - (2) Rated Army aviators (AR 600-105).
 - (3) DAC pilots and contract civilian pilots who are employed by firms under contract to the DA that conduct flight operations or training, utilizing Army aircraft or aircraft leased by the Army. (See para 4-31.)
 - (4) Army aviators considered for return to aviation service.
 - (5) Senior career officers. When directed by DA or NGB under special procurement programs for initial Army aviation flight training, selected senior officers of the Army may be medically qualified under Army Class 2 medical standards.
 - (6) Applicants to DA or NGB civilian-acquired aeronautical skills programs.
 - (7) Other non-U.S. Army personnel.
- c. Class 2F standards apply to—
- (1) Rated FSs (AR 600-105) and APAs.
 - (2) Medical officers, medical students, and physician assistants applying for or enrolled in the Army Flight Surgeon’s Primary Course or Army Aviation Medicine Orientation Course.
- d. Class 2S standards apply to—
- (1) Aeroscout observers (MOS 93B).

(2) Aerial fire support observers (MOS 13F).

e. Class 3 standards apply to non-rated (AR 600–106) soldiers and civilians ordered by a competent authority to participate in regular flights in Army aircraft, but who do not operate aircraft flight controls. These include crew chiefs, aviation maintenance technicians, aerial observers, gunners; unmanned aerial vehicle operators (UAVO), nonrated (AR 600–106) medical personnel selected for aeromedical training, such as flight medical aidmen, psychologists, dentists, and optometrists; and others. (See para 4–32.)

f. Class 4 standards apply to Army military ATCs. See paragraphs 4–33*a* and 4–33*c* for standards for Army military ATCs. See paragraph 4–33*b* for the standards that apply to DAC ATCs and civilian ATCs employed under contract by DA or by firms under contract to DA.

4–3. Aeromedical consultation

Aeromedical administration is detailed in chapter 6. Questions pertaining to aeromedical consultation, policy, standards, and administration should be directed to the Aviation Medicine Approving Authority, Fort Rucker, AL 36362–5333.

4–4. Abdomen and gastrointestinal system

The causes for medical unfitness for flying duty Classes 1/1A/2/2F/2S/3 are the causes listed in paragraph 2–3, plus the following:

- a.* Abdominal fistula or sinus.
- b.* Small and large intestine.
 - (1) History of bowel resection for any cause, with the exception of appendectomy.
 - (2) History of any procedures for the relief of intestinal obstruction, adhesions, or intussusception, with the exception of uncomplicated pylorotomy or intussusception in childhood.
 - (3) History of functional bowel syndrome (irritable colon), megacolon, diverticulitis, diverticulosis with complications, regional enteritis (Crohn’s disease), ulcerative colitis, or proctitis.
- c.* Hepato-pancreato-biliary tract.
 - (1) Enlargement of the liver, except when the liver function tests are normal and the condition does not appear to be caused by active disease.
 - (2) Cholelithiasis.
 - (3) Cholecystectomy until recovery is complete or history of sequelae to cholecystectomy listed in paragraph 2–3.
- d.* History of gastrointestinal bleeding. This excludes minor bleeding from hemorrhoids or acute rectal fissure. (See APL, Peptic Ulcer Disease.)

4–5. Blood and blood-forming tissue diseases

The causes of medical unfitness for flying duty Classes 1/1A/2/2F/2S/3 are the causes in paragraph 2–4, plus the following:

- a.* Anemia, of any etiology.
 - (1) Males with a hematocrit (HCT) less than 40 percent, or females with an HCT less than 37 percent; or
 - (2) If a complete hematologic evaluation results in the diagnosis of physiologic anemia, or anemia due to sickle cell trait or beta thalassemia minor; males with a HCT less than 38 percent, or females with a HCT less than 35 percent. (See APL, Hematocrit and Hemoglobinopathies.)
- b.* History of immunodeficiency diseases. (See also paras 2–351 and 4–26*g*.) (Civilian employees are not disqualified based solely on the presence of the HIV virus. See AR 600–110 and ATB 2, Army Flight Surgeon’s Administrative Guide.)
- c.* History of splenectomy. For any reason, except trauma.
- d.* Thrombophlebitis.
 - (1) Acute, superficial thrombophlebitis until resolved.
 - (2) History of deep vein thrombophlebitis, thrombosis of any deep vessel, or thromboembolism.

4–6. Dental

The causes of medical unfitness for flying duty Classes 1/1A/2/2F/2S/3 are the causes in paragraph 2–5, plus the following:

- a.* Orthodontic appliances, if they interfere with effective oral communication, or pose a hazard to personal or flight safety.
- b.* Dental Fitness Class 3 or 4, until the abnormalities or deficiencies have been corrected.

Note. See APL, Dental Fitness.

4–7. Ears

The causes of medical unfitness for flying duty Classes 1/1A/2/2F/2S/3 are the causes in paragraph 2–6, plus the following:

- a. Infection. Any infectious process of the ear until completely healed, except mild asymptomatic external otitis.
- b. External ear.
 - (1) Deformities of the pinna that cause distractions or hearing loss while wearing protective headgear.
 - (2) History of post auricular fistula.
- c. Middle ear.
 - (1) Barotitis media, until resolved.
 - (2) History of cholesteatoma.
 - (3) History of chronic or recurrent Eustachian tube dysfunction.
 - (4) Otosclerosis.
 - (5) History of simple, radical, or modified radical mastoidectomy.
 - (6) Any surgical procedure in the middle ear that includes fenestration of the oval window or horizontal semicircular canal, any endolymphatic shunting procedure, stapedectomy, the use of any prosthesis or graft, or reconstruction of the stapes.
 - (7) Tympanoplasty, until completely healed with acceptable hearing and motility, as documented by current ear–nose–throat evaluation.
- d. Inner ear.
 - (1) Abnormal labyrinthine function.
 - (2) History of perilymph fistula.
 - (3) Tinnitus, except when associated with high frequency hearing loss.
 - (4) History of vertigo, except physiologic vertigo induced by gravity forces, aircraft spins, or Baranay chair.

4–8. Hearing

The causes of medical unfitness for flying duty Classes 1/1A/2/2F/2S/3 is hearing loss in dB greater than shown in table 4–1. (See APL, Audiometric Evaluation.)

4–9. Endocrine and metabolic diseases

The causes of medical unfitness for flying duty Classes 1/1A/2/2F/2S/3 are the causes listed in paragraph 2–8, plus a history of symptomatic hypoglycemia. (See APL, Diabetes and Glucose Intolerance.)

4–10. Extremities

The causes of medical unfitness for flying duty Classes 1/1A/2/2F/2S/3 are the causes in paragraphs 2–9, 2–10, 2–11, and 4–22, plus dimensions, loss of strength or endurance, or limitation in motion that compromises flying safety. Orthopedic hardware is disqualifying until reviewed by the Aviation Medicine Approving Authority. (See APL, Retained Hardware.)

4–11. Eyes

The causes of medical unfitness for flying duty Classes 1/1A/2/2F/2S/3 are the causes in paragraph 2–12, plus the following:

- a. Lids and conjunctiva.
 - (1) Epiphora (chronic tearing).
 - (2) Trachoma, unless healed without cicatrices.
- b. Cornea.
 - (1) Full- or part-time use of contact lenses, including a history of orthokeratologic procedures to correct refractive error. Selected aircrew may be authorized to use contact lenses during flying duties with a waiver.
 - (2) History of herpetic corneal ulcer or keratitis—acute, chronic, or recurrent.
 - (3) Pterygium that encroaches on the cornea more than 1 mm or is progressive, or for Classes 1/1A, history of surgical removal of a pterygium within the last 12 months.
 - (4) History of keratorefractive surgery accomplished to modify the refractive power of the cornea, to include anterior or radial keratotomy, laser keratoplasty.
- c. History of intraocular lens implant.
- d. Uveal tract.
 - (1) Coloboma of the choroid or iris.
 - (2) History of inflammation of the uveal tract, acute, chronic, or recurrent; including anterior uveitis, peripheral uveitis or pars planitis, posterior uveitis, or traumatic iritis.
- e. Retina.
 - (1) History of central serous retinopathy.
 - (2) History of chorioretinitis, including evidence of presumed ocular histoplasmosis syndrome.
 - (3) History of retinal holes or tears.

f. Optic nerve.

- (1) Optic nerve drusen or hyaline bodies of the optic nerve.
- (2) History of optic or retrobulbar neuritis.

g. Ocular motility.

- (1) Convergence insufficiency, including asthenopia of any degree.
- (2) History of extraocular muscle surgery after age 4, or history of extraocular muscle surgery before age 4 with other residual ocular abnormalities.

- (3) Monofixation syndrome (microtropias).

h. Miscellaneous defects and diseases.

(1) Glaucoma as evidenced by applanation tension 30 mmHg or higher, or secondary changes in the optic disc or visual field associated with glaucoma. (See APL, Glaucoma and Ocular Hypertension.)

(2) Intraocular hypertension as evidenced by two or more determinations of 22 mmHg or higher, or a persistent difference of 4 or more mmHg tension between the two eyes, when confirmed by applanation tonometry. (See APL, Glaucoma and Ocular Hypertension.)

- (3) History of penetrating trauma to the eye or hyphema.
- (4) History of ocular or acephalic migraine with visual disturbance.

4-12. Vision

The causes of medical unfitness for flying duty Classes 1/1A/2/2F/2S/3 are the following:

a. Classes 1/1A.

(1) Distant visual acuity. Uncorrected distant visual acuity greater than 20/50 in each eye. If the distant visual acuity is 20/50 or better in either eye, each eye must be correctable to 20/20 with no more than 1 error per line on the Armed Forces Vision Tester (AFVT) or projected Snellen chart at 20 feet.

(2) Near visual acuity. Uncorrected near visual acuity greater than 20/20 in each eye; with no more than 1 error per line on the AFVT or Snellen near visual acuity card.

(3) Cycloplegic refractive error using the method in ATB 5, Cyclopedic Refraction.

(a) Hyperopia greater than + 3.00 diopters of sphere in any meridian by transposition in either eye. (Spherical equivalent method does not apply.)

(b) Myopia greater than - 1.50 diopters of sphere in any meridian by transposition in either eye. (Spherical equivalent method does not apply.)

(c) Astigmatism greater than +/- 1.00 diopters of cylinder in either eye.

(d) Presbyopic correction greater than 0.00 diopters of add in either eye.

(4) Ocular motility using the methods in APL, Extraocular Motility Disturbances, and APL, Convergence Insufficiencies.

(a) Any degree of tropia detected in ocular motion on the Cover-Uncover Test (Tropia Test) in any four cardinal directions of gaze, or any degree of heterotropia.

(b) Esophoria greater than 8 prism diopters.

(c) Exophoria greater than 8 prism diopters.

(d) Hyperphoria greater than 1 prism diopter.

(e) Any detectable ocular motion on the Cross-Cover Test (Alternate Cover or Phoria Test) in any four cardinal directions of gaze until a complete evaluation by a qualified ophthalmologist or optometrist is reviewed by Commander, U.S. Army Aeromedical Center (USAAMC).

(f) Near point of convergence (NPC) greater than 100 mm.

(5) Color vision performed by test methods in APL, Color Vision Deficiencies.

(a) Five or more errors in reading the 14 test plates of the Pseudoisochromatic Plate (PIP) Set; or

(b) Any error in reading the nine test light pairs of the Farnsworth Lantern (FALANT).

(6) Binocular depth perception (stereo acuity) performed by test methods in ATB 7, Depth Perception Tests. (RANDOT Forms Test, RANDOT Animals Test, and Titmus Stereo Fly are not authorized.)

(a) Any error in line A or B of lines A through F when using depth perception presentation places in the AFVT or Optec 2300 AFVT; or

(b) Any error in levels 1 through 7 of the 10 levels of the Random Dot (RANDOT) Circles Test; or

(c) Any error in the nine levels of the Titmus Graded Circles Stereoacuity Test with nine levels of four circles; or

(d) Binocular stereo acuity worse than 40 seconds of arc.

(7) Field of vision. Any scotoma, other than physiologic.

(8) Night blindness. As noted by history and confirmed by abnormal night vision testing.

b. Classes 2/2F/2S/3. Same as Classes 1/1A, except as listed below:

(1) Distant and near visual acuity. Uncorrected acuity greater than 20/400 in either eye, which must be correctable to 20/20 in each eye.

(2) Manifest refractive error. Refractive error of such magnitude that the individual cannot be fitted with aviation spectacles.

(3) Failed NPC is not disqualifying.

4-13. Genitourinary

The causes of medical unfitness for flying duty Classes 1/1A/2/2F/2S/3 are the causes in paragraphs 2-14 and 2-15, plus the following:

- a. History of persistent hematuria with greater than five red blood cells per high power field on routine analysis.
- b. History of any metabolic abnormality of the urine, to include proteinuria, glycosuria, and hypercalcinuria.
- c. Uncomplicated pregnancy is not disqualifying, but results in flying duty restrictions. (See APL, Pregnancy.) In uncomplicated pregnancies, flying is restricted to synthetic flight simulator training during the entire pregnancy; or multi-crew, multi-engine, non-ejection seat fixed wing aircraft during the 13th through 24th week of gestation. The requirement for physiological training is waived during pregnancy.
- d. Complications of pregnancy. (See APL, Pregnancy.)
- e. History of urinary tract stone formation or retention of urinary tract stone within collecting system. (See APL, Kidney Stones, and APL, Pregnancy.)

4-14. Head and neck

The causes of medical unfitness for flying duty Classes 1/1A/2/2F/2S/3 are the causes in paragraphs 2-16, 2-17, and 4-22.

4-15. Heart and vascular system

The causes of medical unfitness for flying duty Classes 1/1A/2/2F/2S/3 are the causes in paragraphs 2-18 and 2-19, plus the following:

- a. History of any abnormal electrocardiographic findings, including but not limited to:
 - (1) Left axis deviation greater than minus 45 degrees.
 - (2) Acquired right axis deviation greater than 120 degrees.
 - (3) First degree AV-block when the PR interval (interval between the P and R waves on an electrocardiogram (EKG)) cannot be shortened to less than or equal to 220 milliseconds in the unipolar leads during exercise.
 - (4) Mobitz Type II second degree AV block, and third degree AV block.
 - (5) Acquired left anterior or posterior hemiblock.
 - (6) Acquired complete right bundle branch block. (See APL, Acquired Right Bundle Branch Block.)
 - (7) Complete left bundle branch block.
 - (8) Pre-excitation as manifested by Wolff-Parkinson-White pattern or short PR interval (PR interval less than 120 milliseconds in all 12 leads). Wolff-Parkinson-White syndrome.
 - (9) Sinus pause or asystole accompanied by symptoms and/or greater than 2.2 seconds in duration.
 - (10) Bradydysrhythmias accompanied by symptoms and/or hypotension.
 - (11) Supraventricular tachycardia (3 or more beats at a rate greater than 100) to include atrial fibrillation/flutter, multifocal atrial tachycardia, junctional tachycardia, and persistent sinus tachycardia.
 - (12) Frequent uniform or multiform ventricular premature beats, or ventricular premature beats, or ventricular premature beat pairs, as defined by APL, Abnormal Electrocardiogram.
 - (13) Ventricular tachycardia (3 or more beats at a rate greater than 100), to include ventricular fibrillation/flutter and accelerated idioventricular rhythm.
 - (14) Acquired ST and T wave abnormalities consistent with myocardial dysfunction of any etiology.
 - (15) Aeromedically borderline abnormal or abnormal exercise treadmill test as defined by ATB 6, Aeromedical Graded Exercise Test, until reviewed by the Aviation Medicine Approving Authority. (See APL, Abnormal Electrocardiogram.)
- b. History of hypertrophic, dilated, or obstructive cardiomyopathy, to include left ventricular hypertrophy, as documented by clinical or EKG evidence. Hypertrophy due to athletic heart is not disqualifying. (See APL, Aeromedical Cardiovascular Screening Program.)
- c. History of valvular heart disease, to include mitral valve prolapse, as documented by clinical or electrocardiographic findings.
- d. History of myocarditis, or endocarditis, to include subacute bacterial endocarditis. History of pericarditis until reviewed by the Aviation Medicine Approving Authority.
- e. Any evidence of coronary artery disease as outlined by APL, Aeromedical Cardiovascular Screening Program.
- f. For Classes 2/2F, suspected coronary artery disease such as an elevated cardiac risk index, elevated total cholesterol or cholesterol/high-density lipoprotein (HDL) -cholesterol ratio in conjunction with an abnormal aeromedical graded exercise treadmill test and/or abnormal cardiac fluoroscopy as outlined in APL, Aeromedical Cardiovascular Screening Program. (See also ATB 6, Aeromedical Graded Exercise Test, and ATB 9, Cardiac Fluoroscopy.)

- g. History of congenital anomalies of the heart or great vessels, or surgery to correct these anomalies.
- h. History of cor pulmonale or congestive heart failure.
- i. History of hypertension with a systolic pressure of 140 mmHg or greater, and/or diastolic pressure of 90 mmHg or greater, with or without systemic complications confirmed by average reading of a 3-day blood pressure check. (See APL, Hypertension in Aircrew Members.)
- j. Orthostatic hypotension or orthostatic intolerance or symptomatic hypotension. (See para 4-22e.)
- k. History of diseases of the blood and lymphatic vessels, to include but not limited to, aortic aneurysm, arteriosclerotic occlusive disorders, fistulas, vasculitis, vasospastic disorders, thromboembolic disorders, and lymphedema.
- l. History of any cardiac surgical procedure, to include pacemaker insertion, valve replacement, bypass tract ablation by any method, coronary angioplasty, and coronary artery bypass.

4-16. Linear anthropometric dimensions

The causes of medical unfitness for flying duty Classes 1/1A/2/2F/2S/3 are the following:

- a. Classes 1/1A/2/2F/2S. Failure to meet linear anthropometric standards. Total arm reach equal to or greater than 164.0 cm. Sitting height equal to or less than 102.0 cm (except equal to or less than 95.0 cm for Class 2S). Crotch height equal to or greater than 75.0 cm. (See APL, Anthropometry.)
- b. Class 3. Linear anthropometric measurements and body composition not compatible with aviation or crew member safety, or operational effectiveness at the Class 3 aircrew member's workstation.

4-17. Weight and body build

The causes of medical unfitness for flying duty Classes 1/1A/2/2F/2S/3 are the following:

- a. Classes 1/1A and initial Classes 2/2S/2F/3. Body weight and composition exceeding the standards prescribed by AR 600-9.
- b. Classes 2/2F/2S/3—initial civilian and retention.
 - (1) Military aircrew members will be recommended for administrative restriction from flying duty by their commander when body weight or composition exceeds the limits prescribed by AR 600-9.
 - (2) Aircrew members are medically unfit for flying duties when the body weight or build prevents normal functions required for safe and effective aircraft flight, such as interference with aircraft instruments, controls, and aviation life support equipment to include proper function of crash worthy seats, ejection seats, and other safety equipment and mechanisms of egress.

4-18. Lung and chest wall

The causes of medical unfitness for flying duty Classes 1/1A/2/2F/2S/3 are the causes in paragraphs 2-23 and 4-2, plus the following:

- a. Pneumothorax, spontaneous.
 - (1) Classes 1/1A. A history of spontaneous pneumothorax.
 - (2) Classes 2/2F/2S/3.
 - (a) Single instance of spontaneous pneumothorax within the last 2 months, and until clinical evaluation shows complete recovery with full expansion of the lung, normal pulmonary function, and with no additional lung pathology, or other contraindication to flying.
 - (b) Recurrent spontaneous pneumothorax; waiver may be considered if effectively treated by pleuridesis and/or pleurectomy with complete recovery and successful completion of an altitude chamber ride to 18,000 feet.
- b. Pneumothorax, traumatic, as outlined in a(2)(a) above.
- c. Pulmonary tuberculosis or tuberculous pleurisy; except chemoprophylaxis for tuberculin test conversion only is not disqualifying.
- d. Presence of bullae.
- e. Sarcoidosis. (See APL, Sarcoidosis.)

4-19. Mouth

The causes of medical unfitness for flying duty Classes 1/1A/2/2F/2S/3 are the causes in paragraph 2-24, plus the following:

- a. Any infectious lesion until recovery is complete and the part is functionally normal.
- b. Any congenital or acquired lesion that interferes with the function of the mouth or throat.
- c. Any defect in speech that would prevent or interfere with clear and effective communication in the English language over a radio communication system.
- d. Recurrent calculi of any salivary gland or duct.

4–20. Nose

The causes of medical unfitness for flying duty Classes 1/1A/2/2F/2S/3 are the causes in paragraph 2–25, plus the following:

- a.* Acute, self-limited rhinitis when accompanied by eustachian tube dysfunction until clear of all symptoms.
- b.* History of allergic rhinitis or vasomotor rhinitis after age 12 requiring the use of antihistamines for a cumulative period greater than 14 days per year; or systemic steroids, topical steroid, or mast-cell stabilization therapy, or immunotherapy at any time. (See APL, Allergic Rhinitis.)
- c.* Deviation of the nasal septum or septal spurs that results in symptomatic obstruction of airflow, chronic rhinitis, chronic sinusitis, or interference of sinus drainage.
- d.* History of nasal polyps, or sinus polyps, or retention cysts.
- e.* Sinusitis.
 - (1) Classes 1/1A.
 - (a)* Acute sinusitis within the last 5 years unless current sinus x-ray series is normal.
 - (b)* History of or x-ray evidence of chronic sinusitis, and/or surgery to treat chronic sinusitis.
 - (2) Classes 2/2F/2S/3.
 - (a)* Acute sinusitis until resolved.
 - (b)* Chronic sinusitis and/or surgery to treat chronic sinusitis.

4–21. Pharynx, larynx, trachea, and esophagus

The causes of medical unfitness for flying duty Classes 1/1A/2/2F/2S/3 are the causes in paragraph 2–25, plus the following:

- a.* History of recurrent hoarseness interfering with communication.
- b.* History of tracheostomy.
- c.* History of chronic or recurrent eustachian tube dysfunction.

4–22. Neurological disorders

(See table 4–2.) The causes of medical unfitness for flying duty Classes 1/1A/2/2F/2S/3 are the causes in paragraphs 2–26, 2–29d, and 4–14, plus the following:

- a.* History of electroencephalographic abnormalities of any kind; to include spike-wave complexes, spikes, or sharp waves.
- b.* History of any type of vascular headache; to include migraine and cluster types.
- c.* History of neuritis, neuralgia, neuropathy, or radiculopathy until reviewed by the Aviation Medicine Approving Authority.
- d.* History of decompression sickness (Type II) or an air embolism with neurologic involvement.
- e.* History of disturbances in consciousness, single episode or recurrent; to include nontraumatic loss of consciousness, narcolepsy, cataplexy, all forms of paroxysmal convulsive disorders, or single convulsive seizures of any type, except—
 - (1) Single episode of documented vasovagal syncope such as syncope with venipuncture or immunizations.
 - (2) Single episode of documented postural or parade-rest syncope, not otherwise disqualifying.
 - (3) Febrile seizures before the age of 5 with a normal EEG.
- f.* Central nervous system infections.
 - (1) Classes 1/1A. Within 1 year prior to examination, except 6 years for encephalitis, or if there are residual neurological deficits or other sequelae.
 - (2) Classes 2/2F/2S/3. Until complete recovery without residual neurological deficits or other sequelae.
- g.* History of organic mental syndromes; developmental, learning, or sensory processing disorders; or toxic or metabolic central nervous system disorders, until reviewed by the Aviation Medicine Approving Authority.
- h.* History of intracranial embolism, vascular insufficiency, thrombosis, hemorrhage, arteriovenous malformation, or aneurysm.
- i.* History of degenerative or demyelinating process, such as multiple sclerosis, dementia, Alzheimer's disease, Parkinson's disease, or basal ganglia disease.
- j.* For Classes 1/1A, personal or family history of hereditary diseases with neurologic sequelae, such as hepatolenticular degeneration, neurofibromatosis, acute intermittent porphyria, or familial periodic paralysis. A strong family history of such syndromes indicating an hereditary predilection for the disease will be cause for disqualification, even if there are no current signs or symptoms.
- k.* History of benign or malignant neoplasms of the brain, pituitary gland, spinal cord, or their coverings.
- l.* History of diagnostic or therapeutic craniotomy, or any procedure involving penetration of the dura mater or the brain substance, including ventriculo-peritoneal shunts, evacuation of hematomas, and brain biopsy.
- m.* Any defect in the bony substance of the skull, regardless of cause.

n. History of any head injury associated with the following will be cause for permanent disqualification for aviation duty for all Classes. (See also table 4–2.)

- (1) Intracranial hemorrhage or hematoma, to include epidural, subdural, intracerebral, or subarachnoid hemorrhage.
- (2) Any penetration of the dura mater or brain substance.
- (3) Radiographic or other evidence of retained intracranial foreign bodies or bony fragments.
- (4) Transient or persistent neurological deficits indicative of parenchymal central nervous system injury, such as hemiparesis or cranial neuropathy.
- (5) Persistent focal or diffuse abnormalities of the EEG reasonably assumed to be a result of an accident.
- (6) Depressed skull fracture with or without dural penetration.
- (7) Linear or basilar skull fracture with or without dural penetration.
- (8) Posttraumatic syndrome as manifested by changes in personality, impairment of higher intellectual functions, anxiety, headaches, or disturbances of equilibrium that does not resolve within 6 weeks after injury.
- (9) Unconsciousness exceeding 24 hours.
- (10) Cerebrospinal fluid rhinorrhea or otorrhea persisting more than 7 days.

o. History of head injury associated with any of the following will be cause for permanent disqualification for flying duties for Classes 1/1A; and termination of aviation service for a minimum of 2 years for Classes 2/2F/2S/3. (See table 4–2.)

- (1) Linear or basilar skull fracture with loss of consciousness for more than 15 minutes but less than 2 hours.
- (2) Posttraumatic syndrome, as manifested by changes in personality, impairment of higher intellectual functions, anxiety, headaches, or disturbances of equilibrium, that persists for more than 2 weeks, but resolves within 6 weeks of the injury.
- (3) Amnesia (posttraumatic and retrograde, patchy or complete), delirium, disorientation, or impairment of judgment that exceeds 24 hours.
- (4) Unconsciousness for a period of greater than 2 hours, but less than 24 hours.

p. History of head injury associated with any of the following will be cause for a 2-year disqualification for Classes 1/1A; and temporary medical suspension from aviation duty for 3 months for Classes 2/2F/2S/3. (See table 4–2.)

- (1) Linear or basilar skull fracture with loss of consciousness for less than 15 minutes.
- (2) Posttraumatic syndrome, as manifested by changes in personality, impairment of higher intellectual functions, anxiety, headaches, or disturbances of equilibrium, that persists for more than 48 hours but resolves within 14 days of the injury.
- (3) Posttraumatic headaches alone that persist more than 14 days after injury, but resolve within 1 month.
- (4) Amnesia (posttraumatic and retrograde, patchy and complete), delirium, or disorientation that lasts less than 24 hours, but more than 12 hours after injury.
- (5) Unconsciousness for more than 15 minutes but less than 2 hours.
- (6) Cerebrospinal fluid rhinorrhea or otorrhea that clears within 7 days of injury, provided there is no evidence of cranial nerve palsy.

q. History of head injury associated with any of the following will be cause for a 3-month disqualification for Classes 1/1A, and temporary medical suspension from aviation duty for 1 month for Classes 2/2F/2S/3.

- (1) Posttraumatic syndrome, as manifested by changes in personality, impairment of higher intellectual functions, anxiety, headaches, or disturbances of equilibrium, that resolves within 48 hours of the injury.
- (2) Posttraumatic headaches alone that resolves within 14 days after injury.
- (3) Amnesia (posttraumatic and retrograde, patchy and complete), delirium, or disorientation that lasts less than 12 hours after injury.
- (4) Unconsciousness less than 15 minutes.

4–23. Mental disorders

The minimum psychiatric evaluation will include Axis I, II, and III, using diagnostic criteria and terms found in DSM–IV. The causes of medical unfitness for flying duty Classes 1/1A/2/2F/2S/3 are the causes in paragraphs 2–27 through 2–31, except as modified by the following:

- a.* History of any psychotic episode evidenced by impairment in reality testing, to include transient disorders, from any cause except transient delirium secondary to toxic or infectious processes before age 12.
- b.* History of mood disorder, to include major mood disorders, depression, cyclothymic, dysthymic, and mood disorders not otherwise specified.
- c.* History of anxiety disorder, somatoform disorder, or dissociative disorder, including but not limited to those disorders previously described as neurotic. History of any phobias or severe or prolonged anxiety episodes, after age 12, even if they do not meet the diagnostic criteria of DSM–IV.
- d.* History of factitious disorders and disorders of impulse control not elsewhere classified.

- e. History of pervasive or specific developmental disorders usually first seen in childhood. Stuttering, sleepwalking, and sleep terror disorders if occurring after the 14th birthday.
- f. History of personality or behavior disorder. Personality traits insufficient to meet DSM–IV criteria for personality disorder diagnosis may be cause for an unsatisfactory Aeromedical Adaptability (AA) rating (formerly Adaptability Rating for Military Aeronautics (ARMA)). (See para 4–29.)
- g. History of any adjustment disorder until reviewed by the Aviation Medicine Approving Authority.
- h. Excessive alcohol use.
 - (1) History of alcohol abuse or dependence by DSM–IV criteria is disqualifying for all Classes.
 - (2) History of alcohol misuse is disqualifying for all Classes. Alcohol misuse is defined as involvement in an alcohol-related event that should or does lead for referral for addiction dependence or abuse. (See APL, Alcohol-Related Disorders, for aeromedical evaluation, treatment, and disposition guidelines; see also AR 600–85.)
- i. Drug misuse, abuse, or dependence. History of misuse or abuse of any controlled substance, and/or use of any illicit drugs, including marijuana and psychoactive substances for all Classes. (See APL, History of Illicit Drug Use. Para 2–31 also applies.)
- j. History of suicide attempt or gesture at any time.
- k. Insomnia, severe or prolonged.
- l. Unconscious (neurotic) fear of flying manifested as psychiatric or somatic symptoms. Refer aircrew with a conscious fear of flying, that is, those who have made a conscious choice not to fly, to the aviation unit commander for a nonmedical disqualification and flying evaluation board (FEB). (See AR 600–105.)
- m. Recurrent episodes of fainting, near-syncope, vasomotor syncope, or vasomotor instability until reviewed by the Aviation Medicine Approving Authority. (See para 4–22e.)
- n. Emotional responses to situations of stress, either combat or noncombat, when such a reaction may interfere with the efficient and safe performance of an individual’s flying duties as determined by review by the Aviation Medicine Approving Authority.

Note. See APL, Mental Health Findings.

4–24. Skin and cellular tissues

The causes of medical unfitness for flying duty Classes 1/1A/2/2F/2S/3 are the causes listed in paragraph 2–32, plus any skin condition that interferes with the use of aviation clothing or life support equipment.

4–25. Spine, scapula, ribs, and sacroiliac joints

The causes of medical unfitness for flying duty Classes 1/1A/2/2F/2S/3 are the causes listed in paragraphs 2–11 and 2–33, plus the following:

- a. History of chronic or recurrent disabling episodes of back pain, especially when associated with significant objective findings.
- b. History of any fracture or dislocation of the vertebrae, to include insertion of spinal orthopedic hardware. A compression fracture involving less than 25 percent of a single vertebra is not disqualifying if the injury occurred more than 12 months ago and is asymptomatic; except any degree of compression fracture of the cervical vertebrae, twelfth thoracic vertebrae, or first lumbar vertebra. A history of fracture of the transverse or spinous process is not disqualifying if asymptomatic.
- c. Scoliosis.
 - (1) Classes 1/1A. Any degree of scoliosis. Scoliosis may be qualified if the angulation is found to be stable by two standing scoliosis x-ray series done 12 months apart, and the scoliosis angle in the thoracic or lumbar spine is 20 degrees or less by the Cobb method.
 - (2) Classes 2/2F/2S/3. Standing scoliosis x-ray series demonstrating an angle in the thoracic or lumbar spine that exceeds 20 degrees by the Cobb method.

4–26. Systemic diseases

The causes of medical unfitness for flying duty Classes 1/1A/2/2F/2S/3 are the causes in paragraphs 2–34 and 2–35, plus the following:

- a. Malaria.
 - (1) Classes 1/1A. A history of malaria unless—
 - (a) There have been no symptoms for at least 6 months after completion of antimalarial therapy.
 - (b) Complete blood count and red blood cell morphology are normal.
 - (c) A thick smear is negative for parasites.
 - (2) Classes 2/2F/2S/3. A history of malaria unless adequate therapy in accordance with existing directives has been completed. The duration of removal from flying or ATC duties will vary with the type of malaria, the severity of the infection, and the response to treatment. However, personnel may not fly or control air traffic unless they have been afebrile for 7 days, their blood cells are normal in number and structure, their blood hemoglobin (HGB) is at least 12

grams percent, and a thick smear is negative for parasites. A thick smear and a medical evaluation will be performed every 2 weeks for at least 3 months after completion of antimalarial therapy.

b. Motion sickness.

(1) Classes 1/1A. History of motion sickness, other than isolated instances in childhood without emotional involvement; or history of previous elimination from flight training at any time due to airsickness.

(2) Classes 2/2F/2S/3. Recurrent or severe motion sickness of a degree to interfere with the safe and effective completion of the aviation mission. A history of simulator sickness is not disqualifying.

c. History of gravitational force intolerance below 5+Gz as manifested by gray-out, black-out, or gravity-induced loss of consciousness.

d. Drugs, medications, alcohol beverages, immunizations, blood donations, diving, and other exogenous factors in accordance with the guidelines established in AR 40–8 and APL, Medications.

e. For 2 hours following unprotected exposure to temporary incapacitating (riot control) agents or until all symptoms of eye and/or respiratory tract irritation disappears, whichever is longer, and until risk of secondary exposure from contaminated skin, clothing, equipment, or aircraft structures has been eliminated through cleansing, decontamination, change of clothing and equipment, or other measures. In no case will both the pilot and copilot be deliberately exposed at the same time unless one is wearing adequate protective equipment.

f. History of exposure to chemical (other than riot control agents), biological, and nuclear weapons until reviewed by the Aviation Medicine Approving Authority.

g. Presence of HIV–1 or antibody. (Civilian employees: Normally, neither applicants for employment nor current employees may be required to be tested for the presence of the HIV antibody. Civilian employees are not disqualified based solely on the presence of the HIV virus. See AR 600–110 and ATB 2, Army Flight Surgeon’s Administrative Guide.)

h. Chronic fatigue syndrome.

i. Sarcoidosis. (See APL, Sarcoidosis.)

j. Other diseases and conditions that, based upon sound aeromedical principles, may in any way affect or compromise the individual’s health or well-being, flying safety, or mission completion. The local FS will make the initial determination and recommendations to the individual’s commander. The Aviation Medicine Approving Authority will make the final determination of medical fitness for flying duty.

4–27. Malignant diseases and tumors

The causes of medical unfitness for flying duty Classes 1/1A/2/2F/2S/3 are the causes listed below:

a. Benign tumors, same as the causes listed in paragraphs 2–36*a* and 4–22*k*.

b. History of any malignant tumor, except for basal cell carcinoma of the skin that has been removed. (See also APL, Cancer in Aircrew.)

4–28. Sexually transmitted diseases

The causes of medical unfitness for flying duty Classes 1/1A/2/2F/2S/3 are the causes listed in paragraph 2–35*m*.

4–29. Aeromedical Adaptability

a. The cause of medical unfitness for flying duty for all Classes, to include civilian aircrew members and ATCs, is an unsatisfactory AA (formerly ARMA) due to sociobehavioral factors that are considered unsuitable for or unadaptable to Army aeronautics. The unsatisfactory AA may be a manifestation of underlying psychiatric disease (see para 4–23) or may be accompanied by nonmedical disqualifications. (See AR 600–105.) The unsatisfactory AA is not a diagnosis, but is a determination by the FS and aviation commander or supervisor of suitability or adaptability. An unsatisfactory AA may be revealed by interview, records review, command referral, security investigations, or other documented sources.

b. Until reviewed by the Aviation Medicine Approving Authority, an unsatisfactory AA may exist if any of the conditions listed below are present. Trained aircrew with an unsatisfactory AA should also be referred to the aviation unit commander for administrative evaluation of nonmedical disqualifications and determination of fitness to retain the aircrew member’s aeronautical rating or status. (See AR 600–105.) Psychological and psychiatric consultation will be obtained as required by the FS or the Aviation Medicine Approving Authority. The aviation commander and FS will forward their evaluations and recommendations to the Aviation Medicine Approving Authority to make a final recommendation of medical fitness for flying duties. The Aviation Medicine Approving Authority will coordinate with the Chief, Army Aviation Branch, and aeromedical waiver authorities as required. When there is a question of observer bias or loss of objectivity, the Aviation Medicine Approving Authority may obtain additional medical evaluations from other impartial FSs or medical consultants.

(1) Deliberate or willful concealment of significant and/or disqualifying medical conditions on medical history forms or during FS interview.

(2) An attitude toward flying that is clearly less than optimal; for example, the person appears to be motivated

overwhelmingly by the prestige, pay, or other secondary gains rather than the skill, achievement, and professionalism of flying itself.

(3) Clearly noticeable personality traits such as immaturity, self-isolation, difficulty with authority, poor interpersonal relationships, impaired impulse control, or other traits that may interfere with group functioning as a team member in an operational aviation setting, even though there are insufficient criteria for a personality disorder diagnosis.

(4) Review of the history or medical records reveals multiple or recurring physical complaints that strongly suggest either a somatization disorder or a propensity for physical symptoms during times of stress. (See also para 4–23*n*.)

(5) A history of arrests, illicit drug use, or social “acting out” that may indicate immaturity, impulsiveness, or antisocial traits. Experimental use of drugs during adolescence, minor traffic violations, or clearly provoked impulsive episodes may be found fit after review by the Aviation Medicine Approving Authority. (See also para 4–23*i*.)

(6) Significant prolonged or currently unresolved interpersonal or family problems, marital dysfunction, or significant family opposition or conflict concerning the soldier’s aviation career.

c. Until reviewed by the Aviation Medicine Approving Authority, an unsatisfactory AA may be given for lower levels (symptoms and signs) than those mentioned in *b* above if, in the opinion of the FS and aviation commander or civilian supervisor, mental or physical factors might be exacerbated under the stresses of Army aviation or the person might not be able to carry out his or her duties in a mature and responsible fashion. A person may be disqualified for any of a combination of factors listed in *b* above and/or due to personal habits or appearance indicative of attitudes of carelessness, poor motivation, or other characteristics that may be unsafe or undesirable in the aviation environment.

4–30. Reading Aloud Test

The cause of medical unfitness for flying duty Classes 1/1A/2/2F/2S/3 is failure to clearly communicate in the English language in a manner compatible with safe and effective aviation operations. For initial applicants, this is determined by administration of the Reading Aloud Test. (See ATB 2, Army Flight Surgeon’s Administrative Guide.) In questionable cases, the aviation unit commander, ATC supervisor, or other appropriate aviation official will provide a written recommendation to the FS.

4–31. Department of the Army civilian and contract civilian aircrew members

(See para 4–33 for ATC personnel.)

a. The following references apply as noted.

(1) 5 CFR Part 339, Office of Personnel Management, applies to DA civilians.

(2) AR 95–20, Vol 1/AFR 55–22V1/NAVAIRINST 3710.1C/DLAM 8210.1 applies to contract civilian aircrew members who fly in aircraft owned or leased by DOD.

(3) 14 CFR Part 61 and 14 CFR Part 67, Federal Aviation Administration, do not apply since Army civilian aircrew members fly public use aircraft. The agency that owns or operates public use aircraft is responsible for the medical certification of aircrew flying those aircraft.

b. The aeromedical certification of civilian aircrew members has three major components:

(1) *Examination method.* The Army determines the scope of examination and the examiners as outlined in chapter 6, APLs, and ATBs.

(2) *Aeromedical standard.* The classes of medical standards for flying are listed in paragraph 4–2. The medical conditions that pertain to each specific medical standard for flying are contained in paragraphs 4–4 through 4–33.

(3) *Aeromedical disposition.* The Army makes the final determination of fitness for flying duties using the administrative procedures in chapter 6, APLs, and ATBs. The Army may require additional consultations, examinations, and tests before a final determination is made. Civilian aircrew members may submit other medical documents from health care providers of their choice. The Aviation Medicine Approval Authority may consult DA-designated aeromedical consultants and the Army Aeromedical Consultant Advisory Panel (ACAP) as required. The Aviation Medicine Approval Authority makes the final recommendation of aeromedical fitness to the civilian aircrew member waiver authority designated in paragraphs 6–21*e* and 6–21*f*. The recommendation considers the civilian aircrew member’s medical condition, aircraft flown, mission and duties and deployability status. The recommendation may be qualified, disqualified with waiver, or medical termination from aviation service. The waiver authority grants or denies the aeromedical recommendation.

(a) DAC aircrew members granted medical termination from aviation service are referred by the supervisor aviation unit commander to the Civilian Personnel Office for assistance in reassignment to duties not to include flying (DNIF). The Office of Personnel Management makes the final determination of eligibility for medical disability.

(b) Contract civilian aircrew members granted medical termination from aviation service are referred by the Contracting Officer Representative to the contractor management for reassignment to DNIF or termination of employment.

c. The following exception applies to civilian aircrew members. Civilian aircrew members are not required to meet the requirements of the Army Weight Control Program (AR 600–9). Maximal allowable weight and anthropometric

measurements will permit normal function required for safe and effective aircraft flight without interfering with aircraft instruments or controls, aircraft egress, or proper function of crash worthy or ejection seat systems.

4-32. Medical standards for Class 3 personnel

a. Initial and subsequent medical certification of Class 3 aircrew is conducted according to this regulation, and APLs and ATBs issued by the Aviation Medicine Approving Authority.

b. The attending FS makes the final determination of fitness for Class 3 flying duties with the exception of the following conditions that require submission of an Aeromedical Summary to the Aviation Medicine Approving Authority for final aeromedical review and disposition:

- (1) Alcohol/drug abuse or dependence; requires PERSCOM or NGB waiver.
- (2) Type II decompression sickness.
- (3) Coronary artery disease, suspected or proven.
- (4) HIV seropositivity. (Civilian employees: Normally, neither applicants for employment nor current employees may be required to be tested for the presence of the HIV antibody. Civilian employees are not disqualified based solely on the presence of the HIV virus. See AR 600-110 and ATB 2, Army Flight Surgeon's Administrative Guide.)

c. The FS will utilize the following guidelines for Class 3 waiver/suspension recommendations:

(1) Class 3 aircrew with a major physical or psychological disqualification will be recommended for suspension from flying duties. Other disqualifications may be waived for flying duties. The FS will take into consideration the operational duties and responsibilities of Class 3 aircrew before recommending a waiver/suspension action to the aviation unit commander. Questionable cases will be referred to the Aviation Medicine Approving Authority.

(2) A major physical or psychological defect in the operational aviation environment is defined as any defect that will—

- (a) Interfere with duties requiring visual or auditory acuity, speech clarity, dexterity, or adequate range of motion.
- (b) Interfere with wearing aviation life support equipment, or use of controls at their duty station.
- (c) Reduce the ability to withstand rapid changes in atmospheric pressure or forces of acceleration.
- (d) Increase the risk of sudden incapacitation, compromising personal health, aviation safety, mission completion, or deployability.
- (e) Require medications or treatments that compromise flight safety or deployability.

d. The local aviation unit commander or civilian waiver authority, as appropriate, will grant or deny the aeromedical recommendation for waiver or suspension.

4-33. Medical standards for Class 4 ATC personnel

a. Military ATCs. The initial and retention medical standards for fitness for military ATC duties are the same. Military ATCs must also meet the medical fitness standards of chapter 2 for initial qualification and chapter 3 for retention.

b. DAC and DA contract civilian ATCs.

(1) Medical qualification requirements for Department of the Army civilian Air Traffic Controllers are outlined in Office of Personnel Management Operating Manual: Qualification Standards for General Schedule Positions, GS-2152: Air Traffic Control Series, in accordance with section 339.202, title 5, Code of Federal Regulations. These guidelines are available for review on the Internet at www.opm.gov/qualifications/index.htm.

(2) DA contract civilian ATCs may be required by their contractor employer to maintain a Class II Federal Aviation Administration (FAA) medical certification; but this certification is not required by DA or FAA for contract ATCs to control air traffic in DOD facilities (14 CFR 65.31, 33). The initial and subsequent determinations of medical fitness for ATC duties are made as outlined in this regulation. The contract will state that DA contract ATCs will meet the same medical qualification requirements as those for DA civilians set forth in (1) above.

c. Class 4 military ATCs. The causes for unfitness for Class 4 ATC duties are as follows:

- (1) Eye. (See paras 4-11 and 4-12.)
- (2) Ear, nose, and throat. (See also para 4-7.)
 - (a) Unilateral or bilateral disease of the outer, middle, or inner ear that may interfere with the comfortable, efficient use of the standard headphone apparatus, with accurate perception of voice transmissions or spoken communications, or equilibrium.
 - (b) Disease or malformation of the mouth or throat that may interfere with enunciation and clear speech, to include stuttering or stammering. (See paras 4-6, 4-19, and 4-30.)
 - (c) Hearing loss that exceeds the standards in table 4-1.
 - (d) Nose and sinuses. (See para 4-20.)
- (3) Cardiovascular and blood pressure. (See para 4-15.)
- (4) Neuropsychiatric. (See paras 4-22, 4-23, and 4-29.)
- (5) Endocrine. (See para 4-9 and APL, Diabetes and Glucose Intolerance.)
- (6) Musculoskeletal.

(a) Any deformity or condition of the spine or limbs, or absence of any extremity, digit, or any portion thereof, that may interfere with satisfactory and safe performance of duty.

(b) Any condition that predisposes to fatigue or discomfort induced by long periods of standing or sitting.

(7) Weight and body build. These factors must not interfere with the operation of ATC equipment, or the use of work place facilities such as office chair or staircase.

(8) HIV seropositivity. (Civilian employees: Normally, neither applicants for employment nor current employees may be required to be tested for the presence of the HIV antibody. Civilian employees are not disqualified based solely on the presence of the HIV virus. See AR 600–110 and ATB 2, Army Flight Surgeon’s Administrative Guide.)

(9) Other medical conditions. Other organic, systemic, functional, or structural diseases, defects, or limitations that in the opinion of the attending FS may be a potential hazard to safety in the Air Traffic Control System, or predispose to sudden incapacitation or inability to adapt to stress. (See paras 4–26, 4–27, and 4–28.) A pertinent history and clinical evaluation including laboratory screening will be obtained, and when clinically indicated, special consultations and examinations will be accomplished and forwarded to the Aviation Medicine Approving Authority for review.

(10) Medications. Unfitting for ATC duties and requires a waiver. (See APL, Medications.)

Table 4–1
Acceptable audiometric hearing level for Army aviation and air traffic control

	ISO 1964–ANSI 1969 (unaided sensitivity)					
Frequency (HZ)	500	1000	2000	3000	4000	6000
Classes 1/1A	25	25	25	35	45	45
Classes 2/2F/2S/3/4	25	25	25	35	55	65

Table 4–2
Head injury guidelines for Army aviation

Disposition by Class (Refer to the glossary for acronyms and abbreviations used)				
Classes 1/1A	Perm DQ	Perm DQ	2-year DQ	3-month DQ
Classes 2/2F/2S/3/4	Perm DQ	2-year DQ	3-month DQ	4-week DQ
Problem				
Intracranial bleeding	Any	—	—	—
Penetration of dura or brain	Any	—	—	—
Intracranial bone fragment or foreign bodies	Any	—	—	—
CNS deficits indicating parenchymal injury	Any	—	—	—
EEG abnormality due to injury	Any	—	—	—
Depressed skull fracture	Any	—	—	—
Basilar or linear skull fracture with—	LOC >2h	LOC 15m–2h	LOC <15m	—
Post trauma syndrome lasting—	>6wk	2wk–6wk	48h–14d	<48h
Loss of consciousness lasting—	>24h	2–24h	15m–2h	<15m
CSF leaking—	>7d	—	<7d	—
Amnesia, delirium, or disorientation lasting—	—	>24h	12–24h	<12h

Chapter 5

Medical Fitness Standards for Miscellaneous Purposes

5–1. General

This chapter sets forth medical conditions and physical defects that are causes for rejection for—

- Airborne training and duty, Ranger training and duty, and Special Forces training and duty.
- SERE training.
- Freefall parachute training and duty.
- Army service schools.
- Diving training and duty.
- Enlisted MOSSs.
- Geographical area assignments.

5-2. Application

These standards apply to all applicants or individuals under consideration for selection or retention in these programs, assignments, or duties.

5-3. Medical fitness standards for initial selection for Airborne training, Ranger training, and Special Forces training

The causes of medical unfitness for initial selection for Airborne training, Ranger training, and Special Forces training are all the causes listed in chapter 2, plus all the causes listed in this paragraph and paragraphs 5-4 and 5-6.

- a. Abdomen and gastrointestinal system.
 - (1) Paragraph 2-3.
 - (2) Hernia of any variety including inguinal and other abdominal.
 - (3) Operation for relief of intestinal adhesions at any time.
 - (4) Laparotomy within a 6-month period.
 - (5) Chronic or recurrent gastrointestinal disorder.
 - (6) For Special Forces initial training, asplenia (absence of the spleen) for any reason.
- b. Blood and blood-forming tissue diseases.
 - (1) Paragraph 2-4.
 - (2) Sickle cell disease.
- c. Dental. Paragraph 2-5.
- d. Ears and hearing.
 - (1) Paragraphs 2-6 and 2-7.
 - (2) Radical mastoidectomy.
 - (3) Any infectious process of the ear until completely healed.
 - (4) Marked retraction of the tympanic membrane if mobility is limited or if associated with occlusion of the Eustachian tube.
 - (5) Recurrent or persistent tinnitus.
 - (6) History of attacks of vertigo, with or without nausea, emesis, deafness, or tinnitus.
- e. Endocrine and metabolic diseases. Paragraph 2-8.
- f. Extremities.
 - (1) Paragraphs 2-9 through 2-11.
 - (2) Less than full strength and range of motion of all joints.
 - (3) Loss of any digit from either hand.
 - (4) Deformity or pain from an old fracture.
 - (5) Instability of any degree of major joints.
 - (6) Poor grasping power in either hand.
 - (7) Locking of a knee joint at any time.
 - (8) Pain in a weight-bearing joint.
 - (9) Retained hardware that is integral to maintaining fixation or stability, or presents a risk to mobility or a risk of further injury by its presence.
- g. Eyes and vision.
 - (1) Paragraphs 2-12 and 2-13 with exceptions noted below.
 - (2) For Airborne and Ranger training: Distant visual acuity of any degree that does not correct to at least 20/20 in one eye and 20/100 in the other eye within 8 diopters of plus or minus refractive error, with spectacle lenses.
 - (3) For Special Forces training: Distant visual acuity of any degree that does not correct to 20/20 in both eyes with spectacle lenses. Any refractive error in spherical equivalent of worse than plus or minus 8 diopters.
 - (4) For Airborne and Special Forces training: Failure to pass the PIP set or FALANT test for color vision (see para 4-2a) unless the applicant is able to identify vivid red and/or vivid green as projected by the Ophthalmological Projector or the Stereoscope, Vision Testing (SVT).
- h. Genitourinary system. Paragraphs 2-14 and 2-15.
- i. Head and neck.
 - (1) Paragraphs 2-16 and 2-17.
 - (2) Loss of bony substance of the skull.
 - (3) Persistent neuralgia; tic douloureux; facial paralysis.
 - (4) A history of subarachnoid hemorrhage.
- j. Heart and vascular system. Paragraphs 2-18 through 2-19, except for Special Forces training and duty: blood pressure with a preponderant systolic of less than 90 mmHg or greater than 140 mmHg or a preponderant diastolic of

less than 60 mmHG or greater than 90 mmHg, regardless of age. Unsatisfactory orthostatic tolerance test is also disqualifying.

k. Height. No special requirement.

l. Weight. No special requirement.

m. Body build. Paragraph 2–22.

n. Lungs and chest wall.

(1) Paragraph 2–23.

(2) Spontaneous pneumothorax, except a single instance of spontaneous pneumothorax if clinical evaluation shows complete recovery with full expansion of the lung, normal pulmonary function, and no additional lung pathology or other contraindication to flying is discovered and the incident of spontaneous pneumothorax has not occurred within the preceding 3 months.

o. Mouth, nose, pharynx, larynx, trachea, and esophagus. Paragraphs 2–24 through 2–25.

p. Neurological disorders.

(1) Paragraph 2–26.

(2) Active disease of the nervous system of any type.

(3) Craniocerebral injury (para 4–22*m*).

(4) Abnormal emotional responses to situations of stress (both combat and noncombat), when in the opinion of the medical examiner such reactions will interfere with the efficient and safe performance of the soldier's duties.

q. Mental disorders.

(1) Paragraphs 3–31 through 3–37.

(2) Individuals who are under treatment with any mood-ameliorating, tranquilizing, or ataraxic drugs for hypertension, angina pectoris, nervous tension, instability, insomnia, etc., and for a period of 4 weeks after the drug has been discontinued.

(3) Evidence of excessive anxiety, tenseness, or emotional instability. Fear of dark or enclosed spaces, fear of heights.

(4) Fear of flying when a manifestation of a psychiatric illness.

(5) History of psychosis or attempted suicide at any time.

(6) Phobias that materially influence behavior.

(7) Abnormal emotional response to situations of stress, when in the opinion of the medical examiner such reactions will interfere with the efficient and safe performance of duty.

r. Skin and cellular tissues. Paragraph 2–32.

s. Spine, scapulae, and sacroiliac joints.

(1) Paragraph 2–33.

(2) Scoliosis: lateral deviation of tips of vertebral spinous processes more than an inch.

(3) Spondylolysis; spondylolisthesis.

(4) Healed fractures or dislocations of the vertebrae.

(5) Lumbosacral or sacroiliac strain, or any history of a disabling episode of back pain, especially when associated with significant objective findings.

t. Systemic disease and miscellaneous conditions and defects.

(1) Paragraphs 2–34 and 2–35.

(2) Chronic motion sickness.

(3) Individuals who are under treatment with any of the mood ameliorating, tranquilizing, or ataraxic drugs and for a period of 4 weeks after the drug has been discontinued.

(4) Any severe illness, operation, injury, or defect of such a nature or of so recent occurrence as to constitute an undue hazard to the individual.

u. Tumors and malignant disease. Paragraph 2–36.

v. Sexually transmitted diseases. Paragraph 2–35*m*.

5–4. Medical fitness standards for selection for survival, evasion, resistance, escape training

The causes of medical unfitness for SERE training are all the causes listed in chapter 3, plus all the causes listed in this paragraph.

a. Abdomen and gastrointestinal system. Paragraphs 2–3 and 3–5.

b. Blood and blood-forming tissue diseases. Paragraphs 3–7 and 3–42.

c. Dental. Paragraph 3–8.

d. Ears and hearing. Paragraphs 2–6, 2–7, 3–9, and 3–10.

e. Endocrine and metabolic diseases. Paragraphs 2–8*b*, 2–8*c*, 2–8*h*, 2–8*j*, and 3–11.

f. Extremities. Paragraphs 2–9*b*(8), 2–10*b*(3), 2–10*b*(6), 2–11*c*, 2–11*d*(2), 2–11*e*, and 3–12 through 3–14.

g. Eyes and vision. Paragraphs 3–15 and 3–16.

- h.* Genitourinary system. Paragraphs 2–14, 2–15, and 2–36.
- i.* Head and neck. Paragraph 5–3i.
- j.* Heart and vascular system. Paragraphs 2–18 and 2–19.
- k.* Height. No special requirements.
- l.* Weight. No special requirements.
- m.* Body build. Paragraph 2–22.
- n.* Lungs and chest wall. Paragraph 2–23.
- o.* Mouth, nose, pharynx, larynx, trachea and esophagus. Paragraphs 2–24 and 2–25.
- p.* Neurological disorders.
 - (1) Paragraphs 2–26 and 4–22.
 - (2) Active disease of the nervous system of any type.
- q.* Mental disorders.
 - (1) Paragraphs 3–31 through 3–37.
 - (2) Evidence of excessive anxiety, tenseness, or emotional responses to situations of stress (both combat and noncombat), when in the opinion of the medical examiner such reactions will interfere with the efficient and safe performance of the soldier's duties.
- r.* Skin and cellular tissues. Paragraph 2–32.
- s.* Spine, scapulae, and sacroiliac joints. Paragraphs 2–33j and 3–39.
- t.* Systemic disease and miscellaneous conditions and defects.
 - (1) Paragraph 2–35.
 - (2) Individuals who are under treatment with any of the mood ameliorating, tranquilizing, or ataraxic drugs and for a period of 4 weeks after the drug has been discontinued.
 - (3) Any severe illness, operation, injury, or defect of such a nature or of recent occurrence as to constitute an undue hazard to the individual.
- u.* Tumors and malignant diseases. Paragraph 2–36.
- v.* Sexually transmitted diseases. Paragraph 2–35m.

5–5. Medical fitness standards for retention for Airborne duty, Ranger duty, and Special Forces duty

Retention of an individual in Airborne duty, Ranger duty, and Special Forces duty will be based on—

- a.* His or her continued demonstrated ability to perform satisfactorily his or her duty as an Airborne officer or enlisted soldier, Ranger, or Special Forces member.
- b.* The effect upon the individual's health and well-being by remaining on Airborne, Ranger, or Special Forces duty.

5–6. Medical fitness standards for initial selection for free fall parachute training

The causes of medical unfitness for initial selection for free fall parachute training are the causes listed in chapter 2 plus the causes listed in this paragraph and in paragraph 5–3.

- a.* Abdomen and gastrointestinal system. Paragraph 2–3.
- b.* Blood and blood-forming tissue diseases.
 - (1) Paragraph 2–4.
 - (2) Significant anemia or history of hemolytic disease due to variant HGB state.
 - (3) Sickle cell disease.
- c.* Dental.
 - (1) Paragraph 2–5.
 - (2) Any unserviceable teeth until corrected.
- d.* Ears and hearing.
 - (1) Paragraphs 2–6 and 2–7.
 - (2) Abnormal labyrinthine function.
 - (3) Any infectious process of the ear, including external otitis, until completely healed.
 - (4) History of attacks of vertigo with or without nausea, emesis, deafness, or tinnitus.
 - (5) Marked retraction of the tympanic membrane if mobility is limited or if associated with occlusion of the Eustachian tube.
 - (6) Perforation, marked scarring, or thickening of the ear drum.
- e.* Endocrine and metabolic diseases. Paragraph 2–8.
- f.* Extremities.
 - (1) Paragraphs 2–9 through 2–11.
 - (2) Any limitation of motion of any joint that might compromise safety.
 - (3) Any loss of strength that might compromise safety.

- (4) Instability of any degree or pain in a weight-bearing joint.
- (5) Retained hardware that is integral to maintaining fixation or stability, or presents a risk to mobility or a risk of further injury by its presence.
- g. Eyes and vision.
 - (1) Paragraphs 2-12 and 2-13, with exceptions noted in (2) and (3) below.
 - (2) Uncorrected near visual acuity (14 inches) of worse than 20/50 in the better eye. Uncorrected distant visual acuity of worse than 20/100 in either eye. Distant vision that does not correct to 20/20 in both eyes with spectacle lenses. Any refractive error worse than plus or minus 8 diopters.
 - (3) Failure to pass the PIP or FALANT test for color vision unless the applicant is able to identify vivid red and vivid green as projected by the Ophthalmological Projector or the SVT.
- h. Genitourinary system. Paragraphs 2-14 and 2-15.
- i. Head and neck.
 - (1) Paragraphs 2-16 and 2-17.
 - (2) Loss of bony substance of the skull if retention of personal protective equipment is affected.
 - (3) A history of subarachnoid hemorrhage.
- j. Heart and vascular system. Paragraphs 2-18 and 2-19, except blood pressure with a preponderant systolic of less than 90 mmHg or greater than 140 mmHg or a preponderant diastolic of less than 60 mmHg or greater than 90 mmHg regardless of age. An unsatisfactory orthostatic tolerance test is also disqualifying.
- k. Height. Paragraph 2-20.
- l. Weight. Paragraph 2-21.
- m. Body build. Paragraph 2-22.
- n. Lungs and chest wall.
 - (1) Paragraph 2-23.
 - (2) Congenital or acquired defects that restrict pulmonary function, cause air-trapping, or affect ventilation-perfusion.
 - (3) Spontaneous pneumothorax, except a single occurrence at least 3 years before the date of the examination with clinical evaluation showing complete recovery with normal pulmonary function.
- o. Mouth, nose, pharynx, larynx, trachea, and esophagus. Paragraphs 2-24 and 2-25.
- p. Neurological disorders.
 - (1) Paragraphs 2-26.
 - (2) The criteria outlined in paragraph 4-22 for Classes 2 and 3 flying duty apply.
- q. Mental disorders.
 - (1) Paragraphs 2-27 through 2-31.
 - (2) Individuals who are under treatment with any of the mood ameliorating, tranquilizing, or ataraxic drugs for hypertension, angina pectoris, nervous tension, instability, insomnia, etc., and for a period of 4 weeks after the drug has been discontinued.
 - (3) Evidence of excessive anxiety, tenseness, or emotional instability.
 - (4) Fear of flying when a manifestation of a psychiatric illness.
 - (5) History of psychosis or attempted suicide at any time.
 - (6) Phobias that materially influence behavior.
 - (7) Abnormal emotional response to situations of stress, when in the opinion of the medical examiner such reactions will interfere with the efficient and safe performance of duty.
- r. Skin and cellular tissues. Paragraph 2-32.
- s. Spine, scapulae, ribs, and sacroiliac joints.
 - (1) Paragraph 2-33.
 - (2) Spondylolysis; spondylolisthesis.
 - (3) Healed fracture or dislocation of the vertebrae except mild, asymptomatic compression fracture.
 - (4) Lumbosacral or sacroiliac strain when associated with significant objective findings.
- t. Systemic diseases and miscellaneous conditions and defects.
 - (1) Paragraphs 2-34 and 2-35.
 - (2) History of motion sickness, other than isolated instances without emotional involvement.
 - (3) Any severe illness, operation, injury, or defect of such a nature or of so recent an occurrence as to constitute an undue hazard to the individual or compromise safe performance of duty.
- u. Tumors and malignant diseases. Paragraph 2-36.
- v. Sexually transmitted diseases. Paragraph 2-35m.

5-7. Medical fitness standards for retention for free fall parachute duty

Retention of an individual in free fall parachute duty will be based on—

- a. The soldier's demonstrated ability to satisfactorily perform free fall parachute duty.
- b. The effect upon the individual's health and well-being by remaining on free fall parachute duty.
- c. Determination of whether of any severe illness, operation, injury, or defect is of such a nature or of such recent occurrence as to constitute an undue hazard to the individual or compromise safe performance of duty.

5-8. Medical fitness standards for Army service schools

Except as provided elsewhere in this regulation, medical fitness standards for Army service schools are covered in DA Pam 351-4.

5-9. Medical fitness standards for initial selection for marine diving training (Special Forces and Ranger combat diving)

The causes of medical unfitness for initial selection for marine self-contained underwater breathing apparatus (SCUBA) diving training are the causes listed in chapter 2 plus the following:

- a. Abdomen and gastrointestinal system. Paragraph 2-3.
 - (1) Paragraph 2-4.
 - (2) Significant anemia or history of hemolytic disease due to variant HGB state.
 - (3) Sickle cell disease.
- c. Dental.
 - (1) Paragraph 2-5.
 - (2) Any infectious process and any conditions that contribute to recurrence until eradicated.
 - (3) Edentia; any unserviceable teeth until corrected.
 - (4) Moderate malocclusion extensive restoration or replacement by bridges or dentures that interfere with the use of SCUBA. Residual teeth and fixed appliances must be sufficient to allow the individual to easily retain a SCUBA mouthpiece.
- d. Ears and hearing.
 - (1) Paragraphs 2-6 and 2-7.
 - (2) Persistent or recurrent abnormal labyrinthine function as determined by appropriate tests.
 - (3) Any infectious process of the ear, including external otitis, until completely healed.
 - (4) History of attacks of vertigo with or without nausea, emesis, deafness, or tinnitus.
 - (5) Marked retraction of the tympanic membrane if mobility is limited or if associated with occlusion of Eustachian tube. (See pressure test requirement in w below.)
 - (6) Perforation, marked scarring, or thickening of the eardrum.
- e. Endocrine and metabolic diseases. Paragraph 2-8.
- f. Extremities.
 - (1) Paragraphs 2-9 through 2-11.
 - (2) Any limitation of motion of any joint that might compromise safety.
 - (3) Any loss of strength that might compromise safety.
 - (4) Instability of any degree or pain in a weight-bearing joint.
 - (5) History of osteonecrosis (aseptic necrosis of the bone) of any type.
 - (6) Retained hardware that is integral to maintaining fixation or stability, or presents a risk to mobility or a risk of further injury by its presence.
- g. Eyes and vision.
 - (1) Paragraphs 2-12 and 2-13, with exceptions noted in (2) and (3) below.
 - (2) Distant visual acuity that does not correct to 20/20 in both eyes with spectacle lenses. Any refractive error in spherical equivalent of worse than plus or minus 8 diopters.
 - (3) Failure to pass the PIP set or FALANT test for color vision unless the applicant is able to identify vivid red and/or vivid green as projected by the Ophthalmological Projector or the SVT.
- h. Genitourinary system. Paragraphs 2-14 and 2-15.
- i. Head and neck.
 - (1) Paragraphs 2-16 and 2-17.
 - (2) Loss of bony substance of the skull if retention of personal protective equipment is affected.
 - (3) History of subarachnoid hemorrhage.
- j. Heart and vascular system. Paragraphs 2-18 and 2-19, except blood pressure with a preponderant systolic of less than 90 mmHg or greater than 140 mmHg or a preponderant diastolic of less than 60 mmHg or greater than 90 mmHg, regardless of age. An unsatisfactory orthostatic tolerance test is also disqualifying.

- k.* Height. Paragraph 2–20.
- l.* Weight. The individual must meet the weight standards prescribed by AR 600–9. The medical examiner may impose body fat measurements not otherwise requested by the commander.
- m.* Body build.
 - (1) Paragraph 2–22.
 - (2) Obesity of any degree.
- n.* Lungs and chest wall.
 - (1) Paragraph 2–23.
 - (2) Congenital or acquired defects that restrict pulmonary function, cause air-trapping, or affect ventilation or perfusion.
 - (3) Spontaneous pneumothorax, except a single occurrence at least 3 years before the date of the examination with clinical evaluation showing complete recovery with normal pulmonary function.
- o.* Mouth, nose, pharynx, larynx, trachea, and esophagus. Paragraphs 2–24 and 2–25.
- p.* Neurological disorders.
 - (1) Paragraph 2–26.
 - (2) The criteria outlined in paragraph 4–22 for Classes 2 and 3 flying duty apply.
- q.* Psychotic disorders. Disorders with psychotic features, affective disorders (mood disorders), anxiety, somatoform, or dissociative disorders (neurotic disorders).
 - (1) Paragraphs 2–27 through 2–31.
 - (2) Individuals who are under treatment with any of the mood ameliorating, tranquilizing, or ataraxic drugs for hypertension, angina pectoris, nervous tension, instability, insomnia, etc, and for a period of 4 weeks after the drug has been discontinued.
 - (3) Evidence of excessive anxiety, tenseness, or emotional instability.
 - (4) Fear of flying when a manifestation of a psychiatric illness.
 - (5) History of psychosis or attempted suicide at any time.
 - (6) Phobias that materially influence behavior.
 - (7) Abnormal emotional response to situations of stress, when in the opinion of the medical examiner such reactions will interfere with the efficient and safe performance of duty.
 - (8) Fear of depths, enclosed places, or of the dark.
- r.* Skin and cellular tissues. Paragraph 2–32.
- s.* Spine, scapulae, ribs, and sacroiliac joints. (Consultation with an orthopedist and, if available, a diving medical officer (DMO) will be obtained in questionable cases.)
 - (1) Paragraph 2–33.
 - (2) Spondylolisthesis; spondylolysis that is symptomatic or likely to interfere with diving duty.
 - (3) Healed fracture or dislocation of the vertebrae except a mild, asymptomatic compression fracture.
 - (4) Lumbosacral or sacroiliac strain when associated with significant objective findings.
- t.* Systemic diseases and miscellaneous conditions and defects.
 - (1) Paragraphs 2–34 and 2–35.
 - (2) Chronic motion sickness.
 - (3) Any severe illness, operation, injury, or defect of such a nature or of so recent an occurrence as to constitute an undue hazard to the individual or compromise safe performance of duty.
- u.* Tumors and malignant diseases. Paragraph 2–36.
- v.* Sexually transmitted diseases. Paragraph 2–35*m*.
- w.* Pressure equalization and oxygen intolerance. If a hyperbaric chamber is available, examinees will be tested for the following disqualifying condition: Failure to equalize pressure. All candidates will be subjected, in a compression chamber, to a pressure of 27 pounds (12.15 kilogram (kg)) (60 feet) per square inch to determine their ability to withstand the effects of pressure, to include ability to equalize pressure on both sides of the eardrums by Valsalva or similar maneuver. This test should not be performed in the presence of a respiratory infection that may temporarily impair the ability to equalize or ventilate.

5–10. Medical fitness standards for retention for marine diving duty (Special Forces and Ranger combat diving)

Retention of a soldier in marine diving duty (SCUBA) will be based on—

- a.* The soldier’s demonstrated ability to satisfactorily perform marine (SCUBA) diving duty.
- b.* The effect upon the soldier’s health and well being by remaining on marine (SCUBA) diving duty.
- c.* Determination of whether of any severe illness, operation, injury, or defect is of such a nature or of such recent occurrence as to constitute an undue hazard to the individual or compromise safe performance of duty.

5-11. Medical fitness standards for initial selection for other marine diving training (MOS 00B)

The causes of medical unfitness for initial selection for diving training are all of the causes listed in chapter 2, plus the following:

- a. Abdomen and gastrointestinal system.
 - (1) Paragraph 2-3.
 - (2) Hernia of any variety.
 - (3) Operation for relief of intestinal adhesions at any time.
 - (4) Chronic or recurrent gastrointestinal disorder that may interfere with or be aggravated by diving duty. Severe colitis, peptic ulcer disease, pancreatitis, and chronic diarrhea are disqualifying unless asymptomatic on an unrestricted diet for 24 months with no radiographic or endoscopic evidence of active disease or severe scarring or deformity.
 - (5) Laparotomy or celiotomy within the preceding 6 months.
- b. Blood and blood-forming tissue diseases.
 - (1) Paragraph 2-4.
 - (2) Sickle cell disease.
 - (3) Significant anemia or history of hemolytic disease due to variant HGB state.
- c. Dental.
 - (1) Paragraph 2-5.
 - (2) Any infectious process and any conditions that contribute to recurrence until eradicated.
 - (3) Edentia; any unserviceable teeth until corrected.
 - (4) Moderate malocclusion, extensive restoration, or replacement by bridges or dentures that interferes with the use of SCUBA. Residual teeth and fixed appliances must be sufficient to allow the individual to easily retain a SCUBA mouthpiece.
- d. Ears and hearing.
 - (1) Paragraphs 2-6 and 2-7.
 - (2) Perforation, marked scarring, or thickening of the eardrum.
 - (3) Inability to equalize pressure on both sides of the eardrums by Valsalva or similar maneuver. See paragraph 5-9w.
 - (4) Acute or chronic disease of the auditory canal, tympanic membrane, middle or internal ear.
 - (5) Audiometric average level for each ear not more than 25dB at 500, 1000, and 2000 Hz with no individual level greater than 30dB. Not over 45dB at 4000 Hz.
 - (6) History of otitis media or otitis externa with any residual effects that might interfere with or be aggravated by diving duty.
- e. Endocrine and metabolic disease. Paragraph 2-8.
- f. Extremities.
 - (1) Paragraphs 2-9 through 2-11.
 - (2) History of chronic or recurrent orthopedic pathology that would interfere with diving duty.
 - (3) Loss of any digit or portion thereof of either hand that significantly interferes with normal diving duty.
 - (4) Fracture or history of disease or operation involving any major joint until reviewed by a DMO.
 - (5) Any limitation of strength or range of motion of any of the extremities that would interfere with diving duties.
- g. Eyes and vision.
 - (1) Paragraph 2-12.
 - (2) Distant visual acuity, uncorrected, 20/200; not correctable to 20/20, each eye.
 - (3) Near visual acuity, uncorrected, of less than 20/50 or not correctable to 20/20.
 - (4) Failure to pass the PIP Set or FALANT test for color vision, unless the applicant is able to identify vivid red and vivid green as projected by the Ophthalmological Projector or the SVT.
 - (5) Abnormalities of any kind noted during ophthalmoscopic examination that significantly affect visual function or indicate serious systemic disease.
- h. Genitourinary system.
 - (1) Paragraphs 2-14 and 2-15.
 - (2) Chronic or recurrent genitourinary disease or complaints including glomerulonephritis and pyelonephritis.
 - (3) Abnormal findings by urinalysis, including significant proteinuria and hematuria.
 - (4) Varicocele, unless small and asymptomatic.
- i. Head and neck. Paragraphs 2-16, 2-17, and 4-14.
- j. Heart and vascular system.
 - (1) Paragraphs 2-18 and 2-19.
 - (2) Varicose veins that are symptomatic or may become symptomatic as a result of diving duty; deep vein thrombophlebitis; gross venous insufficiency.

- (3) Marked or symptomatic hemorrhoids.
- (4) Any circulatory defect (shunts, stasis, and others) resulting in increased risk of decompression sickness.
- (5) Persistent tachycardia or arrhythmia except for sinus type.
- k. Height. Less than 66 or more than 76 inches.
- l. Weight. Weight related to height that is outside the limits prescribed by AR 600–9.
- m. Body build.
 - (1) Paragraph 2–22.
 - (2) Even though the soldier’s weight or body composition is within the limits prescribed by AR 600–9, he or she will be found medically unfit if the examiner considers that his or her weight or associated conditions in relationship to the bony structure, musculature, and/or total body fat content would adversely affect diving safety or endanger the soldier’s well-being if permitted to continue in diving status.
- n. Lungs and chest wall.
 - (1) Paragraph 2–23.
 - (2) Congenital or acquired defects that restrict pulmonary function, cause air trapping, or affect ventilation–perfusion ratio.
 - (3) Any chronic obstructive or restrictive pulmonary disease at the time of examination.
- o. Mouth, nose, pharynx, larynx, trachea, and esophagus.
 - (1) Paragraphs 2–24 and 2–25.
 - (2) History of chronic or recurrent sinusitis at any time.
 - (3) Any nasal or pharyngeal respiratory obstruction.
 - (4) Chronically diseased tonsils until removed.
 - (5) Speech impediments of any origin, any condition that interferes with the ability to communicate clearly in the English language.
- p. Neurological disorders.
 - (1) Paragraph 2–26.
 - (2) The special criteria that are outlined in paragraph 4–22 for Class 1 flying duty are applicable to diving duty.
- q. Mental disorders.
 - (1) Paragraphs 2–27 through 2–31.
 - (2) The special criteria that are outlined in paragraph 4–23 for Class 1 flying duty are applicable to diving duty.
 - (3) The Military Diving Adaptability Rating (MDAR) may be considered MDAR satisfactory if the applicant meets the standards of paragraph 4–29 with the addition of having no fear of depths, enclosed places, or of the dark.
- r. Skin and cellular tissues. Any active or chronic disease of the skin.
- s. Spine, scapulae, ribs, and sacroiliac joints.
 - (1) Paragraph 2–33.
 - (2) Spondylolysis; spondylolisthesis.
 - (3) Healed fractures or dislocations of the vertebrae until reviewed by a DMO.
 - (4) Lumbosacral or sacroiliac strain, or any history of a disabling episode of back pain, especially when associated with significant objective findings.
- t. Systemic diseases and miscellaneous conditions and defects.
 - (1) Paragraphs 2–34 and 2–35.
 - (2) Any severe illness, operation, injury, or defect of such a nature or of so recent occurrence as to constitute an undue hazard to the individual or compromise safe diving.
- u. Tumors and malignant diseases. Paragraph 2–36.
- v. Sexually transmitted diseases.
 - (1) Active sexually transmitted disease until adequately treated.
 - (2) History of clinical or serological evidence of active or latent syphilis, unless adequately treated, or of cardiovascular or central nervous system involvement at any time. Serological test for syphilis required.
- w. Oxygen intolerance. See paragraph 5–9w.

5–12. Medical fitness standards for retention for other marine diving duty (MOS 00B)

The medical fitness standards contained in paragraph 5–11 apply to all personnel performing diving duty except that divers of long experience and a high degree of efficiency must—

- a. Be free from disease of the auditory, cardiovascular, respiratory, genitourinary, and gastrointestinal systems.
- b. Maintain their ability to equalize air pressure.
- c. Have visual acuity, near and far, that corrects to 20/30 in the better eye.

5-13. Asplenic soldiers

- a.* Asplenic soldiers are disqualified from initial training and duty in military specialties involving significant occupational exposure to dogs or cats.
- b.* Asplenic soldiers are disqualified from initial Special Forces training.

5-14. Medical fitness standards for certain geographical areas

a. All soldiers considered medically qualified for continued military status and medically qualified to serve in all or certain areas of the continental United States (CONUS) are medically qualified to serve in similar or corresponding areas outside the continental United States (OCONUS).

b. Some soldiers, because of certain medical conditions or certain physical defects, may require administrative consideration when assignment to certain geographic areas is contemplated to ensure that they are used within their medical capabilities without undue hazard to their health and well-being. In many instances, such soldiers can serve effectively in a specific assignment that considers all administrative and medical factors. Guidance for assignment limitations for various medical conditions and physical defects is contained in chapter 7 and paragraph *c* below. (Family member screening will be completed according to AR 608-75, using DA Form 5888-R (Family Member Deployment Screening Sheet).)

c. Medical standards for Military Assistance Advisory Groups (MAAGs), military attaches, military missions, and duty in isolated areas where adequate medical care may not be available are listed below. (See AR 55-46, AR 614-200, and AR 600-8-101.)

(1) The following medical conditions and defects will preclude assignments or attachment to duty with MAAGs, military attaches, military missions, or any type duty in OCONUS isolated areas where adequate medical care is not available. These fitness standards also pertain to dependents of personnel being considered.

(a) A history of emotional or mental disorders, including character disorders, of such a degree as to have interfered significantly with adjustment or to be likely to require treatment during this tour.

(b) Any medical conditions where maintenance medication is of such toxicity as to require frequent clinical and laboratory followup or where the medical condition requires frequent followup that cannot be delayed for the extent of the tour.

(c) Inherent, latent, or incipient medical or dental conditions that are likely to be aggravated by the climate or general living environment prevailing in the area where the soldier is expected to reside, to such a degree as to preclude acceptable performance of duty.

(d) Of special consideration is a thorough evaluation of a history of chronic cardiovascular, respiratory, or nervous system disorders. This is especially important in the case of soldiers with these disorders who are scheduled for assignment and/or residence in an area 6,000 feet or more above sea level. While such individuals may be completely asymptomatic at the time of examination, hypoxia due to residence at high altitude may aggravate the condition and result in further progression of the disease. Examples of areas where altitude is an important consideration are La Paz, Bolivia; Quito, Ecuador; Bogota, Columbia; and Addis Ababa, Ethiopia.

(2) Remediable medical, dental, or physical conditions or defects that might reasonably be expected to require care during a normal tour of duty in the assigned area are to be corrected prior to departure from CONUS.

(3) Findings and recommendations of the examining physicians and dentists will be based entirely on the examination and a review of the health record, either outpatient or inpatient medical records. Motivation of the examinee must be minimized and recommendations based only on the professional judgement of the examiners.

5-15. Height—U.S. Military Academy, Reserve Officers—Training Corps, and Uniformed Services University of Health Sciences

The following applies to all candidates to the USMA, the ROTC, and the USUHS. Candidates for admission to the USMA, the ROTC, and the USUHS who are over the maximum height or below the minimum height will automatically be recommended by DODMERB for consideration for an administrative waiver by HQDA during the processing of their cases.

Chapter 6 Aeromedical Administration

6-1. General

- a.* This chapter provides—
 - (1) Administrative policies for completing the Army flying duty medical examination (FDME).
 - (2) General policies for the review and disposition of aeromedically disqualified aviation training program applicants, aircrew, and ATCs.
- b.* The FDME is a periodic physical examination performed for occupational and preventive medicine purposes to

promote and preserve the fitness, deployability, and safety of aviation personnel and resources. The FDME is a screening examination used as a starting point for the careful evaluation and treatment of aircrew member health problems. The FDME focuses on the history, vision, hearing, and cardiopulmonary and neuropsychiatric systems. The FDME and supporting documents provide the aviation commander and Commander, USAAMC with information to make a final determination of medical fitness for flying and ATC duties.

6–2. Definition of terms

- a.* AR 600–105 and AR 600–106 provide additional definitions and policies pertaining to aviation duties.
- b.* The terms aircrew duties, ATC duties, aviation service, flying status, flight status, and flying duty(ies) are interchangeable.
- c.* The terms aircrew and aircrew member are interchangeable. They are personnel who are in or graduated from aviation or ATC training programs. (See paras 4–1 and 4–2.)
- d.* Aeromedical standard of care is the minimum level by which an FS conducts a comprehensive aviation medicine program to conserve aircrew health maintenance, flight safety, and operational readiness. The basis of the standard is promulgated by TSG through regulations, APLs, and ATBs.
- e.* Aviation training programs are military courses of instruction that prepare personnel to perform rated or nonrated flying duties or ATC duties.
- f.* A U.S. military FS is a physician awarded the aeronautical designation of FS after graduation from a basic course in U.S. military aviation medicine.
- g.* An Aerospace Medicine Specialist is an FS who successfully completed a Resident in Aerospace Medicine (RAM), or equivalent as determined by the American Board of Preventive Medicine or TSG.
- h.* An APA is a physician assistant who successfully completed a primary course of instruction in aviation medicine.
- i.* The ACAP is a panel of rated aviators designated by the Commander, U.S. Army Aviation Center, and RAMs/FSs with multiple medical specialty credentials designated by the Commander, USAAMC, to include representatives from the U.S. Army Safety Center, the U.S. Army School of Aviation Medicine, and the U.S. Army Aeromedical Research Laboratory.
- j.* An Aeromedical Summary is a medical evaluation containing medical history, physical, and supportive materials prepared by an FS and forwarded to USAAMC for making a final determination of medical fitness for flying duties.
- k.* Aeromedical disqualification (DQ) is a medical condition that is unfitting for aviation or ATC duties as prescribed in chapters 2 and 4. AR 600–105 contains definitions and procedures for temporary medical suspension, medical termination of aviation service, aeromedical waivers, and return to aviation service after termination of aviation service. AR 600–105 defines procedures for nonmedical disqualifications for aviation service, FEBs, and in-flight aeromedical evaluations.
- l.* Temporary aeromedical DQ is a failure to meet a standard of medical fitness for flying duties due to a minor, self-limited condition that is likely to resolve and result in re-qualification within 365 days. A temporary aeromedical DQ will become a permanent aeromedical DQ if the DQ condition persists for more than 365 days.
- m.* Permanent aeromedical DQ is a failure to meet a standard of medical fitness for flying duties due to a condition that will require a waiver for continuation of aviation service or result in medical termination of aviation service.
- n.* Full flying duties (FFD) is a recommendation of medical fitness permitting flying or ATC duties as annotated by an FS on DA Form 4186 (Medical Recommendation for Flying Duty).
- o.* DNIF is a recommendation of medical unfitness prohibiting flying or ATC duties as annotated by an FS, APA, or other health care professional on DA Form 4186.
- p.* Date of medical incapacitation is the date a disqualifying medical condition was definitively diagnosed by history, examination, or test. The effective date of medical termination from aviation service is based on this date. This date may not always correspond with the date of DNIF issued by the local FS on DA Form 4186.
- q.* Temporary flying duty clearance pending receipt of waiver may be granted following the guidance in APLs for certain conditions.

6–3. Application

The provisions of this chapter apply to FDMEs and Aeromedical Summaries accomplished for aircrew performing aviation or ATC duties in DA aircraft, aircraft leased by the DA, or in Army ATC facilities. This includes Active Army and RC personnel, to include ARNGUS, DACs, and contract civilians under employment by the DA or firms under contract to the DA.

6–4. Responsibilities

- a.* TSG is responsible for the Army Aviation Medicine Program.
- b.* The AMC to TSG—
 - (1) Provides recommendations on the recruitment, selection, utilization and assignment of FSs, APAs, and aerospace medicine specialists.
 - (2) In coordination with the Commander, USAAMC, and the Director, U.S. Army Aeromedical Activity

(USAAMA), develops aeromedical policy and standards for aircrew selection, retention, operational effectiveness, and safety.

(3) In coordination with the Aviation Medicine Approval Authority, recommends medical fitness policy and standards for Army aircrew members to TSG.

(4) Develops memoranda of understanding between the Chief, Aviation Branch; Commander, PERSCOM; Chief, NGB; Commander, USAMEDCOM; and TSG as required.

c. The Commander, USAAMC, maintains the USAAMA, the ACS, the ACAP, and the Aviation Epidemiology Data Register (AEDR).

d. The Director, USAAMA, coordinates with the Commander, USAAMC, the AMC to TSG, and aviation waiver authorities and—

(1) Implements and monitors aeromedical policy and standards for aircrew selection, retention, operational effectiveness, and safety.

(2) Develops a consensus of opinion on the final aeromedical recommendation of flying duties fitness for aircrew training applicants and trained aircrew members through the aeromedical board process. (See paras 6–6 through 6–21.)

(3) Monitors the quality and implementation of the FDME program.

(4) Manages the ACAP, the ACS, and the Aircrew Epidemiology Branch.

e. The ACAP provides consultation and opinions on selected issues and aeromedical board cases pertaining to aeromedical policy, standards, and fitness for flying duties. (See para 6–2*i*.)

f. The Chief, ACS reviews FDMEs, aeromedical board summaries, and organizes tertiary aeromedical consultation and in-flight evaluations of disqualified aircrew members. Selected and eligible aircrew members may be referred to the tertiary aeromedical consultative services of the U.S. Air Force, U.S. Navy, and Allied Nations when approved by the authorities in those services. Requests for tertiary aeromedical consultation are forwarded through the local FS to Commander, USAAMC (MCXY–AER), Fort Rucker, AL 36362–5333, (334) 255–7340. (See AR 600–105.)

g. The Chief, Aircrew Epidemiology Branch, manages the AEDR. The AEDR is a DA-directed aeromedical database for Army aircrew. As directed by TSG, the AEDR is established jointly at USAAMC and the U.S. Army Aeromedical Research Laboratory.

h. The Dean, U.S. Army School of Aviation Medicine—

(1) Manages the aeromedical policy and standards education of FSs, APAs, flight medical aidmen, aeromedical evacuation aviators, and other health care providers supporting the aviation medicine program.

(2) Provides verification of aeromedical policy and standards compliance in the local aviation medicine clinic through the Aviation Resource Management Survey inspection program.

(3) Manages aeromedical physiologic education and training of aircrew members.

i. Directors of health services, MTF commanders, command surgeons, and aviation unit commanders implement the Army Aviation Medicine Program at the local level by providing trained personnel, equipment, and facilities for the proper conduct of the program. They ensure expeditious, accurate completion of FDMEs and aeromedical summaries by military FSs and APAs.

j. Local FSs and APAs—

(1) Provide clinical and preventive medicine care to aircrew members, airfield support personnel, and their families. Provide area support for the aviation medicine care of Army RCs, ARNGUS, ROTC, and Army Recruiting units.

(2) Manage the aeromedical certification of aircrew and ATC by issuance of DA Form 4186, periodic aviation medicine examinations, in-flight evaluations, and aeromedical board summaries.

(3) Provide aircrew physiologic and survival training as specified in FM 3–04.301.

(4) Serve as aviation unit staff officers and members of mishap investigation, aviation safety, and FEBs as per AR 600–105 and AR 385–95.

(5) Develop, implement, and exercise the medical portion of the airfield accident response plan and unit operations, mission, and deployment plans.

(6) Conduct flight line inspections of aviation life support equipment and crash protection systems.

(7) Participate in all aspects of the unit flight mission as per AR 600–105.

6–5. Authorizations

a. The AMC to TSG is the proponent office for chapters 4 and 6.

b. The Commander, USAAMC in coordination with the USAAMA, the ACAP, and the AMC to TSG, issues APLs and ATBs to administer chapters 4 and 6.

6–6. Classification of FDMEs

Paragraph 4–2 outlines the medical standards classification for flying duties. SF 88 and SF 93 have been replaced by DD Form 2808 (Report of Medical Examination) and DD Form 2807–1 (Report of Medical History). The item

numbers are different on the DD forms, and FSs should ensure that all required examinations and tests are completed and recorded on the new DD forms in the appropriate corresponding item number.

6-7. Purpose of FDMEs

a. Purpose categories. The FDME purpose is recorded with the FDME classification in Item 15c of DD Form 2808. There are four purpose categories for FDMEs:

(1) Initial FDME. Initial FDMEs are performed on all Classes 1/1A aviator training program applicants; and all other Classes applying for or awaiting initial aviation or aviation medicine training, inter-service transfer, transition from active duty to RCs, or hiring into the DAC or DA contract civilian aircrew work force. The results of Initial FDMEs are recorded on DD Form 2807-1, DD Form 2808, and on aeromedical continuation sheets.

(2) Fort Rucker Abbreviated Classes 1/1A FDME. Classes 1/1A aviator training program students must have a valid, USAAMC-approved, Initial Classes 1/1A FDME before acceptance into aviator training programs and upon arrival for flight training at Fort Rucker. USAAMC will perform a Fort Rucker Abbreviated Classes 1/1A FDME before the student is enrolled in flight training to revalidate that the student meets Classes 1/1A medical standards of fitness for flying duties. A repeat Initial FDME will be performed if the Initial FDME is no longer valid. The results of the Fort Rucker Abbreviated FDME are recorded on DD Form 2808 and DD Form 2807-1 and associated aeromedical continuation forms; and if baseline medical history verification sheet from USAAMA is not available, USAAMA will determine a final recommendation.

(3) Comprehensive FDME. Comprehensive FDMEs are performed on all Classes of aircrew when Initial FDMEs or Interim FDMEs are not required. (See para 6-8*b* below.) The results of the Comprehensive FDME are recorded on DD Form 2808 and DD Form 2807-1. Report interim changes in medical history on DD Form 2807-1 if these changes were not previously documented on an AEDR Medical History Verification Report or Aeromedical Summary.

(4) Interim FDME. Abbreviated Interim FDMEs are performed on all Classes of aircrew when Initial FDMEs or Comprehensive FDMEs are not required. (See para 6-8*b* below.) The results of the Interim FDME are recorded on DA Form 4497 (Interim (Abbreviated) Flying Duty Medical Examination) or DD Form 2808 with identified blocks specific for interim FDME completion. Report interim changes in medical history on DD Form 2807-1 if these changes were not previously documented on an AEDR Medical History Verification Report or Aeromedical Summary.

b. Guidelines. Refer to ATB 2, Army Flight Surgeon's Administrative Guide, for guidelines on completing each category of examination.

6-8. Frequency and period of validity of FDMEs

a. Classes 1/1A validity is as follows:

(1) Initial Classes 1/1A FDME. The Initial FDME is valid for a period of 18 months from the date of examination. Repeat Initial FDMEs are required if the FDME validity expires while awaiting aviator training program selection or training class dates. The FDME must be valid and qualified by the Commander, USAAMC, before the applicant's acceptance into aviator training programs and upon arrival for flight training.

(2) Fort Rucker Abbreviated Classes 1/1A FDME. This FDME is valid until the last day of the birth month following completion of initial flight training resulting in the designation of "rated aviator."

b. Classes 2/2F/2S/3/4 validity is as follows:

(1) Initial FDME. The Initial FDME is valid for a period of 18 months from the date of examination. Following the Initial FDME, subsequent Comprehensive or Interim FDMEs will be aligned with the aircrew member's birth month using table 6-1.

(2) Comprehensive FDME. The Comprehensive FDME is performed at ages 19, 22, 25, 28, 31, 34, 37, 40, 43, 46, and 49, then annually thereafter. It will be performed within 90 days before the end of the birth month. The FDME is valid until the end of the next birth month. A comprehensive FDME may be required during a postmishap investigation or FEB.

(3) Interim FDME. The Interim FDME is performed in the interim years when an Initial or Comprehensive FDME is not required. It will be performed within 90 days before the end of the birth month and is valid until the end of the next birth month. If retiring, the period of validity will extend to 18 months past the birth month.

(4) Rated aviators in aviation service. (See AR 600-105.) Rated aviators in aviation service are required to maintain a Comprehensive or Interim Class 2 FDME even when not assigned to operational flying duty positions.

(5) Additional Comprehensive FDMEs. These may be required following disqualifying illness or injury present for more than 6 months, postmishap investigation, or FEB. A Comprehensive FDME is required for those who are terminated from aviation service and are requesting a return to aviation service.

(6) Retirement. If an FDME is required within 90 days of retirement from Federal service, a comprehensive FDME with the additional examination requirements for retirement (see chap 8) is required for active duty members, and is encouraged but not required for RC or civilian members.

c. The requirement to perform FDMEs will not be suspended in the event of training exercises or military mobilization unless authorized by TSG. Request authorization through the Commander, USAAMC, ATTN: MCRY-AER, Fort Rucker, AL 36362-5333, who will coordinate authorization with the AMC to TSG.

d. The FDME will be completed to the extent the MTFs permit when aircrew are on duty or in mobilization at a station OCONUS with limited military medical facilities. Attach a cover letter to the FDME addressed to Commander, USAAMC, ATTN: MCXY–AER (USAAMA), explaining the facility limitations. Accomplish a comprehensive FDME within 90 days upon return to a station with adequate medical facilities. Align subsequent Comprehensive or Interim FDMEs with the aircrew member's birth month using table 6–1.

e. During certain missions not supported by U.S. or allied military medical officers (for example, special operations), the FDME may be deferred by the Commander having custody of the field personnel files until the accomplishment of the FDME becomes feasible. Annotate the remarks section of DA Form 4186 with an explanation of the deferment.

6–9. Facilities and examiners

a. U.S. military FSs and APAs at MTFs will conduct initial FDMEs. Initial FDMEs will meet the Army-specific administrative requirements for the completion of such FDMEs as outlined in ATB 2, Army Flight Surgeon's Administrative Guide. The FS will apply U.S. Army aeromedical standards from chapters 2 and 4 for the determination of medical fitness for flying duty.

b. Comprehensive FDMEs and Interim FDMEs for all Classes, except Classes 1/1A, will be conducted when possible by military FSs. The FDME may be conducted by any military or DAC or contract civilian physician when an FS is not available, but an FS or APA will review and sign the DD Form 2808 and DD Form 2807–1 or DA Form 4497 prior to sending the FDME to USAAMC for central review. When an FDME is performed at non–U.S. Army medical facilities, the FDME will be conducted by a military FS or APA to meet the administrative requirements of that branch of the U.S. Armed Forces or host Allied nation. APL, Aeromedical Cardiovascular Screening Program, still applies. The FS must apply Army aeromedical standards from chapters 3 and 4 for the determination of medical fitness for flying duties. FDMEs performed by host Allied nations may be completed in English on Allied documents designed for the same purpose when DD Form 2808 and DD Form 2807–1 are not available. Outline unusual circumstances in a memorandum for record included with the FDME.

c. DAC or DA contract civilian physicians with a previous military aeronautical rating of FS or APA, or military FSs or APAs practicing in medical specialties other than aviation medicine, may be credentialed to complete FDMEs. The U.S. Army School of Aviation Medicine provides Army Aviation Medicine refresher training for FSs/APAs to meet credentialing requirements. Other physicians and health care professionals will sign the DD Form 2808 for the portions of the examination they accomplish. The FDME is invalid and incomplete without the signature of a military FS or APA on the DD Form 2808 and DD Form 2807–1 or DA Form 4497, and a final review stamp placed by the staff of USAAMC on the DD Form 2808 or DA Form 4497.

d. APAs may conduct FDMEs. The FDME must be reviewed and cosigned by the supervising physician.

e. Consultations may be obtained at Government expense when authorized as stated below. (See also paras 4–3 and 4–32.)

(1) Additional tests, procedures, and consultations required to complete Initial FDMEs for all aircrew Classes, to include civilians, active duty, and RCs, will be completed at military outpatient or inpatient MTFs. When fitness for flying duty cannot be determined, MTF commanders or ARNGUS State Adjutant General's Office may permit supplementary examinations from civilian medical sources. The tests and consultations are conducted only to the extent required to determine medical fitness for flying duties and not for the treatment or correction of disqualifying conditions.

(2) Paragraph (1) above applies to Comprehensive FDMEs and Annual FDMEs, except that treatment or correction of disqualifying conditions discovered by the FDME will be completed if the examinee is eligible for such care (AR 40–400).

(3) DACs or contract civilians employed by DA or firms under contract by DA who are military retirees, RC, or ARNGUS aircrew, may be authorized for such care. (See (1) and (2) above, and AR 40–400.)

(4) The DAC or contract civilian may request a waiver of the disqualifying condition from the Commander, USAAMC. The Commander, USAAMC will process any waiver request consistent with guidance for granting waivers.

(5) Commander, USAAMC may direct evaluation of disqualified aircrew eligible for care (AR 40–400) at any U.S. MTF or aeromedical consultation service.

6–10. Disposition and review of FDMEs

a. *Review.* The review of the individual health record and FDME will be completed by an FS or an APA. The FS or APA will counsel the examinee regarding—

(1) Conditions found during the FDME.

(2) Continuing care for conditions under treatment and/or waiver.

(3) General preventive health education, including, but not limited to smoking, cholesterol control, weight control, drug and alcohol abuse, and other high risk behavior.

b. *Profile status.* The FS will ensure that the examinee's current PULHES profile status is recorded in the PULHES section of the DD Form 2808.

c. *Classes 1/1A and Initial Classes 2/2F/2S/4.* Completed FDMEs (originals of DD Form 2807-1, DD Form 2808, aeromedical continuation sheet, interpreted EKG, and other supportive documents) accomplished for application to aviation and aviation medicine training programs will be forwarded through the procurement chain of command of the applicant to Commander, USAAMC, ATTN: MCXY-AER, Fort Rucker, AL 36362-5333 for central aeromedical review and disposition. The FS's office will retain a copy of the FDME and all enclosures for a minimum of 2 years. In no case will the originals be given to the applicant or other individuals not in the procurement chain of command. The Commander, USAAMC must make a final determination of fitness for flying duties before Classes 1/1A/2F/2S/4 applicants may be accepted and assigned to Fort Rucker for aviation and aviation medicine training programs.

d. *Trained Classes 2/2F/2S/4.* Completed Comprehensive and Interim FDMEs (DD Form 2808 and DD Form 2807-1, aeromedical continuation forms, interpreted EKG, and other supportive documents, may include consultations, EKG tracings, radiographs, coronary angiogram, etc., and, if applicable, Aeromedical Summary) will be forwarded directly to Commander, USAAMC, ATTN: MCXY-AER, Fort Rucker, AL 36362-5333, for central aeromedical review and disposition. The FS's office will retain a copy of the FDME and all enclosures for a minimum of 2 years.

e. *Class 3.* The attending FS who signs the FDME is the reviewing authority for recommending disposition on medical fitness for flying duty. Minor medical disqualifications that will in no way affect the safe and efficient performance of flying duties and that will not be aggravated by aviation duties or deployment may be waived by the individual's unit commander upon favorable recommendation by the attending FS. (See also APL, Class 3 Aircrew, and para 4-33.) (See also ATB 2, Army Flight Surgeon's Administrative Guide, for details on the item-by-item completion of FDMEs.)

f. *Tracking.* The flight surgeon or aviation unit will track FDMEs from initiation until posted in the health record with a final disposition by USAAMA. If disqualified, the flight surgeon and aviation unit will take action as per AR 600-105.

g. *Disposal of documentation.* Waiver and suspension recommendation and approval letters will be filed in the individual health record and flight record.

6-11. Issuing DA Form 4186

a. DA Form 4186 is an official document used to notify the aviation commander of certification of medical fitness for all Classes of military and civilian aircrew.

b. DA Form 4186 will be completed—

- (1) After the completion of an FDME.
- (2) After an aircraft mishap.
- (3) After an FEB.
- (4) When reporting to a new duty station or upon being assigned to operational flying duty.
- (5) When admitted to and discharged from any medical or dental treatment facility (inpatient or outpatient, military or civilian), sick in quarters, interviewed for or entered into a drug/alcohol treatment program, or when treated by a health care professional who is not a military FS.
- (6) When treated as an outpatient for conditions or with drugs that are disqualifying for aviation duties; and upon return to flight duties after such treatment and recovery.
- (7) Upon return to flight status after termination of temporary medical suspension, issuance of waiver for aviation service, or requalification after medical or nonmedical termination of aviation service.
- (8) Other occasions as required by the FS.

c. Rated aviators not performing operational flying duties are required to complete an annual FDME with issuance of DA Form 4186 (AR 600-105).

d. Each item of the DA Form 4186 will be completed as directed by the Commander, USAAMC. (See ATB 10, DA Form 4186.) Three copies of the DA Form 4186 will be completed. Copy 1 is placed in the outpatient medical record. Copy 2 is forwarded to the examinee's unit commander who signs and forwards it to the flight operations officer for inclusion in the flight records (AR 95-1 and FM 1-300). Copy 3 is given to the examinee.

e. If the examinee is found qualified for flying duty by the local FS, see chapters 2 and 4. Issuance of the DA Form 4186 will constitute an aeromedical clearance for flying duty pending final review of the FDME by the reviewing authority. The aeromedical clearance will expire when the current FDME is no longer valid. (See para 6-8.)

f. If a disqualifying medical condition is found, a waiver must be granted by the appropriate authority before further flying duties are performed. (See paras 6-12 through 6-21.) For minor defects that will not preclude safe and efficient performance of flying duties and will not be aggravated by aviation duty or military mission, the local commander may permit an individual to continue performance of aviation duties pending completion of the formal waiver process and upon favorable recommendation for temporary FFD by the local FS following the guidelines in APL, Temporary Flying Duties.

g. When used to recommend temporary flying duties, the Remarks section of DA Form 4186 will be completed to reflect a limited length of time for which the clearance is issued, for example: "Temporary FFD, 90 days, pending receipt of waiver."

h. The FS will consult the Commander, USAAMC, ATTN: MCXY-AER, or the major Army command's Aviation

Medicine consultants in U.S. Army, Europe, and Korea, before issue of DA Form 4186 for complex or questionable cases.

i. The validity period of the current FDME (see para 6–8) may be extended for a period not to exceed 30 days on DA Form 4186. After expiration of this extension, the aircrew member or ATC must complete the FDME and be medically qualified or be—

(1) Administratively restricted from flying duties if no aeromedical DQ exists and be considered for a non-medical DQ and FEB (AR 600–105).

(2) Medically restricted from flying duties if an aeromedical DQ exists. In some cases, temporary flying duties may be recommended on DA Form 4186. (See also paras 6–11*f* and 6–12 through 6–21.)

j. Personnel authorized to sign the DA Form 4186 are as follows.

(1) Any physician or health care provider may sign DA Form 4186 for the purpose of restricting aircrew and ATCs from aviation duties when an aeromedical DQ exists. (See *b* above and chap 4.)

(2) Only an FS may sign the DA Form 4186 to return aircrew and ATCs to FFD. Recommended restrictions will be annotated in the Remarks block of DA Form 4186.

(3) A non-FS medical officer or an APA under the supervision of an FS may sign the DA Form 4186 to recommend returning aircrew and ATCs to FFD when an FS is not locally available by either—

(*a*) Obtaining case-by-case telephonic guidance from an FS. The name of the consulted FS will be annotated on DA Form 4186, and on an SF 600 (Health Record—Chronological Record of Medical Care) in the patient health record, according to AR 40–48.

(*b*) In the case of an APA, having an FS review the medical record and cosign the DA Form 4186 within 72 hours.

k. Forms of the other branches of the U.S. Armed Forces and host Allied nations similar to DA Form 4186 will be accepted by the Army when aeromedical support is provided by those Service/nations and DA Form 4186 is not available.

6–12. General principles

a. The Commander, USAAMC is authorized to issue APLs and ATBs that are regulatory in nature. These detail aeromedical policy and disposition for common aeromedical DQs and establish an Army-wide standard of aeromedical care. These series may be obtained from Commander, USAAMC, ATTN: MCFY–AER, Fort Rucker, AL 36362–5333.

b. The FS will make the initial determination of medical unfitness due to failure to meet a medical standard for—

(1) Aircrews. (See chaps 2 and 4, and AR 600–105.) The final determination of medical fitness for flying duties is made by the Commander, USAAMC. Although MEB and PEB documents (AR 635–40) are a valuable source of information, the final recommendation of medical fitness for flying duty is made independent of the recommendations of these boards. The Commander, USAAMC may review the proceedings of FEBs (AR 600–105) in determining fitness for flying duties.

(2) Personnel retention, retirement, or separation. (See chap 3.) The final determination of medical fitness for personnel retention, retirement, or separation is made by the MEB and PEB process (AR 635–40). In the case of aircrew members, the president of the PEB may request a consultation from the Commander, USAAMC, or delay final determinations until the medical fitness for flying duties is determined by the Commander, USAAMC.

c. The FS will complete a history, physical, tests, and consultations to the extent required to—

(1) Confirm the medical disqualification.

(2) Recommend an aeromedical disposition.

(3) Meet the aeromedical standard of care in accordance with APLs and ATBs.

d. For all flying classes, each disqualifying defect or condition will be evaluated to determine if it—

(1) Is progressive.

(2) Is subject to aggravation by military service.

(3) Precludes satisfactory completion of training and/or military service.

(4) Constitutes an undue hazard to the individual or to others.

e. The FS will consider the factors involved in the use of medicines (APL, Medications) for treatment of the condition and determine if—

(1) The medication is effective without aeromedically significant side effects.

(2) There is a problem with medication compliance.

(3) The medication is readily available during mobilization.

(4) The medication does not mask symptoms subject to acute incapacitation or complications in the aviation environment.

f. The FS will consider whether continued flying duty may—

(1) Compromise personal health.

(2) Pose a risk to aviation safety.

(3) Jeopardize mission completion.

(4) Result in deployability limitations.

g. The FS will determine the date of medical incapacitation. The date of medical incapacitation is the date the aeromedical DQ is diagnosed by history, physical examination, or testing. The date of aeromedical incapacitation may not always correspond with the dates of local medical restriction from flying duties by an FS using DA Form 4186 or the date an FS first evaluates the aeromedical DQ.

h. For the purpose of aeromedical DQs, the immediate aviation commander is defined as the aviation unit commander or designated official who maintains the aircrew member's flight or ATC records.

i. Each aeromedical DQ requires—

(1) Temporary medical suspension until the aircrew member is requalified and meets the medical standards of fitness for flying duties within 365 days (para 6–17); or

(2) Medical termination from aviation service (permanent medical suspension) due to a temporary medical suspension imposed for greater than 365 days or a permanent aeromedical DQ without waiver (para 6–18); or

(3) Aeromedical waiver granted by the aviation service waiver authority permitting aviation service despite an aeromedical DQ (para 6–19). (See ATB 3, Aeromedical Summary, for policy on the preparation of the Aeromedical Summary document, and ATB 4, Aeromedical Consultation Service, for policy on use of this service. See also ATB 2, Army Flight Surgeon's Administrative Guide.)

6–13. Responsibilities and review following a change in health of aircrew members

a. Aircrew members will report to an FS a history of the following conditions (see also AR 40–8):

(1) Symptoms indicating a change in health.

(2) Illness requiring the use of medications, visit to a health care provider for evaluation and/or medical-dental care, restriction to quarters, or hospitalization.

(3) Drug or alcohol use that results in legal problems (driving under the influence, driving while intoxicated, positive blood or urine drug screen, arrests for intoxication, family member abuse, etc.), psychological dysfunction (absence or tardiness from work or school, severe marital discord, etc.), medical or psychological incapacitation, or history of evaluation and/or treatment for drug/alcohol misuse, abuse, or dependence.

(4) Current aeromedical waivers or requests for waiver.

(5) HIV positivity.

b. The immediate aviation commander will request an aeromedical consultation with a local FS when an aircrew member develops a change in health. (See *a* above.)

c. The local FS will make a preliminary determination of medical fitness for flying duties and recommend FFD or DNIF by issuance of DA Form 4186. (See also paras 6–11 through 6–21.) Also, the attending FS will forward the FDME with pertinent attachments or Aeromedical Summary to Commander, USAAMC, ATTN: MCXY–AER (USAAMA), Fort Rucker, AL 36362–5333 for review and final recommendation. See ATB 2, Army Flight Surgeon's Administrative Guide, and ATB 3, Aeromedical Summary. For rated flying personnel who have been found permanently disqualified for aviation service and for whom waivers are not being considered, Commander, USAAMC, ATTN: MCXY–AER (USAAMA) will notify the FAA. Authority is according to 5 USC 552a(b)7.

d. In the case of a permanent aeromedical DQ, the Commander, USAAMC, ATTN: MCXY–AER, makes the final recommendation of medical fitness for flying duties to the aviation service waiver authority.

e. The aviation service waiver authority reviews the recommendation of medical fitness for flying duties and makes the final administrative disposition for—

(1) Medical termination from aviation service (permanent medical suspension); or

(2) Continuation of aviation service with administrative aeromedical waiver.

f. The aviation service waiver authorities are listed in paragraph 6–21.

g. The aeromedical consultation authority is Commander, USAAMC, ATTN: MCXY–AER (Chief, Aeromedical Consultation Service), Fort Rucker, AL 36362–5333.

6–14. Review and disposition of disqualifications for Classes 1/1A

a. The FS who signs the FDME will examine all entries to determine that the examinee is qualified.

(1) If the review confirms the applicant is qualified, see paragraph 6–10c.

(2) If the examinee has a minor physical defect that is disqualifying, a complete FDME will be accomplished and the details of the defect recorded. The FDME will be forwarded to Commander, USAAMC, ATTN: MCXY–AER for review and final determination of the aeromedical fitness for flying duties.

(3) If one or more major disqualifying defects exist, the FDME need not be completed. However, the incomplete FDME will be forwarded to the Commander, USAAMC for reference in the event of future re-examination of the applicant. Failure to meet the prescribed standards for vision and/or refractive error, hearing, or anthropometrics are examples of major disqualifying defects.

b. Entrance into aviator training programs with a disqualifying defect requires an exception to policy issued by DA or NGB since waivers may not be granted to Classes 1/1A candidates. An applicant with a known DQ will not be

accepted into or assigned to Fort Rucker for aviator training without written approval for an exception to policy from the waiver authority. Exceptions to policy are generally only recommended for exceptional officers with minor, static DQs. Exceptions to policy are not likely to be recommended for disqualifying conditions that are dynamic and likely to progress with time, are prone to recurrence or exacerbation with military and/or aviation duties, or affect aviation safety and operations. To request an exception to policy, the FS will submit an Aeromedical Summary through Commander, USAAMC, ATTN: MCXY-AER, to the appropriate waiver authority. (See para 6-21.) The applicant will enclose documents with the Aeromedical Summary for review by the waiver authority documenting why the applicant is truly exceptional.

6-15. Review and disposition of disqualifications for Class 3

a. The FS who signs the FDME is the reviewing authority and will make decisions on aeromedical disposition. Minor physical defects that will not affect the safe, efficient performance of flying duties or mission and will not be aggravated by aviation duties or deployment may be waived by the individual's unit commander, the Class 3 waiver authority, upon favorable recommendation by the FS. (Exceptions are stated in paras 4-32 and *d* below.)

b. Notification of aeromedical DQ will be forwarded on DA Form 4186 to the aviation unit commander, along with appropriate recommendations for waiver of DQs or suspension from flying duties in accordance with existing directives.

c. An Aeromedical Summary discussing the case and the basis for aeromedical decision will be prepared by the FS and placed in the aircrew member's individual health record for future reference by the aviation commander and other FSs.

d. Cases involving drug/alcohol abuse or dependence, suspected or proven coronary artery disease, or complicated, questionable cases will be forwarded to Commander, USAAMC, ATTN: MCXY-AER, for review and disposition. (See also APL, Class 3, Aircrew.)

6-16. Review and disposition of disqualifications for Classes 2/2F/2S/4

Initial and periodic FDMEs will be submitted to Commander, USAAMC for review and disposition. (See para 6-10*d*.)

a. If the aircrew member is found medically qualified, the FS prepares a DA Form 4186 and recommends clearance for FFD. (See para 6-11.)

b. If a disqualifying defect is discovered, the FS completes the evaluation and recommends temporary medical suspension, termination from aviation service (permanent suspension), or waiver of the disqualifying defect. (See paras 6-17 through 6-21.)

6-17. Temporary medical suspension

a. A temporary medical suspension restricting aircrew from flying duties is required for temporary aeromedical DQs that are minor, self-limited, and likely to result in requalification within 365 days. Examples include ankle sprain, acute rhinitis, gastroenteritis, and simple closed fracture.

b. Medical termination from aviation service (see para 6-18) is mandatory if the temporary medical suspension exists for greater than 365 days (AR 600-105 and DOD 7000.14-R, Vol 7A). In this case, the temporary medical DQ becomes a permanent medical DQ.

c. The local FS will evaluate all aircrew with possible aeromedical DQs as identified by the aviator, immediate commander, FS, or USAAMC. The FS will follow the established standards of aeromedical care (this regulation and APL and ATB series).

d. The FS will recommend a date of medical incapacitation and recommend DNIF on DA Form 4186.

e. The immediate commander will set the date of medical incapacitation and impose the temporary medical suspension.

f. Aircrew under temporary medical suspension may not be assigned flying/ATC duties or operate the flight controls of a military aircraft. As an exception, the FS may recommend by DA Form 4186 that the officer operate flight simulators, perform ground run-up procedures, and/or undergo an aeromedical consultation with in-flight evaluation. (See AR 600-105.)

g. The immediate commander may remove the temporary medical suspension upon favorable recommendation by an FS on DA Form 4186.

h. The FS will recommend medical termination from aviation service (permanent medical suspension) if the term of temporary medical suspension has or is expected to exceed 365 days. The FS will notify the immediate commander by DA Form 4186 and forward an Aeromedical Summary to Commander, USAAMC, ATTN: MCXY-AER.

6-18. Medical termination from aviation service

a. Medical termination from aviation service (permanent medical suspension) is required for permanent aeromedical DQs that are not likely to result in requalification within 365 days. Continuation of flying duties is only authorized by issuance of orders for an aeromedical waiver (para 6-19) by an aviation service waiver authority.

b. The local FS will evaluate the aeromedical DQ and make a preliminary determination of medical fitness for flying duty.

c. The FS will recommend a medical termination from aviation service (permanent medical suspension) on DA Form 4186 and forward the notification to the immediate commander.

d. The FS will prepare an Aeromedical Summary and forward to Commander, USAAMC, ATTN: MCXY-AER.

e. The Commander, USAAMC, ATTN: MCXY-AER will make final recommendations to the aviation service waiver authority and recommend a—

(1) Date of medical incapacitation.

(2) Final aeromedical disposition:

(a) Medical termination from aviation service; or

(b) Aeromedical waiver for continuation of aviation service with the permanent aeromedical DQ; or

(c) Requalification without aeromedical DQ (“For Information Only”).

f. The aviation service waiver authority will—

(1) Establish the date of medical incapacitation.

(2) Establish the date of medical termination from aviation service and publish an order (AR 600-8-105).

(3) Refer the aircrew member to the appropriate authority for reclassification, rebranching, or Service separation.

(4) Send the health record back to the MTF of origin.

g. The FAA Federal Air Surgeon requires the Commander, USAAMC to report all termination from aviation service actions. This may be done without the knowledge or consent of the aircrew member (5 USC 552).

6-19. Aeromedical waiver

a. In the case of permanent aeromedical DQ, the aircrew member may request consideration for an aeromedical waiver for aviation service through a local military FS.

b. The FS will complete an evaluation within the aeromedical standards of care (this regulation and APL and ATB series). The FS will prepare an Aeromedical Summary and forward to Commander, USAAMC, ATTN: MCXY-AER.

c. The Chief, ACS will—

(1) Review the case.

(2) Arrange for additional evaluation by aeromedical consultants designated by Commander, USAAMC as required.

(3) Authorize and arrange for additional evaluations at U.S. Air Force or U.S. Navy aeromedical consultation services as required.

(4) Arrange for in-flight evaluations as required (AR 600-105).

(5) Present selected cases to the ACAP.

(6) Refer the case with recommendations to Commander, USAAMC, ATTN: MCXY-AER.

d. The Director, USAAMA (for the Commander, USAAMC) will—

(1) Formulate a consensus of aeromedical opinion on the medical fitness for flying duty.

(2) Determine if an aeromedical waiver can be recommended, and if so, determine if the waiver will require recommendations for specific restrictions in the flight environment and/or specific followup medical evaluations to maintain the waiver.

e. The Director, USAAMA will forward final recommendations to the aviation waiver authority.

f. The aviation service waiver authority will—

(1) Review the aeromedical recommendations and supportive enclosures, consider the needs of the U.S. Army, and make a final determination to grant or deny an aeromedical waiver.

(2) Publish orders to permit continuation of aviation service with a waiver or medical termination from aviation service (permanent medical suspension).

(3) Send the health record back to the MTF of origin.

g. The aircrew member will acknowledge the waiver, and if applicable, restrictions and followup evaluation, in writing to the aviation service waiver authority. Failure to do so, or declining the waiver, will be considered a nonmedical DQ due to dereliction of duty and may result in an FEB (AR 600-105).

h. The FS may recommend amendments to the conditions for continuation of waivers in effect, as required, by submitting written justification along with supportive documents to the Commander, USAAMC, ATTN: MCXY-AER, Fort Rucker, AL 36362-5333.

i. If the condition resolves or is no longer disqualifying due to policy and standard changes, the FS may recommend revocation of an aeromedical DQ to the Commander, USAAMC.

6-20. Aeromedical requalification

a. An aircrew member with a medical termination from aviation service may request aeromedical requalification if the medical DQ resolves.

b. The procedure for requesting requalification is the same as the procedure for aeromedical waiver (para 6-19),

except the aviation service waiver authority will determine if requalification meets the needs of the Army, and if so, will—

- (1) Publish orders establishing date of the aeromedical requalification.
- (2) Publish orders of assignment and travel.
- (3) Issue an administrative waiver if required.

6-21. Waiver and suspension authorities

Personnel who are dual-status (such as ARNGUS members and DACs) will require a waiver or suspension action from each authority they are assigned.

a. Active Army or USAR—Classes 1/1A and Class 2: through Commander, USAAMC, ATTN: MCXY-AER, Fort Rucker, AL 36362-5333; for Commander, PERSCOM, ATTN: TAPC-PLA, 200 Stovall Street, Hoffman Building, Room 3N25, Alexandria, VA 22332-0413.

b. Active Army or USAR—Class 2F and aviation audiologists, dentists, optometrists, and psychologists: through Commander, USAAMC, ATTN: MCXY-AER, Fort Rucker, AL 36362-5333; for Commander, PERSCOM, Health Services Division, ATTN: TAPC-OPH-MC, 200 Stovall Street, Hoffman Building, Room 9N68, Alexandria, VA 22332-0413.

c. Active Army or USAR—Classes 2S/4 and Class 3 (for drug and alcohol waivers only), and Class 4: through Commander, USAAMC, ATTN: MCXY-AER, Fort Rucker, AL 36362-5333; for Commander, PERSCOM, ATTN: TAPC-EPL-T, 2461 Eisenhower Avenue, Alexandria, VA 22331-0453.

d. ARNGUS—Classes 1/1A, Classes 2/2F/2S/4, and Class 3 (for drug and alcohol waivers only): through Commander, USAAMC, ATTN: MCXY-AER, Fort Rucker, AL 36362-5333; for Chief, National Guard Bureau, ATTN: NGB-AVN-OP, 111 South George Mason Drive, Arlington, VA 22204-1382.

e. Contract civilians—all Classes: through Commander, USAAMC, ATTN: MCXY-AER, Fort Rucker, AL 36362-5333; through the Contracting Officer Representative; for the Commanding General, or the Commanding General who is designated the waiver authority of the installation with the DA contract (usually the airfield commander or the command aviation officer of the installation with the DA contract; for example, at Fort Rucker, Command Aviation Officer, ATTN: DPT-AD, Fort Rucker, AL 36362). Final determination will then be forwarded to the Contracting Office and the firm under contract to DA.

f. DAC—all Classes: through Commander, USAAMC, ATTN: MCXY-AER, Fort Rucker, AL 36362-5333; through aviation unit Commander; for the Commanding General, or the Commanding General who is designated the waiver authority (usually the airfield commander or command aviation officer; for example, at Fort Rucker, Command Aviation Officer, ATTN: DPT-AD, Fort Rucker, AL 36362). Final determination will then be forwarded to the local Civilian Personnel Office.

g. Class 3, for other than drug and alcohol abuse/dependence: through the local FS; for the local aviation unit Commander.

Table 6-1
Number of months for which a flying duty medical examination (FDME) is valid (Active Component)*

Birth Month	Month in which last FDME was given											
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Jan	12	11	10	9	8	7	18	17	16	15	14	13
Feb	13	12	11	10	9	8	7	18	17	16	15	14
Mar	14	13	12	11	10	9	8	7	18	17	16	15
Apr	15	14	13	12	11	10	9	8	7	18	17	16
May	16	15	14	13	12	11	10	9	8	7	18	17
Jun	17	16	15	14	13	12	11	10	9	8	7	18
Jul	18	17	16	15	14	13	12	11	10	9	8	7
Aug	7	18	17	16	15	14	13	12	11	10	9	8
Sep	8	7	18	17	16	15	14	13	12	11	10	9
Oct	9	8	7	18	17	16	15	14	13	12	11	10
Nov	10	9	8	7	18	17	16	15	14	13	12	11
Dec	11	10	9	8	7	18	17	16	15	14	13	12

Notes:

* Read down the left column to the examinee's birth month; read across to month of last FDME; intersection number is the maximum validity period. When last FDME was within the 3-month period preceding the end of the birth month, the validity period will normally not exceed 15 months. When the last FDME was for entry into aviation training, for FEB, postaccident, posthospitalization, pre-appointment (warrant officer candidate) etc., the validity period will range from 7 to 18 months. Validity periods may be extended, in accordance with 6-11i, by 1 month only for completion of an examination begun before the end of the birth month.

Chapter 7 Physical Profiling

7-1. General

This chapter prescribes a system for classifying individuals according to functional abilities. See also paragraphs 3-25, 3-27, 3-30, 3-45, and 3-46 for additional guidance on coronary artery disease, asthma, seizure disorders, and heat and cold injuries.

7-2. Application

The physical profile system is applicable to the following categories of personnel:

- a. Registrants who undergo an induction or pre-induction medical examination related to Selective Service processing.
- b. All applicants examined for enlistment, appointment, or induction.
- c. Members of any component of the U.S. Army throughout their military service, whether or not on active duty.

7-3. Physical profile serial system

a. The physical profile serial system is based primarily upon the function of body systems and their relation to military duties. The functions of the various organs, systems, and integral parts of the body are considered. Since the analysis of the individual's medical, physical, and mental status plays an important role in assignment and welfare, not only must the functional grading be executed with great care, but clear and accurate descriptions of medical, physical, and mental deviations from normal are essential.

b. In developing the system, the functions have been considered under six factors designated "P-U-L-H-E-S." Four numerical designations are used to reflect different levels of functional capacity. The basic purpose of the physical profile serial is to provide an index to overall functional capacity. Therefore, the functional capacity of a particular organ or system of the body, RATHER THAN THE DEFECT PER SE, will be evaluated in determining the numerical designation 1, 2, 3, or 4.

c. The factors to be considered are as follows:

(1) P—Physical capacity or stamina. This factor, general physical capacity, normally includes conditions of the heart; respiratory system; gastrointestinal system, genitourinary system; nervous system; allergic, endocrine, metabolic and nutritional diseases; diseases of the blood and blood forming tissues; dental conditions; diseases of the breast, and other organic defects and diseases that do not fall under other specific factors of the system.

(2) U—Upper extremities. This factor concerns the hands, arms, shoulder girdle, and upper spine (cervical, thoracic, and upper lumbar) in regard to strength, range of motion, and general efficiency.

(3) L—Lower extremities. This factor concerns the feet, legs, pelvic girdle, lower back musculature and lower spine (lower lumbar and sacral) in regard to strength, range of motion, and general efficiency.

(4) H—Hearing and ears. This factor concerns auditory acuity and disease and defects of the ear.

(5) E—Eyes. This factor concerns visual acuity and diseases and defects of the eye.

(6) S—Psychiatric. This factor concerns personality, emotional stability, and psychiatric diseases.

d. Four numerical designations are assigned for evaluating the individual's functional capacity in each of the six factors. Guidance for assigning numerical designators is contained in table 7-1. The numerical designator is not an automatic indicator of "deployability" or assignment restrictions, or referral to an MEB/PEB. Likewise, the conditions listed in chapter 3, rather than the numerical designator of the profile, will be the determinant for MEB processing.

(1) An individual having a numerical designation of "1" under all factors is considered to possess a high level of medical fitness.

(2) A physical profile designator of "2" under any or all factors indicates that an individual possesses some medical condition or physical defect that may require some activity limitations.

(3) A profile containing one or more numerical designators of "3" signifies that the individual has one or more medical conditions or physical defects that may require significant limitations. The individual should receive assignments commensurate with his or her physical capability for military duty.

(4) A profile serial containing one or more numerical designators of "4" indicates that the individual has one or more medical conditions or physical defects of such severity that performance of military duty must be drastically limited.

e. Anatomical defects or pathological conditions will not of themselves form the sole basis for recommending assignment or duty limitations. While these conditions must be given consideration when accomplishing the profile, the prognosis and the possibility of further aggravation must also be considered. In this respect, profiling officers must consider the effect of their recommendations upon the soldier's ability to perform duty. Profiles must be realistic. All profiles and assignment limitations must be legible, specific, and written in lay terms. If the commander has questions about a profile or is unable to use the soldier within the profile, the procedures in paragraph 7-12 will apply.

(1) Determination of individual assignment or duties to be performed are command/administrative matters. Limitations such as "no field duty," or "no overseas duty," are not proper medical recommendations. (However, they are

included as administrative guidelines in pregnancy profiles.) Profiling officers should provide enough information regarding the soldier's physical limitations to enable the nonmedical commander and PERSCOM to make a determination on individual assignments or duties.

(2) It is the responsibility of the commander or personnel management officer to determine proper assignment and duty, based upon knowledge of the soldier's profile, assignment limitations, and the duties of his or her grade and MOS.

(3) Table 7-1 contains the physical profile functional capacity guide.

(4) See TB MED 287 for profiling soldiers with pseudofolliculitis.

7-4. Temporary vs. permanent profiles

a. Permanent profiles. A profile is considered permanent unless a modifier of "T" (temporary) is added as described in *b* below. A permanent profile may only be awarded or changed by the authority designated in paragraph 7-6.

(1) Profiling officers should ensure when reviewing permanent profiles that the soldier meets the medical retention standards of chapter 3. This is especially important when the profile includes limitations that prohibit the soldier from performing an alternate APFT, from wearing a protective mask, from wearing Kevlar, from firing a rifle, or from wearing load bearing equipment or lifting weights required of the MOS.

(2) Failure to meet chapter 3 standards requires referral to an MEB/PEB.

(3) Permanent profiles may be amended at any time if clinically indicated and will automatically be reviewed at the time of a soldier's periodic examination.

(4) The soldier's commander may also request a review of a permanent profile in accordance with paragraph 7-12.

b. Temporary profiles. A temporary profile is given if the condition is considered temporary, the correction or treatment of the condition is medically advisable, and correction usually will result in a higher physical capacity. Soldiers on active duty and RC soldiers not on active duty with a temporary profile will be medically evaluated at least once every 3 months at which time the profile may be extended by the profiling officer.

(1) The profiling officer must review previous profiles before making a decision to extend a temporary profile. Any extension of a temporary profile must be recorded on DA Form 3349, and if renewed, item 9 on the DA Form 3349 must contain the following statement: "This temporary profile is an extension of a temporary profile first issued on (date)."

(2) Temporary profiles should specify an expiration date. If no date is specified, the profile will automatically expire at the end of the third month. In no case will individuals in military status carry a temporary profile that has been extended for more than 12 months collectively without positive action being taken either to correct the defect or to effect other appropriate disposition. As a general rule, the physician initiating the temporary profile will initiate appropriate arrangements for the necessary correction or treatment of the temporary condition. A temporary profile will be awarded by the authority in paragraph 7-6. Whenever a temporary medical condition is recorded on DA Form 3349 or DD Form 2808, the modifier "T" will be entered immediately preceding the appropriate PULHES numerical designator.

7-5. Representative profile serial and codes

To facilitate the assignment of individuals after they have been given a physical profile serial and for statistical purposes, code designations have been adopted to represent certain combinations of physical limitations or assignment guidance. (See table 7-2.) The alphabetical coding system will be recorded on personnel qualifications records. This coding system will not be used on medical records to identify limitations. The numerical designations under each profile factor, PULHES, are given in table 7-1.

7-6. Profiling officer

a. Commanders of Army MTFs are authorized to designate one or more physicians, dentists, optometrists, podiatrists, audiologists, nurse practitioners, nurse midwives, licensed clinical psychologists, and physician assistants as profiling officers. The commander will assure that those designated are thoroughly familiar with the contents of this regulation. Profiling officer limitations are as follows:

(1) Physicians: No limitations. Changing from or to a permanent numerical designator "3" or "4" requires the signature of two physicians. (One of the physicians is the approving authority; see para 7-8.)

(2) Dentists, optometrists, podiatrists, physical therapists, and occupational therapists: No limitation within their specialty for awarding permanent numerical designators "1" and "2." A temporary numerical designator "3" may be awarded for a period not to exceed 30 days. Any extension of a temporary numerical designator "3" beyond 30 days must be confirmed by a physician. (See para 7-8.)

(3) Audiologists: No limitation within their specialty for awarding permanent numerical designators "1," "2," "3," or "4" in cases of sensorineural hearing loss if retrocochlear lesion has been ruled out. Changing from or to a permanent numerical designator "3" or "4" requires the co-signature of a physician approving authority (para 7-8).

(4) Physician assistants, nurse midwives, nurse practitioners, and licensed clinical psychologists: Limited to awarding temporary numerical designators "1," "2," and "3" for a period not to exceed 30 days. Any extension of a

temporary profile beyond 30 days must be confirmed by a physician, except when the provisions of paragraph 7–9 apply. However, physician assistants with AOC 65DM1 certified in orthopedics have no limitations in awarding temporary orthopedic profiles or permanent profiles with a numerical designator of “1” or “2.” Physician assistants with AOC 65DM1 may award permanent orthopedic profiles of “3” or “4” provided the profile is signed by the physician approving authority.

b. MEPS physicians will also be designated as profiling officers. (See para 7–7*b.*)

7–7. Recording and reporting of initial physical profile

a. Individuals accepted for initial appointment, enlistment, or induction in peacetime normally will be given a numerical designator “1” or “2” physical profile in accordance with the instructions contained in this regulation. Initial physical profiles will be recorded on DD Form 2808 by the medical profiling officer at the time of the initial appointment, enlistment, or induction medical examination.

b. The initial physical profile serial will be entered on DD Form 2808 and also recorded on DD Forms 1966/1 through 6 (Record of Military Processing—Armed Forces of the United States), in the appropriate spaces. When the modifier “T” is entered on the profile serial, or in those exceptional cases where the numerical designator “3” is used on initial entry, a brief, nontechnical description of the defect will be recorded in the “Summary of Defects” section on the DD Form 2808, in addition to the exact diagnosis. All physical, geographic, or climatic area limitations applicable to the defect will also be entered in that section. If sufficient room for a full explanation is not available in that section, proper reference will be made in that section number and an additional sheet of paper attached. It is not uncommon for the MEPS to assign a profile with the numerical designator of “3” or “0” pending a medical waiver review of a disqualifying condition. This is for their administrative purposes only. If the individual receives a medical waiver, the waiver documentation completed by the waiver authority should indicate the appropriate profile in accordance with table 7–1.

7–8. Numerical designator of “3” or “4” in a profile

a. Changing to or from a numerical designator of “3” or “4” in any of the PULHES factors of the profile requires the signature of at least two physicians. One of the two physicians will be the approving authority appointed by the MTF Commander (unless the provisions of 7–8*f* apply). Exception: Profiles for sensorineural hearing loss (if retrocochlear lesion has been ruled out) may be signed by an audiologist providing the physician approving authority also signs the profile. (See *f* below for procedures for RC soldiers.) When determining appropriate physical profiles, the profiling officer and the approving authority should also ensure that the soldier is referred to an MEB if the soldier does not meet medical retention standards.

b. Situations that require a mandatory review of an existing physical profile include—

(1) Return to duty of a soldier hospitalized. The attending physician will ensure that the patient has the correct physical profile, assignment limitations(s), and medical followup instructions, as appropriate.

(2) When directed by the appointing authority in cases of a problematical or controversial nature requiring temporary revision of profile.

(3) At the time of the periodic medical examination.

(4) Upon request of the unit commander.

(5) On request of a PEB.

c. A temporary revision of profile will be completed when, in the opinion of the profiling officer, the functional capacity of the individual has changed to such an extent that it temporarily alters the individual’s ability to perform duty. Temporary profiles written on DA Form 3349 will not exceed 3 months except as provided for in paragraphs 7–8*d* and 7–9. Temporary profiles written on DD Form 689 (Individual Sick Slip) will not exceed 30 days.

d. Tuberculous patients returned to a duty status who require anti-tuberculous chemotherapy following hospitalization will be given a temporary “2” profile under the P factor of the physical profile for a period of 1 year with recommendation that the soldier be placed on duty at a fixed installation and will be provided the required medical supervision for a period of 1 year.

e. The physical profile in controversial or equivocal cases may be verified or revised by the hospital commander or command surgeon.

f. Physical profiles for Reservists not on active duty may be accomplished by the U.S. Army Regional Support Command surgeon, division staff surgeons, USAR medical facility medical corps officers, or the Surgeon, AR–PERSCOM, or their designees. Profiles with numerical designators of “3” or “4” must have the signature of two physicians, one of whom is the approving authority. For ARNGUS soldiers not on active duty, profiles will be accomplished by State ARNGUS providers. The respective State Surgeons will be the approving authority for permanent “3” or “4” profiles. The Chief Surgeon, ARNGUS may review completed profiles of ARNGUS soldiers on active duty whose profiles were accomplished by Active Army physicians and request reconsideration of the profile if appropriate. Direct communication is authorized between units and the profiling authority. Revision of physical profile for RC members will be based on relationship to military duties. Secondary evidence concerning the civilian milieu

may be considered by medical personnel in determining the effect of their recommendation upon RC soldiers. The profiling authority will use DA Form 3349.

g. Individuals who were found unfit by a PEB but COAD used to be assigned a code “V” on their physical profile code. The code “V” is no longer used for this purpose but rather to identify soldiers with restrictions on deployment.

h. MEB members must ensure that the physical profile and assignment limitations are fully recorded on DA Form 3349. In cases where the soldier is referred to a PEB, a copy of the most current DA Form 3349 will be forwarded to the PEB with the MEB proceeding, with distribution of the form as indicated in the “Distribution” block of DA Form 3349. Cooperation between the MEBs, PEB liaison officers, and the PEB is essential when additional medical information or profile reconsideration is requested from the MTF by the PEB. The limitations described on the profile form may affect the decision of fitness by the PEB. Table 7–1 should be used when determining the numerical designator of the PULHES factors. (For example, a soldier should not be given a “3” or “4” solely on the basis of a referral to a PEB.)

i. All soldiers undergoing a TDRL examination must have their physical profile reevaluated. The profile will be based on the soldier’s current medical condition.

7–9. Profiling pregnant soldiers

a. *Intent.* The intent of these provisions is to protect the fetus while ensuring productive use of the soldier. Common sense, good judgement, and cooperation must prevail between policy, soldier, and soldier’s commander to ensure a viable program. This profile has been revised from the previous profile published in the 1995 edition of this regulation. This revision includes mandating an occupation health interview to assess risks to the soldier and fetus and adding additional restrictions to reduce exposure to solvents, lead, and fuels that may be associated with adverse pregnancy outcomes.

b. Responsibilities.

(1) *Soldier.* The soldier will seek medical confirmation of pregnancy and will comply with the instructions of medical personnel and the individual’s unit commander.

(2) *Medical personnel.* A physician will confirm pregnancy and once confirmed will initiate prenatal care of the soldier and issue a physical profile. Nurse midwives or nurse practitioners are authorized to issue routine or standard pregnancy profiles for the duration of the pregnancy. An occupational history will be taken at the first visit to assess potential exposures related to the soldier’s specific MOS. This history is ideally taken by the occupational medicine physician or nurse. However, if this is not feasible, the profiling officer must complete the occupational history. After review of the occupational history, the profiling physician, in conjunction with the occupational health clinic as needed, will determine whether any additional occupational exposures, other than those indicated in the paragraphs below, should be avoided for the remainder of the pregnancy. Examples include but are not limited to hazardous chemicals, ionizing radiation, and excessive vibration. If the occupational history or industrial hygiene sampling data indicate significant exposure to physical, chemical, or biological hazards, then the profile should be revised to restrict exposure from these workplace hazards.

(3) *Unit commander.* The commander will counsel all female soldiers as required by AR 600–8–24 or AR 635–200. The unit commander will consult with medical personnel as required. This includes establishing liaison with the occupational health clinic and requesting site visits by the occupational health personnel if necessary to assess any work place hazards.

c. Physical profiles.

(1) Profiles will be issued for the duration of the pregnancy. The MTF should ensure that the unit commander is provided a copy of the profile, and advise the unit commander as required. Upon termination of pregnancy, a new profile will be issued reflecting revised profile information. Physical profiles will be issued as follows:

(2) Under factor “P” of the physical profile, indicate “T–3.”

(3) List diagnosis as “pregnancy, estimated delivery date.”

d. *Limitations.* Unless superceded by an occupational health assessment, the standard pregnancy profile, DA Form 3349, will indicate the following limitations:

(1) Except under unusual circumstances, the soldier should not be reassigned to overseas commands until pregnancy is terminated. (See AR 614–30 for waiver provisions and for criteria curtailing OCONUS tours.) She may be assigned within CONUS. Medical clearance must be obtained prior to any reassignment.

(2) The soldier will not receive an assignment to duties where nausea, easy fatigue, or sudden lightheadedness would be hazardous to the soldier, or others, to include all aviation duty, Classes 1/1A/2/3. (However, there are specific provisions in para 4–13c that allow the aircrew member to request and be granted permission to remain on flight status. ATC personnel may continue ATC duties with approval of the flight surgeon, obstetrician, and ATC supervisor.)

(3) Restrict exposures to military fuels. Pregnant soldiers must be restricted from assignments involving frequent or routine exposures to fuel vapors or skin exposure to spilled fuel such as fuel handling or otherwise filling military vehicles with fuels such as mogas, JP8, and JP4.

(4) No weapons training in indoor firing ranges due to airborne lead concentrations and bore gas emissions. Firing of weapons is permitted at outdoor sites. (See para 7–9d(9) for other weapons training restrictions.) No exposure to

organic solvent vapors above permissible levels. (For example, work in ARMS room is permitted if solvents are restricted to 1999 MIL-PRF-680, degreasing solvent.)

(5) No work in the motor pool involving painting, welding, soldering, grinding, and sanding on metal, parts washing, or other duties where the soldier is routinely exposed to carbon monoxide, diesel exhaust, hazardous chemicals, paints, organic solvent vapors, or metal dusts and fumes (for example, motor vehicle mechanics). It does not apply to pregnant soldiers who perform preventive maintenance checks and services (PMCS) on military vehicles using impermeable gloves and coveralls, nor does it apply to soldiers who do work in areas adjacent to the motor pool bay (for example, administrative offices) if the work site is adequately ventilated and industrial hygiene sampling shows carbon monoxide, benzene, organic solvent vapors, metal dusts and fumes do not pose a hazard to pregnant soldiers. (See para 7-9d(11) for PMCS restrictions at 20 weeks of pregnancy.)

(6) The soldier should avoid excessive vibrations. Excessive vibrations occur in larger ground vehicles (greater than 1 1/4 ton) when the vehicle is driven on unpaved surfaces.

(7) Upon the diagnosis of pregnancy, the soldier is exempt from mandatory physical training (PT) and from PT testing. Pregnant soldiers are encouraged to participate in a pregnancy PT program, where available. If they participate in a pregnancy PT program, they should obtain the profiling officer's approval prior to beginning the program. The soldier is exempt from wearing of load bearing equipment, including web belt.

(8) The soldier is exempt from all immunizations except influenza and tetanus-diphtheria and from exposure to all fetotoxic chemicals noted on the occupational history form. The soldier is exempt from exposure to chemical warfare and riot control agents (for example, nuclear, biological, and chemical training) and wearing MOPP gear at any time.

(9) The soldier may work shifts.

(10) The soldier must not climb or work on ladders or scaffolding.

(11) At 20 weeks of pregnancy, the soldier is exempt from standing at parade rest or attention for longer than 15 minutes. The soldier is exempt from participating in swimming qualifications, drown proofing, field duty, and weapons training. The soldier should not ride in, perform PMCS on, or drive in vehicles larger than light medium tactical vehicles due to concerns regarding balance and possible hazards from falls.

(12) At 28 weeks of pregnancy, the soldier must be provided a 15-minute rest period every 2 hours. Her workweek should not exceed 40 hours and the soldier should not work more than 8 hours in any one day. The duty day begins when reporting for formation or duty and ends 8 hours later.

e. Performance of duty. A woman who is experiencing a normal pregnancy may continue to perform military duty until delivery. Only those women experiencing unusual and complicated problems (for example, pregnancy-induced hypertension) will be excused from all duty, in which case they may be hospitalized or placed sick in quarters. Medical personnel will assist unit commanders in determining duties.

f. Sick in quarters. A pregnant soldier will not be placed sick in quarters solely on the basis of her pregnancy unless there are complications present that would preclude any type of duty performance.

7-10. Postpartum profiles

a. Convalescent leave (as prescribed by AR 600-8-10) after delivery will be for a period determined by the attending physician. This will normally be for 42 days following normal pregnancy and delivery.

b. Convalescent leave after a termination of pregnancy (for example, miscarriage) will be determined on an individual basis by the attending physician.

c. Prior to commencing convalescent leave, postpartum soldiers will be issued a post partum profile. The temporary profile will be for 45 days. It begins on the day of birth or termination of pregnancy and will allow PT at the soldier's own pace. If a soldier decides to return early from convalescent leave, the temporary profile remains in effect for the entire 45 days.

d. Soldiers will receive clearance from the profiling officer to return to full duty.

e. In accordance with DOD Directive 1308.1, post partum soldiers are exempt from the APFT for 180 days following termination of pregnancy. They are expected to use the time in preparation for the APFT after receiving clearance from their physician to resume physical training.

f. The above guidance will only be modified if, upon evaluation of a physician, it has been determined the post partum soldier requires a more restrictive or longer profile because of complicated or unusual medical problems.

7-11. Preparation, approval, and disposition of DA Form 3349

a. Preparation of DA Form 3349.

(1) DA Form 3349 will be used to record both permanent profiles and temporary profiles. DD Form 689 (Individual Sick Slip) may be used in lieu of DA Form 3349 for temporary profiles not to exceed 30 days and may include information on activities the soldier can perform as well as the physical limitations. An SF 600 may be used to attach additional information to the DA Form 3349 on the physical activities a soldier can or cannot perform if there is inadequate space on the DA Form 3349. This additional SF 600 should be clearly labeled as a continuation of the DA Form 3349.

(2) DA Form 3349 will be prepared as follows.

Note. The following instructions are for DA Form 3349, dated May 1986. If the May 1986 version of the form is modified by the proponent of the form, updated instructions will be distributed by the proponent (DASG-HS-AS) and will supercede those below, pending a regulatory change.

(a) *Item 1.* Record medical condition(s) and/or physical defect(s) in common usage, nontechnical language that a layman can understand. For example, “compound comminuted fracture, left tibia” might simply be described as “broken leg.”

(b) *Item 2.* Enter under each PULHES factor the appropriate profile serial code (1, 2, 3, 4, as prescribed) for the specific PULHES factor.

(c) *Item 3.* Clearly state all assignment limitations. Code designations (defined in table 7-2) are limited to permanent profiles for administrative use only and are to be completed by the MTF before sending a copy to the military personnel office (MILPO) or RC records custodian of military records.

(d) *Item 4.* Check the appropriate block for the type of profile. If the profile is temporary, enter the expiration date.

(e) *Item 5.* Check each block for exercises that are appropriate for the individual to do. Exercises are listed on the reverse of the form for easy reference. The individual can do all of the exercises checked.

(f) *Item 6.* Check all aerobic conditioning exercising the individual can do. The training heart rate will be assumed to be that determined by the directions in block 8 unless otherwise noted. If another training heart rate or training intensity is desired, note it here.

(g) *Item 7.* Check all functional activities the individual can do. If no values are listed in miles or pounds, it will be assumed these are within the normal limitations of a healthy individual.

(h) *Physical Fitness Test.* Check the activities or alternative activities the soldier can perform for the APFT.

(i) *Item 9.* This space is for the following uses. In accordance with paragraph 7-4b, the profiling officer must review previous profiles before making a decision to extend a temporary profile. Any extension of a temporary profile must be recorded on DA Form 3349, and if the temporary profile is renewed, item 9 on the DA Form 3349 must contain the following statement: “This temporary profile is an extension of a temporary profile first issued on (date).” If a soldier is given a permanent “3” or “4” profile, this space would also contain a statement by the examining physician that indicates whether the soldier does or does not meet the medical retention standards of chapter 3. Item 9 may also be used to list any other physical activity not listed elsewhere on the form that is felt to be beneficial for the individual or for location-specific activities.

(j) *Signatures.* Permanent “3” profiles require signatures of two physicians. One of the two physicians will be the approving authority appointed by the MTF Commander (unless the provisions of 7-8f apply). The signature of the first physician is written in the section: “Typed name and grade of profiling officer.” The signature of the physician approving authority is written in the section: “Action by Approving Authority.” As an exception, profiles for sensorineural hearing loss (if retrocochlear lesion has been ruled out) may be signed by an audiologist providing the physician approving authority also signs the profile. Temporary profiles not requiring major assignment limitations require only the signature of one profiling officer.

(k) *Action by approving authority.* The approving authority will be designated by the MTF commander. (In the case of RC soldiers not on active duty, see para 7-8f.) The approving authority for permanent “3” or “4” profiles must be a physician. If the approving authority does not concur with the profiling officer recommendation, the MTF commander will make the final decision.

(l) *Action by the unit commander.* See paragraph 7-12b.

b. *Disposition of the physical profile form (permanent profiles) by the MTF.* The unit commander and MILPO copies of DA Form 3349 will be delivered by means other than the individual on whom the report is made.

(1) One copy to the unit commander.

(2) One copy to the soldier.

(3) One copy to the MILPO.

(4) Original to the soldier’s health record.

(5) One copy to the clinic file.

c. *Disposition of the physical profile form (temporary profiles).*

(1) One copy to the soldier.

(2) One copy to the unit commander.

(3) Original in the soldier’s health record.

7-12. Responsibility for personnel actions

a. Unit commanders and personnel officers are responsible for necessary personnel actions, including appropriate entries on personnel management records and the assignment of the individual to military duties commensurate with the individual’s physical profile and recorded assignment limitations.

b. If the soldier’s commander believes the soldier cannot perform with the permanent profile, the commander will make appropriate comments on the profile form in the section entitled “Action by Unit Commander” and request reconsideration of the profile by the profiling physician. Reconsideration must be accomplished by the physician who

will either amend the profile or revalidate the profile as appropriate. Commanders may also request a review of temporary profiles.

7-13. Physical profile and the Army Weight Control Program

DA Form 3349 will not be used to excuse soldiers from the provisions of AR 600-9. AR 600-9 contains a standard memorandum for completion by a physician if there is an underlying or associated disease process that is the cause of the overweight condition. The inability to perform all APFT events or the use of certain medications is not generally considered sufficient medical rationale to exempt a soldier from AR 600-9.

Table 7-1
Physical profile functional capacity guide

Profile Serial	P Physical capacity	U Upper extremities	L Lower extremities	H Hearing-ears	E Vision-eyes	S Psychiatric
Factors to be considered.	Organic defects, strength, stamina, agility, energy, muscular coordination, function, and similar factors.	Strength, range of motion, and general efficiency of upper arm, shoulder girdle, and upper back, including cervical and thoracic vertebrae.	Strength, range of movement, and efficiency of feet, legs, lower back and pelvic girdle.	Auditory sensitivity and organic disease of the ears	Visual acuity, and organic disease of the eyes and lids.	Type severity, and duration of the psychiatric symptoms or disorder existing at the time the profile is determined. Amount of external precipitating stress. Predisposition as determined by the basic personality makeup, intelligence, performance, and history of past psychiatric disorder impairment of functional capacity
1	Good muscular development with ability to perform maximum effort for indefinite periods.	No loss of digits or limitation of motion; no demonstrable abnormality; able to do hand to hand fighting.	No loss of digits or limitation of motion; no demonstrable abnormality; able to perform long marches, stand over long periods, run.	Audiometer average level for each ear not more than 25 dB at 500, 1000, 2000 Hz with no individual level greater than 30 dB. Not over 45 dB at 4000 Hz	Uncorrected visual acuity 20/200 correctable to 20/20, in each eye.	No psychiatric pathology. May have history of a transient personality disorder.
2	Able to perform maximum effort over long periods.	Slightly limited mobility of joints, muscular weakness, or other musculo-skeletal defects that do not prevent hand-to-hand fighting and do not disqualify for prolonged effort.	Slightly limited mobility of joints, muscular weakness, or other musculo-skeletal defects that do not prevent moderate marching, climbing, timed walking, or prolonged effort.	Audiometer average level for each ear at 500, 1000, 2000 Hz, or not more than 30 dB, with no individual level greater than 35 dB at these frequencies, and level not more than 55 dB at 4000 Hz; or audiometer level 30 dB at 500 Hz, 25 dB at 1000 and 2000 Hz, and 35 dB at 4000 Hz in better ear. (Poorer ear may be deaf.)	Distant visual acuity correctable to not worse than 20/40 and 20/70, or 20/30 and 20/100, or 20/20 and 20/400.	May have history of recovery from an acute psychotic reaction due to external or toxic causes unrelated to alcohol or drug addiction.
3	Unable to perform full effort except for brief or moderate periods.	Defects or impairments that require <i>significant</i> restriction of use.	Defects or impairments that require <i>significant</i> restriction of use.	Speech reception threshold in best ear not greater than 30 dB HL, measured with or without hearing aid; or acute or chronic ear disease.	Uncorrected distant visual acuity of any degree that is correctable not less than 20/40 in the better eye.	Satisfactory remission from an acute psychotic or neurotic episode that permits utilization under specific conditions (assignment when outpatient psychiatric treatment is available or certain duties can be avoided).
4	<i>Functional level below P3.</i>	<i>Functional level below U3.</i>	<i>Functional level below L3.</i>	<i>Functional level below H3.</i>	<i>Visual acuity below E3.</i>	Does not meet S3 above.

**Table 7–2
Profile codes***

Code	Description/assignment limitation	Medical criteria (examples)
CODE A	No assignment limitation.	No demonstrable anatomical or physiological impairment within standards established in table 7–1.
CODE B	May have assignment limitations that are intended to protect against further physical damage/injury. May have minor impairments under one or more PULHES factors that disqualify for certain MOS training or assignment.	Minimal loss of joint motion, visual and hearing loss
CODES C through P	Possesses impairments that limit functions or assignments. <i>The codes listed below are for military personnel administrative purposes. Corresponding limitations are general guidelines and are not to be taken as verbatim limitations. (For example, a soldier with a code C may not be able to run but may have no restrictions on marching or standing.) Item 3 of DA Form 3349 will contain the specific limitations.</i>	
CODE C	Limitations in running, marching, standing for long periods etc.	Orthopedic or neurological conditions
CODE D	Limitations in any type of strenuous physical activity.	Organic cardiac disease; pulmonary insufficiency
CODE E	Limitations requiring dietary restrictions preventing consumption of combat rations.	Endocrine disorders—recent or repeated peptic ulcer activity—chronic gastrointestinal disease requiring dietary management.
CODE F	Limitations prohibiting assignment or deployment to OCONUS areas where definitive medical care is not available.	Individuals who require continued medical supervision with hospitalization or frequent outpatient visits for serious illness or injury.
CODE G	Limitations prohibiting wearing Kevlar, LBE, lifting heavy materials required of the MOS, overhead work.	Arthritis of the neck or joints of the extremities with restricted motion; disk disease; recurrent shoulder dislocation.
CODE H	Limitations on duty where sudden loss of consciousness would be dangerous to self or to others such as work on scaffolding, vehicle driving, or near moving machinery.	Seizure disorders; other disorders producing syncopal attacks of severe vertigo, such as Meniere’s syndrome.
CODE J	Hearing Protection Measures required to prevent further hearing loss. 1. No exposure to noise in excess of 85 dBA (decibels measured on the A scale) or weapon firing without use of properly fitted hearing protection. Annual hearing test required. 2. Further exposure to noise is hazardous to health. No duty or assignment to noise levels in excess of 85 dBA or weapon firing (not to include firing for preparation of replacements for overseas movement (POR) qualification or annual weapons qualification with proper ear protection). Annual hearing test required. 3. No exposure to noise in excess of 85 dBA or weapon firing without use of properly fitted hearing protection. This individual is ‘deaf’ in one ear. Any permanent hearing loss in the good ear will cause a serious handicap. Annual Hearing test required. 4. Further duty requiring exposure to high intensity noise is hazardous to health. No duty or assignment to noise levels in excess of 85 dBA or weapon firing (not to include firing for overseas movement (POR) or weapon firing without use of properly ear protection). No duty requiring acute hearing. A hearing aid must be worn to meet medical fitness standards.	Susceptibility to acoustic trauma.

Table 7–2
Profile codes*—Continued

Code	Description/assignment limitation	Medical criteria (examples)
CODE L	Limitations restricting assignment to cold climates.	Documented history of cold injury; vascular insufficiency; collagen disease, with vascular or skin manifestations.
CODE M	Limitations restricting exposure to high environmental temperature.	History of heat stroke; history of skin malignancy or other chronic skin diseases that are aggravated by sunlight or high environmental temperature.
CODE N	Limitations restricting wearing of combat boots.	Any vascular or skin condition of the feet or legs that, when aggravated by continuous wear of combat boots, tends to develop unfitting ulcers.
CODE P	Limitations restricting wearing or being exposed to required items necessary to perform duty (for example, Latex, wool).	Established allergy to wool, latex.
CODE U	Limitation not otherwise described, to be considered individually. (Briefly define limitation in item 8.)	Any significant functional assignment limitation not specifically identified elsewhere.
CODE V	Deployment. This code identifies a soldier with restrictions on deployment. Specific restrictions are noted in the medical record.	
CODE W	MMRB. This code identifies a soldier with a permanent profile who has been returned to duty by an MMRB (MOS Medical Review Board.)	
CODE Y	Fit for duty. This code identifies the case of a soldier who has been determined to be fit for duty (not entitled to separation or retirement because of physical disability) after complete processing under AR 635–40.	

Notes:

* Codes do not automatically correspond to a specific numerical designator of the profile but are based on the general physical/assignment limitations.

Chapter 8

Medical Examinations—Administrative Procedures

8–1. General

(See chap 6 for aviation administration procedures.) This chapter provides—

- a. General administrative policies relative to military medical examinations.
- b. Requirements for periodic, separation, mobilization, and other medical examinations.
- c. Policies relative to hospitalization of examinees for diagnostic purposes and use of documentary medical evidence, consultations, and the individual health record.
- d. Policies relative to the scope and recording of medical examinations accomplished for stated purposes.

8–2. Applications

The provisions contained in this chapter apply to all medical examinations accomplished at U.S. Army medical facilities or accomplished for the U.S. Army.

8–3. Physical fitness

Maintenance of physical and medical fitness is an individual military responsibility, particularly with reference to preventable conditions and remediable defects. Soldiers have an obligation to maintain themselves in a state of good physical condition so that they may perform their duties efficiently. Soldiers should seek timely medical advice whenever they have reason to believe that a medical condition or physical defect affects, or is likely to affect, their physical or mental well-being. They should not wait until the time of their periodic medical examination to make such a condition or defect known. Commanders will bring this matter to the attention of all soldiers during initial orientation and periodically throughout their period of service.

8–4. Consultations

a. The use of specialty consultants, either military or civilian, is authorized in AR 40–400 and AR 601–270/AFR 33–7/OPNAVINST 1100.4/MCO P–1100.75A.

b. A consultation will be completed in the case of an individual being considered for military service, including USMA and ROTC, whenever—

(1) Verification, or establishment, of the exact nature or degree of a given medical condition or physical defect is necessary for the determination of the examinee's medical acceptability or unacceptability based on prescribed medical fitness standards; or

(2) It will assist higher headquarters in the review and resolution of a questionable or borderline case; or

(3) The examining physician deems it necessary.

c. A consultation will be accomplished in the case of a soldier on active duty whenever it is indicated to ensure the proper medical care and disposition of the soldier.

d. A medical examiner requesting a consultation will routinely furnish the consultant with—

(1) The purpose or reason for which the individual is being examined; for example, enlistment.

(2) The reason for the consultation; for example, persistent tachycardia.

(3) A brief statement on what is desired of the consultant.

(4) Pertinent extracts from available medical records.

e. Reports of consultation will be appended to DD Form 2808 as outlined in paragraph 8-5.

8-5. Distribution of medical reports

a. DD Form 2808 and DD Form 2807-1 are to be used for all military examinations. Medical examinations/histories accomplished on soldiers in accordance with this chapter on an SF 88 (Report of Medical Examination) or SF 93 (Report of Medical History) should be considered valid. However, once the DD Forms are available for use, the DD Forms should be used in lieu of the SF 88 and SF 93. DD Form 2807-2 (Medical Prescreen of Medical History Report) is not required for military medical examinations.

b. A minimum of two copies (both signed) of DD Form 2807-1 and DD Form 2808 will be prepared. One copy of each will be retained by the examining facility. The other copy will be filed as a permanent record in the health record (AR 40-66) or outpatient treatment record. Special instructions for preparation and distribution of additional copies are contained elsewhere in this chapter or in other regulations dealing with programs involving or requiring medical examinations. Copies may be reproduced from signed copies by any duplicating process that produces legible and permanent copies. Such copies are acceptable for any purpose unless specifically prohibited by the applicable regulation. Distribution of copies will not be made to unauthorized personnel or agencies.

c. In the case of general officers (grade O7 and above), the duplicate DD Form 2808 will be forwarded by the examining facility directly to Department of the Army, General Officer Management Office, ATTN: DACS-GO, 200 Army Pentagon, Washington, DC 20310-0200.

8-6. Documentary medical evidence

a. Documentary medical records and other documents prepared by physicians or other individuals may be submitted by, or on behalf of, an examinee as evidence of the presence, absence, or treatment of a defect or disease, and will be given due consideration by the examiner(s). Submission and use of such documentary medical evidence is encouraged. If insufficient copies are received, copies will be reproduced to meet the needs of *b* and *c* below.

b. A copy of each piece of documentary medical evidence received will be appended to each copy of the DD Form 2808, and a statement to this effect will be made in the Summary of Defects section and cross-referenced by the pertinent item number.

c. When a report of consultation or special test is obtained for an examinee, a copy will be attached to each DD Form 2808 as an integral part of the medical report, and a statement to this effect will be made on the DD Form 2808 and cross-referenced by the pertinent item number.

8-7. Facilities and examiners

a. Physicians may perform medical examinations of any type except where a specific requirement exists for the examination to be conducted by a physician qualified in a specialty. Physician assistants, nurse practitioners, optometrists, audiologists, and podiatrists, properly qualified by appropriate training and experience, may accomplish such phases of the medical examination as are deemed appropriate by the examining physician. They may sign the report of medical examination for the portions of the examination they actually accomplish, but the supervising physician will sign the report of medical examination in all cases.

b. In general, medical examinations conducted for the Army will be completed at facilities of the Armed Forces, using military medical officers on Active or Reserve duty, or full-time or part-time civilian employee physicians, with the assistance of dentists, physician assistants, nurse practitioners, optometrists, audiologists, and podiatrists. There may be contract agreements with civilian or VA facilities to perform military medical or separation examinations for Active or Reserve Component Forces. In such cases, agreements must be worked out with the overseeing Army MTF or Reserve Command to ensure that the medical examinations are reviewed by individuals who are familiar with the medical retention standards of chapter 3 (for example, military physicians) and can make a competent determination on whether the soldier meets the medical retention standards of chapter 3 and is therefore medically fit for retention, retirement, or separation.

c. Medical examinations for qualification and admission to the USMA, the U.S. Naval Academy, the U.S. Air Force

Academy, and the respective preparatory schools will be conducted in coordination with DODMERB. (See AR 40–29/AFR 160–13/NAVMEDCOMINST 6120.2/CG COMDTINST M6120.8.)

8–8. Hospitalization

Whenever hospitalization is necessary for evaluation in connection with a medical examination, it may be furnished as authorized in AR 40–400.

8–9. Objectives of medical examinations

The objectives of military medical examinations are to provide information—

- a. To inform the individual of modifiable health risks and to identify potential lifestyle modifications.
- b. Needed to initiate treatment of illness.
- c. To meet administrative and legal requirements.

8–10. Recording of medical examinations

The results of a medical examination will be recorded on DD Form 2808 and such other forms as may be required. (See AR 40–29/AFR 160–13/NAVMEDCOMINST 6120.2/CG COMDTINST M6120.8 for DODMERB forms.) Results will be transferred to DD Form 2766 (Adult Preventive and Chronic Care Flowsheet) as needed.

8–11. Scope of medical examinations

a. The scope of a medical examination is prescribed in paragraph 8–12 and will conform to the intended use of the examination.

b. Limited or screening examinations, special tests, or inspections required for specific purposes (for example, drivers, personnel exposed to industrial hazards, blood donors, food handlers) may be prescribed by other regulations.

c. Each abnormality, whether or not it affects the examinee's medical fitness to perform military duty, will be routinely described. All diagnoses and symptoms will be noted.

8–12. Medical examination requirements and required forms

a. Required forms. The required form for all Army military medical examinations is DD Form 2808. The "Laboratory Findings" section of this form may not contain enough space to include all required tests. If additional space is needed, the "Notes" section in box 73 may be used for that purpose. (MTFs are encouraged to use standard overprints, stamps, etc., in box 73 for that purpose.) Table 8–1 contains model entries and explanatory notes for every box on the DD Form 2808. All items are NOT required on all examinations.

b. All examinations. The following items ARE REQUIRED on ALL Army military medical examinations. (Additional items may be accomplished if clinically indicated.) See paragraphs (3) through (8) below for additional items required for special examinations. The box number from the DD Form 2808 that corresponds to the appropriate item to be completed is listed following each item.

(1) Administrative data. Date of examination (box 1), SSN (box 2), Name of examinee (box 3), Home address (current address, not "home of record" if different) (box 4), Home or contact telephone number (box 5), Grade/rank (box 6), Date of birth (box 7), Age (box 8), Sex (box 9), Race (box 10), Service (box 15a), Component (box 15b), Purpose of exam (box 15c), and Name of examining facility (box 16). (Name and SSN will also be completed on the top of pages 2 and 3 of the DD Form 2808.)

(2) Clinical evaluation section (boxes 17 through 39). This includes examination of head, face, neck, scalp, nose, sinuses, mouth, throat, ears (drums), eyes (includes ophthalmoscopic), heart, lungs, vascular system, anus, abdomen, upper and lower extremities, feet, spine, skin, breast exam, neurologic exam, and testicular exam on males. (Rectal exams are not required on all examinations. Pelvic exams and Pap tests are not required on all female examinations. See paras (3) through (8) below for specific requirements.)

(3) Dental section (box 43), usually completed by a physician or physician assistant. (This does not replace the dental examinations required in AR 40–3.)

(4) Notes section (box 44) (to explain any abnormalities).

(5) Urinalysis for albumin and sugar (boxes 45a and 45b).

(6) Miscellaneous measurements. Height (box 53), weight (box 54), temperature (box 56), pulse (box 57), blood pressure (box 58a), distant vision (box 61), near vision (box 63), and audiometer results (box 71a).

(7) Qualification for service (box 74a). For periodic, separation, and retirement exams, qualification is based on whether the examinee meets the medical retention standards of chapter 3.

(8) Physical profile (box 74b). This section does not replace the requirements for a DA Form 3349 as described in chapter 7.

(9) Summary of defects (box 77).

(10) Recommendations (box 78).

(11) Name and signatures of examining physician assistants (boxes 81a and 81b), and of examining or approving physician (boxes 82a and 82b or 84a and 84b).

c. Periodic, under age 40. In addition to the items listed in “All Examinations” (b(2) above), the following items are required:

- (1) HCT or HGB (box 47).
- (2) HIV testing (box 49). (See AR 600–110.)
- (3) Cholesterol. (Record results in box 73.)
- (4) See paragraph 8–20 for annual pap and pelvic exam and mammogram requirements for female soldiers on active duty. For ARNGUS soldiers and USAR soldiers not on active duty, the periodic examination should include a pap test and pelvic exam or alternatively, results of such tests done within 1 year of the exam may be attached to the DD Form 2808.

d. Periodic, age 40 and older. In addition to the items listed in “All Examinations” (b(2) above), the following items are required. Tests below include those required for the Cardiovascular Screening Program (CVSP). (See para 8–25 for CVSP guidelines.)

- (1) Prostate examination for males (box 30).
- (2) HIV testing (box 49). (See AR 600–110.)
- (3) Rectal exam with stool for occult blood (box 30 for exam). (For occult blood results, record in box 73.)
- (4) PSA test (males). (Record in box 52b.)
- (5) Urine specific gravity and urine microscopic. (Record results in box 52c.)
- (6) Test for intraocular pressure (box 70).
- (7) Fasting blood sugar. (Record results in box 73.)
- (8) Fasting lipid profile, including total cholesterol, LDL, HDL, and triglycerides. (Record results in box 73.)
- (9) EKG. (Record results in box 73.)
- (10) See paragraph 8–20 for annual pap and pelvic exam and mammogram requirements for female soldiers on active duty. For ARNGUS soldiers and USAR soldiers not on active duty, the periodic examination should include a pap test and pelvic exam or alternatively, results of such tests done within 1 year of the exam may be attached to the DD Form 2808.

(11) CVSP. (See para 8–25.)

e. Examination for retirement or separation. (In accordance with para 8–23, retirement examinations are mandatory. Separation examinations are conducted on the request of the soldier or if on review of the medical records it is clinically indicated.) In addition to the items listed in “All Examinations” (b(2) above), the following items are required:

- (1) Prostate for males age 40 and older (box 30).
- (2) Rectal exam with stool for occult blood test for age 40 and older (box 30 for exam). (Use box 73 for occult blood results.)
- (3) HCT or HGB (box 47).
- (4) PSA test for males 40 and older. (Record results in box 52b.)
- (5) Urine specific gravity and urine microscopic. (Record results in box 52c.)
- (6) Chest x–ray (only for soldiers 40 and older). (Record results in box 73.)
- (7) Cholesterol. (Record results in box 73.)
- (8) FBS for those 40 and older. (Record in box 73.)
- (9) EKG for those 40 and over or if clinically indicated. (Record in box 73.)
- (10) See paragraph 8–23i for hepatitis screening requirements.
- (11) DD Form 2697 (Report of Medical Assessment) will also be completed.

f. Initial examinations for appointment, enlistment, or induction. In addition to the items listed in “All Examinations” (b(2) above), the following items are required. (See AR 40–29/AFR 160–13/NAVMEDCOMINST 6120.2/CG COMDTINST M6120.8 for DODMERB exams.)

Note. MEPCOM will provide instructions to the MEPS on completion of the required forms for Army applicants. These instructions will include additional items on the DD Form 2808 that are to be used solely by the MEPS (for example, boxes 75, 79, and 80).

- (1) Pregnancy testing on female applicants (box 46).
- (2) HIV testing (box 49). (See AR 600–110.)
- (3) Drug and alcohol test. (ROTC cadets will be tested during precommissioning physical (boxes 50 and 51).)
- (4) Chest x-ray only if clinically indicated. (Record in box 73.)
- (5) Pelvic exams and pap tests are not required.
- (6) Color vision. (Record results in box 66.)

g. Initial exam for Special Forces, SERE, free fall parachute training (high altitude low opening (HALO), marine diving (Special Forces and Ranger combat diving) and other marine diving (MOS 00B). In addition to the items listed in “All Examinations” (b(2) above), the following items are required:

- (1) Rectal exam with stool for occult blood (required for Special Forces, SERE, HALO, Special Forces and Ranger combat diving) (box 30 for exam). (Use box 73 for occult blood results.)
 - (2) HCT (box 47).
 - (3) HIV (box 49).
 - (4) Urine specific gravity and urine microscopic. (Record in box 52c.)
 - (5) Color vision (boxes 59 and 60).
 - (6) Refraction, if vision does not correct to 20/20 in each eye with spectacle or contact lenses or if uncorrected vision is worse than 20/70 in either eye (not required for SERE) (box 62).
 - (7) Valsalva (required for diving and HALO only) (box 72b).
 - (8) Chest x-ray (not required for SERE). (Record in box 73.)
 - (9) EKG. (Record in box 73.)
 - (10) White blood cell count (diving and HALO only). (Record in box 73.)
 - (11) Sickle cell screen. (Record in box 73.)
 - (12) G6PD (MOS 00B diving, CDQC, and MFF only). (Record in box 73.)
 - (13) Dental examination by a dentist (not required for SERE).
- h.* Additional examinations for female soldiers on active duty or ADT tours in excess of 1 year. See paragraph 8–20a.
- i.* Flying Duty Medical Examinations. See ATB 2, Army Flight Surgeon’s Administrative Guide.
- j.* Airborne Examinations. In addition to the items listed in “All Examinations” (*b*(2) above), the following items are required:
- (1) Valsalva (box 72b).
 - (2) Color vision (boxes 59 and 60).

8–13. Report of medical history forms

a. *Preparation of DD Form 2807–1.* (DD Form 2807–2 (Medical Prescreen of Medical History Report) is not required.) This form is completed by the examinee prior to being examined. The DD Form 2807–1 must be prepared in all cases when the DD Form 2808 is also completed. It provides the examining physician with an indication of the need for special discussion with the examinee and the areas in which detailed examination, special tests, or consultation referral may be indicated. The information entered on this form is considered confidential and will not be released to unauthorized sources. The examinee should be informed of the confidential nature of his or her entries and comments. Trained enlisted medical service personnel and qualified civilians may be used to instruct and assist examinees in the preparation of the report, but will make no entries on the form other than the date of examination and the examining facility. The DD Form 2807–1 will normally be prepared in an original and one copy. All items will be completed. Responses will be typewritten or printed in ink.

b. *Signature.* The examinee will sign the form in black or dark blue ink.

c. *The physician’s (or physician assistant’s) summary and elaboration of the examinee’s medical history.*

(1) The physician (or physician assistant) will summarize and elaborate upon the examinee’s medical history, and in the case of military personnel, the examinee’s health record, cross–referencing his or her comments by item number. All items checked in the affirmative will be clarified and the examiner will fully describe all abnormalities including those of a non–disqualifying nature.

(2) If the examinee is applying for enlistment or appointment and answers reveal that he or she was previously rejected for military service or was discharged for medical reasons, the exact reason should be ascertained and recorded.

(3) A facsimile stamp will not be used for signature. The typed or printed name of the physician or physician assistant and the date will be entered in the designated blocks. The physician or physician assistant will sign in black or dark-blue ink.

8–14. Validity times for DD Forms 2808

a. Medical examinations will be valid for the purpose and within the periods prescribed below, provided there has been no significant change in the individual’s medical condition.

(1) Medical examinations will be valid for 24 months from date of medical examination for entrance into the USMA, the USUHS, the ROTC Scholarship Program, and for the ROTC non-scholarship contracting examination.

(2) Medical examinations will be valid for 24 months from the date of medical examination to qualify for induction, enlistment, re-enlistment, initial appointment as a commissioned officer or warrant officer, OCS, admission to the USMA Preparatory School, and/or ADT (with exceptions noted in (8) below); 24 months for ARNGUS and USAR soldiers’ entry and reentry in the alternate (split) training option. At National Advanced Leaders Camp, a medical screening on a DD Form 2807–1, with a focused medical exam if clinically indicated, and laboratory screening tests for DNA, HIV, and drug/alcohol testing will be accomplished. This medical screening and required laboratory tests will be used to qualify a cadet for continuation in ROTC and subsequent commission, providing the previous ROTC

contracting or DODMERB medical examination is not more than 4 years old. If the previous examination is more than 4 years old, a complete medical examination must be performed and results recorded on DD Form 2808.

(3) See paragraph 6–8 for validity periods for FDMEs.

(4) When accomplished incident to retirement, discharge, or release from active duty, medical examinations are valid for a period of 12 months from the date of examination. If the examination is accomplished more than 4 months prior to release from active duty, discharge, or retirement (or 4 months prior to transition leave date if the soldier requests it), DA Form 3081 (Periodic Medical Examination (Statement of Exemption)) will be attached to the original DD Form 2808.

(5) See table 6–1 for FDMEs.

(6) Medical examinations are valid for 60 months from the date of medical examination to qualify for airborne training. If an ROTC cadet examination was recorded on the DD Form 2351 (DOD Medical Examination Review Board (DODMERB) Report of Medical Examination) instead of the DD Form 2808, the examination is still valid for airborne training provided all required items of the physical examination have been recorded on the respective forms.

(7) Medical examinations are valid for 24 months from completion date of medical examination for entrance to all USAJFKSWCS schools. This includes SFAS; Special Forces Qualification Course (SFQC); MFF; Special Forces CDQC; and SERE training. (Military Freefall Jumpmaster, Dive Supervisor, and Diving Medical Technician (DMT) training are not initial qualification courses. As such, these courses only require a current MFF/CDQC physical that is valid for the period specified in 8–19c(2.) Candidates for DMT, not on dive status, require an initial CDQC physical to attend this school.)

(8) A current periodic medical examination for Active Army soldiers and ARNGUS and USAR soldiers will be valid for reenlistment, attendance at Army or civilian schools, ADT, and active duty for special work (ADSW) and temporary tour of active duty tours unless the specific school requires a shorter validity period (for example, special forces, diving school, or aviation training). (See para 8–19c for definition of a periodic medical examination for active and RC soldiers.) (Shorter validity periods for Army Schools must be prescribed by Army regulation or DA pamphlet.) The periodic examinations will be valid only if there has been no change in the soldier's medical condition since the last complete medical examination. USAR and ARNGUS soldiers will complete DA Form 3081 to indicate there has been no significant change since the last examination. See AR 600–110 for separate requirements for HIV testing.

(9) Medical examinations are valid for 18 months for entry into diving training (MOS 00B) and entry into training for aviation Classes 1/1A/2/3.

b. Except for flying duty, discharge, or release from active duty, a medical examination conducted for one purpose is valid for any other purpose within the prescribed validity periods, provided the examination is of the proper scope specified in table 8–1. If the examination is deficient in scope, only those tests and procedures needed to meet additional requirements need be accomplished and results recorded.

c. The periodic examination obtained from members of the ARNGUS and USAR as defined in paragraph 8–19c(4) will be valid for the purpose of qualifying for immediate reenlistment in ARNGUS and USAR, provided there has been no change in the individual's medical condition since his or her last complete medical examination. (See para 8–18 for requirements at mobilization or contingency operations.)

8–15. Procurement medical examinations

For administrative procedures pertaining to procurement medical examinations (para 2–1) conducted at MEPS, see AR 601–270/AFR 33–7/OPNAVINST 1100.4/MCO P–1100.75A. For procedures pertaining to appointment and enlistment in the ARNGUS and USAR, see chapters 9 and 10 of this regulation. For procedures pertaining to enrollment in the Army ROTC, see AR 145–1. For procedures pertaining to USMA and ROTC Scholarship applicants, see AR 40–29/AFR 160–13/NAVMEDCOMINST 6120.2/CG COMDTINST M6120.8.

8–16. Active duty for training, active duty for special work, and inactive duty training

a. Individuals on ADT/ADSW for 30 days or less are not required to undergo medical examinations prior to separation unless there is clinical indication for the examination.

b. An individual on ADT/ADSW will be given a medical examination if he or she incurs an injury during such training that may result in disability or he or she alleges medical unfitness or disability.

c. Evaluation of medical fitness will be based on the medical fitness standards contained in chapter 3.

8–17. Health records

Medical examiners will review the health record (AR 40–66) of each examinee whenever an examination is conducted for the purpose of relief from active duty, resignation, retirement, separation from the Service, or when accomplished in connection with a periodic medical examination, and will note any significant problems and follow-up as appropriate.

8–18. Mobilization of units and members of Reserve Components of the Army

A current periodic medical examination or a new medical examination is not required incident to mobilization or call-up for war or contingency operations. See paragraph 8–23 for requirements for separation examinations.

8–19. Periodic medical examinations

(See para 8–5 for distribution of reports.)

a. Application.

(1) A periodic medical examination is required for all officers, warrant officers, and enlisted personnel of the Army, regardless of component.

(2) Other than required medical surveillance, the periodic medical examination is not required for an individual who has undergone a medical examination within 1 year, the scope of which is equal to or greater than that of the required periodic medical examination. The soldier will be furnished DA Form 3081 to annotate, if he or she concurs, that there has been no change in his or her condition since the last examination.

(3) The examining physician will thoroughly investigate the examinee's current medical status. When medical history, the examinee's complaints, or review of any available past medical records indicate significant findings, these findings will be described in detail, using SF 507 (Clinical Record—Report on or Continuation of SF), if necessary. The physical profile will be reviewed and revised as appropriate. (See chap 7.)

(4) Soldiers will be found qualified for retention on active duty if they meet the requirements of chapter 3.

(5) Soldiers who do not meet the medical standards of chapter 3 will be referred to an MEB. However, for RC and ARNGUS soldiers not on active duty, see chapters 9 and 10.

(6) All reports of periodic medical examinations will be reviewed by a physician designated by the MTF commander. (Those administered by a MEPS will be reviewed by the Chief Medical Officer.)

(7) The examinee will be counseled on remedial conditions found upon examination (appointments will be made for the purpose of instituting care), continuing care for conditions already under treatment, and general health education matters including, but not limited to smoking, alcohol and drug abuse, weight control, and methods for correction.

(8) All personnel with potential hazardous exposures in their work environment for which medical surveillance examinations are required to ensure that there is no harmful effect to their health will receive appropriate medical surveillance examinations. Such examinations will be specific to job exposure.

b. Followup. Soldiers of the ARNGUS or USAR who are not on active duty will be scheduled for followup appointment and consultations at Government expense when authorized. Treatment or correction of conditions or remediable defects as a result of examination will be scheduled if authorized. If individuals are not authorized treatment, they will be advised to consult a private physician of their own choice at their own expense.

c. Frequency. (See chap 6 for aviators, ATCs, and FSs.)

(1) All general officers (brigadier general and above) on active duty will undergo an annual medical examination within 3 calendar months before the end of their birthday month.

(2) Special Forces/Ranger combat divers and MOS 00B divers must have an examination every 3 years. The examination for divers must be performed by or reviewed by a DMO or an FS trained in diving medicine. The examination for MFF parachutists must be performed every 5 years in conjunction with physiologic training.

(3) ALL OTHER PERSONNEL ON ACTIVE DUTY WILL UNDERGO A PERIODIC EXAMINATION WITHIN 3 CALENDAR MONTHS BEFORE THE END OF THE BIRTHDAY MONTH, AT AGES 30, 35, 40, 45, 50, 55, 60, AND ANNUALLY THEREAFTER. Periodic examinations of active duty soldiers prior to age 30 are not required. An examination completed within the 4 calendar months before the end of the anniversary month will be considered as having been accomplished during the anniversary month.

(4) All members of the Ready Reserve not on active duty will be examined at least once every 5 years. Army commanders, the Commander, AR–PERSCOM, and the Chief, NGB may, at their discretion, direct more frequent medical examinations in individual cases.

(5) All members of the Ready Reserves not on active duty will be screened for medical fitness annually. DA Form 7349 (Initial Medical Review—Annual Medical Certificate) will be used for all Select Reserve soldiers to record the results of this clinical screen. A medical exam will be accomplished, if, upon review of the form, it is clinically indicated. This form will be filed in the individual's health record. DA Form 3725 (Army Reserve Status and Address Verification) (AR 135–133) is used to meet the yearly screen for all other Individual Ready Reserve soldiers.

8–20. Frequency of additional/alternate examinations

a. Female examinations.

(1) In addition to the periodic medical examination, all women in the Army, regardless of age, on active duty or ADT/ADSW tours in excess of 1 year or Active Guard—Reserve (AGR) tours will undergo annual breast and pelvic examinations to include a cervical cytologic screening test for cancer. All women in the Army, under age 25, on active duty or ADT/ADSW tours in excess of 1 year or AGR tours will undergo a screening test for Chlamydia. These special examinations are mandatory and will be accomplished during the month of the soldier's birthday. Periodic medical examinations for ARNGUS and USAR soldiers not on active duty will include current (within 1 year) pelvic

examinations and a cervical cytologic screening test for cancer. Civilian test results attached to the periodic physical for ARNGUS and USAR soldiers not on active duty will be acceptable.

(2) All women in the Army on active duty (including AGR) or ADT tours in excess of 1 year will have a mammographic study accomplished at ages 40, 42, 44, 46, 48, and 50. After age 50, the study will be repeated annually. A record of the examination and test results will be maintained in the health record. More frequent mammographic studies may be performed if clinically indicated.

(3) Army applicants are not required to undergo a pelvic examination or a cytologic screening test. However, once enlisted or appointed, the provisions of paragraph 8–20(1) apply.

b. Medical surveillance examinations. The frequency of medical surveillance examinations varies according to job exposure. Annual or less frequent examinations will be performed during the birthday month. More frequent examinations will be scheduled during the birthday month and at appropriate intervals thereafter.

8–21. Deferment of examinations

a. Army-wide or at specific installations. In circumstances requiring Army-wide or installation deferment of periodic examinations (where conditions of the Service preclude the accomplishment of periodic examinations) because resources are being directed to other missions (for example, screening for mobilization/contingency operations, heavy casualties, etc.), requests for exceptions to policies deferring examinations will be forwarded to TSG (ATTN: DASG–HS–AS).

b. Soldiers in isolated areas. Periodic medical examinations may be delayed by the commander concerned for those soldiers stationed in isolated areas; that is, Army attaches, military missions, and MAAGs, where medical facilities of the U.S. Armed Forces are not available. Medical examinations so delayed will be accomplished at the earliest opportunity in conjunction with leave, temporary duty, or when the individuals concerned are assigned or attached to a military installation having a medical facility. Medical examination of such individuals for retirement purposes may not be delayed.

c. Other deferments. In exceptional circumstances, in the case of an individual soldier, where conditions of the service preclude the accomplishment of the periodic examination, it may be deferred by direction of the commander having custody of personnel files until such time as its accomplishment becomes feasible. An appropriate entry explaining the deferment will be made in the health record and on an SF 600 when such a situation exists.

8–22. Promotion

Officers, warrant officers, and enlisted personnel, regardless of component, are considered medically qualified for promotion on the basis of the periodic medical examination outlined in paragraph 8–20*d*.

8–23. Separation and retirement examinations

a. Soldiers separating from the Army will be given a medical interview using DD Form 2697. The interview will be conducted by a physician, physician assistant, or nurse practitioner to document any complaints or potential service–related (incurred or aggravated) illness or injury. The soldier must acknowledge with his or her signature in block 19 of the form that the information provided is true and complete. This form will be filed in the health record; a copy will be furnished to the Department of Veterans Affairs (VA). See paragraph 8–23*i* for hepatitis screening requirements.

b. Soldiers separating from the Army will receive a separation medical examination if the soldier requests it, or if, on review of the medical records or the DD Form 2697, a physician, a physician assistant, or a nurse practitioner feels an examination is appropriate (with exception noted in *c* below). See table 8–2 for additional requirements based on the type of discharge. See *d* below for soldiers retiring from active service.

c. ARNGUS or USAR soldiers ordered to active duty for war, national emergency, or Presidential Select Reserve Call-Up (10 USC 12301(a), 12302, or 12304) will undergo medical screening prior to mustering out of Federal service (ARNGUS) or release from active duty (USAR). The scope of this screening (for example, medical interview with an examination if clinically indicated vs. a complete medical examination) will be determined by TSG prior to separation based on length of the mobilization/contingency operation and occupational exposures of the soldiers. However, all soldiers, as a minimum, will complete DD Form 2697 prior to mustering out of Federal service or release from active duty in accordance with *a* above.

d. Soldiers retiring from active service are required to undergo a medical examination prior to retirement (DD Form 2808 and DD Form 2807–1 will be completed), and will complete DD Form 2697.

e. Soldiers in paragraphs *a*, *b*, *c*, and *d* above who have indicated on DD Form 2697 that they intend to seek VA disability compensation or who have been referred to the Army Disability Evaluation System for determination of fitness will be given a standard VA compensation and pension physical in addition to any other examinations required by this regulation, AR 40–400, or AR 635–40. For those soldiers, the service medical record, proof of line of duty (LOD) determination, if necessary, and recent laboratory, radiological, and all other associated test results should accompany the claimant for VA benefits to the place of examination so that testing is not duplicated. A complete Review of Systems that documents the individual's physical condition at the time of separation from the military service shall also be conducted as part of the physical examination to minimize duplication. The location for the performance of such VA compensation examination, as well as which facilities shall be used for the laboratory,

radiological, and other specialized testing, will be determined by the MTF commander and the VA medical center director and will be clearly delineated in a cost-neutral memorandum of understanding between the respective facilities.

f. Voluntary requests for medical examinations should be submitted to the commander of the servicing MTF not earlier than 4 months nor later than 1 month prior to the anticipated date of separation or retirement (or if applicable and requested by the soldier, 4 months prior to transition leave). If the examination is accomplished earlier than 4 months, paragraph 8–23g applies.

g. When accomplished incident to retirement, discharge, or release from active duty, medical examinations are valid for a period of 12 months from the date of examination. If the examination is accomplished more than 4 months prior to release from active duty, discharge, or retirement (or 4 months prior to transition leave date if the soldier requests it), DA Form 3081 will be attached to the original DD Form 2808.

h. Soldiers who have been in medical surveillance programs because of hazardous job exposure will have a clinical evaluation and specific laboratory tests accomplished prior to separation even though a complete medical examination may not be required.

i. Soldiers requesting HCV screening will be tested. If the test is positive, medical evaluation to confirm HCV infection, to determine the need for specific treatments, and to provide counseling on lifestyle modifications and steps to protect others from infection will be accomplished. The following statements will overprinted on a DA Form 4700 (Medical Record—Supplemental Medical Data), administered and placed in the medical record for all soldiers separating or retiring from active duty:

(1) *Hepatitis C virus (HCV) is transmitted primarily by injections (for example, blood transfusions, contaminated needles, or sticks with contaminated sharp objects) of contaminated blood. The following are possible sources of HCV infection. If you can answer “yes” to any of these risk factors, you should receive a sample blood test to determine if you could have HCV. If you consider yourself at risk, based on an exposure to a possible source of HCV, you should have a simple blood test for HCV. You will not be asked to identify any specific risk factors to justify HCV testing. If the test is positive, you will receive a medical evaluation to confirm HCV infection, determine your need for specific treatments, and be provided counseling on lifestyle modifications and steps to protect others from infection.*

(2) *Risk factors are—*

(a) *Receiving a transfusion of blood or blood products before 1992.*

(b) *Ever injecting illegal drugs, including use once many years ago.*

(c) *Receiving clotting factor concentrates produced before 1987.*

(d) *Having chronic (long term) hemodialysis.*

(e) *Being told that you have persistent abnormal liver enzyme tests (alanine aminotransferase) or an unexplained liver disease.*

(f) *Receiving an organ transplant before July 1992.*

(g) *Having a needle stick, sharps, or mucosal exposure to potentially HCV-infected blood as part of your occupational duties and not having been previously evaluated for HCV infection.*

(3) *If the test is positive, you will receive a medical evaluation to confirm HCV infection, determine your need for specific treatments, and be provided counseling on lifestyle modifications and steps to protect others from infection.*

(4) *Circle yes or no to the following responses and sign and date.*

(a) *No—I do not want to be tested for HCV.*

(b) *Yes—I want to be tested for HCV.*

(c) *Signature and date.*

8–24. Miscellaneous medical examinations

a. *SFAS, SFQC, MFF parachutists, Special Forces/Ranger Combat divers, and SERE medical examination reports.*

(1) Entrance into SFAS, SFQC, MFF parachuting, Special Forces/Ranger Combat diving, and SERE training will only be accomplished after meeting the medical fitness standards documented by the completion of the appropriate physical exam. The completed DD Form 2808 and DD Form 2807–1 (and supporting documents) must be reviewed and stamped “approved” by the U.S. Army Special Operations Command (USASOC) Surgeon’s Office, or the surgeon’s office that is designated by the USASOC Surgeon’s Office as having review and approval authority.

(2) The Commander, USAJFKSWCS is the waiver authority for USAJFKSWCS schools. Individuals not meeting the medical fitness standards for USAJFKSWCS training courses will have their physicals and requests for waiver forwarded to Commander, USASOC, ATTN: AOMD–MT, Fort Bragg, NC 28307–5217.

b. *Certain geographic areas.*

(1) When an individual is alerted for movement to or is placed on orders for assignment to the system of Army attaches, military missions, MAAGs, or to isolated areas, the commander of the station to which he or she is assigned will refer the individual and his or her dependents, if any, to the medical facility of the command.

(2) The physician of the facility will carefully review the health records and other available medical records of these individuals. Medical fitness standards and factors to consider in the evaluation are contained in paragraph 5–13. Review of the medical records will be supplemented by personal interviews with the individuals to obtain pertinent

information concerning their state of health. The physician will consider such other factors as length of time since the last medical examination, age, and the physical adaptability of the individual to the new area.

(3) If, after review of records and discussion, it appears that a complete medical examination is indicated, a medical examination will be accomplished.

(4) The commander having processing responsibility will ensure that this medical action is completed prior to the individual's departure from his or her home station.

(5) If, as a result of his or her review of available medical records, discussion with the individual and his or her dependents, and findings of the medical examination, if accomplished, the physician finds the individual medically qualified in every respect under paragraph 5–14c and qualified to meet the conditions that will be encountered in the area of contemplated assignment, he or she will complete and sign DA Form 3083 (Medical Examination for Certain Geographical Areas) prior to PCS. A copy of this statement will be filed in the health record or outpatient record (AR 40–66) and a copy forwarded to the commander who referred the individual to the medical facility.

(6) If the physician finds a dependent member of the family disqualified for the proposed assignment, he or she will notify the commander of the disqualification. The examiner will not disclose the cause of the disqualification of a dependent to the commander without the consent of the dependent, if an adult, or a parent if the disqualification relates to a minor. If the soldier or dependent is considered disqualified temporarily, the commander will be so informed and a re-examination scheduled following resolution of the condition.

(7) If the disqualification of the soldier is permanent or if it is determined that the disqualifying condition will be present for an extended period of time, the physician may refer the soldier to a medical board if the soldier does not meet medical retention standards. DA Form 3349 will be completed outlining specific limitations.

8–25. Cardiovascular Screening Program

a. The CVSP is required at the time of the periodic examination for all active duty, ARNGUS, and USAR (Selective Reserve) soldiers age 40 and older.

b. The examination will consist of:

- (1) Physical examination (DD Form 2808).
- (2) Fasting blood sugar.
- (3) Fasting lipid profile, including total cholesterol, LDL, HDL, and triglycerides.
- (4) EKG.
- (5) Smoking history.
- (6) Blood pressure.

c. Medical followup by a health practitioner qualified to measure, interpret and treat cardiovascular risk factors for soldiers who meet one or more of the following criteria: Use of tobacco products (any current use of cigarettes; frequent (daily) use of cigars).

d. Medical followup by a physician qualified to measure, interpret and treat cardiovascular risk factors for soldiers who meet one or more of the following criteria:

(1) A HDL cholesterol less than 35 mg/dL for men, less than 45 mg/dL for women, a LDL cholesterol greater than 160 mg/dL, triglycerides greater than 400 mg/dL or non-HDL cholesterol greater than 190 mg/dL (if LDL cholesterol is unavailable).

(2) A systolic blood pressure equal to or greater than 140 mm Hg, or a diastolic blood pressure equal to or greater than 90 mm Hg. (Followup is not necessary if 3 day serial blood pressure readings do not confirm elevated blood pressures.)

(3) Elevated fasting blood sugar greater than 115 mg/dL.

(4) Abnormal Q waves or other electrocardiographic findings suspicious for possible heart disease.

(5) Other medical conditions as defined by paragraphs 2–18 and 3–21 through 3–24.

(6) Any symptom (chest pain, dizziness, claudication, shortness of breath) that is suspicious for possible cardiac or atherosclerotic etiology. In the case of acute cardiac findings, immediate/emergency referral will be made.

e. The purpose of medical referral is to confirm the presence of a modifiable coronary risk factor and to advise and initiate medically appropriate treatments with the intent to modify cardiovascular risk. This followup may take place at the original examination site depending on availability of personnel (for example, smoking cessation counseling).

Note. If the soldier is already under treatment and the values are normal while on treatment, a separate referral for the purpose of the CVSP is not required. The medical records need to document the medical history, what treatment the soldier is currently under, and where the soldier is obtaining the treatment. If the values are not normal, the soldier will be referred back to his or her primary care provider for further care.

f. RC soldiers will be referred to their own medical provider outside of the military system for any further followup evaluation, treatment, etc. The soldier will provide copies of any records from their civilian medical provider pertaining to the evaluation for inclusion in their military medical health record.

g. Medical records will be annotated that any required referrals have been made. All evaluations and recommendations from the medical followup examination on active and RC soldiers will be placed in the medical record.

h. For all soldiers upon reaching the age of 40, there is no need to require the cardiovascular screen prior to continuing PT and participating in the APFT. However, if a physician feels a profile restricting physical activity is warranted, the physician will complete the medical profile DA Form 3349 in accordance with chapter 7.

8-26. Speech Recognition in Noise Test for H3 profile soldiers

a. The Speech Recognition in Noise Test (SPRINT) will be used by audiologists at all Army facilities to assess all H-3 soldiers to provide recommendations concerning a potential communication handicap.

b. The tape-recorded test consists of monosyllabic words from the NU-6 lists in a background of speech babble noise. Normative data has been developed (see fig 8-1) so that the soldier's score can be compared to a large sample of H-3 soldiers' scores. This score, as a function of the soldier's length in service, will be used to determine an appropriate recommendation based on table 8-3.

c. These recommendations should be made to MMRBs and MEBs, and considered when completing the physical profile assignment limitations on DA Form 3349. The recommendations provide appropriate information with which the boards can make a final determination.

Table 8-1
Recording of medical examination¹

Item box number		Explanatory notes and Model entries (Model entries are in parentheses) Refer to the glossary for acronyms and abbreviations used
1	(Date of examination)	Enter the date on which the medical examination is accomplished.
2	(Social security number)	Examinee's social security number. (SSN 396-38-0699)
3	(Name)	The entire last name, first name, and middle name are recorded. When Jr. or similar designation is used, it will appear after the middle name. (Jackson, Charles John)
4	(Home address)	Examinee's current mailing address (not the "home of record"—if different) (Street number, City, State, Zip Code or Unit mailing address)
5	(Telephone number)	Enter telephone number where the examinee can be reached—home or unit (202-555-1212)
6	(Grade)	Enter examinee's grade (E8, O4)
7	(Date of birth)	Record as year, month, day
8	(Age)	List years of age at the time of examination (28 yr.)
9	(Sex)	Check female or male
10	(Race)	Check the applicable block
11	(Years of government service)	Not required
12	(Agency if not DOD)	To be used by other agencies as appropriate
13	(Organization unit)	The examinee's current military unit of assignment, Active or Reserve. If no current military affiliation, enter a dash. (for example, "B Company, 2D BN, 325th, Inf, 82nd Airborne Division, Fort Bragg, NC 28307-5100")
14a	(Rating or specialty) (Aviators only)	Not required on Army examinations unless directed by USAAMC
14b	Total Flying Time (Aviators only)	Not required on Army examinations unless directed by USAAMC
14c	Last 6 Months (Flying Time - Aviators only)	Not required on Army examinations unless directed by USAAMC.
15a	(Service)	Check the appropriate service
15b	(Component)	Check the appropriate component
15c	(Purpose of examination)	Check or enter the purpose of the examination.
16	(Name of examining facility)	Name of the examining facility or examiner and address. If an APO, include local national location (Military Entrance Processing Station, 310 Gaston Ave., Fairmont, WV 12441-3217).

Table 8-1
Recording of medical examination¹—Continued

Item box number		Explanatory notes and Model entries (Model entries are in parentheses) Refer to the glossary for acronyms and abbreviations used
17 ²	(Head, face, neck, scalp)	Record all swollen glands, deformities, or imperfections of the head or face. If a defect of the head or face, such as moderate or severe acne, cyst, exostosis, or scarring of the face is detected, a statement will be made as to whether this defect will interfere with the wearing of military clothing or equipment. If enlarged lymph nodes of the neck are detected they will be described in detail and a clinical opinion of the etiology will be recorded.
18	(Nose)	Record all abnormal findings. Record estimated percent of obstruction to airflow if septal deviation, enlarged turbinates, or spurs are present.
19	(Sinuses)	Record all abnormal findings ("Marked tenderness over left maxillary sinus").
20	(Mouth, throat)	Record any abnormal findings. Enucleated tonsils are considered abnormal. (Tonsils enucleated)
21	(Ears)	If operative scars are noted over the mastoid area, a notation of simple or radical mastoidectomy will be entered (for example, "Bilateral severe swelling, injection and tenderness of both ear canals").
22	(Eardrums)	Record all abnormal findings. In the event of scarring of the tympanic membrane, the percent of involvement of the membrane will be recorded as well as the mobility of the membrane. If tested, a definite statement will be made as to whether the eardrums move on valsalva maneuver or not and also noted in item 72b.
23	(Eyes)	Record abnormal findings. If ptosis of lids is detected, a statement will be made as to the cause and extent of the interference with vision. When pterygium is found, the following should be noted: <ol style="list-style-type: none"> 1. Encroachment on the cornea, in millimeters, 2. Progression, 3. Vascularity. <p>For example, "Ptosis, bilateral, congenital. Does not interfere with vision. Pterygium, left eye, 3mm encroachment on cornea; nonprogressive, avascular."</p>
24	(Ophthalmoscope)	Whenever opacities of the lens are detected, a statement is required regarding size, progression since last examination, and interference with vision (for example, "Redistribution of pigment, macular, Rt eye, no loss of visual function. No evidence of active organic disease").
25	(Pupils)	Record all abnormal findings.
26	(Ocular motility)	Record all abnormal findings.
27	(Heart)	Abnormal heart findings are to be described completely. Whenever a cardiac murmur is heard, the time in the cardiac cycle, the intensity, the location, transmission, effect of respiration, or change in the position, and a statement as to whether the murmur is organic or functional will be included. When murmurs are described by grade, indicate basis of grade (for example, "Grade II/IV soft, systolic murmur heard only in pulmonic area and on recumbency, not transmitted. Disappears on exercise and deep inspirations, physiological murmur").
28	(Lungs and chest)	Lungs: If rales are detected, state cause. The examinee will be evaluated on the basis of the cause of the pulmonary rales or other abnormal sounds and not simply on the presence of such sounds (for example, "Sibilant and sonorous rales throughout chest. Prolonged expiration"). Breast exam: Note location, size, shape, consistency, discreteness, mobility, tenderness, erythema, dimpling over the mass, etc.
29	(Vascular system)	Adequately describe any abnormalities. When varicose veins are present, a statement will include location, severity, and evidence of venous insufficiency (for example, "Varicose veins, mild, posterior superficial veins of legs. No evidence of venous insufficiency").
30	(Anus, rectum) (Prostate if indicated)	A definite statement will be made that exam has been performed. Note surgical scars and hemorrhoids in regard to size, number, severity, and location. Check fistula, cysts, and other abnormalities (for example, "One small external hemorrhoid, mild. Digital rectal normal. Stool guaiac negative"). In prostate exam note grade of prostatic enlargement, surface, consistency, shape, size, sensitivity, mobility.
31	(Abdomen, viscera)	Include hernia. Note any abdominal scars and describe the length in inches, location, and direction. If a dilated inguinal ring is found, a statement will be included in item 31 as to the presence or absence of a hernia (2-inch linear diagonal scar, right lower quadrant).

Table 8–1
Recording of medical examination¹—Continued

Item box number	Explanatory notes and Model entries (Model entries are in parentheses) Refer to the glossary for acronyms and abbreviations used
32 (External genitalia)	Describe any abnormalities. Include results of testicular exam on males.
33 (Upper extremities)	Record any abnormality or limitation of motion. If applicant has a history of previous injuries or fracture of the upper extremity, as, for example, a history of a broken arm with no significant finding at the time of examination, indicate that no deformity exists and function is normal. A positive statement is to be made even though the “normal” column is checked. If a history of dislocation is obtained, a statement that function is normal at this examination, if appropriate, is desired (for example, “No weakness, deformity, or limitation of motion, left arm”).
34 (Lower extremities)	Record any abnormality or limitation of motion. If applicant has a history of previous injuries or fracture of the lower extremity, as, for example, a history of a broken leg with no significant finding at the time of examination, indicate that no deformity exists and function is normal. A positive statement is to be made even though the “normal” column is checked. If a history of dislocation is obtained, a statement that function is normal at this examination, if appropriate, is required (for example, “No weakness, deformity, or limitation of motion, left leg”).
35 (Feet)	Record any abnormality. When flat feet are detected a statement will be made as to the stability of the foot, presence of symptoms, presence of eversion, stable, bulging of the inner border, and rotation of the astragalus. Pes planus will not be expressed in degree but should be recorded as mild, moderate, or severe (for example, “Flat feet, moderate. Foot asymptomatic, no eversion or bulging; no rotation”). Circle category relating to arch, degree, and symptoms.
36 (Spine, other musculoskeletal)	Include pelvis, sacroiliac, and lumbosacral joints. Check history. If scoliosis is detected, the amount and location of deviation in inches from the midline will be stated.
37 (Identifying body marks)	Only scars or marks of purely identifying significance or those that interfere with function are recorded here. Tattoos that are obscene or so extensive as to be unsightly will be described fully (for example, “1-in. vertical scar, dorsum; 3-in. heart–left forearm; shaped tattoo, lateral aspect middle 1/3 left arm”).
38 (Skin)	Describe pilonidal cyst or sinus. If skin disease is present, its chronicity and response to treatment should be recorded. State also whether the skin disease will interfere with the wearing of military clothing or equipment (for example, “Small discrete angular, flat papules of flexor surface of forearms with scant scale; violaceous in color; umbilicated appearance and tendency to linear grouping”).
39 (Neurologic)	Record complete description of any abnormality.
40 (Psychiatric)	Record all abnormalities. Before a psychiatric diagnosis is made, a minimum psychiatric evaluation will include Axis I, II, and III.
41 (Pelvic)	Note type of exam (for example, “bi-manual”). Record any abnormal findings. (See item 52a for pap smear.)
42 (Endocrine):	Describe every abnormality noted.
43 (Dental)	Examining physicians will apply the appropriate standards prescribed by chapters 2, 3, 4, or 6, and indicate “acceptable” or “non-acceptable.” This does not replace the required annual dental examination by a dentist or the dentist’s determination of the appropriate dental classification.
44 (Notes)	Describe every abnormality noted. Enter pertinent item number before each comment. Continue in item 73 if necessary.
45 ³ (Urinalysis) a. Albumin b. Sugar	Record results (For other urine microscopic or specific gravity, record in box 52c.)
46 (Urine HcG)	Record results
47 (Hemoglobin/hematocrit)	Record Results
48 Blood Type	Record Results
49 (HIV)	Record date, results, add HIV specimen ID label in indicated section.
50 (Drugs)	Record results of Drug Tests, add Drug Test Specimen ID to indicated space.
51 (Alcohol)	Record results of alcohol screen
52 (Other / results)	52a (use to record results of pap smear) 52b (use to record PSA result) 52c (use to record urine microscopic or urine specific gravity.)

Table 8-1
Recording of medical examination¹—Continued

Item box number		Explanatory notes and Model entries (Model entries are in parentheses) Refer to the glossary for acronyms and abbreviations used
53	(Height)	Record in inches to the nearest quarter inch (without shoes). For initial Classes 1 and 1A, initial Class 2 (Aviator), and continuance Class 2 (Aviator) not previously measured: Leg length, sitting height, and functional arm reach will be measured, in accordance with Aeromedical policy letters.
54	(Weight)	Record in pounds to the nearest whole pound (in PT clothes without shoes, or hospital gown).
55	(Maximal allowable weight)	This item is for accession medical examinations only. This does not replace the official weigh-in for soldiers in conjunction with the APFT and AR 600-9
56	(Temperature)	Record in degrees Fahrenheit to the nearest tenth
57	(Pulse)	Record with arm at heart level
58 a,b,c	(Blood pressure)	Record Results (for example, "110/76") (59 b and c are only required if a is elevated).
59	(Red/green vision test)	If examinee fails the color vision tests in item 67, he or she will be tested for Red/green color vision and results recorded as "Pass" or "Fail" (See also item 66)
60	(Other eye or vision test)	For example, results of red lens test.
61	(Distant vision)	Record in terms of the English Snellen Linear System (20/20, 20/30, etc.) of the uncorrected vision of each eye. If uncorrected vision of either eye is less than 20/20, entry will be made of the corrected vision of each eye (for example, "Right 20/50 corr to 20/20 and Left 20/70 corr to 20/20").
62	(Refraction)	The word "manifest" or "cycloplegic," whichever is acceptable, will be entered after refraction. An emmetropic eye will be indicated by plano or 0. For corrective lens, record refractive value (for example, "Right By -1.25 S - 0.25 CX 005. Left By -1.75 S - 0.25 CX 175").
63	(Near vision)	Record results in terms of reduced Snellen. Whenever the uncorrected vision is less than normal (20/20), enter the corrected vision for each eye and lens value after the word "by" (for example, "Right 20/40 corr to 20/20 by Same and Left 20/40 corr to 20/20 by + 0.50").
64	(Heterophoria)	Identify the test used; for example, either Maddox Rod or Stereoscope, Vision Testing (SVT), and record results, Prism Div not required. All subjective tests will be at 20 feet or at a distance setting of the SVT. Record distance interpupillary distance (PD) in mm (for example, "ES deg. 4 EX Deg. 0. R.H. 0 L.H. 0., PD 63").
65	(Accommodation)	Record values without using the word "diopters" or symbols (for example, "Right 10.0; Left 9.5").
66	(Color vision)	Record results in terms of test used, the results and the number of plates missed over number of plates in test. The FALANT (USN) may be utilized. If the examinee fails either of these tests, he or she will be tested for Red/Green vision and the results recorded in item 59 (for example, "PIP, pass, 3/14 or PIP, fail, 9/14").
67	(Depth perception)	Identify the test used. Record the results "Corrected" or "Uncorrected," as applicable. Enter the score for Verhoeff or VTA as "pass" or "fail" plus the number missed over maximum score for that test (for example, "Verhoeff pass 0/8; VTA pass through D; VTA fail 1/9. Randot circles pass 0/10").
68	(Field of vision)	Identify the test used and the results. If a vision field defect is found or suspected in the confrontation test, a more exact perimetric test is made using a perimeter and/or tangent screen. Findings are recorded on a visual chart and described in item 77. Copy of the visual chart must accompany the original DD Form 2808 (for example, "Confrontation test: Normal, full").
69	(Night vision)	Test used and Score
70	(Intraocular tension)	Identify type of test used: applanation or non-contact. Record results numerically in millimeters of mercury of intraocular pressure. Describe any abnormalities (for example, "Normal O.D. 18.9 O.S. 17.3").
71a,b	(Audiometer)	Test and record results at 500, 1000, 2000, 3000, 4000, and 6000 Hertz using procedures prescribed in DA Pam 40-501. (71b is used for repeat tests if applicable)
72a	(Read Aloud Test)	Enter RAT satisfactory or unsatisfactory
72b	(Valsalva)	Enter satisfactory or unsatisfactory

Table 8-1
Recording of medical examination¹—Continued

Item box number	Explanatory notes and Model entries (Model entries are in parentheses) Refer to the glossary for acronyms and abbreviations used
73 (Notes)	Examiner will enter notes on examination as necessary. Significant medical events in the individual's life, such as major illnesses or injuries and any illness or injury since the last in-service medical examination, will also be entered. Such information will be developed by reviewing health record entries and questioning the examinee. Complications or sequelae, or absence thereof, will be noted where appropriate. Comments from other items may also be continued in this space. This space is also used for additional tests when there is no specific box for the test on the DD 2808. For instance enter the results, if accomplished, of EKGs, chest x-rays, FBS, Fasting lipid profile, cholesterol, occult blood tests, sickle cell screens. Overprints or stamps may be used in this space.
74a ⁴ (Examinee/applicant qualification)	Indicate is qualified or not qualified for service. NOTE: EXAMINER SHOULD CORRESPOND THIS WITH THE PURPOSE OF THE EXAMINATION AS CHECKED IN ITEM 15c AND MUST CHECK EITHER QUALIFIED OR UNQUALIFIED IN THIS SECTION AND INSERT WHAT THE SOLDIER/APPLICANT IS QUALIFIED FOR (FOR EXAMPLE, "QUALIFIED FOR ACCESSION (Chap 2); QUALIFIED FOR RETENTION (Chap 3); QUALIFIED FOR SEPARATION (Chap 3); QUALIFIED FOR RETIREMENT (Chap 3)").
74b (Physical profile)	The physical profile as prescribed in chapter 7 will be recorded. Any permanent profile with above a numerical designator of 1 should have a DA Form 3349 attached (for example, "111121").
75 (Signature of examinee)	The examinee will sign the DD Form 2808 if he/she has a disqualifying condition to indicate that he/she has been advised of the disqualifying condition
76 (Significant or Disqualifying Defects)	List the significant or disqualifying defects. On accession exams, list the correct ICD 9 code from chapter 2 that corresponds to the disqualifying condition. Any medical waivers for accession should also be noted here.
77 (Summary of defects)	Summarize medical and dental defects considered to be significant. Those defects considered serious enough to require disqualification or future consideration, such as waiver or more complete survey, must be recorded. Also record any defect that may be of future significance, such as nonstatic defects that may become worse. Enter item number followed by a short, concise diagnosis; do not repeat the full description of a defect that has already been described under the appropriate item. Do not summarize minor, non-significant findings.
78 (Recommendations)	Notation will be made of any further specialized examinations or tests that are indicated.
79 (MEPS WORKLOAD)	(MEPS use only)
80 (Medical inspection date and physicians signature)	Used at the MEPS and includes inspection prior to movement to basic training of ht, wt, body fat if applicable, pregnancy test and a note of qualified or unqualified. The physician signature is the physician who has done the inspection and should not be confused with items 83-85 that are the signatures of the medical examiners who accomplished and reviewed the medical examination.
81-84 (Physician or examiner)	Enter the typed or printed names of examiner and signature (physician, PA or NP). If examination is not performed by a physician, a physician must co-sign the form in item 82a.
85 Administrative review	Any administrative review should be noted here by the signature of the reviewer, grade and date. Also indicate the number of attached sheets if applicable.
86 (Waiver Granted)	Indicate if a waiver was granted, date and by whom.
87 (Number of attached Sheets)	List the number of any attached sheets needed.

Notes:

¹ Not all items are required on all examinations. See paragraph 8-12 to determine the scope of the examination based on the purpose of the examination.

² Note on the DD Form 2808, items 17 through item 39, the examiner must check normal, abnormal or NE (not examined). All abnormalities will be described in item 44 and continued in items 73 and 77 if needed.

³ On page two of the DD 2808, re-enter the name and social security number of the examinee in the spaces provided.

⁴ On page three of the DD 2808, re-enter the name and social security number of the examinee in the spaces provided.

Table 8–2
Schedule of separation medical examination*

Action	Required	Not Required	Can be requested by soldier (in writing)
Retirement after 20 years or more of active duty	X		
Retirement from active service for physical disability, permanent or temporary, regardless of length of service.	X		
Expiration of term of active service (separation or discharge, less than 20 years of service).		X	X
Upon review of health record, evaluating physician or physician assistant at servicing MTF determines that, because of medical care received during active service, medical examination will serve the best interests of soldier and Government: for example, hospitalization for other than diagnostic purposes within 1 year of anticipated separation date.	X		
Individual is member of the ARNGUS on active duty or ADT in excess of 30 days.		X	X
Individual is member of the ARNGUS and has been called into Federal service (10 USC 3501). (See paragraph 8–23 <i>b</i> .)			
Prisoners of war, including internees and repatriates, undergoing medical care, convalescence or rehabilitation, who are being separated.	X		
Officers, warrant officers, and enlisted soldiers previously determined eligible for separation or retirement for physical disability but continued on active duty after complete physical disability processing (AR 635–40, chapter 6, and predecessor regulations).	X (Plus MEB and PEB)		
Officers and warrant officers being processed for separation under provisions of specific sections of AR 635–100 that specify medical examination and/or mental status evaluation.	X		
Officers and warrant officers being processed for separation under provisions of specific sections of AR 635–100, when medical examination and/or mental status evaluation is not a requirement.		X	X
Enlisted soldiers being processed for separation under provisions of AR 635–200, chapters 5 (paras 5–3, (involuntary separations only), 5–11, and 5–12 only), 8, 9, 11 (para 11–3 <i>b</i> only), 12, and 18.	X		
Enlisted soldiers being processed for separation under provisions of AR 635–200, chapters 13, 14, (sec III only), and 15 (both mental evaluation and medical examination required).	X		
Enlisted soldiers being processed for separation under provisions of AR 635–200, chapter 10. (If a medical examination is requested by the soldier, then mental status evaluation is required.)			X
Discharge in absentia (officers and enlisted soldiers):			
Civil confinement.		X	
When a Bad Conduct Discharge or a Dishonorable Discharge is upheld by appellate review and the individual is on excess leave.		X	
Deserters who do not return to military control.		X	
Enlisted soldiers being processed for separation under all other provisions of AR 635–200 not listed above.		X	X

Notes:

* See paragraph 8–23 for additional information on medical examinations for separation/retirement.

Table 8-3
Results of Speech Recognition in Noise Test (SPRINT)

Categories and Recommendations

A	Retention in current assignment.
B	Retention in current assignment with restrictions.
C	Reassignment to, or retention in, non-noise hazardous area of concentration (AOC)/MOS.
D	Discretionary. (The audiologist should make a recommendation of Category C or E based on such factors as stability of loss, potential for further noise exposure, the soldier's AOC/MOS, and the recommendation of the soldier's commander. However, if the soldier has 18 or more years of active Service, the audiologist may recommend Category B.)
E	Separation from service.

CATEGORY	RECOMMENDATION
A	Retention in current assignment
B	Retention in current assignment with restrictions
C	Re-assignment to (or retention in) non-noise hazardous AOC/MOS
D	Discretionary **
E	Separation from service

** For soldiers falling in category D, the audiologist can make a recommendation associated with any category adjacent to Category D. Except for patients with 18+ years on active duty (for which a Category B recommendation could be made), this choice will be between Category C (re-assignment) or Category E (separation). The decision of which recommendation to make should be based on such factors as stability of loss, potential for further noise exposure, the soldier's AOC/MOS, and the recommendation of the local commander.

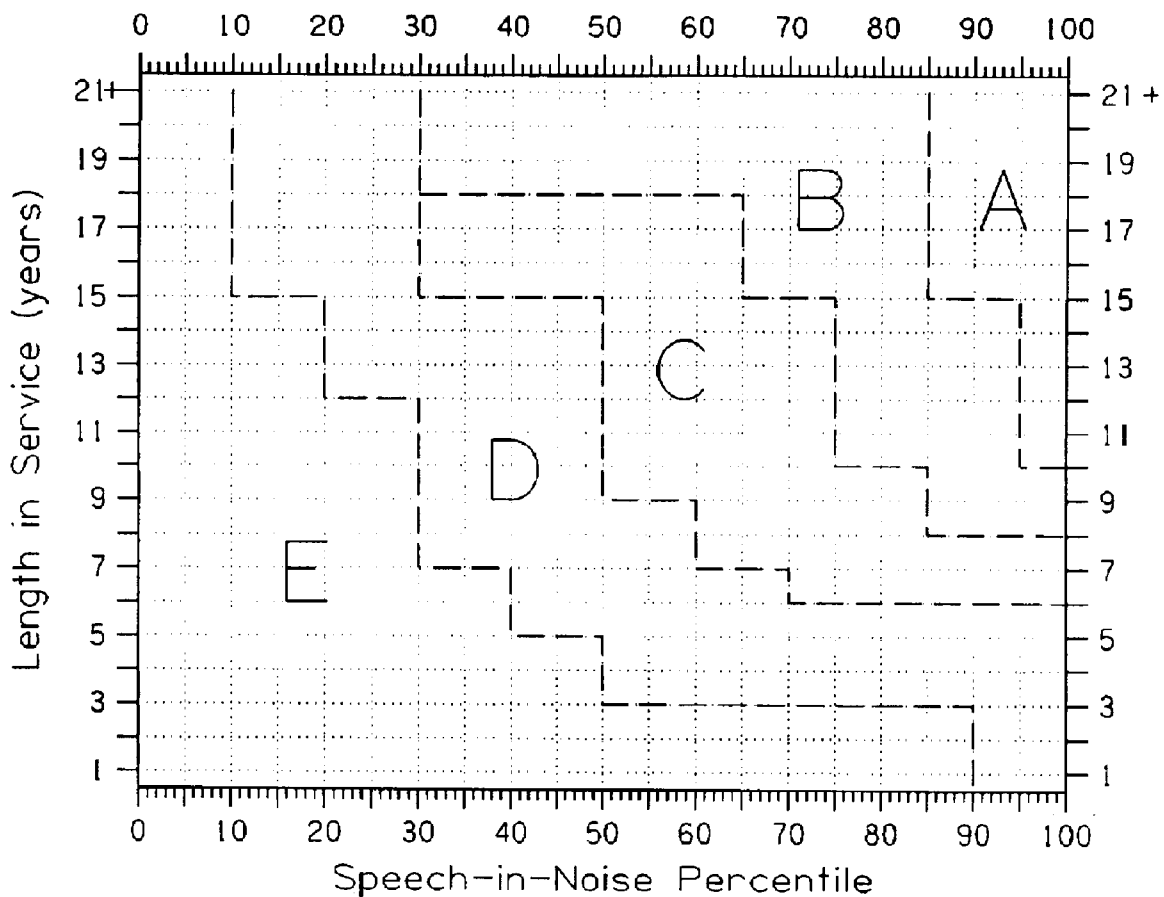


Figure 8-1. Normative data from Speech Recognition in Noise Test

Chapter 9

Army Reserve Medical Examinations

9-1. General

This chapter sets basic policies and procedures for medical examinations. It covers those examinations used to medically qualify individuals for entrance into and retention in the USAR. For policies specific to aviation, see chapter 6.

9-2. Application

a. This chapter applies to the following personnel:

(1) Applicants seeking to enlist or be appointed as commissioned or warrant officers in the USAR. (Medical examinations for entrance into the Army ROTC program are governed by AR 145-1 and AR 145-2.)

(2) USAR members who want to be kept in an active Reserve status.

(3) USAR members who want to enter ADT and active duty.

b. This chapter does not apply to the Active Army or the ARNGUS.

9-3. Responsibility for medical fitness

It is the responsibility of Reservists to maintain their medical and dental fitness. This includes correcting remedial defects, avoiding harmful habits, and controlling weight. It also includes seeking medical advice quickly when they believe their physical well-being is in question.

9-4. Examiners and examination facilities

a. Applicants with prior service and RC soldiers must present a letter of authorization to MEPS or Army medical facilities to receive a medical examination. (Applicants for initial enlistment who do not have prior military service will be examined only at MEPS.)

b. See paragraph 8-7b for examination facilities.

9-5. Examination reports

For all examinations, the examiner will prepare and sign two copies each of DD Form 2808 and DD Form 2807-1. The examining facility will keep one set of these reports. The medical examiner will send the other set of these reports to the commander who authorized the examination. The authorizing commander will then handle these two reports as follows.

a. Reports prepared in examinations for appointment will accompany the application for appointment per AR 135-100.

b. Reports prepared in examinations of ready Reservists will be sent to the unit administrator. If the examination was not accomplished at a military medical facility or at the MEPS, the reports will then be sent to the review authorities named in paragraph 9-9. After review, they will be returned to the unit administrator to be filed in the Reservist's health record. (To ensure against loss, the unit administrator should keep a copy of the reports when sending them for review.)

9-6. Conduct of examinations

a. Medical examinations will be performed per chapter 8. Immunizations should be updated when Reservists are examined. (See AFJI 48-110/AR 40-562/BUMEDINST 6230.15/CG COMDTINST M6230.4E for instructions on updating immunizations.)

b. See paragraph 8-14 for validity periods for medical examinations.

9-7. Types of examinations and their scheduling

a. For periodic examinations, including Special Forces, see chapter 8.

b. Ready Reservists released from active duty or ADT must take their first periodic examination in accordance with paragraph 8-19c(4).

c. Commanders will take proper action against obligated Ready Reservists who fail to take their required periodic examinations.

9-8. Physical profiling

a. Examiners will determine and record physical profiles for Reservists per chapter 7.

b. Profiling officers should be available within USAR medical units.

9-9. Examination reviews

Review of periodic examinations for RC soldiers not on active duty is normally not required if the examination is accomplished at Army medical facilities or MEPS. Chief, USAR or his or her designee may initiate additional reviews if appropriate. (See chap 6 for aviation reviews and chap 1 for all other reviews and waiver authorities.)

9-10. Disposition of medically unfit Reservists

a. Normally, Reservists who do not meet the fitness standards set by chapter 3 will be transferred to the Retired Reserve per AR 140-10 or discharged from the USAR per AR 135-175 or AR 135-178. They will be transferred to the Retired Reserve only if eligible and if they apply for it.

b. Reservists who do not meet medical retention standards may request continuance in active USAR status in accordance with paragraph 9-11 below. In such cases, a medical impairment incurred in either military or civilian status will be acceptable; it need not have been incurred only in the LOD. Reservists with nonduty related medical conditions who are pending separation for not meeting the medical retention standards of chapter 3 may request referral to a PEB for a determination of fitness in accordance with paragraph 9-12 below.

9-11. Requests for continuation in the USAR

a. Requests for continuance will include—

- (1) A copy of the most recent periodic medical examination.
- (2) Any additional medical examinations, consultations, and hospitalization or treatment records pertaining to the unfitting condition. Civilian records are acceptable.
- (3) A summary of the Reservist's experience and qualifications.
- (4) An evaluation by the Reservist's unit commander of the soldier's potential value to the military Service and the ability of the soldier to perform the duties of his or her primary MOS and grade.

b. Requests for continuance will be sent to the Commander, AR-PERSCOM, who will consider each request and determine if the Reservist's experience and qualifications are needed in the Service.

c. Each request for continuance will also be reviewed by the Surgeon, AR-PERSCOM; he or she will determine if—

- (1) The disability may adversely affect the Reservist's performance of active duty. The Reservist's grade, experience, and qualifications must be considered when determining this.
- (2) The rigors of active service would aggravate the condition so that further hospitalization, time lost from duty, or a claim against the Government might result.

d. Waivers requested for officers being considered for assignment/selection to and within the general officer grades will be sent to the Chief, USAR for review and final determination. The Chief, USAR will consider each request and determine if the Reservist's experience and qualifications are needed in the Service. Each request will be reviewed by TSG, who will determine whether—

- (1) The disability may adversely affect the Reservist's performance of active duty as a general officer (O7 and above).
- (2) The rigors of active service would aggravate the condition so that further hospitalization, time lost from duty, or a claim against the Government might result. The Chief, USAR must consider TSG's review when making a final determination.
- (3) Cases where the opinions of TSG and Chief, USAR differ concerning officer(s) being considered for assignment/promotion to and within general officer ranks will be forwarded to ODCSPER, ATTN: DAPE-GO, 300 Army Pentagon, Washington, DC 20301-0300 for final determination.

9-12. Request for PEB evaluation

RC soldiers with nonduty related medical conditions who are pending separation for failing to meet the medical retention standards of chapter 3 of this regulation are eligible to request referral to a PEB for a determination of fitness. Because these are cases of RC soldiers with non-duty related medical conditions, MEBs are not required and cases are not sent through the PEBLOs at the MTFs. Once a soldier requests in writing that his or her case be reviewed by a PEB for a fitness determination, the case will be forwarded to the PEB by the AR-PERSCOM Command Surgeon's Office and will include the results of a medical evaluation that provides a clear description of the medical condition(s) that cause the soldier not to meet medical retention standards.

9-13. Disposition of Reservists temporarily disqualified because of medical defects

a. Normally, Ready or Standby Reservists temporarily disqualified because of a medical defect will be transferred to the Standby Reserve inactive list (AR 140-10). Transfer will be made if—

- (1) The soldier is not required by law to remain a member of the Ready Reserve.
 - (2) The soldier is currently disqualified for retention in an active USAR status.
 - (3) The condition is considered to be remediable within 1 year from the date disqualification was finally determined.
- b.* When determined by the Commander, AR-PERSCOM, to be in the best interest of the service, temporarily

disqualified Reservists may be transferred to or kept in the Standby Reserve for 1 year. This will not be done if the Reservist requests discharge from the USAR or transfers to the Retired Reserve.

c. Reservists who by law must remain members of an RC and whose medical defects are considered to be remediable within 1 year from the date of disqualification will be kept in an active status for 1 year. These reservists will be reassigned to the USAR control group (standby).

d. Reservists who are temporarily disqualified will be examined no later than 1 year from the date of transfer. Those found qualified will be transferred back to the USAR status they held before they were disqualified. See AR 140–10, AR 135–175, and AR 135–178 for disposition of those found disqualified.

Chapter 10

Army National Guard

10–1. General

This chapter sets basic policies, standards, and procedures for medical examinations and physical standards for the ARNGUS. The Health Services Division (NGB–ARS–S), Clinical Services Branch (NGB–ARS) is the office responsible for management of all issues pertaining to this chapter.

10–2. Application

This chapter applies to all ARNGUS soldiers even when administered or operating in their status as members of the ARNG.

10–3. Medical standards

a. Chapter 2 standards apply to all initial enlistments, inductions, and appointments.

b. Chapter 2 standards apply to entry into the AGR Program (title 10 and title 32) for ARNGUS soldiers in accordance with AR 135–18, table 2–1. (Chap 3 standards apply to USAR soldiers for the AGR Program in accordance with AR 135–18, table 2–1.)

c. Chapter 3 standards apply to retention in the ARNGUS.

10–4. Entry into AGR (Title 10/32) Program

a. An appropriate examination will be completed in accordance with chapter 8 within 24 months of the first day of an active duty tour. This examination is to be accomplished at an Active Army MEDDAC, MEDCEN, or MEPS; if the examination is older than 6 months, a DA Form 7349 with review by the State Surgeon will be accomplished within 60 days prior to the first day of duty to assure that chapter 2 standards continue to be met.

b. Any numerical PULHES rating of “3” is disqualifying for entry, but may be submitted for waiver consideration to NGB–ARS. The examination and PULHES must be reviewed and validated by the State Surgeon prior to submission to NGB–ARS. Any examinations older than 6 months will be accompanied by DA Form 7349, completed within the 60 days prior to submission for approval, and prior to entry on active duty.

c. All female soldiers will be required to undergo pregnancy testing within 15 days prior to initiation of any period of active duty or any type of full-time National Guard duty (FTNGD) exceeding 30 days. Standard pregnancy tests performed by accredited medical laboratories are acceptable. Pregnancy is a disqualifying factor for entry on any duty greater than 30 days.

10–5. Active duty for more than 30 days (other than Title 10/32 AGR)

Prior to initiating active duty orders for more than 30 days, the National Guard soldier must have a valid periodic medical examination with a DA Form 7349 completed within the previous 60 days and reviewed by the State Surgeon or Physician Designee in accordance with the standards of chapter 3. (See also para 10–4c for pregnancy testing.) However, during mobilization or call-up for war or contingency operations, the provisions of paragraph 8–18 apply.

10–6. Re-entry on active duty or FTNGD

A soldier may re-enter active duty, if the break in active duty service is less than 180 days from a previous period of active duty, by executing DA Form 7349, reviewed and approved by the State Surgeon. The break in service must be for nonmedical reasons. The medical standards of chapter 3 are applicable, except that pregnancy is a disqualifying factor for reentry.

10–7. Applications for Federal Recognition

Applications for Federal Recognition will include a current Report of Medical Examination (SF 88 or replacement DD Form 2808) and Report of Medical History (SF 93 or replacement DD 2807–1), within 2 years of the board action.

Report of Medical Examination must indicate that soldier meets the standards of chapter 2 for initial appointment, or has received a waiver from the approving authority.

10-8. General officer medical examinations

a. All ARNGUS general officers will undergo a medical examination every 3 years, within 3 calendar months before the end of the officer's birth month. Examinations will be accomplished at any active MTF capable of completing these examinations.

b. All general officers will complete an Annual Medical Certification and the CVSP annually. (See para 8-25.) These examinations may be completed at any Active Army or RC MTF capable of completing these examinations.

c. A copy of each completed physical examination will be forwarded to Chief, National Guard Bureau, ATTN: NGB-GO-AR, Room 2D366, The Pentagon, Washington, DC 20310-2500. NGB-GO-AR is responsible for forwarding completed general officer physical examinations to NGB-ARS for medical review.

d. Physical examinations for promotion to general officer will be obtained at Active Army MEDDAC or MEDCEN facilities, within the 6 months prior to the date of the convening selection board.

10-9. Immunizations

Immunization records will be reviewed and required immunizations will be administered in accordance with AFJI 48-110/AR 40-562/BUMEDINST 6230.15/CG COMDTINST M6230.4E. For Army Special Operations, USASOC Supplement 1 to AFJI 48-110/AR 40-562/BUMEDINST 6230.15/CG COMDTINST M6230.4E applies.

10-10. Periodic medical examinations

(See para 10-8 for periodic examinations for general officers.)

Each officer, warrant officer, and enlisted soldier not on active duty is required to undergo a complete physical examination at least once every 5 years. (See para 10-8 for periodic examinations for general officers.) Cardiovascular screening will be accomplished at the first regularly scheduled physical examination at age 40 years. Members of Early (75 day) Deploying units who are over 40 years of age will undergo complete physical examination every 2 years.

a. Officer and warrant officer. A complete medical examination is required in accordance with chapter 8. The final review and determination of whether the soldier meets the medical retention standards of chapter 3 will be the responsibility of the respective State Adjutants General in consultation with the State Surgeon.

b. Enlisted personnel. A complete medical examination is required in accordance with chapter 8. The final review and determination of medical fitness for retention in the ARNGUS will be the responsibility of the respective State Adjutants General in consultation with the State Surgeon.

c. Flying personnel. Examinations will be in accordance with chapters 4 and 6 of this regulation and USAAMC policy and guidance.

10-11. Waivers

a. Final determination of medical qualification will be made by the Chief, NGB (NGB-ARS), except where the authority for determination has been delegated to the State Adjutants General or reserved to the Active Army.

b. A detailed medical evaluation or consultation concerning a physical defect, and complete justification for the request for waiver should be submitted to Chief, NGB, ATTN: NGB-ARS for determination. The justification will include statements indicating service experience, MOS or position to be placed in, any known specific hazards of the position, the benefit expected to accrue from the waiver, and a recommendation of the State Surgeon. A waiver will not be recommended for medical conditions that are subject to complications or aggravation by reason of military duty.

c. Waivers for aviators, FSs, ATCs, and flight medical aidman, and final determination of medical fitness for flying duty will be made by the Chief, NGB, ATTN: NGB-AVN-OP, with consideration of recommendations made by the Commander, USAAMC, Fort Rucker, AL, in accordance with chapter 4 of this regulation.

d. Waivers for initial training in Airborne, Ranger, Special Forces, HALO, and Diving will not be approved/granted except on the recommendation by the Commander of the appropriate proponent school.

10-12. Profiling

Profiles will be accomplished in accordance with chapter 7.

10-13. Individual responsibility

Each ARNGUS soldier is individually responsible for the maintenance of his or her medical, physical, and mental fitness. This includes correcting remediable defects, avoiding harmful habits, and weight control. The maintenance of good strength and aerobic conditioning is of prime importance to the modern soldier. The APFT is the level of activity that may be expected from the ARNGUS soldier in the normal range of duties.

10-14. Significant incident reporting responsibility

Soldiers' responsibilities include seeking medical advice quickly when they believe their physical well-being is in question. Any hospitalization, significant illness, or disease that occurs when not on duty will be reported to the unit

commander or first sergeant at the earliest possible opportunity and, in all cases, before initiating the next period of training.

10–15. Duty restrictions

Any recommendation of restricted activity that has been made by a private physician will be reported in writing, before performing any duty, and will be honored by the soldier's commander until an evaluation and recommended course of action can be determined by a Medical Corps Officer. It is the individual soldier's responsibility to report any medical problems immediately and to comply with medical restrictions.

10–16. Authorization for examinations

a. Examination authorization letter. Soldiers entitled to medical examinations will be given a letter of authorization by the appropriate commander in accordance with instructions issued by the State Adjutant General. The letter will cite the examinee's name, grade, social security number, organization, purpose of the examination, and other instructions as appropriate regarding payment for the examination and distribution of the completed medical examination.

b. Issuing of orders for examinations. Soldiers undergoing examinations are to be placed on orders if not otherwise in a duty status at the time of the examination.

c. Travel expenses. Travel at Government expense will be authorized if the examination facility is outside of the established local commuting area of the soldier's residence. The examination should be scheduled so that travel, examination, and return home can be accomplished in 1 day. If additional time is required, the soldier will be reimbursed for meals and lodging in accordance with Joint Federal Travel Regulation (JFTR). Government meals and lodging will be used if available. A certificate of non-availability must be submitted with claims for reimbursement. Travel and lodging will be charged to the State's Physical Examination Account.

10–17. Examination authorities

a. Nonprior service and prior service disability separated/retirement applications.

(1) Applicants who are not prior service, or who have had medical, physical, or disability separations/retirements from prior service, or who are soldiers of the ARNGUS who re-enter active duty under the split training option, or who are ARNGUS soldiers who re-enter active duty to complete IDT will be examined only at MEPS. In cases of applicants who have been previously separated for medical reasons, all prior service medical documentation, records, and medical separation board proceedings will be made available to the MEPS prior to scheduling the examination.

(2) Applicants who have a service-connected disability as determined by the VA, even though not separated for medical reasons, will be restricted to MEPS processing. VA disability determination proceedings will be made available to MEPS prior to scheduling the examination.

b. AGR/other full time duty, fitness for duty/physical profile board determination examinations.

(1) Fitness for duty of AGR and other active duty ARNGUS soldiers will be accomplished only at Active Army MTFs.

(2) Permanent profiles issued at other than Army facilities will be submitted to the overseeing Army MTF or NGB–ARS, together with all pertinent examination and treatment records, for review, approval, and translation to Army standards.

c. Other agencies authorized to perform examinations. All other medical examinations may be accomplished by any of the following components, agencies, or civilian physicians, in order of priority. AGR will use Active Army facilities, if available in reasonable commuting distance to duty location.

(1) ARNGUS medical staff as outlined in paragraph 8–7*a*.

(2) Other military medical units or facilities, ARNGUS, Active Army, or other RC having the technical capability of performing the examinations.

(3) MEPS, on a space available basis.

(4) VA medical facilities.

(5) United States Public Health Service facilities.

(6) Civilian physicians legally licensed to practice medicine and to prescribe and administer drugs in the State concerned. Civilian physicians will be evaluated and certified by the State Surgeon or Physician Designee, and provided the appropriate regulations, instruction, training, and materials, in order to assure a militarily appropriate physical examination is conducted, prior to the accomplishment of any examinations.

10–18. Examination review requirements/quality assurance

Physical examinations accomplished at facilities other than MEPS and Active Army facilities will be reviewed by the State Surgeon or Physician Designee for quality assurance, to include AGR personnel physical examinations for other than initial accession into the AGR program. The reviewer will ensure the PULHES profile is in accordance with chapter 7 and table 7–1, that the DD Form 2808 is in accordance with chapter 8, and that medical standards used to qualify or disqualify the applicant or soldier are in accordance with the applicable chapter (for example, chap 2 or chap

3) for the program or purpose applying for. The purpose of examination must be clearly noted. The examination must be approved and signed by the reviewing officer.

10-19. Scope of medical examinations

a. Change from original purpose of examination. In the event a physical examination is to be employed for other than the original stated purpose for which it was performed, the State Surgeon will enter a note on the medical examination certifying that the examination has been reviewed and all additional procedures that may be required have been accomplished and entered on the form, and a new profile based on the applicable medical standards has been assigned. The following is an example of an acceptable entry:

“DATE. This examination has been reviewed by chapter 2 standards. All required items completed. Profile: 111121. Individual Qualified or Not Qualified. Signature.”

b. Required specialty consultations. If additional examinations or specialty consultations beyond the capabilities of the examining facility are required, the State Area Command (STARC) Medical Detachment will be notified. An SF 513 will be completed by the requesting physician and furnished to the soldier. The soldier will be required to provide the completed SF 513 to STARC Medical Detachment for completion of required consultations. Consultations and further examinations will be coordinated, arranged, and scheduled through the STARC Medical Detachment and the MILPO, with counsel of the State Surgeon as needed.

10-20. Report of medical examinations

DD Form 2808 and DD Form 2807-1 continuations and consultations will be submitted as follows:

- a.* The original will be forwarded directly to HQ STARC.
- b.* A copy will be maintained at the examination facility.
- c.* Copies will be prepared and furnished to the unit of membership.
- d.* Copies of the original will be made by the STARC in sufficient number to meet local needs.
- e.* Copies will be submitted to the Chief, NGB, as follows:

(1) Enlistment and reenlistment—as prescribed by NGR 600-200.

(2) Appointment—one copy submitted with NGB Form 62 (Application for Federal Recognition as an ARNG Officer or Warrant Officer and Appointment as a Reserve Commissioned Officer or Warrant Officer of the Army in the ARNG of the United States).

(3) Flying personnel—one copy of DD Form 2808 and DD Form 2807-1 with the annual flight examination, school application, or flight status board, as applicable. DD Form 2807-1 will be completed as prescribed by paragraph 8-13 of this regulation.

10-21. Directed examinations

The Chief, NGB, the State Adjutant General, the commanding officer of a soldier’s unit, or a medical officer may direct the soldier to undergo a medical examination in accordance with AR 600-20 whenever, in the authority’s opinion, the soldier’s medical, physical, dental or mental condition is such that an examination is indicated.

10-22. Administrative information

a. Periodic medical examinations accomplished within the 6 months before the expiration of the current medical examination will be considered as having been accomplished during the anniversary month.

b. Any soldier without a current completed or scheduled physical examination will not attend IDT or AT.

c. HIV testing will be completed in accordance with AR 600-110.

d. A special medical examination is not required for attendance at an Army service school, except as indicated below.

10-23. Special examinations

a. Command and General Staff Course (Resident) and the regular course at the United States Army War College. A DD Form 2808 and a DD Form 2807-1 accomplished within the preceding 12 months will be forwarded with the school application to the (school proponent) NGB. Chapter 3 standards (retention) apply for physical examination review. DA Form 7349 will be accomplished within 60 days preceding the start of school.

b. Entry into Active Army OCS, State OCS, Warrant Officer Candidate School, and Airborne, Ranger, or Pathfinder training. A complete physical examination (DD Form 2808 and DD Form 2807-1) is required, in accordance with chapters 2, 5, and 8 of this regulation, and will be accomplished within the preceding 24 months prior to the first day of school attendance. DA Form 7349 will be accomplished within 60 days preceding the start of school. The DD Form 2808, DD Form 2807-1, and DA Form 7349 will be submitted to NGB-ARS for review and authorization prior to the start of training.

c. Initial flight training course. Physical examinations will be accomplished and approved in accordance with chapters 4 and 8 of this regulation prior to submission to NGB-ARO-TI.

d. Special Forces initial qualification, HALO, and Special Forces SCUBA/Diving examinations. Physical examinations will be accomplished and approved in accordance with paragraph 8-26 prior to submission to NGB-ARS.

10-24. Cardiovascular Screening Program (AGR soldiers)

a. The CVSP for Title 10/32 AGR soldiers will be conducted in accordance with paragraph 8-25 of this regulation.

b. The CVSP applies to Traditional M-Day soldiers in accordance with paragraph 8-25. Soldiers who do not obtain CVSP clearance will be processed through the Medical Duty Review Board (MDRB).

10-25. Annual medical screening

a. *DA Form 7349.* Unit commanders will ensure that each soldier completes a DA Form 7349 annually, not sooner than 180 days prior to the scheduled date of annual training (AT) for the unit. Designated medical personnel will verbally brief the soldiers on the requirements of this screening, the provisions of the Privacy Act, and the consequences of failure to furnish full and complete information required by this screening. The completed DA Form 7349 will be reviewed with the soldier in individual interviews by medical personnel, who will ask for additional information when appropriate. Review of the current valid periodic physical examination will be accomplished in conjunction with review of the DA Form 7349. This constitutes the Unit Level Review, with notes entered in Section 14 of DA Form 7349 (for MOS 91B, 91C) and in section 18 of the DA Form 7349 (by the supervisor). Certificates requiring further review will be forwarded to Commander, STARC Medical Detachment, who will manage the provision of further evaluations.

b. *Medical personnel.* Enlisted personnel (MOS qualified 91B, 91C, 18D) as designated and certified by the State Surgeon, will conduct the initial review insofar as possible. Training and certification will include, but not be limited to, direct supervision and review of the first 50 cases reviewed and an oral examination on chapter 3 of this regulation. MOS qualified 91B, 91C, and 18D will work under the direct supervision of a physician, nurse practitioner, or physician assistant (certified) who will review the work accomplished, and confirm proper categorization of the DA Form 7349 in accordance with paragraph *a* above, and enter the determination in section 14 of DA Form 7349. Upon completion of the training period and demonstration of satisfactory knowledge of this regulation, a Memorandum of Certification will be completed by the supervising medical personnel and the State Surgeon, and will be made a permanent entry in the soldier's Military Personnel Records Jacket (MPRJ-201 file). After certification, only records reviewed by MOS qualified 91B, 91C, or 18D that indicate requirement for further evaluation will be reviewed by the supervisor for final determination. In addition, 10 percent of records of those individuals found fit for duty will be reviewed by the supervisor as an ongoing quality assurance measure. The supervisory personnel will also be available for individual professional consultation on request by the MOS qualified 91B, 91C, or 18D in problematic cases.

c. *Standards of medical review.*

(1) Chapter 3 lists the standards of medical fitness applicable to retention for all components of the U.S. Army, requiring individual assessment for determination of retainability. For the ARNGUS, chapter 3 is interpreted as the standard for retention. Soldiers not meeting the standards of chapter 3 are considered to not meet retention standards and will require review by the State Surgeon and referral to the MDRB, in accordance with this regulation, in order to be retained in the ARNGUS.

(2) Chapter 7 and tables 7-1 and 7-2 establish the policy on physical profiles and documenting a soldier's physical limitations. Functional duty limitations (and as represented by numerical physical profiles and codes) must be carefully and knowledgeably applied to the individual soldier. Any profile of "3" or greater requires referral to an MDRB to determine if the duty restriction causes significant limitations in performing normal military duty for the MOS, specifically including performance in combat situations appropriate to the MOS assigned. It should be noted that the numerical profiles for each MOS as required by DA Pam 611-21 are for the initial award of the MOS only, and are not necessarily related to fitness for retention in a given MOS. The fitness and capacity to be deployed to ALL geographical areas is not a requirement for retention in an MOS, duty assignment, or retention in the ARNGUS.

d. *Finalization of DA Form 7349.* The DA Form 7349 will be categorized as follows:

(1) No significant current history, interval history, or change in physical status, and no indication of requirement for limited duty (profile numerical factors of "1" or "2"). No further action is required; the soldier will be certified for continued duty.

(2) Significant current history, or interval history, or change in physical status, or any indication of requirement for limited duty (profile numerical factors of "3" or "4") temporary or permanent profiles. These soldiers will be further evaluated by forwarding all available information to the State Surgeon and the MDRB for evaluation.

(a) A DA Form 3349 will be completed on all soldiers requiring limitation of duty. The MDRB is the state authority for issuance of permanent profiles for M-Day soldiers, with the exception of soldiers who have been assigned a permanent P-3 or P-4 profile by a military MTF for LOD-related disabilities, and is fully comparable with paragraph 7-8 of this regulation. Permanent profile authority for AGR soldiers rests with Active Army MTF commanders.

(b) Soldiers with restrictions from mandatory strenuous physical activity may not attend AT, ADT, or any type of ADSW, full-time special work, or full-time National Guard Counter Drug until cleared by an MDRB.

(c) Completed DA Form 7349 will become a permanent entry in the soldier's permanent medical treatment record. The soldier may be furnished a copy for his or her own personal medical file.

(d) A database will be maintained at STARC (Standard Installation/Division Personnel System (SIDPERS)) listing the soldiers who have completed unit level DA Form 7349, and will show the results of that screening. If additional steps in the MDRB process are required, the data base will track the dates and results of these examinations. Permanent profile changes and duty changes will be entered in SIDPERS.

10-26. Soldiers pending separation for failing to meet medical retention standards

a. National Guard soldiers with nonduty related medical conditions who are pending separation for failing to meet the medical retention standards of chapter 3 are eligible to request referral to a PEB for a determination of fitness.

b. Because these are cases of soldiers with nonduty related medical conditions, MEBs from Active Army MTFs are not required and cases are not sent through the PEB liaison officers at the MTFs. Once a soldier requests in writing that his/her case be reviewed by a PEB for a fitness determination, the case will be forwarded to the PEB from the soldier's unit (in accordance with guidance provided by NGB-ARS). The documentation will include the results of a medical evaluation that provides a clear description of the medical condition(s) that cause the soldier not to meet medical retention standards. AR 635-40 governs the administrative requirements for such a referral.

10-27. Annual dental screening

a. Dental examinations will be completed annually for all members of Early (75 day) Deploying units in conjunction with the completion of DA Form 7349 or periodic physical examination.

b. Credentialing of sufficient dental personnel to accomplish the screening will be completed by the State Credentials Committee. This will include both organic Dental Corps assets and civilian dentists under contract as may be required.

c. The screening will consist of a dental history and a tongue blade, mirror, and exploratory examination of the oral cavity by a military dental officer or a licensed civilian dentist contractor. The examining dental officer will—

(1) Prepare an SF 603 (Health Record—Dental). This will be retained permanently in the soldier's dental treatment file, which includes panographic and other x-rays.

(2) Assign a Dental Classification 1, 2, 3, or 4, in accordance with AR 40-3, paragraph 6-5.

d. Soldiers in Dental Class 3 or 4 will not be placed in the nondeployable personnel account solely because of dental condition. On warning order of mobilization, those soldiers with Class 3 dental health recorded on the most recent screening, lacking a current panographic x-ray film in the individuals dental record, or in Class 4 (needing examination), will be immediately examined and referred for care in accordance with specific instructions and regulations for the mobilization.

10-28. Physical inspections prior to annual training

a. Unit commanders are responsible for individual inspection of all personnel under their command immediately prior to departure for AT (normally within 72 hours).

b. As a minimum, this screening will consist of—

(1) Confirmation that a valid and approved DA Form 7349 is on hand for each soldier scheduled to attend AT.

(2) Physical observation for any outward signs of existing injury or disease, including bandages, splints, casts, use of crutches, braces, or other orthopedic devices.

(3) A reading of the questions on the DA Form 7349, to include the briefing concerning the Privacy Act and the consequences of less than full disclosure.

(a) Any soldier that answers affirmatively to any question that has not previously been evaluated, or exhibits signs of an obvious physical, psychiatric, or dental condition that is likely to interfere with or be aggravated by AT will be required to be evaluated by a military medical officer, including the completion of a new DA Form 7349 before being allowed to depart for AT.

(b) If this evaluation results in a determination of a significant category change, the soldier may not attend AT until cleared.

(c) Records of these evaluations will be entered on the new DA Form 7349 at the unit. Copies of the new DA Form 7349 will be forwarded to STARC.

c. The commander will certify in the remarks section of unit DA Form 1379 (U.S. Army Reserve Components Unit Record of Reserve Training) that the screening in *b* above took place before unit annual training, and will ensure that this certification includes his or her name, unit, and date—"I (Cdr) of (Unit) performed a physical inspection of each soldier present and attending annual training on (Date), prior to departing for unit annual training." (See also AR 140-185 for examples of DA Form 1379.)

Appendix A References

Section I Required Publications

AFJI 48-110/AR 40-562/BUMEDINST 6230.15/CG COMDTINST M6230.4E

Immunizations and Chemoprophylaxis. (Cited in paras 9-6*a* and 10-9.)

APL series

Aeromedical Policy Letters. (Cited in paras 4-1*e*, 4-4*d*, 4-5*a*(2), 4-6*b*, 4-8, 4-9, 4-10, 4-11*h*(1), 4-11*h*(2), 4-12*a*(4), 4-12*a*(5), 4-13*c*, 4-13*d*, 4-13*e*, 4-15*a*(6), 4-15*a*(12), 4-15*a*(15), 4-15*b*, 4-15*e*, 4-15*f*, 4-15*i*, 4-16*a*, 4-18*e*, 4-20*b*, 4-23*h*(2), 4-23*i*, 4-23*n*, 4-26*d*, 4-26*i*, 4-27*b*, 4-31*b*(1), 4-31*b*(3), 4-32*a*, 4-33*c*(5), 4-33*c*(10), 6-2*d*, 6-2*q*, 6-5*b*, 6-9*b*, 6-10*e*, 6-11*f*, 6-12*a*, 6-12*c*(3), 6-12*e*, 6-15*d*, 6-17*c*, and 6-19*b*.) (These publications are available from Headquarters, U.S. Army Aeromedical Center, ATTN: MCXY-AER, Fort Rucker, AL 36362-5333.)

AR 40-3

Medical, Dental, and Veterinary Care. (Cited in paras 8-12*b*(4) and 10-27*c*(2).)

AR 40-8

Temporary Flying Restrictions Due to Exogenous Factors. (Cited in paras 4-26*d* and 6-13*a*.)

AR 40-29/AFR 160-13/NAVMEDCOMINST 6120.2/CG COMDTINST M6120.8

Medical Examination of Applicants for United States Service Academies, Reserve Officers Training Corps (ROTC) Scholarship Programs, Including 2- and 3-year College Scholarship Programs (CSPs), and the Uniformed Services University of the Health Sciences (USUHS). (Cited in paras 1-6*c*, 8-7*c*, 8-10, 8-12*f*, and 8-15.)

AR 40-48

Nonphysician Health Care Providers. (Cited in para 6-11*j*(3)(*a*).)

AR 40-66

Medical Record Administration and Health Care Documentation. (Cited in paras 8-5*b*, 8-17, and 8-24*b*(5).)

AR 40-400

Patient Administration. (Cited in paras 3-3, 6-9*e*(2), 6-9*e*(3), 6-9*e*(5), 8-4*a*, 8-8, and 8-23*e*.)

AR 55-46

Travel Overseas. (Cited in para 5-14*c*.)

AR 95-1

Flight Regulations. (Cited in para 6-11*d*.)

AR 95-20, Vol 1/AFR 55-22V1/NAVAIRINST 3710.1C/DLAM 8210.1

Contractor's Flight and Ground Operations, Vol I. (Cited in para 4-31*a*(2).)

AR 135-18

The Active Guard Reserve (AGR) Program. (Cited in para 10-3*b*.)

AR 135-100

Appointment of Commissioned and Warrant Officers of the Army. (Cited in para 9-5*a*.)

AR 135-175

Separation of Officers. (Cited in paras 3-7*h*, 9-10*a*, and 9-13*d*.)

AR 135-178

Army National Guard and Army Reserve: Enlisted Administrative Separations. (Cited in paras 3-7*h*, 9-10*a*, and 9-13*d*.)

AR 140-10

Army Reserve: Assignments, Attachments, Details, and Transfers. (Cited in paras 3-7*h*, 9-10*a*, 9-13*a*, and 9-13*d*.)

AR 145-1

Senior Reserve Officer's Training Corps Program: Organization, Administration, and Training. (Cited in paras 8-15 and 9-2a(1).)

AR 145-2

Junior Reserve Officer's Training Corp Program: Organization, Administration, Operation, and Support. (Cited in para 9-2a(1).)

AR 600-8-24

Officer Transfers and Discharges. (Cited in paras 3-3b, and 7-9b(3), and table 8-2.)

AR 600-8-101

Personnel Processing (In-and Out- and Mobilization Processing). (Cited in para 5-14c.)

AR 600-8-105

Military Orders. (Cited in para 6-18f(2).)

AR 600-9

The Army Weight Control Program. (Cited in paras 2-21a, 4-17a, 4-17b(1), 4-31c, 5-9l, 5-11l, 5-11m(2), and 7-13 and tables 2-1 and 2-2.)

AR 600-85

Army Substance Abuse Program. (Cited in para 4-23h(2).)

AR 600-105

Aviation Service of Rated Army Officers. (Cited in paras 4-2b(2), 4-2c, 4-23l, 4-29a, 4-29b, 6-2a, 6-2k, 6-4f, 6-4j(4), 6-4j(7), 6-8b(4), 6-10f, 6-11c, 6-11i(1), 6-12b(1), 6-17b, 6-17f, 6-19c(4), 6-19g, and table 8-1.)

AR 600-106

Flying Status for Nonrated Army Aviation Personnel. (Cited in paras 4-2e and 6-2a.)

AR 600-110

Identification, Surveillance, and Administration of Personnel Infected with Human Immunodeficiency Virus (HIV). (Cited in paras 3-7h, 4-5b, 4-26g, 4-32b(4), 4-33c(8), 8-12c(2), 8-12d(2), 8-12f(2), 8-14a(8), and 10-22d.)

AR 601-270/AFR 33-7/OPNAVINST 1100.4/MCO P-1100.75A

Military Entrance Processing Stations (MEPS). (Cited in paras 8-4a and 8-15.)

AR 608-75

Exceptional Family Member Program. (Cited in para 5-14b.)

AR 611-85

Personnel Selection and Classification: Aviation Warrant Officer Training. (Cited in para 4-2a(1).)

AR 611-110

Selection and Training of Army Aviation Officers. (Cited in para 4-2a(1).)

AR 614-30

Overseas Service. (Cited in para 7-9d(1).)

AR 614-200

Enlisted Assignments and Utilization Management. (Cited in para 5-14c.)

AR 635-40

Physical Evaluation for Retention, Retirement, or Separation. (Cited in paras 2-2c(2)(b), 3-3, 3-3b, 3-3e, 3-7h, 6-12b(1), 6-12b(2), 8-23e, 10-26b, table 7-2, and table 8-2.)

AR 635-200

Enlisted Personnel. (Cited in paras 2-2c(2)(a), 3-3b, 7-9b(3), and table 8-2.)

ATB series

Aeromedical Technical Bulletins. (Cited in paras 4-1e, 4-5b, 4-12a(3), 4-12a(6), 4-15a(15), 4-15f, 4-26g, 4-30, 4-31b(1), 4-31b(3), 4-32a, 4-32b(4), 4-33c(8), 6-2d, 6-5b, 6-7b, 6-9a, 6-10e, 6-11d, 6-12a, 6-12c(3), 6-12i(3), 6-13c, 6-17c, 6-19b, and 8-12i.) (These publications are available from Headquarters, U.S. Army Aeromedical Center, ATTN: MCXY-AER, Fort Rucker, AL 36362-5333.)

DSM-IV

Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Revised, American Psychiatric Association. (Cited in paras 3-30j and 4-23.) (This manual may be obtained from the American Psychiatric Association, 1400 K Street, NW, Washington, DC 20005-2492.)

TB MED 287

Pseudofolliculitis of the Beard and Acne Keloidalis Nuchae. (Cited in para 7-3e(4).)

TC 8-640

Joint Motion Measurement. (Cited in paras 2-9a, 2-10a, 3-12b, and 3-13d.)

Section II**Related Publications**

A related publication is merely a source of additional information. The user does not have to read it to understand this regulation.

AR 40-5

Preventive Medicine

AR 135-91

Service Obligations, Methods of Fulfillment, Participation Requirements, and Enforcement Procedures

AR 135-133

Ready Reserve Screening, Qualification Records System and Change of Address Reports

AR 140-1

Mission, Organization, and Training

AR 140-185

Training and Retirement Point Credits and Unit Level Strength Accounting Records

AR 350-41

Training in Units

AR 385-95

Army Aviation Accident Prevention

AR 600-8-10

Leave and Passes

AR 600-20

Army Command Policy

AR 600-60

Physical Performance Evaluation System

AR 611-75

Personnel Selection, Qualification, and Classification Management of Army Divers

AR 614-10

U.S. Army Personnel Exchange Program With Armies of Other Nations: Short Title: Personnel Exchange Program

AR 635-10

Processing Personnel for Separation

AR 670-1

Wear and Appearance of Army Uniforms and Insignia

DA Pam 40-501

Hearing Conservation Program

DA Pam 351-4

U.S. Army Formal Schools Catalog

DA Pam 600-8

Management and Administrative Procedures

DA Pam 611-21

Military Occupational Classification and Structure

DFAS-IN Regulation 37-1

Finance and Accounting Policy Implementation. www.asafm.army.mil

DOD 7000.14-R, Vol 7A

Department of Defense Financial Management Regulation, Military Pay Policy and Procedures, Active Duty and Reserve Pay

DOD Directive 1308.1

DOD Physical Fitness and Body Fat Program

DOD Directive 6130.3

Physical Standards for Enlistment, Appointment, and Induction

DOD Instruction 6130.4

Criteria and Procedure Requirements for Physical Standards for Appointment, Enlistment, or Induction in the Armed Forces

FM 1-300

Flight Operations Procedures

FM 3-04.301

Aeromedical Training for Flight Personnel

NATO STANAG 3526

Interchangability of NATO Aircrew Medical Categories

NGR 600-200

Enlisted Personnel Management. (This publication is available at <http://www.ngbpdc.ngb.army.mil/arngfiles.asp>.)

OPM HDBK QUAL STDS

Qualification Standards Handbook for General Schedule Positions. (This publication is available at local civilian personnel offices.)

Publication 70-003-A

Coronary Risk Handbook. (American Heart Association.) (This publication is available at all medical examining facilities.)

Publication 70-008-A

Exercise Testing and Training of Apparently Healthy Individuals. (American Heart Association.) (See 70-003-A above for publication source.)

Publication 70-008-B

Exercise Testing and Training of Individuals with Heart Disease or at High Risk for Its Development. (American Heart Association.) (See 70-003-A above for publication source.)

Publication 70-041

The Exercise Standards Book. (American Heart Association.) (See 70-003-A above for publication source.)

TB MED 523

Control of Hazards to Health From Microwave and Radio Frequency Radiation and Ultrasound

TB MED 524

Occupational and Environmental Health: Control of Hazards to Health From Laser Radiation

USASOC Suppl 1 to AFJI 48-110/AR 40-562/BUMEDINST 6230.15/CG COMDTINST M6230.4E

Immunizations and Chemoprophylaxis. (This publication is available from the U.S. Army Special Operations Command, Information Technology Center/Information Services Division, ATTN: AFZA-IT/Installation Publications Center, Fort Bragg, NC 28310.)

Section III**Prescribed Forms**

Except where otherwise indicated below the following forms are available as follows: DA Forms are available on the Army Electronic Library (AEL) CD ROM (EM0001) and the USAPA Web site (www.usapa.army.mil); DD Forms are available on the OSD Web site (<http://web1.whs.osd.mil/icdhome/ddeforms.htm>).

DA Form 3081

Periodic Medical Examination (Statement of Exemption). (Prescribed in para 8-14a(4).)

DA Form 3083

Medical Examination for Certain Geographical Areas. (Prescribed in para 8-24b(5).)

DA Form 3349

Physical Profile. (Prescribed in para 3-24e.)

DA Form 4186

Medical Recommendation for Flying Duty. (Prescribed in para 6-2n.)

DA Form 4497

Interim (Abbreviated) Flying Duty Medical Examination. (Prescribed in para 6-7a.)

DA Form 7349

Initial Medical Review—Annual Medical Certificate. (Prescribed in para 8-19c(5).)

DD Form 2697

Report of Medical Assessment. (Prescribed in para 8-12e(11).)

DD Form 2807-1

Report of Medical History. (Prescribed in para 6-6.)

DD Form 2808

Report of Medical Examination. (Prescribed in para 6-6.)

Section IV**Referenced Forms**

Except where otherwise indicated below the following forms are available as follows: DA Forms are available on the Army Electronic Library (AEL) CD ROM (EM0001) and the USAPA Web site (www.usapa.army.mil); DD Forms are available on the OSD Web site (<http://web1.whs.osd.mil/icdhome/ddeforms.htm>); and GSA Forms are available on the GSA Web site (www.gsa.gov/forms/forms.htm).

DA Form 1379

U.S. Army Reserve Components Unit Record of Reserve Training (This form is available in paper through normal supply channels.)

DA Form 3725

Army Reserve Status and Address Verification

DA Form 4700

Medical Record—Supplemental Medical Data

DA Form 5888-R

Family Member Deployment Screening Sheet

DD Form 689

Individual Sick Slip

DD Forms 1966/1 through 5

Record of Military Processing—Armed Forces of the United States

DD Form 2351

DOD Medical Examination Review Board (DODMERB) Report of Medical Examination

DD Form 2766

Adult Preventive and Chronic Care Flowsheet (This form is available in paper through normal supply channels.)

DD Form 2807-2

Medical Prescreen of Medical History Report

NGB Form 62

Application for Federal Recognition as an ARNG Officer or Warrant Officer and Appointment as a Reserve Commissioned Officer or Warrant Officer of the Army in the ARNG of the United States (This form is available at <http://www.ngbpdc.ngb.army.mil>.)

SF 507

Clinical Record—Report on or Continuation of SF

SF 513

Medical Record—Consultation Sheet

SF 600

Health Record—Chronological Record of Medical Care

SF 603

Health Record—Dental (This form is available in paper through normal supply channels.)

Glossary

Section I Abbreviations

AA

aeromedical adaptability

ABN

abnormal (abnormalities other than hypertrophy)

ACAP

Aeromedical Consultant Advisory Panel

ACS

Aeromedical Consultative Service

ADP

automatic data processing

ADSW

active duty for special work

ADT

active duty for training

AEDR

Aviation Epidemiology Data Register

AFIP

Armed Forces Institute of Pathology

AFVT

Armed Forces Vision Tester

AGR

Active Guard—Reserve

AMC

Aviation Medicine Consultant

AME

aviation medical examiner

AMEDD

Army Medical Department (U.S.)

ANSI

American National Standards Institute

APA

aeromedical physician assistant

APFT

Army Physical Fitness Test

APL

Aeromedical Policy Letter

APO

Army Post Office

ARCOM

USAR Command

ARMA

Adaptability Rating for Military Aeronautics

ARNG

Army National Guard

ARNGUS

Army National Guard of the United States

AR-PERSCOM

U.S. Army Reserve Personnel Command

ASAP

Army Substance Abuse Program

ASD(HA)

Assistant Secretary of Defense (Health Affairs)

AT

annual training

ATB

Aeromedical Technical Bulletin

ATC

air traffic controller

AUS

Army of the United States

AV

atrioventricular

BN

battalion

BP

blood pressure

CAD

coronary artery disease

CAPOC

computerized assisted practice of cardiology

cc

cubic centimeter(s)

CDQC

(Special Forces) Combat Diving Qualification Course

Cdr

commander

CG

commanding general

CIA

Central Intelligence Agency

cm

centimeter

CNS

central nervous system

COAD

continued on active duty

comp.

complications

cont.

continued

CONUS

continental United States

corr

corrected

CQ

charge of quarters

CRST

calcinosis, Raynaud's phenomenon, sclerodactyly, and telangiectasis

CSF

cerebrospinal fluid

CT

Cover Test

CV

cardiovascular

CVSP

Cardiovascular Screening Program

d

day

DA

Department of the Army

DAC

Department of the Army civilian

DAF

Department of the Air Force

dB

decibel(s)

dBA

dB measured on the A scale

deg

degree(s)

Div

divergence

Div Sup

diving supervisor

DMO

diving medical officer

DMT

diving medical technician

DN

Department of the Navy

DNIF

duties not to include flying

DOD

Department of Defense

DODMERB

Department of Defense Medical Examination Review Board

DQ

(aeromedical) disqualification

DSM-IV

Diagnostic and Statistical Manual for Mental Disorders, Fourth Edition

E

eyes (profile)

ECG

electrocardiogram

EEG

electroencephalogram

EKG

electrocardiogram

ENT

ear-nose-throat

EPTS

existed prior to service

ES

esophoria

EX

exophoria

FAA

Federal Aviation Administration

FALANT

Farnsworth Lantern Test (USN)

FAR

Federal Aviation Regulations

FBI

Federal Bureau of Investigation

FDME

flying duty medical examination

FEB

flying evaluation board

FEVI

forced expiratory volume in 1 second

FFD

full flying duties

FS

flight surgeon

FTA-ABS

fluorescent treponemal antibody absorption (test)

FTNGD

full-time National Guard duty

G6PD

glucose-6-phosphate dehydrogenase

G-U

genitourinary

h

hour

H

hearing and ear (profile)

HALO

high altitude low opening

HCT

hematocrit

HCV

hepatitis c virus

HDL

high-density lipoprotein

HGB

hemoglobin

Hgb A

hemoglobin type A

Hgb S

hemoglobin type S

HIV

human immunodeficiency virus (see HTLV–III)

HPSP

Health Professions Scholarship Program

HQDA

Headquarters, Department of the Army

HTLV–III

human T–lymphotrophic virus type III (see HIV)

ICD

International Classification of Disease

IDT

inactive duty training

in

inch(es)

INF

Infantry

IO

initial only

IRR

Individual Ready Reserve

ISO

International Standards Organization

kg

kilogram(s)

L

lower extremities (profile)

L.H.

left hyperphoria

LOC

loss of consciousness

LOD

line of duty

LVH

left ventricular hypertrophy

m

minutes

MAAG

Military Assistance Advisory Group

MDAR

Military Diving Adaptability Rating

MDRB

Medical Duty Review Board

MEB

medical evaluation board

MEDCEN

medical center (U.S. Army)

MEDDAC

medical department activity (U.S. Army)

MEPCOM

U.S. Military Entrance Processing Command

MEPS

military entrance processing stations

METS

metabolic equivalents

MFF

Military Freefall

mg

milligram

mg/dl

milligrams per deciliter

MILPO

military personnel office

mm

millimeter(s)

MMFJM

military freefall jumpmaster

mmHg

millimeters of mercury

MMRB

MOS medical retention board

MOPP

mission oriented protective posture

MOS

military occupational specialty

MTF

military treatment facility

NBC

nuclear, biological, chemical

NGB

National Guard Bureau

NGR

National Guard Regulation

NIBH

not indicated by history

NL

normal

NPC

near point of convergence

OCONUS

outside continental United States

OCS

Officer Candidate School

OD

right eye

ODCSPER

Office of the Deputy Chief of Staff for Personnel

OIC

officer-in-charge

OMPF

official military personnel file

OS

left eye

OTSG

Office of the Surgeon General

P

permanent (profile) and physical capacity or stamina (profile)

PA

posterior anterior (chest x-ray)

Pap smear (test)

Papanicolaou's test

PC

prism convergence

PCS

permanent change of station

PD

pupillary distance

PEB

physical evaluation board

PERSCOM

Total Army Personnel Command

PIP

pseudoisochromatic plates

PMCS

preventive maintenance checks and services

POR

preparation of replacements for oversea movement

P-R interval

interval between the P and R waves on an ECG

PT

physical training

PULHES

(see separate letters for profile codes)

QRS interval

interval between the Q and R and S waves on an ECG

RA

Regular Army

RAM

resident in aerospace medicine

RANDOT

random dots

RBC

red blood cell or corpuscle

RC

Reserve Component

R.H.

right hyperphoria

ROTC

Reserve Officers' Training Corps

RPR

rapid plasma reagin (test)

rt

right

s

psychiatric (profile)

sat.

satisfactory

SCUBA

self-contained underwater breathing apparatus

SERE

survival, evasion, resistance, escape

SFAS

Special Forces Assessment and Selection

SFQC

Special Forces Qualification Course

SIDPERS

Standard Installation/Division Personnel System

SPRINT

speech recognition in noise test

SSI

specialty skill identifier

STARC

State Area Command

STS

serologic test for syphilis

SVT

Stereoscope, Vision Testing

T

temporary (profile)

TDA

table(s) of distribution and allowances

TDRL

Temporary Disability Retired List

TOE

table(s) of organization and equipment

TSG

The Surgeon General

U

upper extremities (profile)

unsat.

unsatisfactory

USA

U.S. Army

USAAMA

U.S. Army Aeromedical Activity

USAAMC

U.S. Army Aeromedical Center

USAFA

U.S. Air Force Academy

USAJFKSWCS

U.S. Army John F. Kennedy Special Warfare Center and School

USAMEDCOM

U.S. Army Medical Command

USAR

U.S. Army Reserve

USAREC

U.S. Army Recruiting Command

USASOC

U.S. Army Special Operations Command

USCGA

U.S. Coast Guard Academy

USMA

U.S. Military Academy

USMC

United States Marine Corps

USMMA

United States Marine Military Academy

USN

U.S. Navy

USNA

U.S. Naval Academy

USUHS

Uniformed Services University of the Health Sciences

VA

Department of Veterans Affairs

VDRL

venereal disease research laboratory (test)

VTA

vision testing apparatus

wk

week

WO

warrant officer

WOC

warrant officer candidate

Section II**Terms****Accepted medical principles**

Fundamental deduction consistent with medical facts and based upon the observation of a large number of cases. To

constitute accepted medical principles, the deduction must be based upon the observation of a large number of cases over a significant period of time and be so reasonable and logical as to create a moral certainty that they are correct.

Applicant

A person not in a military status who applies for appointment, enlistment, or reenlistment in the USAR.

Candidate

Any individual under consideration for military status or for a military service program whether voluntary (appointment, enlistment, ROTC) or involuntary (induction).

Civilian physician

Any individual who is legally qualified to prescribe and administer all drugs and to perform all surgical procedures in the geographical area concerned.

Enlistment

The voluntary enrollment for a specific term of service in one of the Armed Forces as contrasted with induction under the Military Selective Service Act.

Impairment of function

Any anatomic or functional loss, lessening, or weakening of the capacity of the body, or any of its parts, to perform that which is considered by accepted medical principles to be the normal activity in the body economy.

Latent impairment

Impairment of function that is not accompanied by signs and/or symptoms but is of such a nature that there is reasonable and moral certainty, according to accepted medical principles, that signs and/or symptoms will appear within a reasonable period of time or upon change of environment.

Manifest impairment

Impairment of function that is accompanied by signs and/or symptoms.

Medical capability

General ability, fitness, or efficiency (to perform military duty) based on accepted medical principles.

Obesity

Excessive accumulation of fat in the body manifested by poor muscle tone, flabbiness and folds, bulk out of proportion to body build, dyspnea and fatigue upon mild exertion, and frequently accompanied by flat feet and weakness of the legs and lower back.

Physical disability

Any manifest or latent impairment of function due to disease or injury, regardless of the degree of impairment, that reduces or precludes an individual's actual or presumed ability to perform military duty. The presence of physical disability does not necessarily require a finding of unfitness for duty. The term "physical disability" includes mental diseases other than such inherent defects as behavior disorders, personality disorders, and primary mental deficiency.

Physician

A doctor of medicine or doctor of osteopathy legally qualified to prescribe and administer all drugs and to perform all surgical procedures.

Retirement

Release from active military services because of age, length of service, disability, or other causes, in accordance with Army regulations and applicable laws with or without entitlement to receive retired pay. For purposes of this regulation, this includes both temporary and permanent disability retirement.

Sedentary duties

Tasks to which military personnel are assigned that are primarily sitting in nature, do not involve any strenuous physical efforts, and permit the individual to have relatively regular eating and sleeping habits.

Separation (except for retirement)

Release from the military service by relief from active duty, transfer to a Reserve Component, dismissal, resignation, dropped from the rolls of the Army, vacation of commission, removal from office, and discharge with or without disability severance pay.

Section III

Special Abbreviations and Terms

This section contains no entries.

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