Army Regulation 40–501

Medical Services

Standards of Medical Fitness

Headquarters
Department of the Army
Washington, DC
27 February 1998

Unclassified

SUMMARY of CHANGE

AR 40–501
Standards of Medical Fitness

This Change 1--

- Implements changes to medical assessment provisions required by DOD.
- Prescribes the use of DD Form 2697 (Report of Medical Assessment).
- Corrects a misleading editorial error in paragraph 2-10(d).
- Eliminates periodic medical examinations for active duty soldiers at ages 20 and 25.

This revision--

- Revises the medical accession standards in compliance with DOD Directive 6130.3, "Physical Standards for Appointment, Enlistment, and Induction," May 2, 1994 (chap 2).
- Revises the medical retention standards, including new standards on asthma, heat injuries, and cold injuries (paras 3-27, 3-46, and 3-47).
- Incorporates all medical aviation policies and standards into two chapters (chap 4 and chap 6).
- Deletes the chapter on mobilization standards (formerly chap 6).
- Revises DA Form 4497-R (Interim (Abbreviated) Flying Duty Medical Examination) (paras 6-7, 6-9, and 6-10).
- Revises the requirements for medical examinations and deletes Type A and Type B examinations (paras 8-11, 8-12, and table 8-1).
- Prescribes a new form, DA Form 7349-R (Initial Medical Review--Annual Medical Certificate) (para 8-19).
- Incorporates the changes in the Cardiovascular Screening Program (para 8-25).
- Adds the Speech Recognition In Noise Test (para 8-26).

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Effective 27 March 1998

Medical Services

Standards of Medical Fitness

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Acting Secretary of the Army

History. This publication was originally printed on 30 Aug 95. This printing publishes change 1. This publication has been reorganized to make it compatible with the Army electronic publishing database. No content has been changed.

Summary. This change implements changes to the medical assessment provisions required by DOD; prescribes the use of DD Form 2697 (Report of Medical Assessment); corrects a misleading editorial error in paragraph 2–10(*d*); and eliminates periodic medical examinations for active duty soldiers at ages 20 and 25.

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

Proponent and exception authority. The proponent of this regulation is 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 this 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 is not subject to the requirements of AR 11–2. It does not contain management control provisions.

Supplementation. Supplementation of this regulation and establishment of command or local forms are prohibited without prior approval from HQDA (SGPS–CP–B), 5109 Leesburg Pike, Falls Church, VA 22041–3258.

Interim changes. Interim changes to this regulation are not official unless they are authenticated by the Administrative Assistant to the Secretary of the Army. Users will destroy interim changes on their expiration dates unless sooner superseded or rescinded.

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. Distribution of this publication is made in accordance with the initial distribution number (IDN) 092524, intended for command level A for medical activities only of the Active Army, and command level B for all other elements of the Active Army, Army National Guard, and U.S. Army Reserve.

Contents (Listed by paragraph and page number)

* This regulation supersedes AR 40–501, 1 July 87.

Unclassified

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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); Chief, Army National Guard (ARNG); 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. Army Training and Doctrine Command, U.S. Army Medical Command (USAMEDCOM), U.S. Army Reserve Personnel Center (ARPERCEN), and all Army medical 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, and 9.

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. 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 *c* below.

c. Medically unacceptable—prior administrative waiver granted. 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. 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 chapters 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 waiver authorities include but are not limited to TSG, the commanders of USAREC, ARPERCEN, U.S. Total Army Personnel Command (PERSCOM), U.S. Army Reserve Officers' Training Corps (ROTC) Cadet Command, and Superintendent, USMA.

c. 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 for exceptions to this policy will only be made under extraordinary circumstances and only with the approval of TSG (Headquarters, Department of the Army (HQDA) (SGPS–CP–B)).

d. Waivers of medical fitness standards which 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 or purpose involved and the medical condition or 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," May 2, 1994, which establishes the standards in accordance with section 133, Title 10, United States Code (10 USC 133).

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 or infectious diseases which would be likely to endanger the health of other personnel.

(2) Free of medical conditions or physical defects which would require excessive time lost from duty or would likely result in separation from the service 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 (paras 2–3 through 2–41) prescribes the medical conditions and physical defects which 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, providing the individual meets the retention standards of chapter 3. However, the standard in paragraph 2–39*o* 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 Component (AC) and RC, including appointment as a Reserve of the Army or the Army National Guard of the United States. (However, for officers of the ARNG 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 ARNG or USAR who apply for enlistment in the regular Army or who reenter active duty for training (ADT) under the "split–training" option, the standards of chap 3 are applicable.)

(3) Applicants for enlistment in the RC and Federally recognized units or organizations of the ARNG. 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 AC and RC and Federally recognized units or organizations of the ARNG 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, providing the cadet meets the retention standards of chap 3.)

(7) Individuals on the Temporary Disability Retired List (TDRL) who have been found fit on reevaluation and wish to return to active duty. However, the prior disabling defect(s) and any other physical defects identified before placement on the TDRL that would not have prevented reenlistment are not disqualifying.

d. Responsibilities.

(1) The Under Assistant Secretary of Defense for Personnel and Readiness shall ensure that the Assistant Secretary of Defense (Health Affairs) (ASD(HA)) shall review, approve, and issue technical modifications to the standards prescribed in DOD Directive 6130.3; implement these standards through the MEPCOM and the DODMERB; and give direction to the ASD(HA) on the personnel aspects of these standards.

(2) The Secretary of the Army will—

(a) Revise Army policies to conform with the standards contained in DOD Directive 6130.3.

(b) Recommend to the ASD(HA) suggested changes to the standards after Service coordination has been accomplished.

(c) Review all the standards on a quadrennial basis and recommend changes to the ASD(HA). This review shall be initiated by the DODMERB and coordinated by the ASD(HA).

(d) Have authority to grant a waiver of the standards in individual cases for appropriate reasons, unless waiver authority has been withheld by the Secretary of Defense; for example, in the case of human immunodeficiency virus (HIV).

(e) Have authority to change vision standards (particularly for officer–accession programs) and establish other standards for special programs. Notification of any proposed changes in standards shall be provided to the ASD(HA) 60 days before their implementation.

(f) Have authority to issue Army–specific exceptions to these standards, having first submitted these, with justification, for review and approval by the ASD(HA).

2–3. Abdominal organs and gastrointestinal system

The causes for rejection are as follows:

a. Esophagus. Organic disease or authenticated history of, such as ulceration, varices, achalasia, or other dismotility disorders; chronic or recurrent esophagitis if confirmed by appropriate x–ray or endoscopic examinations.

b. Stomach and duodenum.

(1) Gastritis, chronic hypertrophic, severe.

(2) Ulcer of the stomach or duodenum, if diagnosis is confirmed by x–ray examinations, endoscopy, or authenticated history thereof.

(3) Authenticated history of surgical operation(s) for gastric or duodenal ulcer, that is, partial or total gastric resection, gastrojejunostomy, pyloroplasty, truncal or selective vagotomy (or history of such operative procedures for any other cause or diagnosis).

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

(5) Congenital abnormalities of the stomach or duodenum causing symptoms or requiring surgical treatment, except a history of surgical correction of hypertrophic pyloric stenosis of infancy is not disqualifying if currently asymptomatic.

c. Small and large intestine.

(1) Intestinal obstruction or authenticated history of more than one episode if either occurred during the preceding 5 years or if resulting condition remains, producing significant symptoms or requiring treatment.

(2) Symptomatic Meckel's diverticulum.

(3) Megacolon of more than minimal degree.

(4) Inflammatory lesions: diverticulitis, regional enteritis, ulcerative colitis, proctitis.

(5) Intestinal resection; however, minimal intestinal resection in infancy or childhood (for example, for intussusception) is acceptable if the individual has been asymptomatic since the resection and if the appropriate consultant finds no residual impairment.

(6) Malabsorption syndromes.

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

e. Hepato–pancreatico–biliary tract.

(1) Hepatitis within the preceding 6 months; or persistence of symptoms after 6 months, with objective evidence of impairment of liver function, and chronic hepatitis, including hepatitis B carriers.

(2) Hepatic cysts—congenital cystic disease; parasitic, protozoal, or other cysts.

(3) Cirrhosis, regardless of the absence of manifestations such as jaundice, ascites, or known esophageal varices; abnormal liver function, with or without history of chronic alcoholism.

(4) Cholecystectomy, sequelae of, such as postoperative stricture of the common bile duct, reforming of stones in hepatic or common bile ducts, incisional hernia, or post–cholecystectomy syndrome when symptoms are so severe as to interfere with normal performance of duty.

(5) Cholecystitis, acute or chronic, with or without cholelithiasis.

(6) Bile duct abnormalities or strictures.

(7) Pancreas, acute or chronic disease of, if proven by laboratory tests or medical records; and congenital anomalies such as annular pancreas, cystic disease, etc.

f. Anorectal.

(1) Fistula in ano.

(2) Incontinence.

(3) Anorectal stricture.

(4) Excessive mucous production with soiling.

(5) Hemorrhoids—internal or external, when large, symptomatic, or history of bleeding.

(6) Rectal prolapse.

(7) Symptomatic rectocele.

(8) Symptomatic anal fissure.

(9) Chronic diarrhea, regardless of cause.

g. Spleen.

(1) Splenomegaly until the cause is corrected and is not otherwise disqualifying.

(2) Splenectomy, except when accomplished for the following: trauma, causes unrelated to diseases of the spleen, hereditary spherocytosis, or any disease involving the spleen when followed by correction of the condition for at least 2 years (and is not otherwise disqualifying).

h. Tumors. See paragraph 2–40.

i. Abdominal wall.

(1) Scars, abdominal, regardless of cause, the hernial bulging of which interferes with movement.

(2) Scar pain associated with disturbance of function of abdominal wall or contained viscera.

(3) Sinuses of the abdominal wall, to include persistent urachus and persistent omphalomesenteric duct.

j. Hernia.

(1) Hernia other than small asymptomatic umbilical or asymptomatic hiatal.

(2) History of operation for hernia within the preceding 60 days.

k. Other. Congenital or acquired abnormalities, such as gastrointestinal bypass or stomach stapling for control of obesity; and defects that preclude satisfactory performance of military duty or require frequent and prolonged treatment.

2–4. Blood and blood–forming tissue diseases

The causes for rejection are as follows:

a. Anemia. Any hereditary or acquired anemia that cannot be permanently corrected with therapy before appointment or induction.

b. Hemorrhagic disorders. Any congenital or acquired state resulting in a tendency to bleed due to a platelet, coagulation, or vascular abnormality.

c. Leukopenia. Chronic or recurrent, associated with increased susceptibility to infection.

d. Myeloproliferative disease. Myeloproliferative or myelodysplastic disease, or history thereof.

e. Thromboembolic disease. Thromboembolism at any time.

f. Immunodeficiency diseases. Any congenital or acquired immunodeficiency state regardless of etiology.

g. Miscellaneous conditions. For example, porphyria, hemochromatosis, amyloidosis, and post–splenectomy status (except when secondary to causes stated in para 2–3*g*).

2–5. Dental

The cause for rejection are as follows:

a. Disease 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 and/or myofacial pain dysfunction that is not easily corrected.

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

c. Insufficient natural healthy teeth or lack of a serviceable prosthesis, preventing adequate mastication and incision of a normal diet. This includes complex (multiple fixture) dental implant systems that have associated complications that severely limit assignments and adversely affect performance of world–wide duty. Dental implants that are no longer functional must not interfere with continuation of wear of the implant prosthesis or prevent renewal and replacement with a conventional prosthesis.

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

2–6. Ears

The causes for rejection are as follows:

a. Auditory canal.

(1) Atresia or severe stenosis of the external auditory canal.

(2) Tumors of the external auditory canal except mild exostoses.

(3) Severe external otitis, acute or chronic.

b. Auricle. Microtia, severe; or severe traumatic deformity, unilateral or bilateral.

c. Mastoids.

(1) Mastoiditis, acute or chronic.

(2) Residual of mastoid operation with marked external deformity which prevents or interferes with the wearing of a protective mask or helmet.

(3) Mastoid fistula.

d. Meniere's syndrome.

e. Middle ear.

(1) Acute or chronic otitis media of any type.

(2) Presence of attic perforation in which presence of cholesteatoma is suspected.

(3) History of surgery involving the middle ear, excluding myringotomy.

(4) Cholesteatoma, or history thereof.

f. Tympanic membrane.

(1) Any perforation of the tympanic membrane.

(2) Surgery to repair perforated tympanic membrane within the past 120 days.

(3) Thickening or scarring of the tympanic membrane associated with hearing level by audiometric test of 30 decibels (dB) or more average for the speech frequencies (500, 1000, and 2000 cycles per second) in either ear regardless of the hearing level in the other ear.

g. Other. Other diseases and defects of the ear which obviously prevent satisfactory performance of duty or which require frequent and prolonged treatment.

2–7. Hearing

(See also para 2–6.) Audiometers, calibrated to standards of the International Standards Organization (ISO 1964) or the American National Standards Institute (ANSI 1969), will be used to test the hearing of all applicants for appointment, enlistment, or induction. All audiometric tracings or audiometric readings recorded on reports of medical examination or other medical records shall be clearly identified. The causes for rejection are as follows:

a. Hearing threshold greater than pure tone at 500, 1000, and 2000 cycles per second of not more than 30dB on the average (either ear), with no individual level greater than 35dB at these frequencies.

b. Pure tone level not more than 45dB at 3000 cycles per second each ear, and 55dB at 4000 cycles per second each ear.

2–8. Endocrine and metabolic disorders

The causes for rejection are as follows:

a. Adrenal dysfunction of any degree.

b. Cretinism.

c. Diabetes mellitus, any type, including a history of juvenile onset (insulin dependent, type I).

d. Gigantism or acromegaly.

e. Glycosuria persistent, when associated with impaired glucose tolerance or renal tubular defects that cause aminoaciduria, phosphaturia, and renal tubular acidosis.

f. Gout.

g. Hyperinsulinism.

h. Hyperparathyroidism and hypoparathyroidism.

i. Hypopituitarism.

j. Myxedema, spontaneous or postoperative (with clinical manifestations).

k. Nutritional deficiency diseases (including sprue, beriberi, pellagra, and scurvy).

l. Thyroid disorders.

(1) Goiter. Simple goiter with definite pressure symptoms, or so large as to interfere with the wearing of a military uniform or military equipment.

(2) Hyperthyroidism or thyrotoxicosis.

(3) Hypothyroidism, symptomatic or uncontrolled by medication.

(4) Thyroiditis.

m. Other. Other endocrine or metabolic disorders that obviously preclude satisfactory performance of duty, or require frequent or prolonged treatment.

2–9. Upper extremities

(See also para 2–11.) The causes for rejection are as follows:

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—forward elevation to 90 degrees; abduction to 90 degrees.

(2) Elbow—flexion to 100 degrees; extension to 15 degrees.

(3) Wrist—a total range of 60 degrees (extension plus flexion); radial and ulnar deviation combined arc 30 degrees.

(4) Hand—pronation to 45 degrees; supination to 45 degrees.

(5) Fingers—inability to clench fist, pick up a pin or needle, and grasp an object.

(6) Thumb—inability to touch tips of at least three fingers.

b. Hand and fingers.

(1) Absence of the distal phalanx of either thumb.

(2) Absence or loss of distal and middle phalanx of an index, middle, or ring finger of either hand irrespective of the absence or loss of little finger.

(3) Absence of more than the distal phalanx of any two of the following fingers: index, middle finger, or ring finger of either hand.

(4) Absence of hand or any portion thereof except for fingers as noted above.

(5) Hyperdactylia.

(6) Scars and deformities of the fingers or hand which impair circulation, are symptomatic, or which impair normal function to such a degree as to interfere with the satisfactory performance of military duty.

(7) Intrinsic paralysis or weakness (either median or ulnar nerves) sufficient to produce physical findings in the hand (for example, muscle atrophy or weakness).

(8) Wrist, forearm, elbow, arm, and shoulder. Recovery from disease or injury of wrist, forearm, elbow, arm, or shoulder with residual weakness or symptoms such as to preclude satisfactory performance of duty. Grip strength of less than 75 percent of predicted normal when injured hand is compared with the normal hand (nondominant is 80 percent of dominant grip).

2–10. Lower extremities

(See also para 2–11.) The causes for rejection are as follows:

a. Limitation of motion. An individual shall be considered unacceptable if the joint ranges of motion are less that the measurements listed below. Methods of measurement appear in TC 8–640.

(1) Hip—flexion to 90 degrees (minimum); no demonstrable flexion contracture; extension to 10 degrees (beyond 0 degrees); abduction to 45 degrees; rotation of 60 degrees (internal and external combined).

(2) Knee—full extension; flexion to 90 degrees.

(3) Ankle—dorsiflexion to 10 degrees; plantar flexion to 30 degrees; eversion and inversion (total to 5 degrees).

(4) Toes—stiffness that interferes with walking, marching, running, or jumping.

b. Foot and ankle.

(1) Absences of one or more small toes if function of the foot is poor or running or jumping is prevented; absence of a foot or any portion thereof except for toes as noted herein.

(2) Absence of great toe(s); loss of dorsal flexion thereof if function of the foot is impaired.

(3) Claw toes precluding the wearing of appropriate military footwear.

(4) Clubfoot, if there is any residual varus or equinus of the hind foot, degenerative changes in the mid or hind foot or significant stiffness or deformity that precludes foot function or wearing appropriate military footwear.

(5) Pes planus, pronounced cases, with decided eversion of the foot and marked bulging of the inner border, due to rotation of the talus, regardless of the presence or absence of symptoms.

(6) Pes planus, tarsal coalition.

(7) Hallux valgus, if severe, or of any degree if associated with marked exostosis or bunion that would prevent wearing of military footwear.

(8) Hammer toe, hallux limitus, or hallux rigidus that interferes with the wearing of military footwear.

(9) Effects of disease, injury, or deformity including hyperdactylia that prevent running, are accompanied by disabling pain, or prohibit the wearing of military footwear.

(10) Ingrowing toe nails, if severe, and not remediable.

(11) Obliteration of the transverse arch associated with permanent flexion of the small toes.

(12) Overriding of any of the toes if symptomatic or sufficient to interfere with the wearing of military footwear.

(13) Pes cavus, symptomatic or with contracted planter fascia, dorsiflexed toes, tenderness under the metatarsal heads, and callosities under the weight bearing areas.

(14) Planter fasciitis that is refractory to medical treatment or will impair function of the foot.

(15) Neuroma, confirmed 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.

(2) Physical findings of an unstable or internally deranged joint. History of anterior cruciate ligament injury, even if repaired, is disqualifying.

(3) History of surgical correction of knee ligaments.

(4) Authenticated history of congenital dislocation of the hip, osteochondritis of the hip (Legg–Perthes disease), or slipped femoral epiphysis of the hip. These conditions are not disqualifying if there is no x–ray evidence of residual deformity or degenerative changes, or with any clinically significant limitation of motion.

(5) Authenticated history of hip dislocation within two years before examination or degenerative changes on x ray from old hip dislocation.

(6) Osteochondritis of the tibial tuberosity (Osgood–Schlatter disease), if symptomatic or with obvious prominence of the part and x–ray evidence of separated bone fragment.

d. General.

(1) Deformities of one or both lower extremities that have interfered with function to such a degree as to prevent the individual from following a physically active vocation in civilian life or that would interfere with the satisfactory completion of prescribed training and performance of military duty.

(2) Diseases or deformities of the hip, knee, or ankle joint that interfere with walking, running, or weight bearing.

(3) Pain in the lower back or leg that is intractable and disabling to the degree of interfering with walking, running, and weight bearing.

(4) Shortening of a lower extremity 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 are as follows:

a. Arthritis.

(1) Active, subacute, or chronic arthritis.

(2) Chronic osteoarthritis or traumatic arthritis 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 retropatellar knee pain syndrome with or without confirmatory arthroscopic evaluation.

c. Disease of any bone or joint, healed, with such resulting deformity or rigidity, that function is so impaired it will interfere with military service.

d. Dislocation, old, unreduced; substantiated history of recurrent dislocations of major joints; instability of a major joint.

e. Fractures.

(1) Malunited fractures.

(2) Ununited fractures, except for ulnar styloid process.

(3) Any old or recent fracture in which a plate, pin, metal rod, wire or screws used for fixation were left in place; a pin, wire, or screw not subject to easy trauma is not disqualifying.

f. Injury of a bone or joint of more than a minor nature, yet without fracture or dislocation, that occurred within the preceding 6 weeks.

g. Joint replacement.

h. Muscular paralysis, contracture, or atrophy, if progressive or of sufficient degree to interfere with military service.

i. Myotonia congenita.

j. Osteochondritis dessicans.

k. Osteochondromatosis or multiple cartilaginous exostoses.

l. Osteomyelitis, active or recurrent, any bone, or substantiated history of osteomyelitis of any of the long bones.

m. Osteoporosis.

n. Scars, extensive, deep, or adherent to the skin and soft tissues or neuromas of an extremity that are painful, that interfere with muscular movements, that preclude the wearing of military clothing or equipment, or that show a tendency to break down.

o. Implants; silastic or other devices implanted to correct orthopedic abnormalities.

2–12. Eyes

The causes for rejection are as follows:

a. Lids.

(1) Blepharitis, chronic, of more than mild degree. Cases of acute blepharitis will be rejected until cured.

(2) Blepharospasm.

(3) Dacryocystitis, acute or chronic.

(4) Destruction of the lids, complete or extensive, sufficient to impair protection of the eye from exposure.

(5) Adhesions of the eyelids to each other or to the eyeball which interfere with vision.

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

(7) Marked inversion or eversion of the eyelids sufficient to cause troublesome watering of the eyes (entropion or ectropion).

(8) Lagophthalmos.

(9) Ptosis interfering with vision.

(10) Trichiasis, severe.

b. Conjunctiva.

(1) Conjunctivitis, chronic, including trachoma; acute conjunctivitis until cured.

(2) Pterygium, recurring after two operative procedures, encroaching on the cornea in excess of 3 mm, interfering with vision, or is progressive (as evidenced by marked vascularity on a thickened elevated head).

(3) Xerophthalmia.

c. Cornea.

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

(2) History of keratorefractive surgery accomplished to modify the refractive power of the cornea, or of lamellar or penetrating keratoplasty. Laser surgery to reconfigure the cornea is also disqualifying.

(3) Keratitis, acute or chronic.

(4) Ulcer, corneal; history of recurrent ulcers or corneal abrasions (including herpetic ulcers).

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

d. Uveal tract. Inflammation of the uveal tract except healed traumatic choroiditis.

e. Retina.

(1) Angiomatoses, phakomatoses, retinal cysts, and other congenito–hereditary conditions that impair visual functions.

(2) Chorioretinitis, unless a single episode that has healed and does not interfere with vision.

(3) Degenerations of the macula to include macular cysts, holes, and other degenerations (hereditary or acquired degenerative changes and other conditions affecting the macula, including all types of primary and secondary pigmentary degenerations).

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

(5) Inflammation of the retina (histoplasmosis, toxoplasmosis or vascular conditions of the retina to include Coats' disease, diabetic retinopathy, Eales' disease, and retinitis proliferans), unless a single episode has healed and does not interfere with vision.

f. Optic nerve.

(1) Congenito–hereditary conditions of the optic nerve or any other nervous system pathology affecting the efficient function of the optic nerve.

(2) Optic neuritis, neuroretinitis, or secondary optic atrophy resulting therefrom or documented history of attacks of retrobulbar neuritis.

(3) Optic atrophy (primary or secondary).

(4) Papilledema.

g. Lens.

(1) Aphakia (unilateral or bilateral), pseudophakia, or lens implant.

(2) Dislocation, partial or complete, of a lens.

(3) Opacities of the lens which interfere with vision or which are considered to be progressive.

h. Ocular mobility and motility.

(1) Diplopia, documented, constant or intermittent from any cause or of any degree.

(2) Nystagmus, with both eyes fixing, congenital or acquired.

(3) Strabismus of 40 prism diopters or more, uncorrectable by lenses to less than 40 diopters.

(4) Strabismus of any degree accompanied by documented diplopia.

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

(6) 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 diseases and conditions.

(1) Abnormal conditions of the eye or visual fields due to diseases of the central nervous system. Meridian specific visual fields minimums are:

(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.

(3) Asthenopia, severe.

(4) Exophthalmos, unilateral or bilateral, non–familial.

(5) Glaucoma, 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) Hemianopsia of any type.

(7) Loss of normal pupillary reflex reactions to light or accommodation to distance or Adie's syndrome.

(8) Loss of visual fields due to organic disease.

(9) Night blindness.

(10) Residuals of old contusions, lacerations, penetrations, etc., impairing visual function required for satisfactory performance of military duty.

(11) Retained intraocular foreign body.

(12) Tumors. (See *a*(6) above and para 2–40.)

(13) Any organic disease of the eye or adnexa not specified above, which threatens vision or visual function.

2–13. Vision

The causes for rejection are as follows:

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

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

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

c. Refractive error. Any refractive error in spherical equivalent of worse than –8.00 or +8.00 diopters; or if ordinary spectacles cause discomfort by reason of ghost images, prismatic displacement, etc.; if an ophthalmological consultation reveals a condition is disqualifying; or if refractive error is 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 keratoconus, corneal scars, and irregular astigmatism.

e. Color vision. Although there is no standard, color vision will be tested, since adequate color vision is a prerequisite for entry into many military specialties. 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

(See also para 2–40.) The causes for rejection are as follows:

a. Abnormal uterine bleeding, including menorrhagia, metrorrhagia, or polymenorrhea.

b. Amenorrhea, primary or secondary, if unexplained or otherwise disqualifying.

c. Dysmenorrhea, incapacitating to a degree recurrently necessitating absences of more than a few hours from routine activities.

d. Endometriosis, or confirmed history thereof.

e. Hermaphroditism.

f. Hydrocele or left varicocele, if painful, or any right varicocele unless urological evaluation reveals no disease.

g. Menopausal syndrome, physiologic or artificial if manifested by more than mild constitutional or mental symptoms, or artificial menopause if less than 13 months have elapsed since cessation of menses. In all cases of artificial menopause, the clinical diagnosis will be reported; if accomplished by surgery, the pathologic report shall be obtained and recorded.

h. Ovarian cysts, persistent, clinically significant.

i. Pelvic inflammatory disease, acute or chronic.

j. Pregnancy.

k. Testicle(s). (See also para 2–40.)

(1) Absence of both testicles, or unexplained absence of a testicle.

(2) Undiagnosed enlargement or mass of testicle or epididymis.

(3) Undescended testicle(s).

l. Urethritis, acute or chronic.

m. Uterus.

(1) Congenital absence of.

(2) Generalized enlargement of uterus due to any cause.

(3) Papanicolaou's (Pap) smears graded Class 3 or 4 or any smear in which the descriptive terms condyloma accuminatum, human papilloma virus, dysplasia, carcinoma–in–situ, or invasive cancer are used.

n. Vagina.

(1) Congenital abnormalities that interfere with physical activities.

(2) Condyloma accuminatum.

o. Vulva.

(1) Condyloma accuminatum.

(2) Dystrophic conditions.

(3) Vulvitis, acute or chronic including herpes genitalis.

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

2–15. Urinary system

(See paras 2–8 and 2–40.) The causes for rejection are as follows:

a. Cystitis, chronic. Individuals with acute cystitis are unacceptable until the condition is cured.

b. Enuresis determined to be a symptom of an organic defect not amenable to treatment. (See also para 2–32.)

c. Epispadias or hypospadias when accompanied by evidence of infection of the urinary tract, or if clothing is soiled when voiding.

d. Hematuria, cylindruria, pyuria, or other findings indicative of renal tract disease.

e. Incontinence of urine.

f. Kidney.

(1) Absence of one kidney, regardless of cause.

(2) Acute or chronic infections of the kidney.

(3) Cystic or polycystic kidney, confirmed history of.

(4) Horseshoe kidney.

(5) Hydronephrosis or pyonephrosis.

(6) Nephritis, acute or chronic.

(7) Pyelitis, pyelonephritis.

g. Orchitis, chronic, or chronic epididymitis.

h. Penis, amputation of, if the resulting stump is insufficient to permit micturition in a normal manner.

i. Peyronie's Disease.

j. Prostate gland, hypertrophy of, with urinary retention; chronic prostatitis.

k. Proteinuria 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.

l. Renal calculus.

(1) Substantiated history of bilateral renal calculus at any time.

(2) Verified history of renal calculus at any time with evidence of stone formation within the preceding 12 months, current symptoms, or positive x ray for calculus or nephrocalcinosis.

m. Skenitis.

n. Urethra, stricture of.

o. Urinary fistula.

p. Other diseases and defects of the urinary system that obviously preclude satisfactory performance of duty or require frequent and prolonged treatment.

2–16. Head

The causes for rejection are as follows:

a. Abnormalities that are apparently temporary in character resulting from recent injuries until a period of 3 months has elapsed. These include severe contusions and other wounds of the scalp and cerebral concussion. (See para 2–28.)

b. Chronic arthritis, complete or partial ankylosis, or recurrent dislocation of the temporomandibular joint.

c. Deformities of the skull of any degree in the nature of depressions, exostoses, etc., of a degree which would prevent the individual from wearing a protective mask or military headgear.

d. Deformities of the skull of any degree associated with evidence of disease of the brain, spinal cord, or peripheral nerves.

e. Depressed fractures that required surgical evaluation or were associated with a laceration of the dura mater or focal necrosis of the brain. (See para 2–28.)

f. Loss or congenital absence of the bony substance of the skull not successfully corrected by reconstructive materials.

g. All cases involving absence of the bony substance of the skull that have been corrected but in which the defect is in excess of one square inch (6.45 centimeter (cm)) or the size of a 25–cent piece.

2–17. Neck

The causes for rejection are as follows:

a. Cervical ribs 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 of branchial cleft origin or those developing from remnants of the thyroglossal duct, with or without fistulous tracts.

c. Fistula, chronic draining, of any type.

d. Nonspastic contraction of the muscles of the neck or cicatricial contracture of the neck to the extent that it interferes with the wearing of a uniform or military equipment or is so disfiguring as to make the individual objectionable in common social relationships.

e. Spastic contraction of the muscles of the neck, persistent, and chronic.

f. Tumor of thyroid or other structures of the neck. (See para 2–40.)

2–18. Heart

The causes for rejection are as follows:

a. All valvular heart diseases including those improved by surgery except mitral valve prolapse and bicuspid aortic valve. These latter two conditions are not reasons for rejection unless there is associated tachyarrhythmia, mitral regurgitation, aortic stenosis, insufficiency, or cardiomegaly.

b. Coronary heart disease.

c. History of symptomatic arrhythmia or electrocardiographic evidence of arrhythmia.

(1) Supraventricular tachycardia, atrial flutter, and atrial fibrillation (unless there has been no recurrence during the preceding 2 years off all medications), ventricular tachycardia, or fibrillation. Premature atrial or ventricular contractions are disqualifying when sufficiently symptomatic to require treatment or result in physical or psychological impairment. Multifocal premature ventricular contractions are disqualifying irrespective of symptoms or treatment. However, healthy highly trained individuals can have multifocal premature ventricular contractions or nonsustained ventricular tachycardia with a normal prognosis. Cases should be considered on an individual basis for waiver consideration. Ventricular arrhythmias are disqualifying when associated with a physiologic or actuarial significance.

(2) Left bundle branch block, Mobitz type II second degree atrioventricular (AV) block and third degree AV block, accelerated AV conduction (Wolff–Parkinson–White Syndrome), and Lown–Ganong–Levine–Syndrome associated with an arrhythmia. Conduction disturbances such as first degree AV block, left anterior hemiblock, right bundle branch block, or Mobitz type I second degree AV block are not disqualifying when asymptomatic and are not associated with underlying cardiovascular disease.

d. Hypertrophy or dilatation of the heart as evidenced by chest x ray, electrocardiogram (EKG), or echocardiogram. Cardiomyopathy, myocarditis, or history of congestive heart failure from any cause even though currently compensated. Care must be taken to avoid rejection of highly conditioned individuals with sinus bradycardia, increased cardiac volume, and apparent abnormal cardiac enlargement, as indicated by EKG and x ray.

e. Pericarditis except in individuals who have been free of symptoms for 2 years and manifest no evidence of cardiac restriction or persistent pericardial effusion.

f. Persistent tachycardia (resting pulse rate of 100 or greater), regardless of cause.

g. Congenital anomalies of heart and great vessels with physiologic or actuarial significance, which have not been totally corrected.

2–19. Vascular system

The causes for rejection are as follows:

a. Abnormalities of the arteries and blood vessels, aneurysms, atherosclerosis, or arteritis.

b. Hypertensive vascular disease, evidenced by three consecutive diastolic blood pressure measurements greater than 90 mmHg or three consecutive systolic pressure greater than 140 mmHg. High blood pressure requiring medication or a history of treatment including dietary restriction is also disqualifying.

c. Pulmonary or systemic embolization, history of.

d. Vasomotor disturbance, including orthostatic hypotension and Raynaud's phenomenon.

e. Vein diseases; recurrent thrombophlebitis, thrombophlebitis during the preceding year, or any evidence of venous incompetence, such as large or symptomatic varicose veins, edema, or skin ulceration.

2–20. Height

The causes for rejection are as follows:

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.

Table 2–1
Military acceptable weight (in pounds) as related to age and height for males—initial Army procurement (See notes 1 and 2)

		Maximum weight by years of age			
Height (inches)	Minimum weight any 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

Table 2–1
Military acceptable weight (in pounds) as related to age and height for males—initial Army procurement (See notes 1 and 2)—Continued

Height (inches)	Minimum weight any age	Maximum weight by years of age			
		17–20	21–27	28–39	40 and over
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

Notes:

1. If a male exceeds these weights, percent body fat will be measured per the method described in AR 600–9.
2. If a male also exceeds this body fat, he will be rejected for service:

Maximum body fat by years of age			
17–20	21–27	28–39	40 and over
24%	26%	28%	30%

Table 2–2
Military acceptable weight (in pounds) as related to age and height for females—initial Army procurement (See notes 1 and 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
72	125	172	177	183	188
73	128	177	182	188	193
74	130	183	189	194	198

Table 2–2
Military acceptable weight (in pounds) as related to age and height for females—initial Army procurement (See notes 1 and 2)—Continued

Height (inches)	Minimum weight any age	Maximum weight by years of age			
		17–20	21–27	28–39	40 and over
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

Notes:

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

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

Maximum body fat by years of age			
17–20	21–27	28–39	40 and over
30%	32%	34%	36%

2–22. Body build

The causes for rejection are as follows:

a. Congenital malformation of bones and joints. (See paras 2–9, 2–10, and 2–11.)

b. Deficient muscular development that would interfere with the completion of required training.

c. Evidence of congenital asthenia or body build that would interfere with the completion of required training.

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

The causes for rejection are as follows:

a. Abnormal elevation of the diaphragm, either side.

b. Abscess of the lung.

c. Acute infectious processes of the lung, chest wall, pleura, or mediastinum, until cured.

d. Asthma, including reactive airway disease, exercise induced bronchospasm or asthmatic bronchitis, reliably diagnosed at any age. Note: Reliable diagnostic criteria should consist of the following elements:

(1) Substantiated history of cough, wheeze, and or dyspnea which persists over a prolonged period of time (generally more than 6 months) or

(2) If the diagnosis 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. Bronchoprovocation or exercise testing should be performed by a board certified pulmonologist or allergist.

e. Bronchitis, chronic, with pulmonary function impairment that would interfere with duty performance or restrict activities.

f. Bronchiectasis.

g. Bronchopleural fistula.

h. Bullous or generalized pulmonary emphysema.

i. Chronic fibrous pleuritis of sufficient extent to interfere with pulmonary function, or which produces dyspnea on exertion.

j. Chronic mycotic diseases of the lung including coccidioidomycosis, residual cavitation or more than a few small–sized inactive and stable residual nodules demonstrated to be due to mycotic disease.

k. Congenital malformation or acquired deformities of the chest wall that reduce the chest capacity or diminish respiratory or cardiac functions to a degree that interferes with vigorous physical exertion.

l. Empyema, residual intrapleural collection or unhealed sinuses of chest wall following operation or other treatment for empyema.

m. Extensive pulmonary fibrosis from any cause, producing dyspnea on exertion or significant reduction in pulmonary function tests.

n. Foreign body in trachea or bronchus.

o. Foreign body of the chest wall causing symptoms.

p. Foreign body of the lung or mediastinum causing symptoms or active inflammatory reaction.

q. Lobectomy, history of, with residual pulmonary disease. Removal of more than one lobe is cause for rejection regardless of the absence of residuals.

r. Multiple cystic disease of the lung; solitary cyst, large and incapacitating.

s. New growth of the breast, mastectomy, acute mastitis, chronic cystic mastitis of more than mild degree or if symptomatic.

t. Osteomyelitis of rib, sternum, clavicle, scapula, or vertebra.

u. Other symptomatic traumatic lesions of the chest or its contents.

v. Pleurisy with effusion, within the previous 2 years, unknown origin.

w. Pneumothorax during the 3 years preceding examination if due to a simple trauma or surgery; during the 3 years preceding examination if of spontaneous origin. Surgical correction is acceptable if no significant residual disease or deformity remains and pulmonary function tests fall within normal limits. Recurrent spontaneous pneumothorax ipsilaterally is disqualifying regardless of cause, after one failed attempt at surgical correction or pleural sclerosis.

x. Sarcoidosis. (See para 2–38.)

y. Significant abnormal findings of the chest wall, lung(s), pleura, or mediastinum.

z. Silicone injections, without encapsulation, in breasts for cosmetic purposes. Surgical placement of encapsulated implants is acceptable if a minimum of 9 months have elapsed since surgery and site is well healed with no complications reported.

aa. Suppurative periostitis of rib, sternum, clavicle, scapula, or vertebra.

ab. Tuberculous lesions. (See para 2–38*n*.)

ac. Unhealed recent fracture of the ribs, sternum, clavicle, or scapula, or unstable fracture regardless of fracture age.

2–24. Mouth

The causes for rejection are as follows:

a. Hard palate, perforation of.

b. Cleft lip, unless satisfactorily repaired by surgery.

c. Leukoplakia, stomatitis, or ulcerations of the mouth, if severe.

d. Ulcerations, perforation, or extensive loss of substance of the hard or soft palate, extensive adhesions of the soft palate to the pharynx, or complete paralysis of the soft palate. Unilateral paralysis of the soft palate that does not interfere with speech or swallowing and is otherwise asymptomatic is not disqualifying. Loss of the uvula that does not interfere with speech or swallowing is not disqualifying.

2–25. Nose and sinuses

The causes for rejection are as follows:

a. Allergic manifestations.

(1) Atrophic rhinitis.

(2) Allergic rhinitis, if moderate or severe and not controlled by oral medication, desensitization, or topical corticosteroid medication.

b. Anosmia or parosmia.

c. Choana, atresia or stenosis of, if symptomatic.

d. Epistaxis, chronic recurrent.

e. Nasal polyps or a history of nasal polyps, unless surgery was performed at least a year before examination and there is no evidence of recurrence.

f. Nasal septum, perforation of, associated with either the interference of function, ulceration, or crusting, and when the result of organic disease; if progressive; or if respiration is accompanied by a whistling sound.

g. Sinusitis, acute.

h. Sinusitis, chronic when more than mild:

(1) Evidenced by any of the following: chronic purulent nasal discharge, nasal polyps, hyperplastic changes of the nasal tissue, or symptoms requiring frequent medical attention.

(2) Confirmed by transillumination or x–ray examination or both.

i. Vasomotor rhinitis, if moderate or severe and not controlled by medication.

2–26. Pharynx, trachea, and larynx

The cause for rejection are as follows:

a. Laryngeal paralysis, sensory or motor, due to any cause.

b. Larynx, organic disease of, such as neoplasm, polyps, granuloma, ulceration, and chronic laryngitis.

c. Dysphonia plicae ventricularis.

d. Tracheostomy or tracheal fistula.

2–27. Other defects and diseases of the mouth, nose, throat, pharynx, and larynx

The causes for rejection are as follows:

a. Aphonia, or history of, or recurrent, if the cause was such as to make a subsequent attack probable.

b. Deformities or conditions of the mouth, tongue, throat, pharynx, larynx, and nose that interfere with mastication and swallowing of ordinary food, or with speech or breathing.

c. Destructive syphilitic disease of the mouth, nose, throat, or larynx.

d. Pharyngitis and nasopharyngitis, chronic, with positive history and objective evidence, if of such a degree as likely to result in excessive time lost in the military environment.

2–28. Neurological disorders

The causes for rejection are as follows:

a. Cerebrovascular conditions. Any history of subarachnoid or intracerebral hemorrhage, vascular insufficiency, arteriovenous malformation, or aneurysm whether transient or with secondary infarction involving the central nervous system.

b. Congenital malformations if associated with neurological manifestations or if the process is expected to be progressive; meningocele even if uncomplicated.

c. Degenerative, and hereditodegenerative disorders affecting the cerebrum, basal ganglia, cerebellum, spinal cord, peripheral nerves, or muscles.

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

e. Head injury, all types. Applicants with a history of head injury are unacceptable at any time if they display any of the following:

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

(2) Permanent motor or sensory deficits.

(3) Impairment of intellectual function.

(4) Alteration of personality.

(5) Central nervous system shunt of all types.

f. Head injury, severe. Applicants with a history of severe head injury are unfit for a period of at least 5 years after which they may be considered fit if complete neurological and neuropsychological evaluation (see table 2–3) shows no residual dysfunction or complications: Severe head injuries are defined by one or more of the following:

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

(2) Depressed skull fracture.

(3) Laceration or contusion of dura or brain.

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

(5) Associated abscess or meningitis.

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

(7) Focal neurologic signs.

(8) Radiographic evidence of retained metallic or bony fragments.

(9) Leptomeningeal cysts or arteriovenous fistula.

(10) Early post–traumatic seizure(s) occurring within 1 week of injury but more than 30 minutes after injury.

Table 2–3
Evaluation for risk of head injury sequelae

Degree of head injury: Mild (para 2–29h). **Minimum observation time:** 1 month. **Evaluation requirements:** Complete neurological examination by a physician.
Degree of head injury: Moderate (para 2–29g). **Minimum observation time:** 2 years **Evaluation requirements:** Complete nuerological examination by a neurologist or internist. Computerized topography (CT) scan.
Degree of head injury: Severe (para 2–29ff). **Minimum observation time:** 5 years for closed head trauma, l0 years for penetrating head trauma. **Evaluation requirements:** Complete neurological examination by a neurologist or neurosurgeon. CT scan. Neuropsychological evaluation.

g. Head injury, moderate. Applicants with a history of moderate head injury are unfit for a period of at least 2 years after which they may be considered fit if complete neurological evaluation (see table 2–3) 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.

h. Head injury, mild. Applicants with a history of mild head injury, as defined by a period of unconsciousness or amnesia, alone or in combination, of 1 hour or less are unfit for at least 1 month after which they may be acceptable if neurological evaluation (see table 2–3) shows no residual dysfunction or complications.

i. Head injury, with persistent sequelae. Applicants with a history of head injury with 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.

j. Infectious diseases.

(1) Meningitis, encephalitis, or poliomyelitis within 1 year prior

to examination, or if there are residual neurological defects that would interfere with satisfactory performance of military duty.

(2) Neurosyphilis of any form (general paresis, tabes dorsalis, meningovascular syphilis).

k. Narcolepsy, cataplexy, sleep apnea syndrome and similar states, except that sleep paralysis is not disqualifying by itself.

l. Paralysis, tremor or weakness, deformity, discoordination, pain, sensory disturbance, intellectual deficit, disturbances of consciousness, or personality abnormalities regardless of cause if there is any indication that such involvement is likely to interfere with prolonged normal function in any practical manner or is progressive or recurrent.

m. All forms of generalized or partial epilepsy that have persisted beyond the age of 5 unless the applicant has been free of seizures for a period of 5 years immediately preceding examination for military service while taking no medication for seizure control and has a normal electroencephalogram (EEG). All such cases will be referred to TSGs Consultant in Neurology for a determination of fitness. Documentation in these cases must be from attending or consulting physicians and include an original EEG taken within 3 months, a current neurology consultation containing details of the epileptic history, and an assessment of the present neurological status. Cases from the military entrance processing station (MEPS) will be sent through the MEPCOM to TSGs Neurology Consultant.

n. Any substantiated history or evidence of acquired chronic or recurrent disorders such a myasthenia gravis, polymyositis, and muscular sclerosis.

o. Central nervous system shunts of all kinds.

Note. Diagnostic concepts and terms utilized in paragraphs 2–29 through 2–33 are in consonance with the Diagnostic and Statistical Manual, DSM–III–R, American Psychiatric Association, 1987.

2–29. Disorders with psychotic features

The cause for rejection is a history of a mental disorder with gross impairment in reality testing. This does not include transient disorders associated with intoxication, severe stress, or secondary to a toxic, infectious, or other organic process.

2–30. Mood disorders

The causes for rejection are symptoms, diagnosis, or history of a major mood disorder requiring maintenance treatment or hospitalization.

2–31. Anxiety, somatoform, dissociative, or factitious disorders (neurotic disorders)

The causes for rejection are as follows:

a. History of such disorders resulting in any or all of the below:

(1) Hospitalization.

(2) Prolonged care by a physician or other professional.

(3) Loss of time from normal pursuits for repeated periods even if of brief duration.

(4) Symptoms or behavior of a repeated nature which impaired social, school, or work efficiency.

b. History of an episode of such disorders within the preceding 12 months, which was sufficiently severe to require professional attention or absence from work or school for more than a brief period (maximum of 7 days).

2–32. Personality, behavior, or academic skills disorders

The causes for rejection are as follows:

a. Personality or behavior disorders, as evidenced by frequent encounters with law enforcement agencies, antisocial attitudes or behavior which, while not sufficient cause for administrative rejection, are tangible evidence of impaired characterological capacity to adapt to military service.

b. Personality or behavior disorders where it is evident by history, interview, or psychological testing that the degree of immaturity, instability, personality inadequacy, impulsiveness, or dependency will seriously interfere with adjustment in the Army as demonstrated by repeated inability to maintain reasonable adjustment in school, with employers and fellow workers, and other social groups.

c. Other behavior problems including but not limited to conditions such as authenticated evidence of functional enuresis or encopresis not due to an organic condition, sleepwalking, or eating disorders, that are habitual or persistent, occurring beyond age 12, or stammering or stuttering of such a degree that the individual is normally unable to express himself or herself clearly or to repeat commands.

d. Specific academic skills disorders, chronic history of academic skills disorders or perceptual defects secondary to organic or functional mental disorders that interfere with work or school after age 12. Current use of medication to improve or maintain academic skills disorders (for example, methylphenidate hydrochloride) is disqualifying.

e. History of attempted suicide or serious suicide gesture.

2–33. Psychosexual conditions

The causes for rejection are as follows:

a. Transsexualism and other gender identity disorders.

b. Exhibitionism, transvestism, voyeurism and other paraphilias.

2–34. Substance misuse

The causes for rejection are as follows:

a. Alcohol dependence or history of.

b. Drug dependence or history of.

c. Drug abuse characterized by—

(1) The evidence of use of any controlled hallucinogenic, or other intoxicating substance at time of examination, when the use cannot be accounted for as the result of the advice of a recognized health care practitioner.

(2) Documented misuse or abuse of any controlled substance (including cannabinoids or anabolic steroids) requiring professional care within a 1–year period prior to examination. Use of marijuana or other cannabinoids (not habitual use) or experimental or casual use of other drugs short of addiction or dependence may be waived by competent authority as established by the Army if there is evidence of current drug abstinence and the individual is otherwise qualified for service.

(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.

d. Alcohol abuse characterized by the use of alcoholic beverages which leads to misconduct, unacceptable social behavior, poor work or academic performance, impaired physical or mental health, lack of financial responsibility, or a disrupted personal relationship.

2–35. Skin and cellular tissues

The causes for rejection are as follows:

a. Acne, severe, or when extensive involvement of the neck, shoulders, chest, or back would be aggravated by or interfere with the wearing of military equipment, and not amenable to treatment. Patients under treatment with isotretinoin are medically unacceptable until 8 weeks after completion of course of therapy.

b. Atopic dermatitis, 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 5.

c. Contact dermatitis, involving rubber or other materials used in any type of required protective equipment.

d. Cysts.

(1) Cysts, other than pilonidal, of such a size or location as to interfere with the normal wearing of military equipment.

(2) Pilonidal cysts, if evidenced by the presence of a tumor mass or a discharging sinus. History of pilonidal cystectomy within 1 year before examination is disqualifying.

e. Dermatitis factitia.

f. Dermatitis herpetiformis.

g. Eczema, any type, that is chronic and resistant to treatment.

h. Elephantiasis or chronic lymphedema.

i. Epidermolysis bullosa.

j. Fungus infections, systemic or superficial types, if extensive and not amenable to treatment.

k. Furunculosis, extensive recurrent, or chronic.

l. Hyperhidrosis of hands or feet, chronic or severe.

m. Ichthyosis, severe.

n. Keloid formation, if the tendency is marked or interferes with the wearing of military equipment.

o. Leprosy, any type.

p. Leukemia cutis: mycosis fungoides, Hodgkin's disease. (See para 2–40*b* for additional remarks on Hodgkin's disease and the potential for service qualification.)

q. Lichen planus.

r. Neurofibromatosis (Von Recklinghausen's disease).

s. Nevi or vascular tumors, if extensive, interferes with function, or exposed to constant irritation.

t. Pemphigus or pemphigold.

u. Photosensitivity: any primary sun–sensitive condition, such as polymorphous light eruption or solar uticaria; any dermatosis aggravated by sunlight such as lupus erythematosus.

v. Psoriasis or a verified history thereof.

w. Radiodermatitis.

x. Scars 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.

y. Scleroderma.

z. Tattoos that will significantly limit effective performance of military service.

aa. Urticaria, chronic.

ab. Warts, plantar, which have materially interfered with a useful vocation in civilian life.

ac. Xanthoma, if disabling or accompanied by hyperlipemia.

ad. Any other chronic skin disorder of a degree or nature which requires frequent outpatient treatment or hospitalization, or interferes with the satisfactory performance of duty.

2–36. Spine and sacroiliac joints

(See also para 2–11.) The causes for rejection are as follows:

a. Arthritis. (See para 2–11*a*.)

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. Substantiation or documentation of the complaint without objective physical findings is required.

c. Deviation of curvature of spine 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 the wearing of 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. Diseases of the lumbosacral or sacroiliac joints of a chronic type associated with pain referred to the lower extremities, muscular spasm, postural deformities, and limitation of motion in the lumbar region of the spine.

e. Fusion involving more than two vertebrae. Any surgical fusion is disqualifying.

f. Granulomatous diseases either active or healed.

g. Healed fractures or dislocations of the vertebrae. 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.

h. Juvenile epiphysitis with any degree of residual change indicated by x ray or kyphosis.

i. Ruptured nucleus pulposus (herniation of intervertebral disk) or history of operation for this condition.

j. Spina bifida when symptomatic or if there is more than one vertebra involved, dimpling of the overlying skin, or a history of surgical repair.

k. Spondylolysis that is symptomatic or likely to interfere with performance of duty or limit assignments, even if successfully fused.

l. Weak or painful back requiring external support such as a corset or brace; recurrent sprains or strains requiring limitation of physical activity or frequent treatment.

m. Spondylolisthesis.

2–37. Scapulae, clavicles, and ribs

(See para 2–11.) The causes for rejection are:

a. Fractures, until well healed, and until determined that the residuals thereof will not preclude the satisfactory performance of military duty.

b. Injury within the preceding 6 weeks, without fracture or dislocation, of more than a minor nature.

c. Osteomyelitis.

d. Prominent scapulae interfering with function or with the wearing of a uniform or military equipment.

2–38. Systemic diseases

The causes for rejection are:

a. Amyloidosis.

b. Ankylosing spondylitis.

c. Eosinophilic granuloma, when occurring as a single localized bony lesion and not associated with soft tissue or other involvement, should not be a cause for rejection once healing has occurred. All other forms of the Histiocytosis X spectrum should be rejected, however.

d. Lupus erythematosus.

e. Mixed connective tissue disease.

f. Polymyositis/dermatomyositis complex.

g. Progressive systemic sclerosis, including CREST (calcinosis, Raynaud's phenomenon, esophageal dysfunction, sclerodactyly and telangiectasis) variant. A single plaque of localized scleroderma (morphea) that has been stable for at least 2 years is not disqualifying.

h. Psoriatic arthritis.

i. Reiter's Disease.

j. Rheumatoid arthritis.

k. Rhabdomyolysis, or history thereof.

l. Sarcoidosis, unless there is substantiated evidence of a complete spontaneous remission of at least 2 years duration.

m. Sjogren's Syndrome.

n. Tuberculosis.

(1) Active tuberculosis in any form or location, or substantiated history of active tuberculosis within the previous 2 years.

(2) Substantiated history of one or more reactivations or relapses of tuberculosis in any form or location or other definite evidence of poor host resistance to the tubercle bacillus.

(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 not disqualified providing they have received a complete course of standard chemotherapy for tuberculosis. In addition, individuals with a tuberculin reaction 10mm or greater and without evidence of residual disease in pulmonary or non–pulmonary sites are eligible for enlistment, induction and appointment provided they have or will be treated with chemoprophylaxis in accordance with the guidelines of the American Thoracic Society and U.S. Public Health Service.

o. Vasculitis (Bechet's, Wegener's granulomatosis, polyarteritis nodosa).

2–39. General and miscellaneous conditions and defects

The causes for rejection are:

a. Allergic manifestations. A reliable history of a life–threatening generalized reaction with 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. Any deformity, abnormality, defect, or disease that impairs general functional ability to such an extent as to prevent satisfactory performance of military duty.

d. Chronic metallic poisoning, especially beryllium, manganese, and mercury. Undesirable residuals from lead, arsenic, or silver poisoning make the applicant unacceptable.

e. Cold injury, residuals of, such as: frostbite, chilblain, immersion foot, trench foot, deep–seated ache, paresthesia, hyperhidrosis, easily traumatized skin, cyanosis, amputation of any digit, or ankylosis.

f. Cold urticaria and angioedema.

g. Filariasis: trypanosomiasis, amebiasis, schistosomiasis, uncinariasis (hookworm) associated with anemia, malnutrition, etc., and other similar worm or animal parasitic infestation, including the carrier states thereof, if more than mild.

h. Heat pyrexia (heatstroke, sunstroke, etc.). Documented evidence of a predisposition (including disorders of sweat mechanism and a previous serious episode), recurrent episodes requiring medical attention, or residual injury resulting therefrom (especially cardiac, cerebral, hepatic, and renal).

i. Industrial solvent and other chemical intoxication, chronic, including carbon disulfide, trichloroethylene, carbon tetrachloride, and methyl cellosolve.

j. Malignant hyperthermia.

k. Motion sickness. An authenticated history of frequent incapacitating motion sickness after the 12th birthday is disqualifying. For entrance into USMA or ROTC scholarship programs, admission of frequent, incapacitating motion sickness will suffice for disqualification.

l. Mycotic infection of internal organs.

m. Myositis or fibrositis, severe, chronic.

n. Organ transplant recipient.

o. Presence of HIV–I or antibody. Presence is confirmed by repeatedly reactive enzyme–linked immunoassay serological test and positive immunoelectrophoresis (Western Blot) test, or other Food and Drug Administration approved confirmatory test.

p. Reactive tests for syphilis 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 or if the test reverts to a non–reactive status during an appropriate follow–up period (3 to 6 months).

q. Residual of tropical fevers and various parasitic or protozoal infestations that, in the opinion of the medical examiner, preclude the satisfactory performance of military duty.

r. Rheumatic fever during the previous 2 years, or any history of recurrent attacks, Sydenham's chorea at any age.

s. Sleep apnea (obstructive sleep apnea or sleep disordered breathing) which causes daytime hypersomnolence or snoring that interferes with the sleep of others.

2–40. Tumors and malignant diseases

The causes for rejection are:

a. Benign tumors.

(1) Benign tumors of the head or face that interfere with function or preclude the wearing of face or protective masks or a helmet.

(2) Benign tumors of the eyes, ears, or upper airway that interfere with function.

(3) Benign tumors of the thyroid or other neck structures such as to interfere with function or the wearing of a uniform or military equipment.

(4) Benign tumors of the breast (male or female), chest, or abdominal wall that would interfere with military duty.

(5) Benign tumors of the respiratory, gastrointestinal, genitourinary, or musculoskeletal systems that interfere with function or the wearing of a uniform or military equipment.

(6) Benign tumors of the musculoskeletal system likely to continue to enlarge, be subjected to trauma during military service, or show malignant potential.

(7) Benign tumors of the skin which interfere with function, have malignant potential, interfere with military duty or the wearing of the uniform or military equipment.

(8) Benign tumors of the central nervous system, or history of if likely to recur.

(9) Benign tumors of the peripheral nerves that interfere with function, have malignant potential, interfere with military duty or the wearing of the uniform or military equipment.

b. Malignant tumors diagnosed by accepted laboratory procedures, and even though surgically removed or otherwise treated, with exceptions as noted. (Individuals who have a history of childhood cancer and who have not received any surgical or medical cancer therapy for 5 years and are free of cancer will be considered, on a case by case basis, fit for acceptance into the Army. Applicants must provide information about the history and present status of their cancer.)

(1) Malignant tumors of the auditory canal, eye, or orbit or upper airway.

(2) Malignant tumors of the breast (male or female).

(3) Malignant tumors of the lower airway or lung.

(4) Malignant tumors of the heart.

(5) Malignant tumors of the gastrointestinal tract, liver, bile ducts, or pancreas.

(6) Malignant tumors of the genitourinary system, male or female. Wilm's tumor and germ cell tumors of the testis treated surgically and/or with current chemotherapy in childhood after a 2–year disease–free interval off all treatment may be considered on a case by case basis for service.

(7) Malignant tumors of the musculoskeletal system.

(8) Malignant tumors of the central nervous system and its membranous coverings, unless 5 years postoperative, off treatment without recurrence, and without otherwise disqualifying residuals of surgery or the original lesion.

(9) Malignant tumors of the endocrine glands.

(10) Malignant melanoma or history thereof. Other skin tumors such as basal cell and squamous cell carcinomas surgically removed are not disqualifying.

(11) Malignant tumors of the hematopoietic system.

(a) Lymphomatous diseases: non–Hodgkin's lymphoma (all types); Hodgkin's disease, active or recurrent. However, Hodgkin's disease treated with radiation therapy and/or chemotherapy and disease–free off treatment for 5 years may be considered for service. Large cell lymphoma will likewise be considered on a case–by–case basis after a 2–year disease–free interval off all therapy.

(b) Leukemias: all types, except acute lymphoblastic leukemia treated in childhood without evidence of recurrence.

(c) Multiple myeloma.

2–41. Sexually transmitted diseases

In general, the finding of acute, uncomplicated venereal disease that can be expected to respond to treatment is not a cause for medical rejection for military service. The following are cause for rejection:

a. Chronic sexually transmitted disease that has not satisfactorily responded to treatment. The finding of a positive serologic test for syphilis following adequate treatment is not in itself considered evidence of chronic venereal disease. See paragraph 2–39*p*.

b. Complications and permanent residuals of sexually transmitted diseases when they are progressive, or of such a nature as to interfere with the satisfactory performance of duty, or are subject to aggravation by military service.

c. Neurosyphilis. See paragraph 2–28*j*.

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, ARNG, and USAR.

b. All enlisted soldiers of the Regular Army, ARNG, and USAR.

c. Students already enrolled in the HPSP and USUHS programs.

d. Soldiers placed on the TDRL if the condition was present during active duty. (See AR 635–40.)

e. Enlisted soldiers of the ARNG or USAR who apply for enlistment in the regular Army.

f. Commissioned and warrant officers of the ARNG or USAR who apply for appointment in the Active Army.

g. Soldiers of the ARNG or USAR who reenter active duty under the "split–training option." (However, the weight standards of tables 2–1 and 2–2 apply to split option trainees.)

h. 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 a medical evaluation board (MEB) as defined in AR 40–3 and will be referred to a physical evaluation board (PEB) as defined in AR 635–40, with the following caveats:

a. USAR or ARNG 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 of this regulation and will not be referred to a PEB.

b. Soldiers pending other than honorable administrative discharges (under AR 635–200 and AR 635–100) will be referred to an MEB. In the case of enlisted soldiers, the results of the MEB will be forwarded to the court martial convening authority who will determine if the soldier will be referred to a PEB, or will be discharged administratively. See AR 635–200, paragraph 1–35, for further guidance on administrative separations of enlisted soldiers. See AR 635–40, paragraph 4–4, for processing of commissioned or warrant officers.

c. A soldier will not be referred to an MEB or PEB because of impairments which were known to exist at the time of acceptance in the Army and which have remained essentially the same in degree of severity and have not interfered with successful performance of duty.

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

e. If the Secretary of Defense prescribes less stringent standards during 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 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 medical problems and all physical limitations the soldier has. Determination of fitness or unfitness will be made by a PEB. 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 AR 635–40, chapter 9, 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 residuals 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, hiatus hernia 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. 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, peptic, 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, 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. Polycythemia, when response to therapy is unsatisfactory, or when therapy is such as to require prolonged, intensive medical supervision.

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 270(b)), 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 270(b), referral to a PEB will be determined under AR 635–40, chapter 8. 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, AR 140–10, NGR 600–200, or NGR 635–100, 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 or associated tissues when, following restorative surgery, there are residuals which are incapacitating, or interfere with the individual's satisfactory performance of military duty, or leave unsightly deformities which are disfiguring.

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 hyperfunction which 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 hypoglycemic drugs in addition to restrictive diet 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. Hyperthyroidism with severe symptoms or which does not respond to treatment.

j. Hypofunction, adrenal cortex requiring medication for control.

k. Hypoparathyroidism with objective evidence and severe symptoms not controlled by maintenance therapy.

l. Hypothyroidism with objective evidence and severe symptoms not controlled by medication.

m. Hypogammaglobulinemia.

n. 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 a 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 which 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, leg, or thigh.

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, which 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 which is refractory to medical or surgical treatment, interferes with the satisfactory performance of military duties, and prevents the wearing of military footwear.

(6) Hammertoes, severe, which 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 3–14 *a.*

d. Joint ranges of motion. Motion which 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 plantar flexion to 10 degrees.

e. Shortening of an extremity. Shortening of an extremity which exceeds 2 inches.

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 gonococcic or tuberculous infection, see paragraphs 3–40*j* and 3–45*b*.

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.

h. Muscles.

(1) Flaccid paralysis of one or more muscles with loss of function which 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 which 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 which interferes with stability and function.

m. Tendon transplant with fair or poor restoration of function with weakness which 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, which 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 3–16*e*, 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 3–16*e*, 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.

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

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

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

(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, and which 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 which 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 which 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 which precludes the satisfactory performance of duty.

(10) Pyelonephritis or pyelitis, when chronic, which 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, with more than mild mental and constitutional symptoms not amenable to treatment.

h. Chronic pelvic pain without demonstrative pathology 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 following treatment and convalescent period there remain more than mild mental or constitutional symptoms.

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. Urethrostomy, 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.

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:

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 paragraph 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 paragraph 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 paragraph 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 which 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 paragraph 3–25) apply.

d. Periarteritis nodosa with definite evidence of functional impairment.

e. Chronic venous insufficiency (postphlebitic 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. Erythromelalgia. Persistent burning pain in the soles or palms not relieved by treatment.

b. Hypertensive cardiovascular disease and hypertensive vascular disease. Diastolic pressure consistently more than 110 mmHg following an adequate period of therapy in an ambulatory status, or any documented history of hypertension, regardless of the pressure values, if associated with one or more of the following:

(1) More than minimal changes in the brain.

(2) Heart disease.

(3) Kidney involvement, with moderate impairment of renal functions.

(4) Grade III (Keith–Wagner–Barker) changes in the fundi.

c. Rheumatic fever, active, with or without 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 paragraph 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 paragraph 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 paragraph 3–25) apply.

h. Cardiac arrhythmia ablation procedures, 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 paragraph 3–25) apply.

3–25. Trial of duty and profiling

a. Trial of duties 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 and a physical activity prescription on DA Form 3349 will be provided by a physician. Upon completion of the trial of duty period, an addendum to the MEB will be completed. An addendum to the MEB by a cardiologist or internist 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, MEB addendum, and an updated DA Form 3349 will then be forwarded 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 P3 Profile with specific written limitations and instructions for physical and cardiovascular rehabilitation on DA Form 3349. When the addendum to the medical board is accomplished, a permanent numerical designator in the "P" factor of the physical profile will be given 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 "3." Individuals who are asymptomatic, but with objective evidence of myocardial ischemia or other cardiovascular functional abnormality.

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

3–26. Tuberculous lesions

The causes for referral to an MEB are as follows:

a. Pulmonary tuberculosis—

(1) When treatment and return to useful duty will probably require more than 15 months including an appropriate period of convalescence, or 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.)

(2) When a member of the USAR 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 will be capable of performing full–time military duty. Individuals who are retained in the Reserve while undergoing treatment may not be called or ordered to active duty (including mobilization), ADT, or inactive duty training during the period of treatment and convalescence.

b. Tuberculous emphysema.

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, or asthmatic bronchitis within the criteria outlined in paragraphs (1) through (5) below:

(1) Definitions/diagnostic criteria are as follows:

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

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

(c) Airway hyperactivity is the presence of an exaggerated decrease in airflow induced by a standard bronchoprovocation challenge such as methacholine inhalation. Demonstration of exercise induced bronchospasm is diagnostic of airway hyperactivity, however, failure to induce bronchospasm with exercise does not rule out the diagnosis of asthma.

(2) Chronic asthma is cause for MEB/PEB referral if it requires the regular use of medications (inhaled or oral, bronchodilator or anti–inflammatory) to allow the soldier to perform all military training and duties.

(3) Acute, self limited, reversible airflow obstruction and airway hyperactivity can be caused by upper respiratory infections and inhalation of irritant gases. This should not be diagnosed as asthma unless significant symptoms or airflow abnormalities persist for more than 6 months.

(4) Soldiers who are diagnosed as having asthma may be placed on a Temporary profile with a T3 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 without medication, the soldier will be referred to an MEB/PEB.

(5) All soldiers meeting an MEB for asthma should be evaluated by an internist, pulmonologist, or allergist.

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 which require repeated hospitalization.

c. Bronchiectasis or bronochiolectasis. Cylindrical or saccular type which is moderately symptomatic, with paroxysmal cough at frequent intervals throughout the day or with moderate emphysema with a moderate amount of bronchiectastic sputum, or with recurrent pneumonia, or with residuals or complications which 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 which 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 fatigability 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 and chest

The cause for referral to an MEB is a 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, which 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 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 which is suppurative, complicated by polyps, and which 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 dystrophy, 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 of duty.

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 be 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 a 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 P3 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 P2 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 condition, 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 utilized in paragraphs 3–31 through 3–37 are in consonance with DSM–III–R. 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. Affective disorders (mood disorders)

The causes for referral to an MEB are persistence or recurrence of symptoms sufficient to require extended or recurrent hospitalization, necessity for limitations of duty or duty in protected environment or resulting in interference with effective military performance.

3–33. Anxiety, somatoform, or dissociative disorders (neurotic disorders)

The causes for referral to an MEB are persistence or recurrence of symptoms sufficient to require extended or recurrent hospitalization, necessity for limitations of duty or duty in protected environment or resulting in interference with effective military performance.

3–34. Organic mental disorders

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

3–35. Personality, sexual, or factitious disorders; disorders of impulse control not elsewhere classified; psychoactive disorders

These 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 appropriate administrative channels.

3–36. Adjustment disorders

Transient, situational maladjustments due to acute or special 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 which 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 or requiring periodic hospitalization.

c. Amyloidosis. Generalized.

d. Cysts and tumors. (See paras 3–42 through 3–44.)

e. Dermatitis herpetiformis. Not responsive to therapy.

f. Dermatomyositis.

g. Dermographism. Interfering with the satisfactory 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. Hyperhydrosis. 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*c*.)

q. Lichen planus. Generalized and not responsive to treatment.

r. Lupus erythematosus. Cutaneous or mucous membranes involvement which 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 which seriously interferes with the function of an extremity.

aa. Tuberculosis of the skin. See paragraph 3–40*k*.

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. 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 which interferes with the satisfactory performance of duty.

af. Other skin disorders. If chronic, or of a nature which 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. Congenital anomalies.

(1) Dislocation, congenital, of hip.

(2) Spina bifida; demonstrable signs and moderate symptoms of root or cord involvement.

(3) Spondylolysis or spondylolisthesis with more than mild symptoms resulting in repeated outpatient visits, or repeated hospitalization or limitations affecting performance of duty.

b. Coxa vara. More than moderate with pain, deformity, and arthritic changes.

c. 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.

d. Kyphosis. More than moderate, interfering with function, or causing unmilitary appearance.

e. 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.

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 fatigability, lassitude, depression, or general malaise.

d. Leprosy. Any type which 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 which 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, 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. See *v* below.

l. Spondyloarthropathies. Chronic or recurring episodes of arthritis causing functional impairment supported by objective, subjective, and radiographic findings; or arthritis requiring medications for control which need frequent monitoring by a physician.

(1) Ankylosing spondylitis.

(2) Reiter's syndrome.

(3) Psoriatic arthritis.

(4) Arthritis associated with inflammatory bowel disease.

(5) Whipple's disease.

m. Systemic lupus erythematosus. See *v* below.

n. Sjogren's syndrome. When chronic, more than mildly symptomatic, and resistent to treatment after a reasonable period of time. See *v* below.

o. Progressive systemic sclerosis, diffuse and limited disease. See *v* below.

p. Myopathy to include inflammatory, metabolic or inherited. See *v* below.

q. Systemic vasculitis involving major organ systems, chronic. See *v* below.

r. Hypersensitivity angiitis. 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. See *v* below.

s. Behcet's syndrome. See *v* below.

t. Adult onset Still's disease. See *v* below.

u. Mixed connective tissue disease and other overlap syndromes. See *v* below.

v. Any chronic or recurrent systemic inflammatory disease or arthritis which interferes with successful performance of duty or requires geographic assignment limitations,or requires medication for control that requires frequent monitoring by a physician.

3–41. General and miscellaneous conditions and defects

The causes for referral to an MEB are as follows:

a. Allergic manifestations.

(1) Allergic rhinitis. (See 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 3–46 and 3–47.)

c. Sleep apnea. Obstructive sleep apnea or sleep–disordered breathing, which causes daytime hypersomnolence or snoring that interferes with the sleep of others and which 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.

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

b. Malignant neoplasms in individuals on active duty, and treatment is refused by the individual.

c. Presence of malignant neoplasms or reasonable suspicion thereof when an individual not on active duty is unwilling to undergo treatment or appropriate diagnostic procedures.

d. 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.

e. The above definitions of malignancy or malignant disease exclude basal cell carcinoma of the skin and carcinoma of the uterine cervix.

3–43. Neoplastic conditions

The causes for referral to an MEB are neoplastic conditions of the lymphoid and blood–forming tissues.

3–44. Benign neoplasms

The causes for referral to an MEB are as follows:

a. Benign tumors, except as noted in *b* below, are not generally a cause of unfitness because they are usually remediable. Individuals who refuse treatment should be considered unfit only if their condition precludes their satisfactory performance of military duty.

b. The following, upon the diagnosis thereof, are normally considered to render the individual unfit for further military service.

(1) Ganglioneuroma.

(2) Meningeal fibroblastoma, when the brain is involved.

c. Pigmented villonodular synovitis is a cause for referral when severe enough to prevent successful performance of duty.

3–45. 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.

3–46. Heat illness and injury

The causes for referral to an MEB are as follows:

a. Heat exhaustion.

(1) Definition: Collapse, including syncope, occurring during or immediately following exercise–heat stress without evidence of organ damage or systemic inflammatory activation.

(2) Single 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) Definitions:

(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 Army Physical Fitness Test (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 an addendum to the MEB and referral to a PEB.

3–47. Cold injury

The causes for referral to an MEB are as follows:

a. Frostbite (freezing cold injury).

(1) Definition: 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 non regulation items, to be worn under authorized outer garments.

(3) Soldiers with frostbite more than first degree will be given a

P–3 temporary profile, renewed as required, 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 injury. They are allowed to use all the protection equipment for 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. Trenchfoot (nonfreezing cold injury).

(1) Definition: 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) Definition: 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)	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: e.g., 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, squash, 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 two 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: e.g., 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 any acitivities requiring ≥ 5 metabolic equivalents: e.g., 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 out activities listed above (specific 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 physical 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 whose ordinary physical activity should be markedly restricted.	Class IV—Guarded despite therapy.
Class E—Patients with cardiac disease who should be at complete rest, confined to bed or chair.	

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 ARNG.

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

c. This chapter lists medical conditions and physical defects which 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.

d. A failure to meet medical standards for flying duties remains disqualifying for flying duties until reviewed by the Commander, U.S. Army Aeromedical Center (USAAMC). Commander, USAAMC may recommend qualified for information only, qualified with waiver, or medical termination from aviation service. Commander, USAAMC, issues Aeromedical Policy Letters (APLs) and Aeromedical Technical Bulletins (ATBs) that provide detailed recommendations for specific, common disqualifications. Refer all questionable cases to Commander, USAAMC (MCXY–AER), 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; non–rated (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 (see para 4–33) apply to—

(1) Army military ATCs.

(2) DAC ATCs.

(3) 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 Commander, USAAMC, ATTN: MCXY–AER, 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 4, 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 a 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 23, Hematocrit and Hemoglobinopathies.)

b. History of immunodeficiency diseases. (See also paras 2–39*o* 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/3/4 are the causes listed 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 25, Dental Fitness.

4–7. Ears

The causes of medical unfitness for flying duty Classes 1/1A/2/2F/2S/3/4 are the causes listed 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 which 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 cause of medical unfitness for flying duty Classes 1/1A/2/2F/2S/3/4 is hearing loss in dB greater than shown in table 4–1. (See APL 17, Audiometric Evaluation.)

4–9. Endocrine and metabolic diseases

The causes for medical unfitness for flying duty Classes 1/1A/2/2F/2S/3/4 are the causes listed in paragraph 2–8, plus a history of symptomatic hypoglycemia. (See APL 16, 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 listed in paragraphs 2–9, 2–10, 2–11, and 4–22; plus dimensions, loss of strength or endurance, or limitation in motion which compromise flying safety. Orthopedic hardware is disqualifying until reviewed by Commander, USAAMC. (See APL 30, Retained Hardware.)

4–11. Eyes

The causes of medical unfitness for flying duty Classes 1/1A/2/2F/2S/3/4 are the causes listed 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, recurrent.

(3) Pterygium which encroaches on the cornea more than 1 millimeter (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, posteri or 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 6, 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 6, 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/3/4 are the following:

a. Class 1.

(1) *Color vision.*

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

(b) One or more errors in reading the nine test light pairs of the Farnsworth Lantern (FALANT). If there are one or more errors in the reading of nine FALANT test light pairs, then there may be no more than two errors on repeat challenge with 18 FALANT test light pairs (two sets of nine pairs). (See APL 18, Color Vision Deficiencies.)

(2) *Binocular depth perception.*

(a) Any error in line B, C, or D when using the Armed Forces Vision Tester, or

(b) Any error in reading the eight test bar sets of the Verhoeff Stereometer, or

(c) Any error in levels 1 through 7 of the 10 levels of the Random Dot (RANDOT) Circles Test. (RANDOT Forms Test is not authorized.)

(d) Binocular depth perception worse than 30 seconds of arc. (See ATB 7, Depth Perception Tests.)

(3) *Distant visual acuity.* Uncorrected, worse than 20/20 in each eye; with no more than 1 error per line on the Armed Forces Vision Tester or projected Snellen chart at 20 feet.

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

(5) *Near visual acuity.* Uncorrected, worse than 20/20 in each eye; with no more than 1 error per line on the Armed Forces Vision Tester or Snellen near visual acuity card.

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

(7) *Ocular motility.*

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

(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 (Alternate Cover or Phoria) Test in any four cardinal directions of gaze until a complete evaluation by a qualified ophthalmologist or optometrist has been forwarded to the Commander, USAAMC for review.

(f) Near point of convergence (NPC) greater than 100 mm. (See APL 8, Extraocular Motility Disturbances; also APL 19, Convergence Insufficiencies.)

(8) *Cycloplegic refractive error.* Performed by the method in ATB 5, Cylopedic Refraction, to include transposition—

(a) Astigmatism in excess of +/–0.75 diopters of cylinder.

(b) Hyperopia in excess of +2.00 diopters of sphere (spherical equivalent method not applicable).

(c) Myopia in excess of— 0.25 diopters of sphere (spherical equivalent method not applicable).

b. Class 1A. Same as Class 1 except as listed below:

(1) *Distant visual acuity.* Uncorrected worse than 20/50 in each eye and/or not correctable with spectacle lenses to 20/20 in each eye; with no more than 1 error per line on the Armed Forces Vision Tester or projected Snellen chart at 20 feet.

(2) *Cycloplegic refractive error.* Performed by the method in ATB 5, Cyclopedic Refraction, to include transposition—

(a) Astigmatism in excess of +/–0.75 diopters of cylinder.

(b) Hyperopia in excess of +3.00 diopters of sphere (spherical equivalent method not applicable).

(c) Myopia in excess of –0.75 diopters of sphere (spherical equivalent method not applicable).

c. Classes 2/2F/2S/3/4. Same as Class 1, except as listed below:

(1) *Distant and near visual acuity.* Uncorrected worse than 20/400 in any eye, and/or not correctable with spectacle lenses to 20/20 in any eye.

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

(3) *NPC.* 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 listed 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 urinalysis.

b. History of any metabolic abnormality of the urine, to include proteinuria, glycosuria, and hypercalciuria.

c. Uncomplicated pregnancy is not disqualifying, but results in flying duty restrictions. (See APL 12, 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 12, Pregnancy.)

e. History of urinary tract stone formation or retention of urinary tract stone within collecting system. (See APL 27, Kidney Stones, and APL 12, Pregnancy.)

4–14. Head and neck

The causes of medical unfitness for flying duty Classes 1/1A/2/2F/2S/3 are the causes listed 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/3/4 are the causes listed in paragraphs 2–18 through 2–19 plus the following:

a. History of any abnormal electrocardiographic findings, to include but not be 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 EKG) cannot be shortened to less than or equal to 220 milliseconds in the unipolar leads during exercise.

(4) Mobitz Type II second AV block, and third degree AV block.

(5) Acquired left anterior or posterior hemiblock.

(6) Acquired complete right bundle branch block. (See APL 7, 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 beat pairs, as defined by APL 2, 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 Commander, USAAMC. (See APL 2, 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 28, Aeromedical Cardiovascular Screening Program.)

c. History of valvular heart disease, to include mitral valve prolapse, as documented by clinical or echocardiographic findings. (See APL 29, Heart Murmurs.)

d. History of myocarditis, or endocarditis, to include subacute bacterial endocarditis. History of pericarditis until reviewed by Commander, USAAMC.

e. Any evidence of coronary artery disease as outlined by APL 28, 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 28, 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 3, Hypertension in Aircrew Members.)

j. Orthostatic hypotension or orthostatic intolerance, or symptomatic hypotension. (See para 4–22*e*.)

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:

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 11, 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 work station.

4–17. Weight and body build

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

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 listed in paragraphs 2–23 and 4–26, 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 15, Sarcoidosis.)

4–19. Mouth

The causes of medical unfitness for flying duty Classes 1/1A/2/ 2F/2S/3/4 are the causes listed 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 which interferes with the function of the mouth or throat.

c. Any defect in speech which 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/3/4 are the causes listed 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 14, Allergic Rhinitis.)

c. Deviation of the nasal septum or septal spurs which 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 for medical unfitness for Classes 1/1A/2/2F/2S/3/4 are the causes listed in paragraphs 2–26 and 2–27, 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/3/4 are the causes listed in paragraphs 2–28, 2–32*d*, 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 Commander, USAAMC.

d. History of decompression sickness (Type II) or 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/3/4.* 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 Commander, USAAMC.

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 a 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 head injury associated with any of 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 the injury.

(6) Depressed skull fracture with or without dural penetration.

(7) Linear or basilar skull fracture with unconsciousness for more than 2 hours.

(8) Post–traumatic syndrome as manifested by changes in personality, impairment of higher intellectual functions, anxiety, headaches, or disturbances of equilibrium which does not resolve within 6 weeks after the 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 duty for Classes 1/1A; and termination of aviation service for a minimum of 2 years for Classes 2/2F/2S/3/4. (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) Post–traumatic syndrome, as manifested by changes in personality, impairment of higher intellectual functions, anxiety, headaches, or disturbances of equilibrium, which persists for more than 2 weeks, but resolves within 6 weeks of the injury.

(3) Amnesia (post–traumatic and retrograde, patchy or complete), delirium, disorientation, or impairment of judgment which 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/3/4. (See table 4–2.)

(1) Linear or basilar skull fracture with loss of consciousness for less than 15 minutes.

(2) Post–traumatic syndrome, as manifested by changes in personality, impairment of higher intellectual functions, anxiety, headaches, or disturbances of equilibrium, which persists for more than 48 hours, but resolves within 14 days of the injury.

(3) Post–traumatic headaches alone which persist more than 14 days after the injury, but resolve within 1 month.

(4) Amnesia (post–traumatic and retrograde, patchy or complete), delirium, or disorientation which 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 which 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/3/4.

(1) Post–traumatic syndrome, as manifested by changes in personality, impairment of higher intellectual function, or anxiety, which resolves with 48 hours of injury.

(2) Post–traumatic headaches alone, which resolve within 14 days of injury.

(3) Amnesia (post–traumatic and retrograde, patchy or complete), delirium or disorientation for less than 12 hours.

(4) Unconsciousness lasting less than 15 minutes.

4–23. Mental disorders

The minimum psychiatric evaluation will include Axis I, II, III utilizing diagnostic criteria and terms found in the DSM–III–R. The causes of medical unfitness for flying duty Classes 1/1A/2/ 2F/2S/3/ 4 include the causes listed below, and those in paragraphs 2–29 through 2–34, 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–III–R.

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–III–R 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 Commander, USAAMC.

h. Excessive alcohol use.

(1) History of alcohol abuse or dependence by DSM–III–R 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 which should or does lead to referral for addiction dependence or abuse. (See APL 26, 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 31, History of Illicit Drug Use. Para 2–34 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 non–medical 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 Commander, USAAMC. (See para 4–22*e*.)

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 Commander, USAAMC.

Note. See APL 20, Mental Health Findings.

4–24. Skin and cellular tissues

The causes for medical unfitness for Classes 1/1A/2/2F/2S/3 are the causes listed in paragraph 2–35, 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 for medical unfitness for Classes 1/1A/2/2F/2S/3 are the causes listed in paragraphs 2–11, 2–36, and 2–37, 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 vertebra, 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 for medical unfitness for Classes 1/1A/2/2F/2S/3/4 are the causes listed in paragraphs 2–38 and 2–39, plus the following:

a. Malaria.

(1) *Classes l/lA.* 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/3/4.* 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 9, 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 all 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 Commander, USAAMC.

g. Presence of HIV–1 or antibody. (See AR 600–110.) (Civilian employees are not disqualified based soley 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 15, Sarcoidosis.)

j. Other diseases and conditions, which 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. Commander, USAAMC will make the final determination of medical fitness for flying duty.

4–27. Malignant diseases and tumors

The causes for medical unfitness for Classes 1/1A/2/2F/2S/3/4 are the causes listed below:

a. Benign tumors, same as the causes listed in paragraphs 2–40*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 24, Cancer in Aircrew.)

4–28. Sexually transmitted diseases

The causes for medical unfitness for Classes 1/1A/2/2F/2S/3/4 are the causes listed in paragraph 2–41.

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 Commander, USAAMC, 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 Commander, USAAMC. The aviation commander and FS will forward their evaluations and recommendations to Commander, USAAMC to make a final recommendation of medical fitness for flying duties. Commander, USAAMC 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 Commander, USAAMC 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 which 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 psychological stress. (See also para 4–23*n*.)

(5) A history of arrests, illicit drug use, or social "acting out" which may indicate immaturity, impulsiveness, or antisocial traits. Experimental use of drugs during adolescence, minor traffic violations, or clearly provoked isolated impulsive episodes may be found fit after review by Commander, USAAMC. (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 Commander, USAAMC, 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 which 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/3/4 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 (RAT). (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 minimum standards guidelines for the initial consideration of hiring DAC pilots are U.S. Army Class 2 standards as per chapter 4 . Subsequent determination of medical fitness for flying DA aircraft will be conducted by DA as outlined in this regulation. The job description will state that DAC pilots will maintain a current Army Class 2 medical certification.

b. Chief, U.S. Army Aviation Branch, Commander, U.S. Army Safety Center, and Commander, USAAMC have determined the initial and subsequent determinations of medical fitness for DA contract civilian pilots flying aircraft owned or leased by DA are made as per chapter 4 of this regulation and AR 95–20/AFR 55–22/NAVAIRINST 3710.1/DLAM 8210.1. The contract will state that DA contract civilian pilots will maintain a current Army Class 2 medical certification. Federal Aviation Administration (FAA) medical certification is not required to fly aircraft owned or leased by DA.

c. The Army Aviation Medicine Program will conduct a Class 2 Army flying duty medical examination (FDME) on all DAC and DA contract civilian pilots on initial hire, and then annually within 90 days before the last day of their birth month, to determine if they meet Army Class 2 medical standards of fitness for flying duties. Any military FS may conduct the examination. Additional interim examinations are required if a pilot develops a change in health that may affect the status of the medical certification. The pilot is required to report interim changes in health to the FS. DA obligation to pay for medical examinations, tests, or consultations is only to the extent required to determine if the civilian pilot is medically qualified. Once medically disqualified, subsequent medical examinations, tests, or consultations that may be required by DA for waiver consideration are the financial responsibility of the disqualified civilian pilot unless the civilian pilot is eligible for DOD health care delivery (AR 40–3).

d. If the attending military FS finds the civilian pilot qualified under Army Class 2 medical fitness standards, the FS will issue the status of "full flying duties" (FFD) on a DA Form 4186 (Medical Recommendation for Flying Duty), valid until the last day of the next birth month. The FS will forward the FDME to Commander, USAAMC, ATTN: MCXY–AER, Fort Rucker, AL 36362–5333 for central review and verification of medical fitness.

e. If the attending military FS finds the civilian pilot disqualified under Army Class 2 medical fitness standards, the FS will issue the status of "duties not to include flying" (DNIF) on DA Form 4186. In certain circumstances outlined in the Army APL series or upon direct approval by the U.S. Army Aeromedical Consultation Service (AMCS), USAAMC, the status of "temporary FFD pending receipt of waiver" may be issued on DA Form 4186. The FS will prepare and forward an Aeromedical Summary of the medical disqualification (see ATB 2, Army Flight Surgeon's Administrative Guide, and ATB 3, Aeromedical Summary) to USAAMC for central review and verification of medical fitness. If the civilian pilot desires a consideration for aeromedical waiver of the medical disqualification, the local FS or USAAMC may direct additional medical examinations, tests, or consultations by DA–designated health care providers and institutions to evaluate the disqualifying medical condition. Civilian pilots may submit additional medical documents from health care providers or institutions of their choice. USAAMC will make a final determination of medical fitness for flying duties recommending a waiver of the medical disqualification or suspension from flying duties to the designated waiver authority. USAAMC may seek additional aeromedical consultation from DA–designated aeromedical consultants or the Army Aeromedical Consultant Advisory Panel (ACAP) as required. USAAMCs final disposition recommendation will take into consideration the civilian pilot's medical condition, aircraft flown, mission and duties, and deployability status. Medical disqualification of "preference eligible" DAC applicants are forwarded by the waiver authority to the Office of Personnel Management (OPM) for review.

f. The waiver authority will grant or deny the recommendation for aeromedical waiver or suspension from flying duties. A complete guide to waiver authorities is provided in paragraphs 6–21*e* and 6–21*f*.

g. If the waiver authority grants suspension from flying duties, the disposition will be as follows:

(1) *DAC pilots.* The suspended DAC pilot will be referred by the supervisor aviation unit commander to the Civilian Personnel Office for assistance in reassignment to other DNIF. OPM will make the final determination of eligibility for medical disability.

(2) *DA contract civilian pilots.* The suspended DA contract civilian pilot will be referred by the DA Contract Representative Officer to contractor management for reassignment to DNIF flying or termination of employment.

h. The following special provision applies to all civilian pilots. Civilian pilots are not required to meet the requirements of the Army Weight Control Program (AR 600–9). Maximum allowable body weight and anthropometrics will be that which does not prevent normal function required for safe and effective aircraft flight, to include interference with aircraft instruments and controls. Minimum body size, weight, and physical strength will be that which allows safe and effective flight in Army aircraft to include proper function of ejection seats and other safety equipment. The local FS will prepare an Aeromedical Summary with recommendations as required and refer these cases to Commander, USAAMC for final determination.

i. Civilian aircrew members who perform regular duties in DA aircraft in flight, but do not operate aircraft flight controls, will be evaluated under Army Class 3 medical fitness standards by the

attending military FS who makes the determination of fitness for flying duties. Waivers and suspensions are granted or denied by the responsible waiver authority. Questionable cases will be referred to USAAMC for consultation and review.

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 Commander, USAAMC.

b. The attending FS makes the final determination of fitness for Class 3 flying duties with the exception of the following conditions, which require submission of an Aeromedical Summary to the Commander, USAAMC 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 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.)

(5) Any other condition for which the FS or local aviation commander requests a consultation with the AMCS, Fort Rucker, AL 36362–5333.

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 Commander, USAAMC.

(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 of 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

The initial and retention medical standards for fitness for Class 4 ATC duties are the same.

a. Military ATCs. 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) The minimum standard guidelines for the initial consideration of hiring and retaining Government agency ATCs are outlined in this regulation. The job description will state that DAC ATCs will maintain a current Army Class 4 medical certification.

(2) DA contract civilian ATCs may be required by their contractor employer to maintain a Class II 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 maintain a current Army Class 4 medical certification.

(3) Paragraphs 4–31*c* through 4–31*g* also apply to civilian ATCs, replacing references to Class 2 with Class 4 and references to pilot or flying with ATC. Paragraphs 4–31*h* and 4–31*i* do not apply to civilian ATCs.

c. Class 4 ATCs. The causes of medical 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 with 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, 4–21, 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 16, 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 which 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 stair case.

(8) *HIV seropositivity.* Civilian employees are not disqualified based soley 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 in the opinion of the attending FS, that 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 Commander, USAAMC for review.

(10) *Medications.* Unfitting for ATC duties and requires a waiver. (See APL 9, 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 (see note)

Disposition by Class Classes 1/1A Classes 2/2F/2S/3/4 Problem	Perm DQ	2–year DQ	3–month DQ	4–week DQ
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 skulll 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 leak lasting—	>7d	. . .	<7d	. . .
Amnesia, delirium, or disorientation lasting—	. . .	>24h	12–24h	<12h

Note: Abbreviations used in this table are as follows:

CNS . . . central nervous system

CSF . . . cerebrospinal fluid

d . . . day

DQ . . . disqualification

EEG . . . electroencephalogram

h . . . hour

LOC . . . loss of consciousness

m . . .minutes

wk . . . week

Chapter 5
Medical Fitness Standards for Miscellaneous Purposes

5–1. General
This chapter sets forth medical conditions and physical defects which are causes for rejection for—

a. Airborne training and duty, Ranger training and duty, and Special Forces training and duty.

b. Survival, evasion, resistance, escape (SERE) training.

c. Army service schools.

d. Diving training and duty.

e. Enlisted MOSs.

f. 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.

(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 and duty, 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.

g. Eyes and vision.

(1) Paragraphs 2–12 and 2–13 with exceptions noted below.

(2) For Airborne and Ranger and Special Forces training and duty: 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 Airborne and Special Forces training and duty: Failure to

identify red and/or 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, exception 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 2–27.

p. Neurological disorders.

(1) Paragraph 2–28.

(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 2–29 through 2–34.

(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.

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

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

(6) Phobias which 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 2–35.

s. Spine, scapulae, and sacroiliac joints.

(1) Paragraphs 2–36 and 2–37.

(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 2–38 and 2–39.

(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 2–40.

v. Sexually transmitted diseases. Paragraph 2–41.

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 3–43.

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*c*, 2–8*e*, 2–8*l*, 2–8*m*, and 3–11.

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

g. Eyes and vision.

(1) Paragraphs 2–12 and 2–13.

(2) Refraction not required if vision correctable to 20/20 with spectacles or contact lens.

h. Genitourinary system. Paragraphs 2–14, 2–15, and 2–40.

i. Head and neck. Paragraph 5–3*i.*

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*c.*

n. Lungs and chest wall. Paragraph 2–23.

o. Mouth, nose, pharynx, larynx, trachea and esophagus. Paragraphs 2–25 through 2–27.

p. Neurological disorders.

(1) Paragraphs 2–28 and 4–22.

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

q. Mental disorders.

(1) Paragraphs 3–27 through 3–31.

(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 2–35.

s. Spine, scapulae, and sacroiliac joints. Paragraphs 2–36*l* and 3–39.

t. Systemic disease and miscellaneous conditions and defects.

(1) Paragraph 2–39.

(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 2–40.

v. Sexually transmitted diseases. Paragraph 2–41.

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 which might compromise safety.

(3) Any loss of strength which might compromise safety.

(4) Instability of any degree or pain in a weight bearing joint.

g. Eyes and vision.

(1) Paragraphs 2–12 and 2–13, with exceptions noted in (2) and (3) below.

(2) Uncorrected distant visual acuity of worse than 20/70 in the better eye or worse than 20/200 in the poorer eye or vision which does not correct in both eyes within 8 diopters of plus or minus refractive error, with spectacle lenses.

(3) Failure to identify red and green as projected by the Ophthalmological Projector or the SVT.

h. Genitourinary system. Paragraphs 2–14 and 2–15.

i. Head and neck.

(l) 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 which 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 through 2–27.

p. Neurological disorders.

(1) Paragraphs 2–28.

(2) The criteria outlined in paragraph 4–22 for Classes 2 and 3 flying duty apply.

q. Mental disorders.

(1) Paragraph 2–39 through 34.

(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 which 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 2–35.

s. Spine, scapulae, ribs, and sacroiliac joints.

(1) Paragraphs 2–36 and 2–37.

(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 2–38 and 2–39.

(2) Blood donations. Personnel will not perform free fall parachute duties for 72 hours following the blood donation.

(3) History of motion sickness, other than isolated instances without emotional involvement.

(4) 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 2–40.

v. Sexually transmitted diseases. Paragraph 2–41.

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.

5–8. Medical fitness standards for Army service schools

Except as provided elsewhere herein, 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.

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 infectious process and any conditions which contribute to recurrence until eradicated.

(3) Edentia; any unserviceable teeth until corrected.

(4) Moderate malocclusion, extensive restoration or replacement by bridges or dentures which 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 which might compromise safety.

(3) Any loss of strength which 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.

g. Eyes and vision.

(1) Paragraphs 2–12 and 2–13, with exceptions noted below:

(2) Uncorrected distant visual acuity of worse than 20/70 in the better eye and 20/200 in the poorer eye. Vision which does not correct to 20/20 in both eyes within 8 diopters of plus or minus refractive error, with spectacle lenses.

(3) Failure to identify red and/or 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 which 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 and clinical evaluation show complete recovery with normal pulmonary function.

o. Mouth, nose, pharynx, larynx, trachea, and esophagus. Paragraphs 2–24 through 2–27.

p. Neurological disorders.

(1) Paragraph 2–28.

(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 2–29 through 2–34.

(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 which 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 2–35.

s. Spine, scapulae, ribs, and sacroiliac joints. (Consultation with an orthopedist and, if available, diving medical officer will be obtained in questionable cases.)

(1) Paragraphs 2–36 and 2–37.

(2) Spondylolisthesis; spondylolysis which 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 2–38 and 2–39.

(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 2–40.

v. Sexually transmitted diseases. Paragraph 2–41.

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.

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 which 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 which contribute to recurrence until eradicated.

(3) Edentia; any unserviceable teeth until corrected.

(4) Moderate malocclusion, extensive restoration or replacement by bridges or dentures, which interfere with the use of SCUBA. Residual 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 5–9*w*.

(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 25 dB at 500, 1000, and 2000 Hz with no individual level greater than 30dB. Not over 45 dB at 4000 Hz.

(6) History of otitis media or otitis externa with any residual effects which 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 any chronic or recurrent orthopedic pathology which would interfere with diving duty.

(3) Loss of any digit or portion thereof of either hand which significantly interferes with normal diving duties.

(4) Fracture or history of disease or operation involving any major joint until reviewed by a diving medical officer.

(5) Any limitation of the strength or range of motion of any of the extremities which would interfere with diving duty.

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 which 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 which 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 which 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 and 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 which 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 through 2–27.

(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 which interferes with the ability to communicate clearly in the English language.

p. Neurological disorders.

(1) Paragraph 2–28.

(2) The special criteria which are outlined in paragraph 4–22 for Class 1 flying duty are applicable to diving duty.

q. Mental disorders.

(1) Paragraphs 2–29 through 2–34.

(2) The special criteria which are outlined in paragraph 4–23 for Class 1 flying duty are also 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) Paragraphs 2–36 and 2–37.

(2) Spondylolysis; spondylolisthesis.

(3) Healed fractures or dislocations of the vertebrae until reviewed by a diving medical officer.

(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 2–38 and 2–39.

(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 2–40.

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 5–9*w*.

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, which corrects to 20/30 in the better eye.

5–13. Medical fitness standards for enlisted military occupational specialties and specific medical restrictions for officer and enlisted occupational specialties

a. The medical fitness standards to be utilized in the initial selection of soldiers to enter a specific enlisted MOS are contained in AR 611–201. Visual acuity requirements for this purpose will be based upon the soldier's vision corrected by spectacle lenses.

b. Soldiers who fail to meet the minimum medical fitness standards established for a particular enlisted MOS, but who perform the duties of the MOS to the satisfaction of the commander concerned, are medically fit to be retained in that specialty except when there is medical evidence that continued performance therein will adversely affect their health and well–being.

c. Asplenic soldiers are disqualified from initial training and duty in military specialties involving significant occupational exposure to dogs or cats.

d. Asplenic soldiers are disqualified from initial Special Forces training and duty.

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 geographical areas is contemplated to ensure that they are utilized 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 *c* below. (Family member screening will be accomplished according to AR 600–75 utilizing 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 U.S. military MTFs are limited or nonexistent are listed below. (See AR 55–46, AR 600–200, 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 U.S. military MTFs are nonexistent. 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 condition where maintenance medication is of such toxicity as to require frequent clinical and laboratory follow–up or where the medical condition requires frequent follow–up by an MTF that cannot be delayed for the extent of the tour.

(c) Inherent, latent, or incipient medical or dental conditions which 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, Colombia; and Addis Ababa, Ethiopia.

(2) Remediable medical, dental, or physical conditions or defects which 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 judgment of the examiners.

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

The following applies to all candidates to the USMA, ROTC, and the USUHS: Candidates for admission to the USMA, 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.

5–16. Vision—officer assignment to Armor, Field Artillery, Infantry, Corps of Engineers, Military Intelligence, Military Police Corps, and Signal Corps

a. Individuals being initially appointed or assigned as officers in Armor, Field Artillery, Infantry, Corps of Engineers, Military Intelligence, Military Police Corps, and Signal Corps may possess uncorrected distance visual acuity of any degree that corrects with spectacle lenses to at least 20/20 in one eye and 20/100 in the other eye within 8 diopters of plus or minus refractive error, and be able to identify without confusion the colors vivid red and vivid green. Refractive error corrected by orthokeratology or keratorefractive surgery is disqualifying.

b. Retention of an officer in any of the branches listed in *a* above will be based on the officer's—

(1) Demonstrated ability to perform appropriate duties commensurate with his or her age and grade.

(2) Medical fitness for retention in Army service determined pursuant to chapter 3, including paragraphs 3–15 and 3–16.

(3) Continuance on active duty or in RC service not on active duty under appropriate regulations although determined to be medically unfit for retention in Army service.

5–17. Hearing—officer assignment to Armor, Field Artillery, Infantry, Corps of Engineers, Military Intelligence, Military Police Corps, and Signal Corps

a. Individuals being initially appointed or assigned as officers in these branches may not possess hearing levels greater than those levels cited as Profile serial H–1, table 7–1.

b. Retention of an officer in any of the branches listed in *a* above will be based on the officer's—

(1) Demonstrated ability to perform appropriate duties commensurate with his or her age and grade, and

(2) Medical fitness for retention in Army service under paragraph 3–10.

5–18. Medical fitness standards for training and duty at nuclear power plants

The causes for medical unfitness for initial selection, training, and duty as nuclear power plant operators and/or officer in–charge of nuclear power plants are all the causes listed in chapter 2, plus the following:

a. Paragraph 5–14*c*.

b. Inability to distinguish and identify without confusion the color of an object, substance, material, or light that is uniformly colored a vivid red or a vivid green.

c. Familial history of any of the following:

(1) Congenital malformations.

(2) Leukemia.

(3) Blood clotting disorders.

(4) Mental retardation.

(5) Cancer.

(6) Cataracts (early).

d. Abnormal results from the following studies which will be accomplished:

(1) White cell count (with differential).

(2) HCT.

(3) HGB.

(4) Red cell morphology.

(5) Sickle cell preparation (regardless of race).

(6) Platelet count.

(7) Fasting blood sugar.

e. Presence or history of psychiatric illness requiring hospitalization or extensive treatment, or personality disorders, including alcoholism, where either, in the opinion of the examining officer, would make assignment at this specialty inadvisable.

Chapter 6
Aeromedical Administration

6–1. General

a. This chapter provides—

(1) Administrative policies for completing the Army 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, 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 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 and 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 non–medical disqualifications for aviation service, FEBs, and inflight 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 180 days. A temporary aeromedical DQ will become a permanent aeromedical DQ if the DQ condition persists for more than 180 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. FFD is a recommendation of medical fitness permitting flying or ATC duties as annotated by an FS on DA Form 4186.

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 ARNG, 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 and is the proponent for all aeromedical policy and standards.

b. The Commander, USAAMC establishes the U.S. Army Aeromedical Activity (USAAMA), which coordinates through the Commander, USAAMC with TSG and Chief, Army Aviation Branch to—

(1) Develop, implement, and continuously assess aeromedical policy and standards for issues such as medical selection and retention of aircrew, operational effectiveness of aircrew, longevity of aircrew careers, and aviation safety.

(2) Make a final recommendation of medical fitness for flying duties, waivers, exceptions to policies, and medical termination from aviation service of aircrew and aircrew training candidates by the central review, study, and analysis of FDMEs and Aeromedical Summaries.

(3) Organize and manage the ACAP. ACAP provides a consensus of opinion for the Commander, USAAMC and the TSG Aviation Medicine Consultant on selected issues pertaining to aviation medicine policy, standards, and aeromedical fitness for flying duty.

(4) Provide for aeromedical specialty consultation and medical in flight evaluations through management of the AMCS. (See *d* below.)

(5) Implement quality assurance and improvement review of FDMEs and Aeromedical Summaries.

(6) Support education and training pertaining to aeromedical policy, standards, and regulations.

(7) Develop memorandums of understanding with the Chief, Army Aviation Branch, as required for outlining operational and administrative procedures for coordinating the Army Aviation Medicine Program with the Army Aviation Program.

(8) Maintain a permanent aeromedical database on Army aircrew members. (See *e* below.)

(9) Support Aviation Resource Management Surveys.

(10) Perform other missions as tasked.

c. Directors of health services, MTF commanders, command surgeons, and aviation unit commanders will 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 will ensure the expeditious, accurate completion of FDMEs and Aeromedical Summaries by military FSs and APAs.

d. The responsibilities of the AMCS are as follows:

(1) A central AMCS is established at USAAMC, Fort Rucker, AL 36362–5333 for tertiary aeromedical evaluations, to include aeromedical in flight evaluations of aircrew members who do not meet the medical fitness standards for flying duties.

(2) Requests for aeromedical consultation are forwarded for review and approval through a military FS to the Commander, USAAMC (MCXY–AER).

(3) Commander, USAAMC also approves and refers selected and eligible medically disqualified military, DAC, or contract civilian aircrew to aeromedical consultation services of the U.S. Navy and U.S. Air Force when approved by appropriate medical authority of those Services.

Note. See also ATB 4, Aeromedical Consultation Service and AR 600–105.

e. The Aviation Epidemiological Data Repository (AEDR) is a

DA–directed aeromedical database on Army aircrew. The AEDR mission is tasked to the TSG and is jointly established by the USAAMC and the U.S. Army Aeromedical Research Laboratory, Fort Rucker, AL 36362. The AEDR is used to assess the adequacy of and modify aeromedical policy and standards through epidemiological study, to develop a basis for entry and retention medical standards in aviation specialties, and to conduct aeromedical research and development in support of the Army aviation mission and the Army Aviation Medicine Program. The AEDR also supports review and disposition of aeromedical DQs, aviation medicine clinical care, clinical investigations and publications, medicolegal actions, Congressional and command inquiry, aircrew operational readiness, and aviation personnel administration.

f. The FAA does not have privileges for the operation of DA aircraft or medical certification of aircrew operating DA aircraft since the FAA designates DA aircraft as "public" use aircraft. Flying DA aircraft is a privilege granted by DA, and is not a right of ownership since DA assumes liability for its aircraft. Flying DA aircraft is considered an arduous or hazardous duty because the aircrew member's medical condition may adversely effect the safe and effective completion of aviation duties, and the aviation operational environment may adversely impact on the medical condition of the aircrew member. TSG has the authority and responsibility to determine the medical fitness for flying duty of all DAC and DA contract civilian aircrew members flying in aircraft owned or leased by DA (5 CFR 339.202, 203, 205, and 301; and AR 95–20/AFR 55–22/NAVAIRINST 3710.1/DLAM 8210.1). TSG conducts an aviation medicine program (medical evaluation program) for the medical certification of civilian aircrew members and designates the examining medical care professional when they order or offer an examination (5 CFR 339.303). TSG may order psychiatric evaluation of civilian aircrew members when actions or behavior result in performance or conduct problems on the job (5 CFR 339.301).

g. The FAA does not have jurisdiction over the medical certification of DAC or contract ATCs working in DOD facilities. Controlling air traffic is considered an arduous or hazardous duty because the ATC medical condition may adversely effect the safe and effective control of aircraft traffic creating a public safety hazard. TSG has the authority and responsibility to determine the medical fitness for ATC duty of all DAC and DA contract ATC working in DA facilities (5 CFR 339.202, 203, 205, and 301; 14 CFR 65.31, 33; and AR 95–20/AFR 55–22/NAVAIRINST 3710.1/DLAM 8210.1). TSG conducts an aviation medicine program (medical evaluation program) for the medical certification of ATCs and designates the examining medical care professional when they order or offer an examination (5 CFR 339.303). TSG may order psychiatric evaluation of ATCs when actions or behavior result in performance or conduct problems on the job (5 CFR 339.301).

6–5. Authorizations

a. The Commander, USAAMC is authorized to establish the USAAMA and ACAP, and, in coordination with the Aviation Medicine Consultant to TSG and with the advice of ACAP, issue APLs and ATBs in regards to aeromedical standards and policies to assure the continuity and quality of the aeromedical standard of care for Army aircrew worldwide.

b. The Aviation Medicine Consultant to TSG is the proponent office for chapters 4 and 6.

6–6. Classification of FDMEs

Paragraph 4–2 outlines the medical standards classification for flying duties. The class of medical standards applied during the FDME is recorded in Item 5, Standard Form (SF) 88 (Report of Medical Examination).

6–7. Purpose of FDMEs

The FDME purpose is recorded with the FDME classification in Item 5, SF 88. There are four purpose categories for FDMEs:

a. 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 SF 88, SF 93 (Report of Medical History), and aeromedical continuation SF 93.

b. 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 SF 88, SF 93, and aeromedical continuation SF 93; and if baseline medical history verification sheet from USAAMA is not available, USAAMA will determine a final recommendation.

c. 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 SF 88 and SF 93. Report interim changes in medical history on SF 93 if these changes were not previously documented on an AEDR Medical History Verification Report or Aeromedical Summary.

d. 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–R (Interim (Abbreviated) Flying Duty Medical Examination) or SF 88 with identified blocks specific for interim FDME completion. DA Form 4497–R, located at the back of this regulation, will be reproduced locally on 8½– by 11–inch paper. (Addtionally, DA Form 4497–R is authorized for electronic generation.) Report interim changes in medical history on SF 93 if these changes were not previously documented on an AEDR Medical History Verification Report or Aeromedical Summary.

e. 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, 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 post–mishap 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, post–mishap 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: MCXY–AER, Fort Rucker, AL 36362–5333, who will coordinate authorization with the Aviation Medical Consultant to TSG.

d. The FDME will be accomplished 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 military 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 SF 88/SF 93 or DA Form 4497–R 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 28, 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 SF 88 and SF 93 are not available. Outline unusual circumstances in a memorandum for record included with the FDME.

c. DAC or DA contract civilian physicians with 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. 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 SF 88 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 SF 88 and 93, or DA Form 4497–R, and a final review stamp placed by the staff of USAAMC on the SF 88, or DA Form 4497–R.

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 accomplished at military outpatient or inpatient MTFs when fitness for flying duty cannot be determined. MTF commanders or ARNG 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 40–3).

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

(4) However, DACs or contract civilians employed by DA or firms under contract by DA who are not eligible for care (AR 40–3) will be advised to consult a private physician of their choice at their own expense once it is determined during a FDME or interim evaluation that they are medically disqualified for Army aircrew duties. These disqualified civilians are also responsible for the costs of additional tests, procedures, and consultations that may be directed by Commander, USAAMC to determine if the disqualified civilian aircrew member is eligible for a waiver, or for a continuation of a waiver.

(5) Commander, USAAMC may direct evaluation of disqualified aircrew eligible for care (AR 40–3) at any U.S. military MTF or aeromedical consultation service.

(6) The military aircrew member's unit is responsible for temporary duty costs (travel and per diem) to obtain recommended medical evaluations. Civilian aircrew members eligible for evaluation and care are responsible for their own travel and lodging costs.

6–10. Disposition and review of FDMEs

a. Review. The review of the Individual Health Record and FDME will be accomplished by an FS or 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 Item 76, SF 88.

c. Classes 1/1A and Initial Classes 2/2F/2S/4. Completed FDMEs (originals of SF 88, SF 93, aeromedical continuation of SF 93, 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 FSs 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. 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 (originals of SF 88, SF 93, DA Form 4497–R, interpreted EKG findings, and other supportive documents, may include consultations, EKG tracings, radiographs, coronary angiogram, etc.; and if applicable, Aeromedical Summary) will be directly forwarded to the Commander, USAAMC, ATTN: MCXY–AER, Fort Rucker,

AL 36362–5333, for central aeromedical review and disposition. The FSs office will retain a copy of the FDME and all attachments 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. In the case of minor medical disqualifications, which will in no way affect the safe and efficient performance of flying duties and which 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 13, Class 3 Aircrew, and para 4–33.) (See also ATB 2, Army Flight Surgeon's Administrative Guide, for detail on the item by item completion of FDMEs.)

6–11. Issuing DA Form 4186

a. DA Form 4186 (Medical Recommendation for Flying Duty) 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 which 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 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). 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 21, 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; example "Temporary FFD, 90 days, pending receipt of waiver."

h. The FS will consult the Commander, USAAMC, ATTN: MCXY–AER, or the MACOM 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 nonmedical 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 SF600 in the patient health record, according to AR 40–48, paragraph 3–3*a*(5).

(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 Services/nations and DA Form 4186 is not available.

6–12. General principles

a. 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: MCXY–AER, Fort Rucker, AL 36362–5333.

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

(1) *Aircrew duties.* (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 consultation from the Commander, USAAMC, or delay final deliberations 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 duty 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 medications (APL 9, 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 180 days (para 6–17); or,

(2) Medical termination from aviation service (permanent medical suspension) due to a temporary medical suspension imposed for greater than 180 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 utilization of this service. See also ATB 2, Army Flight Surgeon's Administrative Guide.)

6–13. Responsibilities

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 medication, 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.), psychosocial 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 waivers.

(5) HIV seropositivity.

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 waiver is not being considered, Commander, USAAMC, ATTN: MCXY–AER (USAAMA) will notify the FAA. Authority is pursuant to 5 USC 552a(b)7.

d. In the case of a permanent aeromedical DQ, the Commander, USAAMC, ATTN: MCXY–A, 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 an 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 6–10*c*.

(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 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. Current personnel regulations only provide for Exceptions to Policy for commissioned officer applicants. Exceptions to Policy are generally only recommended for exceptional commissioned 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 which 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 or other FSs.

d. Cases involving drug/alcohol abuse or dependence, suspected or proven coronary artery disease, or complicated, questionable cases will be forwarded to the Commander, USAAMC, ATTN: MCXY–AER, for review and disposition. (See also APL 13, 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 paragraphs 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 180 days. Examples include ankle sprain, acute rhinitis, gastroenteritis, simple closed fracture.

b. Medical termination from aviation service (see para 6–18) is mandatory if the temporary medical suspension exists for greater than 180 days (AR 600–105 and DODPM). 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 FS 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 180 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 180 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–A, 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 310–10).

(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, AMCS 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–A.

d. The Director, USAAMA will, for the Commander, USAAMC—

(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 follow–up medical evaluations to maintain the waiver.

e. The Director, USAAMA will forward final recommendations to the aviation service 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 treatment facility of origin.

g. The aircrew member will acknowledge the waiver, and if applicable, restrictions and follow–up 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 standards 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 ARNG 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 Ave, Alexandria, VA 22331–0453.

d. ARNG—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 civilian—all Classes: through Commander, USAAMC, ATTN: MCXY–AER, Fort Rucker, AL 36362–5333; through the Contracting Representative Officer; for the Commanding General, or Commanding General designated waiver authority (usually airfield commander or command aviation officer; for example, at Fort Rucker, Command Aviation Officer, ATTN: DPT–AD, Fort Rucker, AL 36362), of the installation with the DA contract. Final determination will then be forwarded to the Contracting Office and the firm under contract to the 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 Commanding General designated waiver authority (usually 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)

	Month in which last FDME was given											
Birth month	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, post–accident, post–hospitalization, pre–appointment (warrant officer candidate), etc., the validity period will range from 7 to 18 months. Validity periods may be extended, in accordance with paragraph 8–26j, 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*a*, 3–30, 3–46, and 3–47 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 preinduction 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 which do not fall under other specific factors of the system.

(2) U—Upper extremities. This factor concerns the hands, arms, shoulder girdle, and 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. 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 which 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 which 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. The numerical designator "4" does not necessarily mean that the soldier is unfit because of physical disability as defined in AR 635–40. When a numerical designator "4" is used, there are significant limitations which must be fully described if such an individual is returned to duty.

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 utilize 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," "no overseas duty," or "must have separate rations" are not proper medical recommendations.

(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. 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. The soldier's commander may also request a review of a permanent profile.

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. 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 a total of 12 months without positive action being taken either to correct the defect or to effect other appropriate disposition. For RC members, a determination involving entitlement to pay and allowances while disabled is an adjunct consideration. 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 SF 88 or is referred to in a routine personnel action, 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 numerical designators in the various factors and most significant assignment limitations. (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

Commanders of Army MTFs are authorized to designate one or more physicians, dentists, optometrists, podiatrists, audiologists, nurse practitioners, 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:

a. Physicians: No limitations. Changing from or to a permanent numerical designator "3" or "4" requires a physical profile board (PPBD) (para 7–8).

b. 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. (The second member of the PPBD must always be a physician.) (See para 7–8.)

c. Audiologists: No limitation within their specialty for awarding permanent numerical designators "1," "2," "3," or "4," in cases of sensioneural hearing loss if retrocochlear lesion has been ruled out. Changing from or to a permanent numerical designator "3" or "4" requires a PPBD (para 7–8).

d. Physician assistants, nurse midwives, nurse practitioners, and licensed clinical psychologists are 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. (Physician assistants and nurse practitioners will not be appointed as members of PPBDs.)

e. MEPS physicians will also be designated as profiling officers.

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 herein. Initial physical profiles will be recorded on SF 88 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 SF 88 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 modifier "T" is entered on the profile serial, or in those exceptional cases where the numerical designator "3" or "4" is used on initial entry, a brief, nontechnical description of the defect will be recorded in item 74, SF 88, in addition to the exact diagnosis. All assignment, geographic, or climatic area limitations applicable to the defect will also be entered in item 74. If sufficient room for a full explanation is not available in item 74 of SF 88, proper reference will be made in that item and an additional sheet of paper attached.

7–8. Physical profile boards

a. PPBDs will be appointed by the MTF commander and will normally consist of two qualified physical profiling officers, one of whom must always be a physician. However, PPBDs for sensioneural hearing loss (if retrocochlear lesion has been ruled out) may consist of audiologists rather than physicians. In addition to the two profiling officers, the permanent profile must be signed by the approving authority. The approving authority is always a physician (for example, the deputy commander for clinical services (DCCS)). (See *f* below for procedures for RC soldiers.)

b. Situations which require consideration of a PPBD are—

(1) Return to duty of a soldier hospitalized over 6 months. The board will ensure that the patient has the correct physical profile, assignment limitations(s) and medical follow–up instructions, as appropriate.

(2) Permanent revision of a soldier's physical profile from or to a numerical designator "3" or "4."

(3) When directed by the appointing authority in cases of a problematical or controversial nature requiring temporary revision of profile.

(4) Upon request of the unit commander.

c. A temporary revision of profile will be accomplished 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. A profiling officer is authorized to issue a temporary profile without referring the case to the PPBD or to the PPBD approving authority. 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 antituberculous 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 a PPBD, hospital commander, or command surgeon.

f. Physical profiles for Reservists not on active duty may be accomplished by the U.S. Army Reserve Command (ARCOM)/U.S. Army Reserve General Officer Command (GOCOM) staff surgeons, medical corps commander of USAR hospitals, or the Surgeon, AR-PERCEN without a PPBD. For members of the ARNG not on active duty, such profile revisions will be accomplished by The Surgeon NGB, the State surgeon, or his or her designated medical officer. (See NGR 40–501.) 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 continued on active duty should have a code "V" on their physical profile code. These soldiers will appear before an MEB and a PEB prior to retirement.

h. Physical profile and assignment limitations as determined by MEB proceedings will take precedence over all previously issued temporary and permanent profiles awarded on DA Form 3349 in the soldier's medical records. Accordingly, 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 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 will 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 utilization of the soldier. Common sense, good judgement, and cooperation must prevail between policy, patient, and patient's commander to ensure a viable program.

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. If confirmed, he or she will initiate prenatal care of the patient and issue a physical profile. (Nurse midwives may issue routine or standard pregnancy profiles for the duration of the pregnancy.) The profiling officer should ensure that the unit commander is provided a copy of the profile, and advise the unit commander as required.

(3) *Unit commander.* He or she will counsel all women as required by AR 635–100 or AR 635–200. The unit commander will consult with medical personnel as required.

c. Physical profiles.

(1) Profiles will be issued for the duration of the pregnancy. 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."

(4) The profile will indicate the following limitations:

(a) Except under unusual circumstances, the soldier should not be reassigned to or from overseas commands until pregnancy is terminated. (See AR 614–30 for waiver provisions.) She may be assigned within CONUS. Any reassignment must be cleared by her physician.

(b) Upon the diagnosis of pregnancy, the soldier is exempt from the regular physical training (PT) program of the unit, exempt from PT testing, exempt from wearing of load bearing equipment, including web belt, exempt from all immunizations except influenza and tetanus–diphtheria, and exempt from exposure to chemical agents in

nuclear, biological, and chemical training. This includes wearing MOPP gear at any time for training purposes.

(c) At 20 weeks of pregnancy, the soldier is exempt from standing at parade rest or attention for longer than 15 minutes and is exempt from participating in weapons training, swimming qualifications, drown proofing and field duty.

(d) The soldiers will not receive an assignment to duties where nausea, easy fatigability, or sudden light–headedness would be hazardous to the soldier or others, to include all aviation duty, Classes 1/1A/2/3. (However, the provisions of para 4–13*c* will be followed when the aircrew member requests permission to remain on flight status.) Class 2A ATC personnel, may continue ATC duties with approval of the FS, obstetrician, and ATC supervisor.

(e) The soldier may work shifts.

(f) 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: however, it does not preclude assignment as charge of quarters (CQ) and other like duties performed in a unit, to include normal housekeeping duties. (CQ is part of the 40–hour workweek.)

d. 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.

e. 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 which would preclude any type of duty performance.

f. Convalescent leave (as prescribed by AR 630–5).

(1) Convalescent leave after delivery will be for a period determined by the attending physician. This will normally be for 42 days following normal pregnancy and delivery.

(2) Convalescent leave after abortion will be determined on an individual case basis by the attending physician.

7–10. Postpartum profiles

a. Upon termination of pregnancy, and prior to convalescent leave, postpartum soldiers will be issued a postpartum profile. The temporary profile will be for 45 days and will restrict physical fitness testing, but will allow PT training at the soldier's own pace.

b. Upon termination of the profile, the guidelines of FM 21–20 apply. FM 21–20 allows soldiers 90 days from the termination of a temporary profile to train for the PT test. Therefore, the pregnant soldier will not be tested for a total of 135 days from termination of pregnancy, but will be expected to use the time in preparation for the APFT.

c. The above guidance will only be modified if, upon evaluation of a physician, it has been determined the postpartum 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. (See figure 7–1.)

(1) DA Form 3349 will be used to record both permanent profiles and temporary profiles. DD Form 689 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.

(2) DA Form 3349 will be prepared as follows:

(a) Item 1. Record medical condition(s) and or/physical defect(s) in common usage, nontechnical language which 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).

(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. Any other activity that is felt to be beneficial for the individual may be listed here. This space may also be used locally for location–specific activities.

(j) Signatures. Permanent "3" profiles and permanent "2" profiles requiring major assignment limitation(s) require signatures of a minimum of two profiling officers. In exceptional cases, as required in paragraph 7–8, a third officer will also sign. Temporary profiles not requiring major assignment limitations require only the signature of one profiling officer.

(k) Action by approving authority. The approval authority will be designated by the MTF commander. (In the case of RC soldiers not on active duty, see para 7–8*f.*) The approval authority for permanent "3" or "4" profiles must be a physician and is usually the DCCS. If the approval authority does not concur with the PPBD recommendations, the PPBD findings will be returned to the PPBD for reconsideration. If the approving authority does not concur in the reconsidered PPBD findings, the MTF commander will make the final decision. Appeals on the MTF commander's decision must be directed to USAMEDCOM.

(l) Action by the unit commander. See paragraph 7–12*b.*

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) Original and one copy to the unit commander.

(2) One copy to the MILPO.

(3) One copy to the soldier's health record.

(4) One copy to the clinic file.

c. Disposition of the physical profile form (temporary profiles). 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) Original and one copy to the unit commander.

(2) Record the T profile in the soldier's health record.

(3) Soldiers with profiles for pseudofolliculitis of the beard will be furnished an additional copy.

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.

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
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.	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 musculoskeletal defects which do not prevent hand–to–hand fighting and do not disqualify for prolonged effort.	Slightly limited mobility of joints, muscular weakness, or other musculoskeletal defects which do not prevent moderate marching, climbing, running, digging, 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 20/40—20/70, 20/30—20/100, 20/20—20/400.	May have history of recovery from an acute psychotic reaction due to external or toxic causes unrelated to alcohol or drug addiction. Individuals who have been evaluated by a physician (psychiatrist) and found to have a character and behavior disorder will be processed through appropriate administrative channels.
3	Unable to perform full effort except for brief or moderate periods.	Defects or impairments which interfere with full function requiring *significant* restriction of use.	Defects or impairments which interfere with full function requiring *significant* 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 not falling below retention standard. Aided speech reception threshold measured at "comfort level" ; i.e., volume control of hearing aid adjusted to 50 dB HL speech noise.	Uncorrected distant visual acuity of any degree which is correctable not less than 20/40 in the better eye or an acute or chronic eye disease not falling below retention standards.	Satisfactory remission from an acute psychotic or neurotic episode which permits utilization under specific conditions (assignment when outpatient psychiatric treatment is available or certain duties can be avoided.
4	*Functional level below P3.*	*Functional level below U3.*	*Functional level below L3.*	*Hearing level below H3.*	*Visual acuity below E3.*	*Does not meet S3 above.*
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 back, including cervical, thoracic, and lumbar vertebrae.	Strength, range of movement, and efficiency of feet, legs, pelvic girdle, and lower back.	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.

Table 7–2
Profile codes

Serial/code	Description/assignment limitation	Medical criteria
(1) Profile Serial 111111.		
CODE A	No assignment limitation. Considered medically fit for initial assignment under all PULHES factors for Ranger, Airborne, Special Forces training, and training in any MOS.	No demonstrable anatomical or physiological impairment within standards established in table 7–1.
(2) Profile serial with a "2" as the lowest numerical designator.		
CODE B	May have assignment limitations which are intended to protect against further physical damage/injury. Combat fit. May have minor impairment under one or more PULHES factors which disqualify for certain MOS training or assignment.	Minor loss of digits, minimal loss of joint motion, visual and hearing loss below those prescribed for Code A in table 7–1.
(3) Profile serial with a "3" or "4" as the lowest numerical designator in any factor or as specified by a PPBD.	Possesses impairments which limit functions or assignments but within which the individual is capable of performing military duty. *The codes listed below are for military personnel administrative purposes. Corresponding limitations are general guidelines and are not to be taken as verbatim limitations (e.g., 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.*	
CODE C	No crawling, stooping, running, jumping, marching, or standing for long periods. (State time permitted in item 8.).	Vascular insufficiency; symptomatic flat feet; low back pathology; arthritis of low back or lower extremities.
CODE D	No mandatory strenuous physical activity. (State time in item 8.)	Organic cardiac disease; pulmonary insufficiency; hypertension, more than mild.
CODE E	No assignment to units requiring continued consumption of combat rations.	Endocrine disorders—recent or repeated peptic ulcer activity—chronic gastro–intestinal disease requiring dietary management.
CODE F	No assignment to isolated areas where definitive medical care (U.S. Armed Forces hospital) is not available.	Individuals who require continued medical supervision or periodic followup. Cases of established pathology likely to require frequent outpatient care or hospitalization.
CODE G	No assignment requiring handling of heavy materials including weapons (except individual weapon: for example, rifle, pistol, carbine, etc.). No overhead work; no pullups or pushups. (State time permitted in item 8.)	Arthritis of the neck or joints of the upper extremities with restricted motion; cervical disk disease; recurrent shoulder dislocation.
CODE H	No assignment where sudden loss of consciousness would be dangerous to self or others such as work on scaffolding, handling ammunition, vehicle driving, or near moving machinery.	Epileptic disorders (cerebral dysrhythmia) of any type; other disorders producing syncopal attacks of severe vertigo, such as Meniere's syndrome.
CODE J	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 is 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 POR qualification or annual weapons qualification with proper ear protection). No duty requiring acute hearing. A hearing aid must be worn to meet medical fitness standards.	Susceptibility to acoustic trauma.
CODE L	No assignment which requires daily exposure to extreme cold. (List specific time or areas in item 8.)	Documented history of cold injury; vascular insufficiency; collagen disease, with vascular or skin manifestations.
CODE M	No assignment requiring exposure to high environmental temperature. (List specific time or areas in item 8.)	History of heat stroke; history of skin malignancy or other chronic skin diseases which are aggravated by sunlight or high environmental temperature.

Table 7–2
Profile codes—Continued

Serial/code	Description/assignment limitation	Medical criteria
CODE N	No continuous wearing of combat boots. (State the length of time in item 8.)	Any vascular or skin condition of the feet or legs which, when aggravated by continuous wear of combat boots, tends to develop unfitting skin lesions.
CODE P	No continuous wearing of woolen clothes. (State the length of time in item 8.)	Established allergy to wool, moderate.
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. Includes conditions described under Profile S–3.
(4) Profile serial numerical designator is determined by the functional capacity guide (table 7–1).		
CODE V	Department of the Army Flag. This code identifies the case of a soldier with a disease, injury, or medical defect which is below the prescribed medical criteria for retention but who is continued in the military service pursuant to chapter 9, this regulation, AR 635–40, or predecessor directives. Such individuals generally have rigid and strict limitations as to duty, geographic, or climatic area utilization. In some instances the individual may have to be utilized only within close proximity to a medical facility capable of handling such cases.	
CODE W	Waiver. This code identifies the case of an individual with disease, injury, or medical defect which is below the prescribed medical criteria for retention who has accepted under the previously applicable standards for physicians, dentists, and allied medical specialists or who is granted a waiver by direction of the Secretary of the Army. Such soldiers generally have rigid and strict limitations as to duty, geographical, or climatic area utilization. In some instances the soldier may have to be utilized only within close proximity to a medical facility capable of handling such cases.	
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, and has had his or her physical profile and appropriate assignment limitations determined by the medical board or The Surgeon General.	

PHYSICAL PROFILE

For use of this form, see AR 40-501; the proponent agency is the Office of The Surgeon General

1. MEDICAL CONDITION

Knee Pain

2.

P	U	L	H	E	S
1	1	T3	1	1	1

3. ASSIGNMENT LIMITATIONS ARE AS FOLLOWS

No running over one mile. No deep knee bend activities.

CODES

4. THIS PROFILE IS ☐ PERMANENT ☐ TEMPORARY EXPIRATION DATE:

5. THE ABOVE STATED MEDICAL CONDITION SHOULD NOT PREVENT THE INDIVIDUAL FROM DOING THE FOLLOWING ACTIVITIES

☐ Groin Stretch	☐ Thigh Stretch	☒ Lower Back Stretch	☒ Neck & Shoulder Stretch	☒ Neck Stretch
☐ Hip Raise	☐ Quads Stretch & Bal.	☒ Single Knee to Chest	☒ Upper Back Stretch	☒ Ankle Stretch
☐ Knee Bender	☒ Calf Stretch	☒ Straight Leg Raise	☒ Chest Stretch	☒ Hip Stretch
☐ Side-Straddle Hop	☒ Long Sit	☒ Elongation Stretch	☒ One-Arm Side Stretch	☒ Upper Body Wt Tng
☐ High Jumper	☒ Hamstring Stretch	☒ Turn and Bounce	☒ Two-Arm Side Stretch	☐ Lower Body Wt Tng
☐ Jogging In Place	☒ Hams. & Calf Stretch	☒ Turn and Bend	☒ Side Bender	☐ All

6. AEROBIC CONDITIONING EXERCISES

☒ Walk at Own Pace and Distance
☐ Run at Own Pace and Distance
☒ Bicycle at Own Pace and Distance
☒ Swim at Own Pace and Distance
☒ Walk or Run in Pool at Own Pace

☐ Unlimited Walking
☐ Unlimited Running
☐ Unlimited Bicycling
☒ Unlimited Swimming

☐ Run at Training Heart Rate for ___ Min.
☐ Bicycle at Training Heart Rate for ___ Min.
☐ Swim at Training Heart Rate for ___ Min.

7. FUNCTIONAL ACTIVITIES

☐ Wear Backpack (40 Lbs.)
☐ Wear Helmet
☐ Carry Rifle
☐ Fire Rifle
With Hearing Protection
☐ KP/Mopping/Mowing Grass
☐ Marching Up to ___ Miles
☐ Lift Up to ___ Pounds
☒ All

PHYSICAL FITNESS TEST

☐ Two Mile Run ☒ Walk
☒ Push-Ups ☒ Swim
☒ Sit-Ups ☒ Bicycle

8. TRAINING HEART RATE FORMULA

MALES 220 FEMALES 226

MINUS (-) AGE
MINUS (-) RESTING HEART RATE
TIMES (x) % INTENSITY
PLUS (+) RESTING HEART RATE

50% EXTREMELY POOR CONDITION
60% HEALTHY, SEDENTARY INDIVIDUAL
70% MODERATELY ACTIVE, MAINTENANCE
80% WELL TRAINED INDIVIDUAL

9. OTHER

TYPED NAME AND GRADE OF PROFILING OFFICER	SIGNATURE	DATE
John X. Smith, CPT, MC	John X. Smith	10 May 1986
TYPED NAME AND GRADE OF PROFILING OFFICER	SIGNATURE	DATE

ACTION BY APPROVING AUTHORITY

PERMANENT CHANGE OF PROFILE ☐ APPROVED ☐ NOT APPROVED

TYPED NAME, GRADE & TITLE OF APPROVING AUTHORITY	SIGNATURE	DATE

ACTION BY UNIT COMMANDER

THIS PERMANENT CHANGE IN PROFILE SERIAL ☐ DOES ☐ DOES NOT REQUIRE A CHANGE IN MEMBER'S
☐ MILITARY OCCUPATIONAL SPECIALTY ☐ DUTY ASSIGNMENT BECAUSE:

TYPED NAME AND GRADE OF UNIT COMMANDER	SIGNATURE	DATE

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name (last, first, middle); grade; SSN; hospital or medical facility)*

Jones, James Q.
PFC
10 May 86
US Army Health Clinic, Ft. Ord

UNIT

ISSUING CLINIC AND PHONE NUMBER
Orthopedic Clinic 999-9999

DISTRIBUTION
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DA FORM 3349, MAY 86 REPLACES DA FORM 5302-R (TEST) DATED FEB 64 AND DA FORM 3349 DATED 1 JUN 80, WHICH ARE OBSOLETE

Figure 7-1. Sample of a completed DA Form 3349

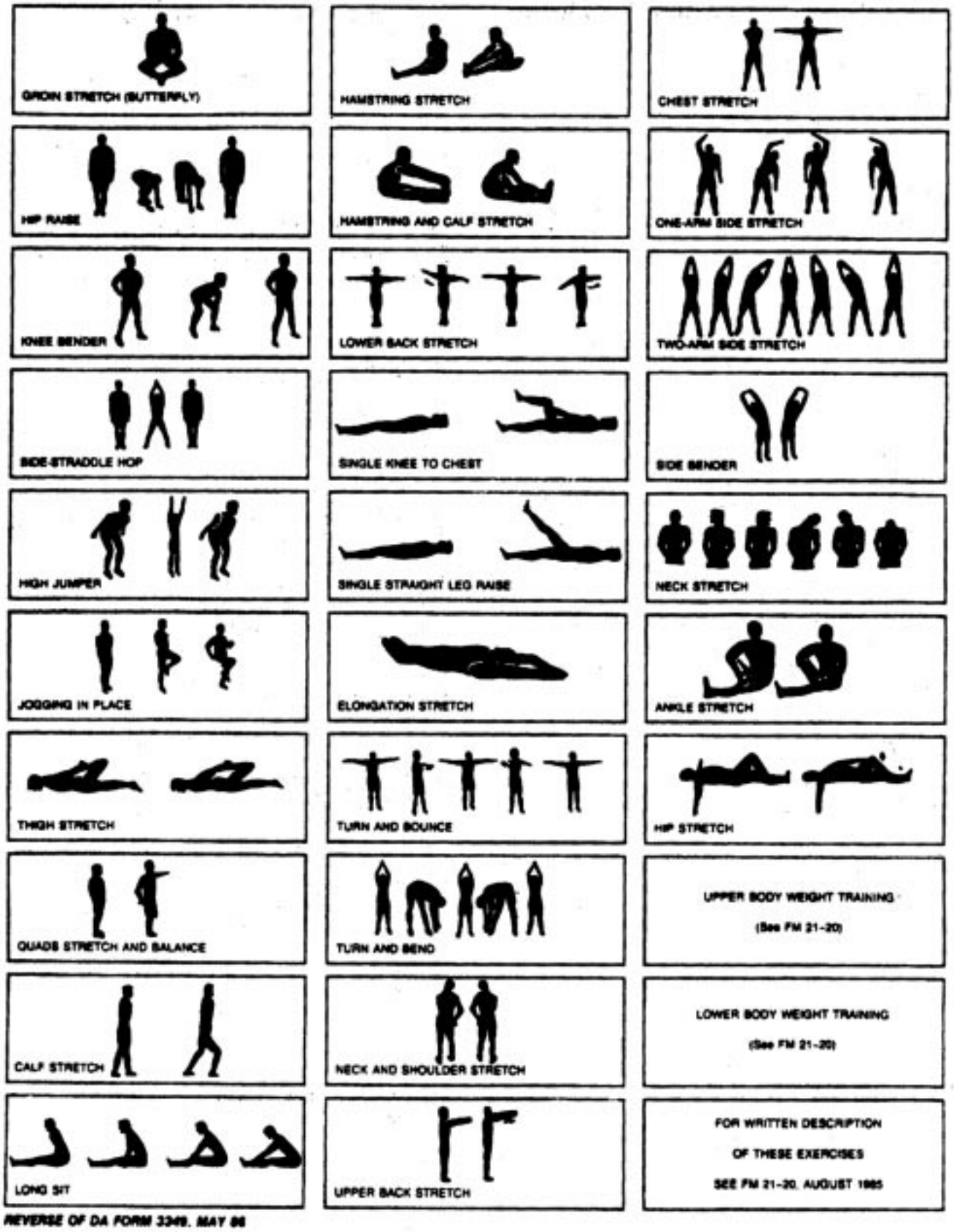

Figure 7-1. Sample of a completed DA Form 3349—Continued

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 40–3 and AR 601–270/AFR 33–7/OPNAVINST 1100.4/MCO P–1100.75.

b. A consultation will be accomplished 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 SF 88 as outlined in paragraph 8–5.

8–5. Distribution of medical reports
a. A minimum of two copies (both signed) of SF 88 and SF 93 (when required) 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 which 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.

b. The duplicate report (SF 88) in the case of general officers (Brigadier General and above) will be forwarded by the examining facility direct to Deputy Chief of Staff for Personnel, ATTN: DAPE–GO, 300 Army Pentagon, Washington, DC 20310–0300.

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 SF 88, and a statement to this effect will be made in item 73 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 SF 88 as an integral part of the medical report, and a statement to this effect will be made in item 73 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. Dentists will accomplish item 44 of the SF 88 when they are reasonably available. 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 SF 88 for the portions of the examination they actually accomplish, but the supervising physician will sign the SF 88 in all cases.

b. In general, medical examinations conducted for the Army will be accomplished 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.

c. Medical examinations for qualification and admission to the USMA, the U.S. Naval Academy (USNA), the U.S. Air Force Academy (USAFA), and the respective preparatory schools will be conducted at medical facilities specifically designated in the annual catalogs of the respective academies. See AR 40–29/AFR 160–13/NAVMEDCOMINST 6120.2/CG COMDTINST M6120.8 for medical examination requirements.

d. Medical examinations for ARNG and USAR purposes will be conducted by medical officers or civilian physicians at medical facilities in the order of priority specified in chapter 9 or NGR 40–501, as appropriate.

e. Additional tests, procedures, or consultations, necessary to supplement a medical examination normally will be accomplished at a medical facility (including MEPS) designated by the commander of the facility requesting the supplemental medical examination. Only on the authority of that commander will supplementary examinations be obtained from civilian medical sources. Funds available to the requesting commander will be used for payment of the civilian medical services he or she authorized.

8–8. Hospitalization
Whenever hospitalization is necessary for evaluation in connection

with a medical examination, it may be furnished as authorized in AR 40–3.

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 SF 88, SF 93, and such other forms as may be required. (See AR 40–29/AFR 160–13/NAVMEDCOMINST 6120.2/CG COMDTINST M6120.8 for use of DD Form 2351 (DOD Medical Examination Review Board (DODMERB) Report of Medical Examination). This form is used in place of the SF 88 and SF 93 for DODMERB exams.)

8–11. Scope of medical examinations

a. The scope of a medical examination is prescribed in paragraph 8–12 and in table 8–1 and will conform to the intended use of the examination. Health Risk Appraisals (HRAs) are required for all periodic medical examinations; however, this is not a substitute for a complete medical history and medical 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 Standard Form 88

a. Table 8–1 contains model entries and explanatory notes for every item on the SF 88. All items are NOT required on all examinations. The following items ARE REQUIRED on all examinations (additional items may be accomplished if clinically indicated):

(1) Items 1 through 42.

(2) Items 44, 45B, and 45C.

(3) Items 51 through 55.

(4) Items 57A, 58A, 59, 61, and 71.

(5) Items 73 through 81.

b. Periodic, under age 40. In addition to *a* above, the following items on the SF 88 are required:

(1) Item 50 (cholesterol in conjunction with the HRA).

(2) Item 50 (HCT or HGB).

(3) Item 50 (HIV testing). (See AR 600–110.)

c. Periodic, age 40 and older. In addition to *a* above, the following items on the SF 88 are required:

(1) Item 32 (rectal exam with stool guaiac).

(2) Item 45*a* (urine microscopic).

(3) Item 45*d* (urine specific gravity).

(4) Item 50 (fasting blood sugar (FBS), cholesterol).

(5) Item 50 (Cardiovascular Screening Program (CVSP)). (See para 8–25.)

(6) Item 50 (HIV testing). (See AR 600–110.)

d. Examination for retirement (mandatory), discharge (in conjunction with exam if given). In addition to *a* above, the following items on the SF 88 are required:

(1) Item 46 (chest x ray).

(2) Item 45*a* (urine microscopic).

(3) Item 45*d* (urine specific gravity).

(4) Item 50 (HCT or HGB).

e. Initial examinations for appointment, enlistment, or induction. In addition to *a* above, the following items on the SF 88 are required (see AR 40–29/AFR 160–13/NAVMEDCOMINST 6120.2/CG COMDTINST M6120.8 for use of DD Form 2351 used in place of the SF 88 and SF 93 for DODMERB exams):

(1) Item 43 (pelvic exam).

(2) Item 46 (Chest x ray not required for examinations accomplished in CONUS, Alaska, Hawaii, or Puerto Rico. Chest x ray required on all other OCONUS examinations for appointment, enlistment, or induction.)

(3) Item 47 (serology).

(4) Item 50 (drug and alcohol testing). (ROTC cadets will be tested during precommissioning physical.)

(5) Item 50 (Pregnancy testing on female applicants).

(6) Item 50 (HIV testing). (See AR 600–110.)

f. 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 *a* above, the following items on the SF 88 are required:

(1) Item 23 (Valsalva required for diving and HALO only).

(2) Item 46 (chest x ray) (not required for SERE).

(3) Item 47 (serology).

(4) Item 48 (EKG).

(5) Item 50 (HIV, HCT).

(6) Item 50 (White blood cell count on diving and HALO only).

(7) Item 50 (sickle cell screen).

(8) Item 50 (G6PD on MOS 00B diving only).

(9) Item 60 (Refraction, if vision does not correct to 20/20 each eye with spectacle or contact lenses or if uncorrected vision is worse than 20/70 in either eye).

(10) Item 64 (color vision).

(11) Item 81 (dentist must sign) (not required for SERE).

g. Additional examinations for female soldiers on active duty or ADT tours in excess of 1 year. See paragraph 8–20*a.*

h. FDMEs. See ATB 2, Army Flight Surgeon's Administrative Guide.

8–13. Standard Form 93

a. Preparation of SF 93. SF 93 is prepared by the examinee prior to being examined. SF 93 must be prepared in all cases when the SF 88 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 apprised 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 information required in items 6 (date of examination) and 7 (examining facility or examiner, and address). SF 93 will normally be prepared in an original and one copy.

b. Identification and administrative data.

(1) Items 1 through 7 will be typewritten or printed in ink.

(2) Item 8 contains a brief statement by examinees expressing their opinion of their present state of health. If unsatisfactory health is indicated in generalized terms such as "fair" or "poor," examinees will elaborate briefly to include pertinent information of their past medical history.

(3) Items 9 and 11 provide a means of determining the examinee's state of health past and present, and possibly identifying medical conditions which should be evaluated in the course of the medical examination. The examinee will complete all items by checking "yes" or "no" for each.

(4) Item 12 will be completed by all female examinees.

(5) Items 13 and 14 will be completed by each examinee. Students who have not had full–time employment will enter the word "student" in item 13. Members of the Active Army who had no full–time employment prior to military service will enter "soldier" or "Army officer" as appropriate in item 13.

(6) Items 15 through 24. These questions and the answers are concerned with certain other environmental and medical conditions which can contribute to the physician's evaluation of the examinee's present and future state of health. All answers checked "yes" will be fully explained by the examinee to include dates, locations, and

circumstances. The examinee will sign the form in black or dark–blue ink.

c. Physician's (or physician's assistant) summary and elaboration of examinee's medical history.

(1) The physician (or physician's assistant) will summarize and elaborate upon the examinee's medical history as revealed in items 8 through 24 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 nondisqualifying nature.

(2) If the examinee is applying for enlistment or appointment and answers reveal that he or she was previously rejected for military service (item 22) or was discharged for medical reasons (item 23), 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's assistant and the date will be entered in the designated blocks. The physician or physicians assistant will sign in black or dark–blue ink.

8–14. Validity—reports of medical examination

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) Two years from date of medical examination for entrance into USMA, the USUHS, and the ROTC Scholarship Program.

(2) Two years from the date of medical examination to qualify for induction, enlistment, reenlistment, or appointment as a commissioned officer or warrant officer, for advanced ROTC, OCS, admission to the USMA Preparatory School, and/or ADT (with exceptions noted in (8) below); 2 years for ARNG and USAR soldiers' entry and reentry in the alternate (split) training option. (Medical examinations administered to ROTC Cadets at Advanced Camp are valid for 2 years from the date of examination to qualify for continuance in ROTC, appointment as a commissioned officer, and for cadets' entrance on active duty or ADT.)

(3) Approximately 1 year from date of examination (FAA Second Class) to qualify for entry into training for ATC duties. These examinations are valid for the remainder of the month in which the examination was taken plus the next 12 calendar months.

(4) When accomplished incident to retirement, discharge, or release from active duty, medical examinations are valid for a period of 1 year 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–R (Periodic Medical Examination (Statement of Exemption)) will be attached to the original SF 88. DA Form 3081–R, located at the back of this regulation, will be reproduced locally on 8½– by 11–inch paper. The form number, title, and date should appear on each reproduced copy.

(5) Three months from date of Secretarial approval for reentry into the Army of soldiers on the TDRL who have been found physically fit.

(6) Twelve months from the date of medical examination for entrance to initial training in Special Forces, Military Free Fall (HALO), Special Forces SCUBA, Water Infiltration Course (WIC), and SERE.

(7) Twelve months from the date of medical examination to qualify for airborne training, except in the case of ROTC cadets who may have an examination within 18 months to qualify for airborne training.

(8) A current periodic medical examination for active Army soldiers and ARNG and USAR soldiers will be valid for reenlistment, attendance at Army or civilian schools, ADT, and Active Duty for Special Work 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 8–19*c* 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 ARNG soldiers will complete DA Form 3081–R to indicate there has been no significant change since the last examination. See AR 600–110 for separate requirements for HIV testing.

(9) Eighteen 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 ARNG and USAR as defined in paragraph 8–19*c*(4) will be valid for the purpose of qualifying for immediate reenlistment in ARNG 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–1100.75. For procedures pertaining to appointment and enlistment in the ARNG and USAR, see chapter 9 of this regulation and NGR 40–501. 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 and inactive duty training

a. Individuals on ADT 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 will be given a medical examination if he or she incurs an injury during such training which 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 within 1 year a medical examination, 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–R 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.

(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. Follow–up. Members of the ARNG or USAR who are not on active duty will be scheduled for follow–up 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, MOS 00B divers, and military freefall parachutists must have an examination every 3 years. The examination for divers must be performed by or reviewed by a Diving Medical Officer or an FS trained in diving medicine. The examination for military freefall parachutists must be performed or reviewed by an FS.

(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 accomplished 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 during the anniversary month of their last recorded medical examination. Army commanders, the Commander, ARPERCEN, 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–R (Initial Medical Review—Annual Medical Certificate) will be used 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. This form, located at the back of this regulation, will be reproduced locally on 8½– by 11–inch paper.

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 tours in excess of 1 year or ARNG Active Guard—Reserve (AGR) tours will undergo annual breast and pelvic examinations to include a cervical cytologic screening test for cancer. This special examination is mandatory and will be accomplished during the month of the soldier's birthday. All ARNG mobilization day (drilling guardsmen) periodic physicals will include current (within 1 year) pelvic examinations and PAP smear results. Civilian test results attached to the periodic physical for ARNG will be acceptable.

(2) All women in the Army on active duty or ADT tours in excess of one 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.

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: SGPS–CP–B).

b. Soldiers on duty at MTFs with limited services. Soldiers on duty at stations or locations having inadequate military medical facilities to accomplish the complete medical examination will be given as much of this examination as local military medical facilities permit, and will undergo a complete medical examination when official duties take them to a station having adequate facilities. This does not apply to retirement or separation examinations which must be accomplished within the required time.

c. Soldiers in isolated areas. Periodic medical examinations may be waived 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 waived will be accomplished at the earliest opportunity 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 waived.

d. 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 SF 600 (Health Record—Chronological Record of Medical Care) 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.

8–23. Separation

a. Soldiers separating from the Army will be given a medical interview using DD Form 2697 (Report of Medical Assessment). The interview will be conducted by a physician, physician assistant, or nurse practioner 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.

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, physician assistant, or nurse practioner 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. ARNG 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 federal service (ARNG) 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 (SF 88 and SF 93 will be completed), and will complete DD Form 2697.

e. Voluntary requests for medical examinations will 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). MTF commanders will not request a delay in administrative processing unless physical disability consideration is required (that is, referral of a medical evaluation board to physical evaluation board).

f. 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.

8–24. Miscellaneous medical examinations

a. Special Forces Initial Qualification, military free fall parachutists, Special Forces/Ranger combat divers, WIC, and SERE medical examination reports. Entrance into Special Forces Qualification Course, military free fall parachuting, Special Forces/Ranger combat diving, WIC, and SERE training will only be accomplished after determination of medical fitness to undergo such training has been made by the Commander, 1st Special Warfare Training Group. The original SF 88, SF 93, and allied documents will be forwarded to the review and waiver authority U.S. Army Special Operations Command Surgeons Office, Chief, Medical Training Division, ATTN: AOMDT–MT, Fort Bragg, NC 28307–5000. The reviewed medical examination forms and allied documents will be returned directly to the sender to be incorporated in the soldier's application for training.

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 5–14*c* and qualified to meet the conditions which will be encountered in the area of contemplated assignment, he or she will complete and sign DA Form 3083–R (Medical Examination for Certain Geographical Areas). This form, located at the back of this regulation, will be reproduced locally on 8 1/2– by 11–inch paper. The top margin of the form will be approximately 3/4–inch for filing in the health record and outpatient record. 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/Health Risk Appraisal

a. Frequency. The CVSP and HRA or the revised Health Enrollment Assessment Review (HEAR) are required at the time of the periodic medical examination. (HRA/HEAR is required at all periodic medical examinations. CVSP is added at age 40.) This does not preclude accomplishing the HRA/HEAR at times other than the periodic examination (for example, health promotion programs).

b. Intent. The CVSP and the HRA are intended to—

(1) Conduct health risk factor screening for all *asymptomatic* Active Army, ARNG, and USAR soldiers.

(2) Emphasize identification of individual cardiovascular risk factors.

(3) Provide advice and assistance in controlling risk factors.

(4) Provide instruction for safe and regular aerobic exercise.

c. Criteria. The periodic physical examination will be used as the vehicle for accomplishing the CVSP/HRA for Active Army, AGR, ARNG, and USAR soldiers.

(1) Personnel are identified for the periodic physical examination and CVSP/HRA and notified through procedures in DA Pam 600–8.

(2) For all Active Army and AGR soldiers, the initial CVSP/HRA will be accomplished on the periodic physical examination coinciding with the 40th birthday. The CVSP/HRA for all ARNG and USAR soldiers will be accomplished at the first physical examination on or immediately after the 40th birthday.

(3) Subsequently CVSP/HRA will be accomplished during periodic physicals, as defined by paragraphs 8–19*c*(3) for the Active Army and paragraph 8–19*c*(4) for RC soldiers not on active duty.

(4) For all soldiers, both Active Army and RC, upon reaching the age of 40, there is no need to require CVSP/HRA prior to continuing PT and participating in the APFT. No profile for exercise will be automatically given. The determination for a medical profile, if medically warranted, can only be made by an examining physician. The physician will complete the medical profile DA Form 3349. Unless a profile is granted, there will be no change in the soldier's exercise requirement or the participation in the APFT.

(5) Soldiers under the age 40 will undergo periodic physical examinations in accordance with paragraph 8–19. The examination

includes screening for cardiovascular risk factors using the HRA and the periodic physical examination.

d. Risk factors. The CVSP is based on the seven risk factors taken from the Framingham study. The seven risk factors will be used to calculate a risk factor index as outlined by the American Heart Association Publication 70–003–A. The CVSP is divided into two parts.

e. Screening instructions, Part I.

(1) The examination will consist of:

(a) Physical examination (SF 88).

(b) DA Form 5675 (Health Risk Appraisal).

(c) Fasting blood sugar.

(d) Serum cholesterol and HDL ratio, if feasible.

(e) EKG.

(f) Smoking history (number of cigarettes per day).

(g) Blood pressure.

(2) Part I examination information will be used to calculate the CVSP risk index and to generate the DA Form 4970–E (Medical Screening Summary—Cardiovascular Risk Screening Program). The computer program which is used to analyze the HRA data and produce the DA Form 4970–E is available from the Commander, U.S. Army Health Care Systems Support Activity, ATTN: HSHS–S (HRA), Greenway Park, 2455 NE Loop 410, Suite 150, San Antonio, TX 78215–5607.

(3) CVSP risk index values:

(a) 7.49 or less—no further medical workup unless indicated by specific cardiovascular risk factors. (See para *f*(2)*(a)* below.)

(b) 7.50 or greater—individual will be referred for Part II evaluation.

(c) Results of the CVSP will be computer–generated on the DA Form 4970–E. The DA Form 4970–E will be completed and maintained in the soldier's medical records. Computer generated medical profiles are not valid and will not exempt a soldier's participation in the Army's physical fitness program.

f. Screening instructions. Part II. (See NGR 40–501 for additional instructions for National Guard soldiers.)

(1) Using CVSP criteria, abnormalities or significant cardiovascular risk factors found during the Phase I examination will be used for medical treatment and referral purposes only. For specific elevated risk parameters described below in (2)*(a)*, the soldier will be evaluated by the appropriate medical facility.

(2) Referral to Part II is based on the presence of any one of the following criteria from the Part I examination:

(a) A Framingham risk index of equal–to–or–greater than 7.5.

(b) A total cholesterol to HDL ratio of equal–to– or–greater than 6.0 or a total cholesterol of equal–to–or–greater than 270 milligrams per deciliter (mg/dl).

(c) Other indications deemed appropriate during the physical examination to include elevations in blood pressure (systolic blood pressure equal or greater than 160 mmHg and/or a diastolic blood pressure equal or greater than 90 mmHg), elevated fasting blood sugar greater than 115 mg/dl, or other active medical conditions as defined in chapters 2 and 3. During the medical examination, if soldiers have symptoms (chest pain, dizziness, claudication) that are suspicious for a possible cardiac or atherosclerotic etiology, they should be referred to appropriate medical facilities.

(3) The Part II screen will be performed by a cardiologist, general internist, or family practitioner who is privileged to perform and interpret the cardiovascular risk factors.

(a) Evaluation and treatment of Active Duty soldiers will be provided at appropriate MTFs.

(b) RC soldiers will be referred to their own medical provider outside of the military medical system.

(c) An independent history and medical examinations are to be recorded on an SF 513 (Medical Record—Consultation Sheet.)

(4) All evaluative tests and recommendations will be placed in the medical record.

(5) If an individual is found to be medically unable to perform physical conditioning or take the APFT, a physical profile on DA Form 3349 will be accomplished. (See chap 7.) A temporary profile cannot be renewed for longer than 12 months. If the soldier does not meet medical retention standards of chapter 3, the provisions of paragraph 3–3 are applicable.

g. CVSP data collection. An updated DA Form 4970–E will be completed with results of the evaluation, and filed in the soldier's medical records. The computer–generated information will be stored and accessed at local computer sites in the physical examination locations. The data collected will be part of the HRA which will be sent quarterly to the U.S. Army Health Care Systems Support Activity, ATTN: HSHS–S (HRA), 2455 NE Loop 410, Suite 150, San Antonio, TX 78217–5607.

h. Source of information. The medical guidelines for CVSP/HRA are provided by the Readiness Division (SGPS–FP) of TSG. Questions should be addressed to the program manager, HQDA (SGPS–FP), 5109 Leesburg Pike, Falls Church, VA 22041–3258.

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 MOS Medical Retention Boards, 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 examination (see notes 1 and 2)
(See para 8–12 to determine what items must be completed)

Item SF 88	Explanatory notes	Model entries
1 (Name)	The entire last name, first name, and middle name are recorded. If the individual's first and/or middle name consists of initial(s) only, indicate by adding (IO). When Jr. or similar designation is used, it will appear after the middle name. If there is no middle name or initial, put a dash after the first name.	Jackson, Charles Guy; Rush, Benjamin–; Osler, William Z. (IO); Jenner, Edward Thomas Jr.; Baird, J.T. (IO).
2 (Grade)	Enter examinee's grade and component. The entry USA is used for all personnel on active duty with the United States Army. Reserve Components of the Army are indicated by USAR or ARNGUS. If the examinee has no military status, enter the word "Civilian," leaving space for later insertion of grade and component upon entry into the military service.	CPT, USA; MAJ, USAR; SGT, USA; SFC, ARNGUS; Civilian.

Table 8–1
Recording of medical examination (see notes 1 and 2)
(See para 8–12 to determine what items must be completed)—Continued

Item SF 88	Explanatory notes	Model entries
3 (SSN)	Examinee's social security number. If none, enter a dash.	396–38–0699; —
4 (Home address)	Examinee's current civilian mailing address. Do not confuse with military organization or present temporary mailing address.	
5 (Purpose of exam)	Enter the purpose of the examination. If for more than one purpose, enter each. If for aviation personnel, enter "Flight" plus Class 1, 1A, 2, 2A or 3; and enter "Initial," "Repeat," or "Periodic," as required.	Induction; RA Enlistment; Periodic; RA Commission; Retirement; Flight Class 1 (Initial).
6 (Date)	Enter the date on which the medical examination is accomplished. Record in military style. This item is to be completed at the medical examining facility.	10 Feb 87; 3 Mar 87.
7 (Sex)	Do not use an abbreviation.	Male.
8 (Race)	Enter the appropriate race or ethnicity: American Indian/Alaskan Native, Asian, Black, White, or Unknown.	
9 (Years of Government Service)	Enter total active duty time in the military and/or full time civil service or Federal employment only. Express as years plus twelfths. Reserve time may be entered in item 16.	
10 (Agency)	Enter branch of military service or civilian agency as appropriate. Do not confuse with components of the services.	DA; DAF; DN; USMC; FBI; CIA; State Dept.
11 (Unit)	The examinee's current military unit of assignment, Active or Reserve. If no current military affiliation, enter a dash.	B Company, 2D BN, 325th Inf, 82nd Airborne Division, Fort Bragg, NC 28307–5100; —.
12 (Date of birth)	Record in military style; that is, day, month and year, followed by age, in parenthesis.	14 Jan 43 (21); 26 Mar 20 (45).
13 (Place of birth)	Name of city and State of examinee's birth. If not born in a city or town, enter county and State. If born in a foreign country, enter city or town and country.	Baltimore, MD; Dinwiddie County, VA; Marseilles, France.
14 (Next of kin)	Name, followed by relationship in parentheses, and address of next of kin. This is the person to be notified in the event of death or emergency. If there is no next of kin, enter "None."	Mrs. Annie F. Harris (Wife), 1234 Fairfax Ave., Atlanta, GA 20527–1234; None.
15 (Place of exam)	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; Dr. Raymond T. Fisher, 311 Marcy Street, Phoenix, AZ 39404–0311.
16 (Other information)	List any prior service number(s) and service(s). In the case of service academy examinees, enter the title, full name, and address of sponsor (individual who requested the examination). For Selective Service registrants, list the examinee's Selective Service number and identify it as such. Identifying or administrative data for the convenience of the examining facility should be entered either in item 16, if space allows, or in the upper right hand corner of the SF 88. If the examination is for an aviation procurement program and the examinee has prior military service, enter the branch of service.	
17 (Rating specialty)	The individual's current military job or specialty by title and SSI or MOS, including total time in this capacity expressed in years and/or twelfths. For pilots, enter current aircraft flown and total flying time in hours. In the case of free fall parachuting and/or marine (SCUBA) diving, so state and report the time in months or years of qualification.	
18 (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.	2 in. vertical scar right forehead, well healed, no symptoms. 3 discrete freely movable, firm 2 cm nodes in the right anterior cervical chain, probably benign.
19 (Nose)	Record all abnormal findings. Record estimated percent of obstruction to air flow if septal deviation, enlarged turbinates, or spurs are present.	20 percent obstruction to air flow on right due to septal deviation.
20 (Sinuses)	Record all abnormal findings.	Marked tenderness over left maxillary sinus.
21 (Mouth, throat)	Record any abnormal findings. Enucleated tonsils are considered abnormal.	Tonsils enucleated.
22 (Ears)	If operative scars are noted over the mastoid area, a notation of simple or radical mastoidectomy will be entered.	Bilateral severe swelling, injection and tenderness of both ear canals.

Table 8–1
Recording of medical examination (see notes 1 and 2)
(See para 8–12 to determine what items must be completed)—Continued

Item SF 88	Explanatory notes	Model entries
23 (Eardrums)	Record all abnormal findings. If tested, a definite statement will be made as to whether the ear drums move on valsalva maneuver or not. 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.	Valsalva normal bilaterally, 2mm oval perforation, left posterosuperior quadrant. No motion on valsalva maneuver, completely dry. No evidence of inflammation at present.
24 (Eyes)	Record abnormal findings. If ptosis of lids is detected, a statement will be made as to the cause of the interference with vision. When pterygium is found, the following should be noted: 1. Encroachment on the cornea, in millimeters, 2. Progression, 3. Vascularity.	Ptosis, bilateral, congenital. Does not interfere with vision. Pterygium, left eye. Does not encroach on cornea; nonprogressive, avascular.
25 (Ophthalmoscope)	Whenever opacities of the lens are detected, a statement is required regarding size, progression since last examination, and interference with vision.	Redistribution pigment, macular, rt eye, possibly due to solar burn. No loss of visual function. No loss of visual function. No evidence of active organic disease.
26 (Pupils)	Record all abnormal findings.	
27 (Ocular motility)	Record all abnormal findings.	
28 (Lungs and chest)	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.	Sibilant and sonorous rales throughout chest. Prolonged expiration. See item 73 for cause.
29 (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 (IV or VI).	Grade II/IV soft, systolic murmur heard only in pulmonic area and on recumbency, not transmitted. Disappears on exercise and deep inspirations (physiological murmur).
30 (Vascular system)	Adequately describe any abnormalities. When varicose veins are present, a statement will include location, severity, and evidence of venous insufficiency.	Varicose veins, mild, posterior superficial veins of legs. No evidence of venous insufficiency.
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 ½ in. linear diagonal scar, right lower quadrant.
32 (Anus, rectum)	A definite statement will be made if the examination is performed. Note surgical scars and hemorrhoids in regard to size, number, severity, and location. Check fistula, cysts, and other abnormalities.	One small external hemorrhoid, mild. Digital rectal normal. Stool guaiac negative.
33 (Endocrine)	Record all abnormal findings.	
34 (G–U system)	Whenever a varicocele or hydrocele is detected, a statement will be included indicating the size and the presence of pain. If an undescended testicle is detected, a statement will be included regarding the location of the testicle, particularly in relation to the inguinal canal.	Varicocele, left small.
35 (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.	No weakness, deformity, or limitation of motion, left arm.
36 (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, 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.	Flat feet, moderate. Foot stable, asymptomatic, no eversion or bulging; no rotation.
37 (Lower extremities)	Record as for item 35.	
38 (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.	Scoliosis, right, 1/2 in. from midline at level of T–8.

Table 8–1
Recording of medical examination (see notes 1 and 2)
(See para 8–12 to determine what items must be completed)—Continued

Item SF 88	Explanatory notes	Model entries
39 (Body marks)	Only scars or marks of purely identifying significance or which interfere with function are recorded here. Tattoos which are obscene or so extensive as to be unsightly will be described fully.	1–in. vertical scar, dorsum left forearm. 3–in. heart–shaped tattoo, nonobscene, lateral aspect middle 1/3 left arm.
40 (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.	Small discrete angular, flat papules of flexor surface of forearms with scant scale; violaceous in color; umbilicated appearance and tendency to linear grouping. Similar lesion on glans penis.
41 (Neurologic)	Record complete description of any abnormality.	
42 (Psychiatric)	Record all abnormalities. Before a psychiatric diagnosis is made, a minimum psychiatric evaluation will include Axis I, II, and III. This is not to be confused with AA (item 72).	
43 (Pelvic)	Check vaginal or rectal. Record any abnormal findings.	Normal.
44 (Dental)	Examining physicians or dentists will apply the appropriate standards prescribed by chapters 2, 3, 4, or 6, and indicate “acceptable” or “nonacceptable.” Examining physicians or dentists will also indicate the appropriate dental classification as defined by AR 40–3, paragraph 10–5.	Acceptable. Dental Class 2.
45A B C D (Urine)	Identify tests used and record results.	
46 (Chest x ray)	Note place and date taken, and findings.	Womack Army Community Hospital, Ft Bragg, NC 28307–5000, 11 July 1985, negative.
47 (Serology)	Kahn, Wasserman, VDRL or cardiolipin microflocculation tests recorded as nonreactive or reactive. On reactive reports note date, place, and titre.	Nonreactive. Reactive.
48 (EKG)	Representative original samples of all leads (including precordial leads) properly mounted and identified on SF 520 will be attached to the original SF 88. SF 520 should be attached to all copies of SF 88. The interpretation of the EKG will be entered in item 48 on all copies of SF 88.	Normal. Abnormal—see attached SF 520.
49 (Blood type)	None.	
50 (Other tests)	Identify test(s) and record results.	
51 (Height)	Record in inches to the nearest quarter inch (without shoes). For Class 1 and 1A aviation personnel, record the time of day if near height limits. 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 guidance from HQDA (SGPS–CP–B), on all applicants less than 68 inches in height. Date will be recorded in item 73.	71½.
52 (Weight)	Record in pounds to the nearest whole pound (without clothing and shoes).	164.
53 (Color hair)	Record as black, blond, brown, gray, or red.	Brown.
54 (Color eyes)	Record as blue, brown, gray, or green.	Blue.
55 (Build)	Enter X in appropriate space. If obese, enter X in two spaces as appropriate. For the definition of obesity, see the glossary.	
56 (Temperature)	Record in degrees Fahrenheit to the nearest tenth.	98.6.
57A (Sitting BP) B (Recumbent BP) C (Standing BP)	None.	110/76.

Table 8–1
Recording of medical examination (see notes 1 and 2)
(See para 8–12 to determine what items must be completed)—Continued

Item SF 88	Explanatory notes	Model entries
58A (Sitting pulse) B, C, D (Post exercise pulse) E (Standing pulse)	None.	
59 (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.	20/100 corr to 20/20. 20/50 corr to 20/20.
60 (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.	By −150 S + 0.25 CX 05. By −150 S + 0.25 CX 175.
61 (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."	20/40 corr to 20/20 by same. 20/40 corr to 20/20 by + 0.50.
62 (Heterophoria)	Identify the test used; for example, either Maddox Rod or Stereoscope, Vision Testing (SVT), and record results, Prism Div and PD not required. All subjective tests will be at 20 feet or at a distance setting of the SVT.	ES deg. 4 EX Deg. 0. R.H. 0 L.H. 0.
63 (Accommodation)	Record values without using the word "diopters" or symbols.	Right 10.0; Left 9.5.
64 (Color vision)	Record results in terms of test used. Pass or Fail— 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 color vision and results recorded as "pass" or "fail" red/green.	Pseudo–isochromatic plate; or PIP. Pass 3/14. Fail 9/14.
65 (Depth perception)	Identify the test used. Record the results as "Corrected" or "Uncorrected," as applicable. Enter the score for Verhoeff or VTA as "pass" or "fail" plus number missed over maximum score for that test.	Verhoeff pass 0/8. VTA pass through D; fail 1/9. RANDOT circles 0/8.
66 (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 the perimeter and tangent screen. Findings are recorded on a visual chart and described in item 73. Copy of chart must accompany original SF 88.	Confrontation test: Normal, full.
67 (Night vision)	None.	
68 (Red lens test)	Record test results and describe all abnormalities.	Normal.
69 (Intraocular tension)	Record results numerically in millimeters of mercury of intraocular pressure. Describe any abnormalities; continue in item 73 if necessary.	Normal. O.D. 18.9, O.S. 17.3.
70 (Hearing)	None.	
71 (Audiometer)	Test and record results at 500, 1000, 2000, 3000, 4000, and 6000 Hertz using procedures prescribed in DA Pam 40–501.	
72 (Psychological psychomotor)	Enter as "AA sat." or "AA unsat." Unsatisfactory AA requires a summary of defects responsible for failure in time 73. Results of other psychological testing, when accomplished, will be attached to SF 88. The MDAR rating will include consideration of requirements of paragraph 5–9w. If the chamber required for paragraph 5–9w is not available, the test will be conducted at the Naval Diving and Salvage Training School. Include a statement in item 73 in answer to paragraph 5–9w whether he or she has fear of depths, enclosed places or of the dark.	AA sat. AA unsat.— see item 73. RAT sat. MDAR sat. MDAR unsat.
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. If additional space is needed, use SF 507. History and related comments recorded on SF 93, when used, will not be transferred or commented on except as necessary in connection with the examination. All aviation personnel will include and sign the following entry: "I understand I must be cleared by a flight surgeon after hospitalization or sick in quarters (AR 600–105); must inform him or her after treatment or activities which may require restriction (AR 40–8); I have read AR 40–8; I have informed the examining physician of any changes in health since last examination." (Rubber stamp may be used.)	No significant or interval history. Traumatic cataract, left eye, removed 29 July 1984, no comp., see items 59 and 60 for vision correction. Item 72 cont: History of multiple idiopathic syncopal attacks.

Table 8–1
Recording of medical examination (see notes 1 and 2)
(See para 8–12 to determine what items must be completed)—Continued

Item SF 88	Explanatory notes	Model entries
	Other statements of medical history, such as "no history of asthma, allergies, loss of consciousness, or convulsions," etc., may also be used. Results of cardiovascular screening will be entered as follows: Favorable or Unfavorable.	
74 (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 which may be of future significance, such as nonstatic defects which may become worse. Enter item number followed by a short, concise diagnosis; do not repeat the full description of a defect which has already been described under the appropriate item. Do not summarize minor, nonsignificant findings.	
75 (Recommendations)	Notation will be made of any further specialized examinations or tests that are indicated. Item 75 will also include the statement "protective mask spectacles required (AR 40–3)" whenever indicated under the criteria given in AR 40–3.	
76 (Physical profile)	The physical profile as prescribed in chapter 7 will be recorded.	111121.
77 (Examinee qualified/not qualified)	Except as noted below, check box A or B, as appropriate, and enter purpose of the examination as stated in item 5.	
78 (Disqualifying defects)	List all disqualifying defects by item number. This listing is required even though the defects are stated in item 74. If qualified, enter a dash.	
79–81 (Physician, dentist names)	Enter the typed or printed names of examiners. Examinations accomplished for enlistment or induction, entrance on active duty of Reserve Component soldiers, and all periodic, discharge, relief from active duty, and retirement examinations must be signed by a physician. Dentists, optometrists, podiatrists, audiologists, nurse practitioners, and physician assistants may also sign attesting to that portion of the examination actually accomplished by them.	

Table 8–1
Recording of medical examination (see notes 1 and 2)
(See para 8–12 to determine what items must be completed)—Continued

Item SF 88	Explanatory notes	Model entries
82 (Reviewing officer name)	See paragraph 8–14d.	

Legend for Table 8-1:
AA—Aeromedical Adaptability
APO—Army Post Office
ARNGUS—Army National Guard of the United States
BN—battalion
BP—blood pressure
CIA—Central Intelligence Agency
cm—centimeter(s)
comp—complications
corr—corrected
DA—Department of the Army
DAF—Department of the Air Force
deg—degree(s)
Div—divergence
DN—Department of the Navy
EKG—electrocardiogram
ES—esophoria
EX—exophoria
FALANT—Farnsworth Lantern
FBI—Federal Bureau of Investigation
G–U—genitourinary
in—inch(es)
INF—Infantry
IO—initial only
L.H.—Left hyperphoria
MDAR—Military Diving Adaptability Rating
mm—millimeter(s)
MOS—military occupational specialty
PD—pupillary distance
RA—Regular Army
RANDOT—random dot (test)
R.H.—right hyperphoria
rt—right
sat—satisfactory
SCUBA—self–contained underwater breathing apparatus
SVT—Stereoscope, Vision Testing
unsat—unsatisfactory
USA—U.S. Army
USAFA—U.S. Air Force Academy
USAR—U.S. Army Reserve
USCGA—U.S. Coast Guard Academy
USMA—U.S. Military Academy
USMC—U.S. Marine Corps
USMMA—U.S. Marine Military Academy
USN—U.S. Navy
USNA—U.S. Naval Academy
VDRL—venereal disease research lab (test)
VTA—vision testing apparatus

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. Abbreviations used in this table are listed in legend above.

Table 8–2
Schedule of separation medical examinations (see note)

Action	Required	Not required	Can be requested by soldier (in writing)
Retirement after 20 or more years 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 ARNG on active duty or ADT in excess of 30 days.		X	X
Individual is member of the ARNG and has been called into Federal service (10 USC 3502). (See para 8–23b.)			
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, chap 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 AR 635–100, when medical examination and/or mental status evaluation is not a requirement.		X	X
Enlisted soldiers being processed for separation under the provisions of AR 635–200, chapters 5 (paras 5–3, (involuntary separations only), 5–11, and 5–12 only), 8, 9, 11 (para 11–3b 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)

Category	Recommendation
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 Category 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.)

Table 8–3
Results of Speech Recognition in Noise Test (SPRINT)—Continued

Category	Recommendation
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.

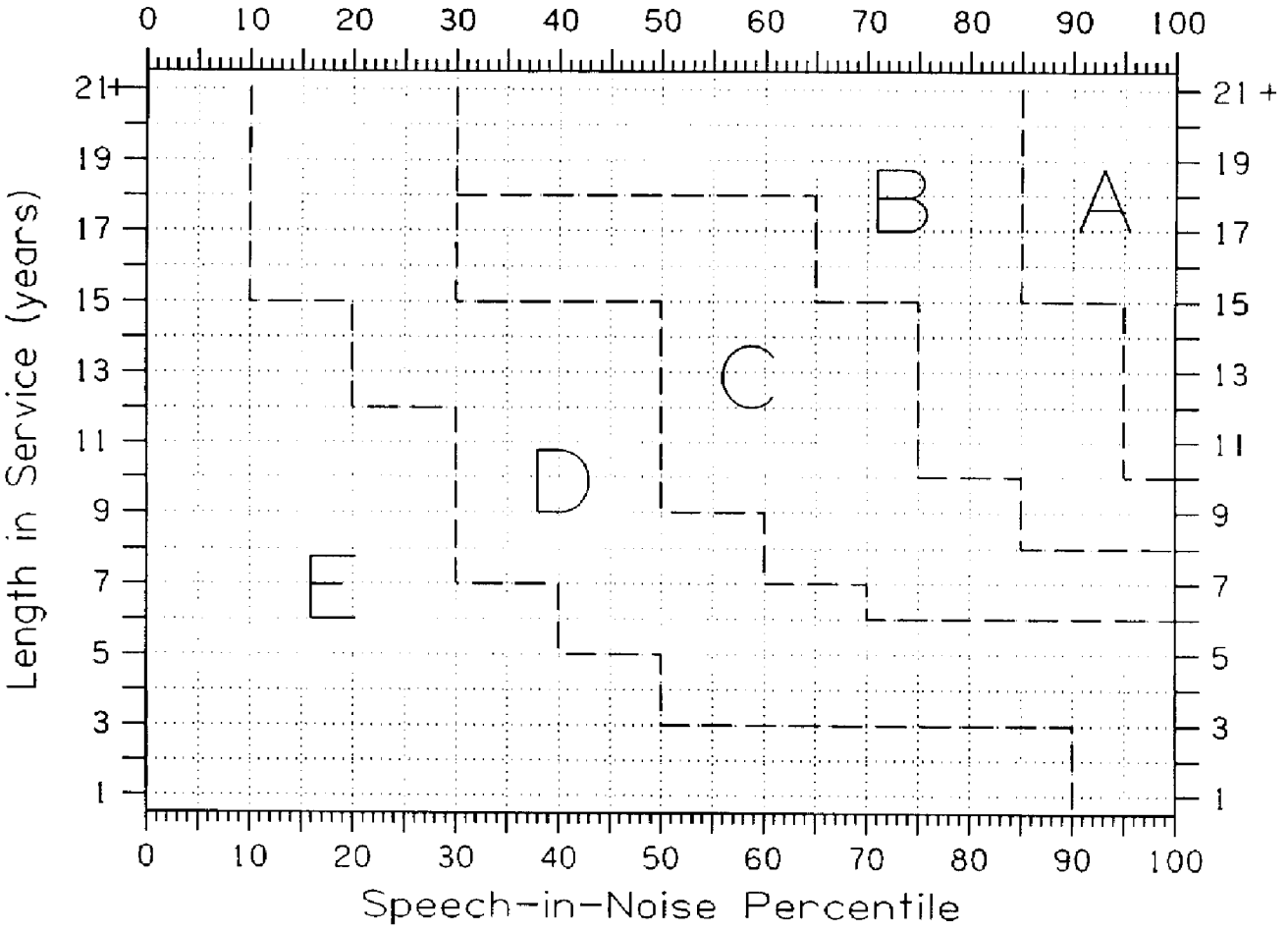

Figure 8-1. Normative data from Speech Recognition in Noise Test

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 ARNG.

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. Travel for examinations
a. Examinations held in certain places are less expensive than others. If travel to one of these places creates less expenses for the Government, travel orders may be issued to the following persons:

(1) Applicants for enlistment or reenlistment.

(2) Ready Reservists who by law or regulation must have medical examinations required by 10 USC 1004.

(3) Reservists who need an examination to determine their medical fitness.

(4) Reservists who apply for voluntary orders to active duty and Reservists who are required by regulation to have an examination before entry on active duty.

(5) Reservists who are members of the Standby Reserve. For these persons, the commanding general, ARPERCEN will arrange examinations at Government expense, using the examiners cited in paragraph 9–6 below.

b. Army area commanders, major ARCOM commanders, and the Commanding General, ARPERCEN may issue travel orders for medical examinations.

9–5. Cost of examinations
Medical examinations made by the examiners cited in paragraph 9–6 will be done without cost to Reservists and applicants.

9–6. Examiners and examination facilities
a. Applicants for enlistment who do not have any prior military service will be examined only at MEPS.

b. Applicants with prior service and RC soldiers must present a letter of authorization from a unit commander, a unit advisor, an Army area commander, or Commanding General, ARPERCEN to receive a medical examination.

c. Examinations may be done by the examiners listed in (1) through (5) below.

(1) Medical officers of the Armed Forces RCs who are not on active duty.

(2) ARNG medical officers and other Armed Forces RC medical units may do examinations. Such examinations must be coordinated between the components.

(3) Medical officers at Armed Forces MTFs or at MEPS may also be chosen as examiners.

(4) When the medical officers above are unavailable, physicians or facilities of Government agencies other than DA may be used.

(5) When physicians of other Government agencies are unavailable, civilian physicians may be used in accordance with established procedures and with the approval of the CONUS U.S. Army Medical Activity (MEDDAC) commander in the local area, the local area U.S. Army Medical Center (MEDCEN) commander, or CG, ARPERCEN.

9–7. Examination reports
a. For all examinations, the examiner will prepare and sign two copies each of SF 88 and SF 93. The examining facility will keep one set of these reports. The medical examiner will send the other set of SF 88 and SF 93 to the commander who authorized the examination. The authorizing commander will then handle these two reports as follows:

(1) Reports prepared in examinations for appointment will accompany the application for appointment per AR 135–100.

(2) Reports prepared in examinations of ready Reservists will be sent to review authorities named in paragraph 9–12. After review, they will be returned to the authorizing commander to be filed in the Reservist's health record. (To ensure against loss, the commander should keep a copy of the reports when sending them for review.)

(3) Reports prepared in examinations of standby Reservists will be sent to Commanding General, ARPERCEN for review. After review, they will be returned to the authorizing commander for filing in the Reservist's health record. (To ensure against loss, the commander should keep a copy of the reports when sending them for review.)

(4) Reports prepared in periodic examinations will be sent to the proper reviewing authority (para 9–12). After review, they will be returned to the authorizing commander to be filed in the Reservist's health record. (To ensure against loss, the commander should keep a copy of the reports when sending them for review.)

(5) Reports prepared in examinations for tours of ADT will be handled per AR 135–210.

b. After their entrance examinations, Reservists will complete DA Form 3081–R any time they enter or are relieved from ADT or active duty of 30 days or more providing there is an SF 88 in the unit file. When completed, this form will be sent to the USAR unit commander for filing in the Reservist's health record.

9–8. Conduct of examinations
a. Medical examinations will be performed per chapter 8. Immunizations should be updated when Reservists are examined. (See AR 40–562/NAVMEDCOMINST 6230.3/AFR 161–13/CG COMDTINST M6230.4 for instructions on updating immunizations.)

b. See paragraph 8–14 for validity periods for medical examinations.

c. Reservists who have been injured or hospitalized for illness during their tour must be medically examined prior to their separation. (A report of consultation may be used in these cases addressing the specific medical condition. A complete SF 88 is not required.)

d. If medical fitness for appointment, enlistment, or reenlistment cannot be determined otherwise, hospitalization is authorized. (See AR 40–3.)

e. The Commanding General, U.S. Army Forces Command (FORSCOM) will set detailed procedures for using training time for medical examinations and may permit examinations during annual training.

9–9. 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 8–19*c*(4).

c. Commanders will take proper action against obligated Ready Reservists who fail to take their required periodic examinations.

d. Examinations for Reserve officers appointed from the ROTC Program are as follows:

(1) Officers who have had an examination within 24 months of

their scheduled date of entry on ADT need not be given an entry examination. (The examination given them must have been of the scope prescribed by chap 8.) Orders directing these officers to report for active duty or ADT will state the date of their most recent qualifying examination. The orders must also include the following statement: "You are medically qualified for entry on (active duty or active duty for training)."

(2) Officers whose last examination was given more than 24 months from active duty or ADT will have an entry examination within 5 working days after reporting to their first duty station. This examination will be of the scope prescribed by chapter 8. Orders directing these officers to report for active duty or ADT will state the date of their most recent qualifying examination.

9–10. 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 to provide this support within chosen areas: such officers need to be designated in units approved to do medical examinations. Normally, only the designated profiling officer may verify and change the physical profiles of Reservists not on active duty.

9–11. Standards of medical fitness

a. The standards of medical fitness for RC soldiers are the same as the standards for active soldiers. Chapter 2 standards are required for enlistment and appointment. Chapter 3 standards are required for retention.

b. Other standards.

(1) For other duties, such as Airborne, marine diving, and Ranger or Special Forces, chapter 5 prescribes standards for the selection and retention of both officers and enlisted personnel.

(2) Reservists will meet the standards of AR 600–9.

9–12. Examination reviews

(See chap 6 for aviation reviews.)

a. The DODMERB, USAFA, Colorado Springs, CO 80840–6518 is the review authority for reports of examinations given applicants for entrance into the ROTC Scholarship Program and the USMA. Only DODMERB may determine the medical fitness of applicants entering these programs. (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.

b. MEPS, under the purview of MEPCOM, is the review authority for enlistment and non–scholarship ROTC program examinations accomplished in their facilities. The Commanding General, USAREC, is the waiver authority for original enlistment.

c. MEDCEN or MEDDAC Commanders are the review authorities for entry into non–scholarship 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. The Commanding General, ROTC Command is the waiver authority for all ROTC programs.

d. Review and waiver authority for applicants for U.S. Army Medical Department (AMEDD) personnel procurement programs will be determined by TSG after appropriate coordination with the Office of the Deputy Chief of Staff for Personnel (ODCSPER).

e. Review and waiver authority for other direct appointment programs (for example, Chaplin Corps, Judge Advocate General Corps) is the Commanding General, ARPERCEN.

f. Review authority for periodic examinations for RC soldiers not on active duty. Review is normally not required if the examination is accomplished at Army MTFs or MEPS. Chief, Army Reserve or his or her designee (for example, ARCOM and GOCOM commanders, ARPERCEN Surgeon) may initiate additional reviews if appropriate. Additional reviews (or reviews of examinations not accomplished at Army MTFs or MEPS) should be accomplished by RC medical examination facilities or RC units with Medical Corps officer positions.

9–13. 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 are found unfit may request continuance in active USAR status. In such cases, physical disability incurred in either military or civilian status will be acceptable; it need not have been incurred only in the line of duty.

c. Requests for continuance will include—

(1) A report of an examination of the scope prescribed by chapter 8.

(2) A summary of the Reservist's experience and qualifications.

(3) An evaluation by his or her unit commander of his or her potential value to the military Service.

d. Requests will be sent to the Commanding General, ARPERCEN who will consider each request and determine if the Reservist's experience and qualifications are needed in the Service.

e. Each request will also be reviewed by the Surgeon, ARPERCEN: 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.

f. Separation of Reservists who are accepted in the USAR then later found disqualified for active duty, ADT, or retention will be deferred pending review by the Commanding General, ARPERCEN.

g. Waivers requested for officers being considered for assignment/selection to and within the general officer ranks will be sent to the Chief, Army Reserve for review and final determination. The Chief, Army Reserve 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 TSGs review when making a final determination.

(3) Cases where the opinions of TSG and Chief, USAR Reserve 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.

9–14. 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 Commanding General, ARPERCEN, 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.

9–15. Dental examinations

a. A dental record will be prepared for each USAR member (see AR 40–66) including the requirement for a panographic radiograph in the record, and a confirmed copy on file with the Central Panograph Storage Facility.

b. To meet the requirements for the dental record, an examination should be performed by dental officers of the Armed Forces RC who are not on extended active duty. However, the need for the examination will be satisfied if the USAR member, during periods of active duty, becomes eligible for and receives care from Active Army facilities. Active Army dental activities will cooperate with Reserve units to fulfill the panographic requirement.

Appendix A
References

Section I
Required Publications

APL series
Aeromedical Policy Letters. (Cited in paras 4–1*d*, 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*(1)(*b*), 4–12*a*(7), 4–13*c*, 4–13*d*, 4–13*e*, 4–15*a*, 4–15*a*(6), 4–15*a*(12), 4–15*b*, 4–15*c*, 4–15*e*, 4–15*f*, 4–15*i*, 4–16*a*, 4–18*e*, 4–20*b*, 4–23, 4–23*h*(2), 4–23*i*, 4–26*d*, 4–26*i*, 4–27*b*, 4–31*e*, 4–32*a*, 4–33*c*(5), 4–33*c*(10), 6–2*d*, 6–2*q*, 6–5*a*, 6–9*b*, 6–10*e*, 6–11*f*, 6–12*a*, 6–12*c*(3), 6–12*e*, 6–15, 6–17*c*, and 6–19*b*.) (Available from Headquarters, U.S. Army Aeromedical Center, ATTN: MCXY–AER, Fort Rucker, AL 36362–5333.)

ATB series
Aeromedical Technical Bulletins. (Cited in paras 4–1*d*, 4–5*b*, 4–12*a*(2)(*d*), 4–12*a*(8), 4–12*b*(2), 4–12*f*, 4–15*a*(15), 4–26*g*, 4–30, 4–31*e*, 4–32*a*, 4–32*b*(4), 4–33*c*(8), 6–2*d*, 6–4*d*, 6–5, 6–7*e*, 6–9*a*, 6–10*e*, 6–11*d*, 6–12*a*, 6–12*c*(3), 6–12*i*, 6–13*c*, 6–17*c*, 6–19*b*, and 8–12*h*.) (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 3–3, 4–31*c*, 6–9*e*, 8–4*a*, 8–8, 9–8*d*, and table 8–1.)

AR 40–8
Temporary Flying Restrictions Due to Exogenous Factors. (Cited in paras 4–26*d*, 6–13*a*, and table 8–1.)

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 8–10, 8–12*e*, 8–15, and 9–12*a*.)

AR 40–66
Medical Record Administration. (Cited in paras 8–5*a*, 8–17, 8–24*b*(5), and 9–15*a*.)

AR 40–562/NAVMEDCOMINST 6230.3/AFR 161–13/CG COMDTINST M 6230.4
Immunizations and Chemoprophylaxis. (Cited in para 9–8*a*.)

AR 55–46
Travel of Dependents and Accompanied Military and Civilian Personnel To, From, or Between Overseas Areas. (Cited in para 5–14*c*.)

AR 95–1
Flight Regulations. (Cited in para 6–11*d*.)

AR 95–20/AFR 55–22/NAVAIRINST 3710.1/DLAM 8210.1
Contractor's Flight and Ground Operations. (Cited in paras 4–31*b*, 6–4*f*, and 6–4*g*.)

AR 135–100
Appointment of Commissioned and Warrant Officers of the Army. (Cited in para 9–7*a*(1).)

AR 135–175
Separation of Officers. (Cited in paras 3–7*h*, 9–13*a*, and 9–14*d*.)

AR 135–178
Separation of Enlisted Personnel. (Cited in paras 3–7*h*, 9–13*a*, and 9–14*d*.)

AR 135–210
Order to Active Duty as Individuals During Peacetime. (Cited in para 9–7*a*(5).)

AR 140–10
Assignments, Attachments, Details, and Transfers. (Cited in paras 3–7*h*, 9–13*a*, 9–14*a*, and 9–14*d*.)

AR 145–1
Senior Reserve Officer's Training Corps Program: Organization, Administration, and Training. (Cited in paras 8–15 and 9–2*a*(1).)

AR 145–2
Junior Reserve Officer Training Program. (Cited in para 9–2*a*(1).)

AR 310–10
Military Orders. (Cited in para 6–18*f*(2).)

AR 600–8–101
Personnel Processing (In–and–Out and Mobilization Processing). (Cited in para 5–14*c*.)

AR 600–9
The Army Weight Control Program. (Cited in paras 2–21*a*, 4–17*a*, 4–17*b*(1), 4–31*h*, 5–9*l*, 5–11*l*, 5–11*m*(2), 9–11*b*(2), table 2–1, and table 2–2.)

AR 600–75
Exceptional Family Member Program. (Cited in para 5–14*b*.)

AR 600–85
Alcohol and Drug Abuse Prevention and Control Program. (Cited in para 4–23*h*(2).)

AR 600–105
Aviation Service of Rated Army Officers. (Cited in paras 4–2*b*(2), 4–2*c*, 4–23*l*, 4–29*a*, 4–29*b*, 6–2*a*, 6–2*k*, 6–4*d*, 6–8*b*(4), 6–11*c*, 6–11*i*(1), 6–12*b*(1), 6–17*b*, 6–17*f*, 6–19*c*(4), 6–19*g*, and table 8–1.)

AR 600–106
Flying Status for Nonrated Army Aviation Personnel. (Cited in paras 4–2*e* and 6–2*a*.)

AR 600–110
Identification, Surveillance, and Administration of Personnel Infected with Human Immunodeficiency Virus (HIV). (Cited in paras 3–7*h*, 4–5*b*, 4–26*g*, 4–32*b*(4), 4–33*c*(8), 8–12*b*(3), 8–12*c*(6), 8–12*e*(6), and 8–14*a*(8).)

AR 600–200
Enlisted Personnel Management System. (Cited in para 5–14*c*.)

AR 601–270/AFR 33–7/OPNAVINST 1100.4/MCO P–1100.75
Military Entrance Processing Stations (MEPS). (Cited in paras 8–4*a* and 8–15.)

AR 611–85
Selection of Enlisted Volunteers for Training as Aviation Warrant Officers. (Cited in para 4–2*a*(1).)

AR 611–110
Selection and Training of Army Aviation Officers. (Cited in para 4–2*a*(1).)

AR 611–201
Enlisted Career Management Fields and Military Occupational Specialties. (Cited in para 5–13*a*.)

AR 614–30
Overseas Service. (Cited in para 7–9*c*(4)(*a*).)

AR 630–5
Leave and Passes. (Cited in para 7–9*f*.)

AR 635–40
Physical Evaluation for Retention, Retirement, or Separation. (Cited in paras 3–2*d*, 3–3, 3–4, 3–7*h*, 6–12*b*, 7–3*d*(4), table 7–2, and table 8–2.)

AR 635–100
Officer Personnel. (Cited in paras 3–3*b*, 7–9*b*(3), and table 8–2.)

AR 635–200
Enlisted Personnel. (Cited in paras 3–3*b*, 7–9*b*(3), and table 8–2.)

DSM–III–R
Diagnostic and Statistical Manual, Third Edition, Revised, American Psychiatric Association, 1987. (Cited in paras 2–28, 3–30, and 4–2.) (This manual may be obtained from the American Psychiatric Association, 1400 K St., NW, Washington, DC 20005–2492.)

FM 21–20
Physical Fitness Training. (Cited in para 7–10*b*.)

NGR 40–501
Medical Examination for Members of the Army National Guard. (Cited in paras 7–8*f*, 8–7*d*, 8–15, and 8–25*f*.)

TB MED 287
Pseudofolliculitis of the Beard. (Cited in para 7–3*e*(4).)

TC 8–640
Joint Motion Measurement. (Cited in paras 2–9*a*, 2–10*a*, 3–12*b*, and 3–13*d*.)

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 publication.

AR 37–106
Finance and Accounting for Installations: Travel and Transportation Allowances

AR 40–5
Preventive Medicine

AR 40–48
Nonphysician Health Care Providers

AR 135–133
Ready Reserve Screening, Qualification Records System and Change of Address Reports

AR 135–91
Service Obligations, Methods of Fulfillment, Participation Requirements, and Enforcement Procedures

AR 140–1
Army Reserve Mission, Organization, and Training

AR 140–185
Training and Retirement Point Credits and Unit Level Strength Accounting Records

AR 600–6
Individual Sick Slip (DD Form 689)

AR 600–20
Army Command Policy

AR 611–75
Selection, Qualification, Rating and Disrating of Marine Divers

AR 614–10
U.S. Army Exchange Program With Armies of Other Nations: Short Title: Personnel Exchange Program

AR 635–10
Processing Personnel for Separation

Civil Service Handbook X–118
Qualification Standards. (This publication is available at local civilian personnel offices.)

DA Pam 40–501
Hearing Conservation

DA Pam 351–4
U.S. Army Formal Schools Catalog

DA Pam 600–5
Handbook on Retirement Services for Army Personnel and Their Families

DA Pam 600–8
Military Personnel Management and Administrative Procedures

DOD Directive 6130.3
Physical Standards for Enlistment, Appointment, and Induction. (This publication may be obtained from the Naval Publications and Forms Center, Code 3015, 5801 Tabor Avenue, Philadelphia, PA 19120–5099 using DD Form 1425 (Specifications and Standards Requisition).)

DODPM
DOD Military Pay and Allowances Entitlements Manual

NATO STANAG 3526
Interchangability of NATO Aircrew Medical Categories

NGR 40–3
Medical Care for Army National Guard Members

NGR 600–200
Enlisted Personnel Management

NGR 635–100
Termination of Appointment and Withdrawal of Federal Recognition

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 295
Medical Officers' Guide for Management of Pregnant Servicewomen

TB MED 523
Control of Hazards to Health From Microwave and Radio Frequency Radiation and Ultrasound

TB MED 524
Control of Hazards to Health From Laser Radiation

Section III
Prescribed Forms

DA Form 3081–R
Periodic Medical Examination (Statement of Exemption). (Prescribed in paras 8–14*a*(4), 8–14*a*(8), 8–19*a*(2), and 9–7*b*.)

DA Form 3083–R
Medical Examination for Certain Geographical Areas. (Prescribed in para 8–24*b*(5).)

DA Form 3349
Physical Profile. (Prescribed in paras 3–24*e*, 3–25*b*, 3–25*c*, 7–4*b*, 7–8*c*, 7–8*f*, 7–8*h*, 7–9*b*, 7–11, 8–24*b*(7), 8–25*c*(4), 8–25*f*(5), and 8–26*c*.)

DA Form 4186
Medical Recommendation for Flying Duty. (Prescribed in paras 4–31*d*, 4–31*e*, 6–2*n*, 6–2*o*, 6–2*p*, 6–8*e*, 6–11, 6–12*g*, 6–13*c*, 6–16*a*, 6–15*b*, 6–17*d*, 6–17*f*, 6–17*g*, 6–17*h*, and 6–18*c*.)

DA Form 4497–R
Interim (Abbreviated) Flying Duty Medical Examination. (Prescribed in paras 6–7*d*, 6–9*b*, 6–9*c*, and 6–10*d*.)

DA Form 4970–E
Medical Screening Summary—Cardiovascular Risk Screening Program. (Prescribed in para 8–25*e*(2), 8–25*e*(3), and 8–25*g*.)

DA Form 5675
Health Risk Appraisal. (Prescribed in para 8–25*e*(1)(*b*).)

DA Form 7349–R
Initial Medical Review—Annual Medical Certificate. (Prescribed in para 8–19*c*(5).)

DD Form 2697
Report of Medical Assessment. Prescribed in paras 8–23*a*, 8–23*b*, 8–23*c*, and 8–23*d*.)

SF 88
Report of Medical Examination. (Prescribed in paras 6–6, 6–7, 6–9*b*, 6–9*c*, 6–10*b*, 6–10*c*, 6–10*d*, 7–4*b*, 7–7*a*, 7–7*b*, 8–4*e*, 8–5, 8–6*b*, 8–6*c*, 8–7*a*, 8–10, 8–12, 8–13*a*, 8–14*a*(4), 8–24*a*, 8–25*e*, 9–7*a*, 9–7*b*, and 9–8*c*.)

SF 93
Report of Medical History. (Prescribed in paras 6–7, 6–9*b*, 6–9*c*, 6–10*c*, 6–10*d*, 8–5*a*, 8–10, 8–13, 8–24*a*, and 9–7*a*.)

Section IV
Referenced Forms

DA Form 5888–R
Family Member Deployment Screening Sheet

DD Form 689
Individual Sick Slip

DD Forms 1966/1 through 6
Record of Military Processing Armed Forces of the United States

DD Form 2351
DOD Medical Examination Review Board (DODMERB) Report of Medical Examination

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

Appendix B
Reading Aloud Test

B–1.
The RAT will be administered to all applicants. The test will be conducted as follows:

a. Have the examinee stand erect, face the examiner across the room and read aloud, as if he or she were confronting a class of students.

b. If he or she pauses, even momentarily, on any phrase or word, the examiner immediately and sharply says, "What's that?" and requires the examinee to start again with the first sentence of the test. The true stammerer usually will halt again at the same word or phonetic combination and will often reveal serious stammering.

c. Have the applicant read aloud as follows: "You wished to know all about my grandfather. Well, he is nearly 93 years old; he dresses himself in an ancient black frock coat, usually minus several buttons; yet he still thinks as swiftly as ever. A long flowing beard clings to his chin giving those who observe him a pronounced feeling of the utmost respect. When he speaks, his voice is just a bit cracked and quivers a trifle. Twice each day he plays skillfully and with zest upon our small organ. Except in winter when the ooze of snow or ice is present, he slowly takes a short walk each day. We have often urged him to walk more and smoke less, but he always answers, “Banana oil” Grandfather likes to be modern in his language."

B–2.
When administered to aviation personnel, to include ATC personnel, the RAT will be used to determine the individual's ability to clearly enunciate, in the English language, in a manner compatible with safe and effective aviation operations. The examining physician will consult with a local instructor pilot or ATC supervisor in questionable cases.

Glossary

Section 1
Abbreviations

AA
aeromedical adaptability

AC
Active Component

ACAP
Aeromedical Consultant Advisory Panel

ADT
active duty for training

AEDR
Aviation Epidemiological Data Repository

AFR
Air Force Regulation

AGR
Active Guard—Reserve

AMCS
U.S. Army Aeromedical Consultation Service

AMEDD
U.S. Army Medical Department

ANSI
American National Standards Institute

AOC
Area of Concentration

APA
aeromedical physician assistant

APFT
Army Physical Fitness Test

AR
Army Regulation

ARCOM
U.S. Army Reserve Command

ARMA
Adaptability Rating for Military Aeronautics

ARNG
Army National Guard

ARPERCEN
U.S. Army Reserve Personnel Center

ASD(HA)
Assistant Secretary of Defense (Health Affairs)

ATC
air traffic controller

AV
atrioventricular

cc
cubic centimeter(s)

cm
centimeter(s)

CONUS
continental United States

CQ
charge of quarters

CREST
calcinosis, Raynaud's phenomenon, esophageal dysfunction, sclerodactyly and telangiectasis

CT
computerized tomography

CVSP
Cardiovascular Screening Program

DA
Department of the Army

DA Pam
Department of the Army Pamphlet

DAC
Department of the Army Civilian

dB
decibel(s)

dBA
dB measured on the A scale

DCCS
deputy commander for clinical services

DLAM
Defense Logistics Agency Manual

DNIF
duties not to include flying

DOD
Department of Defense

DODMERB
Department of Defense Medical Examination Review Board

DQ
disqualification

E
eyes (profile)

EEG
electroencephalogram

EKG
electrocardiogram

FAA
Federal Aviation Administration

FALANT
Farnsworth Lantern

FDME
flying duty medical examination

FEB
flying evaluation board

FEV1
forced expiratory volume in 1 second

FFD
full flying duties

FM
Field Manual

FORSCOM
U.S. Army Forces Command

FS
flight surgeon

FTA–ABS
fluorescent treponemal antibody absorption (test)

GOCOM
U.S. Army Reserve General Officer Command

H
hearing and ears (profile)

HALO
high altitude low opening (free fall)

HCT
hematocrit

HDL
high–density lipoprotein

HEAR
Health Enrollment Assessment Review.

HGB
hemoglobin

HIV
human immunodeficiency virus

HPSP
Health Professions Scholarship Program

HQDA
Headquarters, Department of the Army

HRA
Health Risk Appraisal

IRR
Individual Ready Reserve

ISO
International Standards Organization

kg
kilogram(s)

L
lower extremities (profile)

MAAG
Military Assistance Advisory Group

MCO
Marine Corps Order

MDAR
Military Diving Adaptability Rating

MEB
medical evaluation board

MEDCEN
U.S. Army Medical Center

MEDDAC
U.S. Army Medical Activity

MEPCOM
U.S. Military Entrance Processing Command

MEPS
Military Entrance Processing Station(s)

mg
milligram (s)

mg/dl
milligrams per deciliter

MILPO
military personnel office

mm
millimeter(s)

mmHg
millimeters of mercury

MOPP
Mission–Oriented Protective Posture

MOS
military occupational specialty

MTF
medical treatment facility

NAVAIRINST
Naval Air Instruction

NAVMEDCOMINST
Navy Medical Command Instruction

NGB
National Guard Bureau

NGR
National Guard Regulation

NPC
near point of convergence

OCONUS
outside continental United States

OCS
Officer Candidate School

ODCSPER
Office of the Deputy Chief of Staff for Personnel

OPM
Office of Personnel Management

OPNAVINST
Navy Operating Instructions

P
physical capacity or stamina (profile)

Pap smear (test)
Papanicolaou's test

PEB
Physical Evaluation Board

PERSCOM
U.S. Total Army Personnel Command

PIP
Pseudoisochromatic Plate

POR
preparation of replacements for oversea movement

PPBD
physical profile board

P–R interval
interval between the P and R waves on an EKG

PT
physical training

PULHES
(see separate letters "P–U–L–H–E–S" for profile codes)

RAM
Resident in Aerospace Medicine

RANDOT
random dot (test)

RAT
Reading Aloud Test

RC
Reserve Component

ROTC
Reserve Officers' Training Corps

RPR
rapid plasma reagin (test)

S
psychiatric (profile)

SCUBA
self–contained underwater breathing apparatus

SERE
survival, evasion, resistance, and escape

SPRINT
Speech Recognition in Noise Test

SVT
Stereoscope, Vision Testing

T
temporary (profile)

TB MED
Technical Bulletin Medical

TC
Training Circular

TDRL
Temporary Disability Retired List

TSG
The Surgeon General

U
upper extremities (profile)

USAAMA
U.S. Army Aeromedical Activity

USAAMC
U.S. Army Aeromedical Center

USAFA
U.S. Air Force Academy

USAMEDCOM
U.S. Army Medical Command

USAR
U.S. Army Reserve

USAREC
U.S. Army Recruiting Command

USC
United States Code

USMA
United States Military Academy

USNA
U.S. Naval Academy

USUHS
Uniformed Services University of the Health Sciences

VDRL
venereal disease research laboratory (test)

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 which is not accompanied by signs and/or symptoms but which 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 which 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 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, which 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 service 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
There are no entries in this section.

Index

This index is organized alphabetically by topic and subtopic. Topics and subtopics are identified by paragraph number.

TAB TAB TAB TAB

PERIODIC MEDICAL EXAMINATION
(Statement of Exemption)

(For use of this form, see AR 40-501; the proponent is the Office of The Surgeon General)

DATE

LAST NAME - FIRST NAME - MIDDLE INITIAL, GRADE & SSN *(Type or print)*

ORGANIZATION

I underwent a medical examination in conjunction with _____

_____

on or about _____ at _____
(date)

_____
(medical treatment facility)

and to the best of my knowledge there has been no significant change in my medical condition since the accomplishment of that medical examination.

_____
(Signature)

M TAB TAB TAB

MEDICAL EXAMINATION FOR CERTAIN GEOGRAPHICAL AREAS

(For use of this form, see AR 40-501; the proponent is the Office of The Surgeon General)

DATE

SOLDIER'S LAST NAME - FIRST NAME - MIDDLE INITIAL, GRADE & SSN *(Type or print)*

ORGANIZATION	COUNTRY ASSIGNED

DEPENDENTS

NAME	RELATIONSHIP	AGE

Based upon a review of available medical records and the results of examination as necessary, the following recommendations are submitted:

____ Soldier is medically qualified to undertake proposed assignment.

____ Soldier is not medically qualified to undertake proposed assignment.

____ Dependents listed above ____ are ____ are not medically qualified to accompany soldier.

REMARKS:

(Continue on reverse side if necessary)

MEDICAL TREATMENT FACILITY

TYPED OR PRINTED NAME OF EXAMINING PHYSICIAN	SIGNATURE OF EXAMINING PHYSICIAN

INTERIM (ABBREVIATED) FLYING DUTY MEDICAL EXAMINATION

For use of this form, see AR 40-501; the proponent agency is OTSG

1. EXAM DATE (DD/MM/YY)

2. NAME *(Last, First, MI)* | 3. SSN | 4. RANK | 5. BIRTH DATE (DD/MM/YY)

6. COMPONENT *(Check one or more)*
☐ AD-RA ☐ AD-USAR ☐ USAR-AGR ☐ USAR-TPU ☐ USAR-IRR
☐ ARNG-AGR ☐ ARNG ☐ DAC ☐ CIV CONTRACTOR ☐ RET-MIL

7. AVIATION DUTY *(Check one)*
☐ AVIATOR ☐ FS/APA
☐ AEROSCOUT ☐ CLASS 3 ☐ ATC (CLASS 4)

8. UNIT OF ASSIGNMENT AND COMPLETE UNIT ADDRESS

9. UNIT PHONE

10. HOME PHONE

11. LIST YOUR AEROMEDICAL WAIVERS IN EFFECT

12. LIST YOUR MEDICATIONS AND DOSAGES

13. I understand that I must be cleared by a flight surgeon after hospitalization or sick in quarters, or after treatment or activities requiring restriction. I am informing the flight surgeon of my medical history or any change in my health since my last FDME. I have read AR 600-105 (Aviation service) and AR 40-8 (Exogenous factors).

PATIENT'S SIGNATURE

14a. EXAM FACILITY ADDRESS

15. BLOOD PRESS | 16. PULSE | 17. HEIGHT (Ins) | 18. WEIGHT (Lbs) | 19. %BODY FAT

b. EXAM FACILITY PHONE | c. AEDR FACILITY CODE

20a. DEPTH PERCEPTION TEST
☐ VTA ☐ VERHOEFF ☐ RANDOT CIRCLES

b. TEST SCORE

c. TEST RESULT
☐ PASS ☐ FAIL

21. EYE EXAMINATION

	a. DISTANT VISION	b. NEAR VISION
RIGHT	20/ corr to 20/	20/ corr to 20/
LEFT	20/ corr to 20/	20/ corr to 20/

22. INTRAOCULAR PRESSURE

	mmHg
RIGHT	
LEFT	

23. AUDIOMETRIC SCREENING *(Decibels)*

	500 Hz	1000	2000	3000	4000	6000
RIGHT						
LEFT						

24. HISTORY AND EXAMINATION. Enter pertinent history and physical findings below as per ATB 2. Continue on reverse, if required. If review of the most recent USAAMA AEDR History Verification Form shows no change in history, enter "No significant interval history."

25. ELECTROCARDIOGRAM FINDINGS

THIS BOX IS FOR USAAMA USE ONLY

26. RECOMMENDATION
☐ QUALIFIED ☐ DISQUALIFIED, CONTINUE WAIVERS ☐ NEW DISQUALIFICATION, SEND AEROMEDICAL SUMMARY AND SF 88/93

27. AEROMEDICAL PHYSICIAN ASSISTANT STAMP AND SIGNATURE

28. FLIGHT SURGEON STAMP AND SIGNATURE

INITIAL MEDICAL REVIEW - ANNUAL MEDICAL CERTIFICATE

For use of this form , see AR 40-501; the proponent agency is OTSG

DATA REQUIRED BY THE PRIVACY ACT OF 1974

Authority Section 133, Title 10, United States Code (10 USC 133).

Purpose The primary use of this information is to provide medical information of sufficient detail to ensure uniformity in medical evaluation.

Routine Uses Used to evaluate soldiers in terms of medical conditions and physical defects which may require medical care or which may require a determination of medical fitness for duty.

Disclosure The requested information is mandatory because of the need to document all medical incidents in view of future rights and benefits. If the requested information is not furnished, comprehensive health care may not be possible, but **CARE WILL NOT BE DENIED.**

PART I -- COMPLETED BY SOLDIER

Please check the appropriate response column for each question below.	YES	NO
1. Do you currently have any medical/dental problems?		
2. Have you had any medical or dental problems since your last periodic physical examination?		
3. Have you been seen by or been treated by a dentist, physician, or other health care provider since your last periodic physical examination?		
4. Have you been hospitalized or had surgery since your last periodic physical examination?		
5. Are you currently taking medication, or have you taken prescription medication since your last examination?		
6. Are you currently or have you in the past received a VA Disability, Workmen's Compensation, or other type of compensation for health or physical reason?		

7. LIST ANY MEDICATIONS YOU ARE CURRENTLY TAKING

8. EXPLAIN ANY POSITIVE ANSWERS GIVEN ABOVE

I certify that the above information is true and correct to the best of my knowledge. I further understand that false statements made on this form may be cause for reassignment, discharge, or other disciplinary action.

9. SSN	10. RANK/GRADE	11. MOS	12. DATE

13a. PRINTED/TYPED NAME	13b. SIGNATURE

DA FORM 7349-R, MAR 95

PART II -- COMPLETED BY INITIAL REVIEWER

14. INITIAL REVIEWER'S NOTES

15. ☐ FULLY FIT ☐ REQUIRES FURTHER EVALUATION	16. SIGNATURE	17. DATE

PART III -- COMPLETED BY PHYSICIAN

18. PHYSICIAN'S REVIEW NOTES

19. ☐ FIT ☐ UNFIT (USAR refer to para 9-13 & 9-14 AR 40-501) ☐ UNFIT (Army National Guard refer to MDRB)	20. Complete "PULHES" using the Physical Profile Functional Capacity Guide in Table 7-1, AR 40-501.	P	U	L	H	E	S

21. DA FORM 3349 IS ATTACHED ☐ YES ☐ NO	22. SIGNATURE	23. DATE

PART IV -- COMPLETED BY APPROVING AUTHORITY

24. MISCELLANEOUS RECOMMENDATIONS

25. SIGNATURE	26. DATE

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