

16 February 1993

Medical Service

**MEDICAL EXAMINATION AND STANDARDS**

This regulation establishes examination procedures, examination requirements, examination recording, and medical standards for medical examinations given by the Air Force. It prescribes procedures and references the authority for retiring, discharging, or retaining members who, because of physical disability, are unfit to perform their duties. It implements Department of Defense Directive (DoDD) 1205.9, 6 October 1960, portions of DoDD 1332.18, 25 February 1986, and DoDD 6130.3, 31 March 1986. This regulation applies to all applicants for military service, scholarship programs, US Air Force Reserves (USAFR) and Air National Guard (ANG) when published in the NGR (AF) 0-2. This regulation is affected by the Privacy Act of 1974. Authority to collect and maintain records is outlined in Section 8013, Title 10, United States Code, and Executive Order 9397. Each form affected by the Privacy Act which is required by this regulation either contains a Privacy Act Statement incorporated in the body of the document or is covered by DD Form 2005, Privacy Act Statement—Health Care Records. For a list of acronyms used throughout this regulation, see attachment 1.

**SUMMARY OF CHANGES**

This revision eliminates duplication and nonregulatory explanation; changes requirements for separation and retirement physicals (paragraph 1-3c); establishes time limits on elective surgery and procedures performed before separation and retirement (paragraph 1-4f(3)); changes medical conditions requiring HQ AFMOA/SGPA review (paragraph 1-7d); deletes instruction on completing AF Form 1485, Flight Medicine Followup Suspense Card, which will be included in the revision of AFP 160-17 (paragraph 1-7); incorporates AFR 160-39, Medical Clearance for Flying Duty of Foreign Military/North Atlantic Treaty Organization (NATO) Personnel (paragraph 1-10); incorporates AFR 160-104, Medical Examination for Federal Aviation Administration (FAA) Certification (paragraph 1-11); deletes instructions on completing AF Form 422, Physical Profile Serial Report, which will be included in the revision of AFP 160-17; changes medical standards for air traffic control duty (chapter 4); combines all flying duty standards in chapter 6; significant changes in medical standards for flying duty (chapter 6); revises medical standards for survival training instructor duty (paragraph 7-11); defines scheduling procedures for Individual Mobilization Augmentees (IMA) (paragraph 8-12d); revises chapter 9 and deletes instruction on filling out SF 88, which will be included in the revision of AFP 160-17; and revises chapter 10.

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## Chapter 1

## GENERAL INFORMATION AND ADMINISTRATIVE PROCEDURES

**Section A—General Information****1-1. Medical Standards:**

a. Medical standards and physical examination requirements are established to ensure acquisition and retention of members who are physically and temperamentally adaptable to the conditions of military life.

b. These standards apply to:

(1) Applicants for enlistment, commission, training in the Air Force, US Air Force Academy, Reserve Officers' Training Corps (ROTC) Scholarship Program, and the Uniformed Services University of Health Sciences (USUHS).

(2) USAFR, ANG, and Health Professions Scholarship Program (HPSP) personnel entering active duty with the Regular Air Force, unless otherwise specified in other directives.

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

(4) Members of all components on extended active duty (EAD) not excluded by AFR 35-4, Air Force Reserve (AFRES) and ANG personnel not on EAD, but eligible under AFR 35-4.

**1-2. Standard Medical Examination:**

a. Definition. A standard medical examination is one that is conducted and recorded according to the format and procedures prescribed in AFP 160-17, Physical Examination Techniques.

b. Option. As long as all requirements are met, a medical examination may serve more than one purpose.

c. Requirements. A standard medical examination is required before:

(1) Entrance into active military service, Air Reserve Forces, AFROTC, Air Force Academy (AFA), and Officer Training School (OTS).

(2) Termination of active military service (when specified by paragraph 1-3).

(3) Periodically, as required by this regulation (see attachment 2).

d. Examiners:

(1) A credentialed flight surgeon of any service or government agency may give flying examinations. When non-Air Force flight surgeons examine US Air Force flying personnel they must send the results to the examinee's MAJCOM/SG for review and certification. (HQ AFMOA/SGPA, Bolling AFB DC 20332-6188,

serves as MAJCOM/SG for all Air Force Elements (AFELM).

(2) A medical officer or physician employed by the armed services regardless of active duty status, as well as by designated Air Force physician assistants, Air Force specialty code (AFSC) 928X, or primary care nurse practitioners AFSC 9756C, under the supervision of, and subject to review by a physician will give all other standard medical examinations.

e. Where Given. Examinations are usually given at medical facilities of the uniformed services. HQ AFMOA/SGPA or HQ AFMPC/DPMM, as appropriate, must authorize exceptions.

f. Military Entrance Processing Stations (MEPS) Examinations. If a MEPS does not have the capability of performing required ancillary studies, these items will be done at the examinee's initial training location or first permanent duty station.

g. Tests. All Air Force components will be tested for:

(1) Blood type and Rh factor.  
(2) Glucose-6-Phosphate Dehydrogenase (G6PD).

(3) Hemoglobin-S. Confirm positive results with electrophoresis.

(4) Human Immune Virus (HIV) Antibody. Confirm repeatedly positive enzyme immunoassay by Western Blot.

h. Hospitalization. Hospitalization is authorized in military or other government hospitals for civilian examinees whose medical qualification for military service or flying training cannot be determined without hospital study (see AFR 168-6).

**NOTES:**

1. Air Force enlisted and OTS personnel will receive the tests in g (1), (2), and (3) above at Lackland AFB, Texas, during basic or OTS training.

2. Military Indoctrination for Medical Service Officers (MIMSO) students will receive the tests in g(1), (2), and (3) above at their first permanent duty station.

3. All other entrants will receive the tests in g(1), (2), and (3) above at their entry point or first permanent duty station.

4. Examiners will record results of the tests in g(1), (2), and (3) on AF Form 1480, Summary of

Care, in the blank space immediately below the "FAMILY HISTORY" space.

5. Applicants for EAD will be tested for HIV as part of EAD application physical examination.

### **1-3. Medical Examination for Separation or Retirement:**

a. Policy. Separation or retirement will not be delayed past the scheduled date of separation or retirement just to complete a physical examination unless medical hold (see paragraph 1-3f) is appropriate.

b. Purpose of Examination. To identify medical findings that may require attention and to document current medical status, not to determine eligibility for physical disability separation or retirement.

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

(2) The law that provides for disability retirement and separation is Title 10, United States Code, chapter 61. Disability compensation for ratable service-connected defects which have not precluded active service is provided under a separate law (Title 38, United States Code) administered by the Veterans Administration.

c. Mandatory Examination. A standard medical examination for separation or retirement is only mandatory when:

(1) The member has not had a standard medical examination within 5 years of scheduled separation date or 3 years of scheduled retirement date.

(2) Medical authority believes an examination should be done for either clinical or administrative reasons.

(3) The member has a "4" physical profile serial (assignment availability code 31 or 37).

(4) The member is on Limited Assignment Status (LAS).

(5) Separation is involuntary, or is voluntary in lieu of trial by court martial, or retirement in lieu of involuntary administrative separation. **EXCEPTION:** The member had an initial enlistment or periodic physical examination within 24 months of projected separation or retirement, or the member is separated or retired in absentia.

(a) If last physical is within 24 months of separation or retirement, an abbreviated medi-

cal examination as outlined in paragraph 1-3d is appropriate.

(b) AFR 36-2, governing involuntary separation of officers requires the following statement be entered on the SF 88: "*There are no physical or mental defects that would warrant processing under AFR 35-4.*"—Place this statement as last entry in item 73.

(6) The member is an ANG member separating from federal service. A copy of a standard medical examination must be sent to HQ ARPC/DSFRA for retention as required by Title 10, United States Code, chapter 8502.

(7) The member has been tentatively approved by HQ AFMPC for early separation from active duty and assignment or enlistment in the USAFR or ANG under PALACE CHASE or PALACE FRONT, and the date of application is more than 3 years since completion of the most recent military physical examination. See AFR 35-46 if military physical examination within the past 3 years.

(8) The member is a repatriated prisoner of war (assignment limitation code 5 or 7). The evaluation will include Medical Evaluation Board (MEB) review unless HQ AFMPC/DPMMM believes one is not required, and the member declines in writing to undergo MEB consideration. Forward copy of examination to addresses in paragraph 1-7b.

d. Abbreviated Examination. Members who are not required to have a standard medical examination in paragraph 1-3c may request one. The scope of examination is as follows:

(1) A completed SF 93, Report of Medical History.

(2) An examination by a credentialed health care provider. The examiner will appropriately document his or her examination on SF 88, Report of Medical Examination, and the examination will be only as extensive as considered necessary to determine continued qualification for worldwide duty. **NOTE:** The abbreviated separation and retirement examination will include all required tests outlined in attachment 2 and AFP 160-17. If at all possible, termination occupational examinations should be done at the same time.

e. Administrative Responsibilities:

(1) Member's Commander. The commander must make sure the member is available for examination until medical processing is completed.

**(2) Medical Facility:**

(a) Directors of Base Medical Services (DBMS) are responsible for prompt scheduling and completion of required examinations and monitoring of consultations including those done at other facilities.

(b) If the examinee is found qualified for continued active duty, medical facility personnel must file the report of examination in the member's health record.

(c) If the examinee's qualification for continued military service is questionable under chapter 3 of this regulation, medical facility personnel must initiate MEB processing. If the examinee is within 60 calendar days of scheduled separation or retirement, they must request medical hold (see f below). Separation or retirement processing continues unless medical hold is approved.

(d) If the examinee is placed in medical hold status, and an MEB is directed, medical facility personnel must comply with AFRs 35-4 and 168-4.

**(3) HQ AFMPC/DPMMM:**

(a) If member is qualified for continued active duty, HQ AFMPC/DPMMM returns the approved medical evaluation report with instructions for disposition of the examinee to the examining medical facility. Both must be filed in the member's health record.

(b) If member's qualification for continued active duty is questionable, HQ AFMPC/DPMMM directs the responsible medical treatment facility (MTF) to accomplish MEB processing. If the member is within 60 calendar days of scheduled separation or retirement, HQ AFMPC/DPMMM authorizes medical hold and informs the servicing CBPO, the member's MAJCOM/SG and HQ AFMPC/DPMARR/DPMARS/DPMADS/ DPMRAS2.

(4) HQ AFMPC/DPMADS. When an MEB report is referred to a Physical Evaluation Board (PEB), HQ AFMPC/DPMADS notifies all appropriate agencies of the final decision and provides disposition instructions.

**f. Medical Hold:**

(1) Medical hold is an administrative action retaining a member on active duty beyond an established date of separation or retirement date. HQ AFMPC/DPMMM is the sole approval authority. Medical hold by HQ AFMPC/DPMMM is not appropriate for members who are being involuntarily separated, unless normal separation is imminent or HQ AFMPC has approved an involuntary separa-

tion date. The DBMS may request the discharge authority to postpone separation action.

(2) Requests for medical hold are sent directly to HQ AFMPC/DPMMM and must include a narrative summary, the date of projected separation or retirement, whether or not MEB processing has been initiated, whether or not administrative or punitive discharge is pending, and the identity of the servicing CBPO that is implementing the separation or retirement.

(3) Medical hold will not be approved for the purpose of evaluating or treating chronic conditions, performing diagnostic studies, elective surgery and its convalescence, other elective treatment of remedial defects, or for conditions that do not warrant termination of active duty through the Disability Evaluation System. Elective surgery or procedures will not be performed within 6 months of retirement or separation without prior HQ AFMPC/DPMMM approval. If application is approved, the patient must first be briefed that he or she will be retired or separated on schedule despite hospitalization or convalescence.

(4) Enlisted members cannot be forced to remain in service beyond their expiration of term of service (ETS). They must agree in writing to a medical hold per AFR 39-10, chapter 2. For officers, medical hold does not require their consent.

(5) Members sentenced to dismissal or punitive discharge by a court martial, or who are under charges which may result in such sentences, are not eligible for MEB or disability processing under AFR 35-4. Medical hold is not authorized in such cases unless court martial sentences are suspended, or court martial charges are dropped to permit separation or retirement in lieu of court martial, or charges are held in abeyance pending a sanity determination. Therefore, if a physical or mental defect exists that warrants MEB action, such action should be started and pursued despite pending court martial action and denial of medical hold.

(6) Medical hold cannot be imposed after the date of separation or retirement has elapsed. Therefore, MTFs must verify the separation or retirement date of each member who is hospitalized and may need an MEB, to assure separation or retirement is not imminent (within 60 calendar days).

(7) Members who already have orders for separation or retirement due to disability but experience a significant clinical change before

actual release from active duty, may require revocation of orders and reprocessing of MEB. The servicing MTF should make direct contact by the most expeditious means with HQ AFMPC/DPMADS (Disability Processing Division) for instruction.

#### **1-4. Periodic Medical Examinations:**

a. Frequency. Examinations should be scheduled at a frequency listed in attachment 2. Flying examinations may be scheduled up to 6 months early for personnel who have extenuating circumstances. HQ AFMOA/SGPA may grant operational commands specific exceptions to prescribed examination frequency requirements.

##### **b. Disposing of Reports:**

(1) For qualified personnel who meet the standards contained in this regulation, file the medical reports in the member's health record (AF Form 2100 or AF Form 2100A series).

(2) Present personnel whose qualification for worldwide service is questionable to an MEB, under the provisions of AFR 168-4. (Present ANG and USAFR personnel to MEB if authorized by AFR 35-4.)

(3) For personnel not qualified for flying and being considered for waiver, submit to waiver authority according to paragraph 1-8.

(4) For rated flying personnel who have been found permanently disqualified for aviation service and waiver is not being considered, submit one copy of medical examination and allied medical documents through the MAJCOM/SG to HQ AFMOA/SGPA, Bolling AFB DC 20332-6188 for notification to the FAA. Authority is pursuant to 5 U.S.C. 552a(b)7.

(5) Maintain a complete copy of each examination performed by the examining facility according to AFR 4-20, volume 2.

#### **1-5. Medical Examination Requirements for Applicants to US Service Academies and AFROTC 4-Year Scholarship Program. See AFR 160-13.**

### **Section B—Administrative Procedures**

#### **1-6. Medical Recommendation for Flying or Special Operational Duty.** Use AF Form 1042, Medical Recommendation for Flying or Special Operational Duty, to convey medical qualification for flying or special operational duty.

a. **Applicability.** Applies to each US Air Force, USAFR, and ANG MTF or medical unit that provides medical care for flying or special operational duty personnel.

b. **Fitness Assessment.** The flight surgeon or, in the case of Space Operations Duty, the medical provider must convey the result of his or her fitness assessment using AF Form 1042. A new form is required when an individual is found temporarily medically unfit or fit to return to duty, medically qualified by appropriate review authority following disqualification, fit for duty following initial or periodic medical examination, incoming clearance to a new base, post aircraft mishap, and clearance for foreign military personnel. NOTE: On medical examinations the form is dated the date examination is completed and the individual is found qualified. If the examination cannot be completed for reasons beyond the member's control, the appropriate waiver authority may extend certification to cover administrative processing.

c. **Distribution.** Distribute the form as follows:

(1) Original to patient's health record. For transit personnel, send original and 2 copies to the individual's home base for distribution.

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

(3) One copy to the unit Flight Management Officer (FMO) for flying personnel or the duty section for others.

(4) One, handwritten, abbreviated copy to the individual.

d. **Record of Action.** The flight surgeon will maintain a monthly log of restrictions and re-qualifications on AF Form 1041, Medical Recommendation for Flying or Special Operational Duty Log. And, dispose of AF Form 1041 as specified in AFR 4-20, volume 2.

**1-7. Waiver of Medical Conditions.** The authority to grant a waiver for defects listed as disqualifying in chapters 4, 5, 6, and 7 is shown in attachment 3. There is no authority to waive physical defects that interfere with worldwide duty according to chapter 3.

a. **Initiating Waivers.** Forward all relevant medical information (paragraph 1-8) to the proper reviewing authority (attachment 3) when the examining physician believes a waiver is justified.

**b. Term of Validity of Waivers:**

(1) The reviewing authority establishes the term of validity of waivers for medical defects.

(2) Waiver of defects or items of history present at the time of entry to active duty are considered indefinite and need not be periodically reviewed.

(3) An expiration date is placed on waivers for conditions that may progress or when periodic reevaluation is required.

(4) If the condition is resolved so that the member is qualified by the appropriate medical standards, it is not necessary to remove the waiver, but it is necessary to notify the waiver authority to allow inclusion of this information in the Waiver File according to paragraph 1-8d(3). Categorical waivers must not be removed or altered except by combined HQ USAF/XO/DP/SG action.

**c. Flying Training:****(1) Undergraduate Flying Training:**

(a) HQ ATC/SG is the waiver authority for all flying training applicants, but may forward any controversial or questionable cases to HQ AFMOA/SGPA for review. HQ AFMOA/SGPA is final waiver authority for all flying training applicants.

(b) To qualify for entry into the AFA, ROTC, or OTS as a pilot or navigator candidate, applicants must be Flying Class I or IA qualified.

**(2) Flight Surgeon and Flight Nurse Training:**

(a) Applicants for training leading to the rating of flight surgeon will meet the medical standards for Flying Class II. Certification and waiver authority is outlined in attachment 3.

(b) Applicants for training leading to the designation of flight nurse must meet the medical standards for Flying Class III. Certification and waiver authority is outlined in attachment 3. HQ AFRES/SG and NGB/SG are waiver and certification authorities for nurses entering training who are assigned to their commands.

**d. Flying Duty:**

**(1) Waiver Authority for Rated Officers.** For rated officers, HQ AFMOA/SGPA retains waiver authority as listed below.

(a) All initial categorical flying waivers and changes thereof.

(b) Any condition that has resulted in medical disqualification. **NOTE:** Authority to grant non-rated flying duty (Class III) waivers to rated personnel who have been medically dis-

qualified for rated flying duty (Class II) is delegated to individual's MAJCOM of assignment.

(c) Any condition listed in chapter 3.

(d) Any condition that results in initial Aeromedical Consultation Service (ACS) evaluation.

(e) Any condition requiring maintenance medication except those listed in paragraph 6-32a(4).

(f) All waiver requests on general officers.

(g) In the opinion of the MAJCOM/SG, any controversial condition that warrants a HQ AFMOA/SGPA decision.

**(2) Delegation of Waiver Authority for Flying Personnel:**

(a) Authority is delegated to MAJCOM/SG to renew all waivers initially granted by AFMOA/SGPA, except those for general officers and those in which the ACS recommends any change in waiver status. Waivers should not be granted or renewed for active ACS Study Group conditions without concurrence from AL/AOC.

(b) Command surgeons may delegate waiver authority to another command surgeon when personnel of their own command are tenants on bases of the other command. Command surgeons must furnish AFMOA/SGPA a copy of any such agreement.

(c) Command surgeons may selectively further delegate their waiver authority to local SGP's; but, must furnish copies of such policy to HQ AFMOA/SGPA.

**(3) Centralized Waiver Repository (WAVR File).** When a MAJCOM/SG or HQ AFMOA/SGPA certifies a waiver request for flying duty for US Air Force personnel, the MAJCOM/SG will update the individual's record in the WAVR File. For personnel not already in the WAVR File, the MAJCOM/SG sends this data at least every 2 weeks to WAVR File, AL/AOCF, Brooks AFB TX 78235-5301. Quarterly, ACS sends suspense rosters to all MAJCOM/SG waiver authorities. Upon receipt of a new roster, each MAJCOM/SG will update and correct the suspense roster and will return it to ACS. The title and Reports Control Symbol for these reports are "WAVR" File RCS: HAF SGP(AR)7202 and must be included in the title of all reports sent. Emergency status code is C-2 (submit after C-1 priorities); minimize code is N (No). HQ AFMOA/SGPA will update the waiver file for all categorical waiver actions.

**e. Waivers for Enlisted Occupations:**

(1) The medical service does not make recommendations for medical waivers for entry into or retention for those who fall below qualification standards imposed by personnel authorities in AFR 35-1 or AFR 39-1. US Air Force resource managers will determine if a waiver request is appropriate.

(2) When requested, the medical service may provide professional opinion to line or personnel authorities.

f. Waiver Case Files. All waiver granting authorities must maintain copies of their waiver actions. AFR 4-20, volume 2, contains disposition instructions. Transfer active cases (with copy of PCS orders) to gaining waiver authority, within 30 calendar days, when the individual is reassigned.

g. Waiver Suspense File. The base flight surgeon is responsible for assuring waiver renewals are submitted in a timely fashion.

**1-8. Submission of Reports of Medical Examination to Certification or Waiver Authority:**

a. Initial Waiver. When sending medical reports for review, send the following TYPE-WRITTEN documents in 3 copies (including originals when possible) and in the order listed, to the reviewing authority:

- (1) SF 88. One original and two copies.
- (2) SF 93. One original and two copies.

(3) SF520, Clinical Record—Electrocardiographic Record, if clinically indicated or required in attachment 2. One mounted tracing. (Includes exercise tolerance test, holter monitor, echocardiogram, etc.)

(4) SF 513, Medical Record—Consultation Sheet. One original and two copies (include full name, title, AFSC or equivalent civilian specialty identifier, and office address of consultant).

(5) SF 502, Medical Record—Narrative Summary (Clinical Resume), if hospitalized.

(6) AF Form 618, Medical Board Report, if appropriate. (See AFR 168-4.)

(7) AF Form 1139, Request for Tumor Board Appraisal and Recommendation. In cases of malignancy, send with documentation of required followup studies. A new tumor board should not be required for waiver renewal; however, followup requirements will be addressed in the aeromedical summary.

(8) SF 515, Medical Record—Tissue Examination, in cases of malignancy. (Initial waiver request.)

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

(10) Any other relevant documentation.

(11) Aeromedical summary.

(12) AF Form 1042 when flying status is at issue. Attach to the original set of documents.

b. Waiver Renewal. When an individual is not in cycle for a complete medical examination, the examiner may use AF Form 1446, Medical Examination—Flying Personnel. The examiner will note pertinent systems evaluation in the remarks block, and provide a current aeromedical summary, AF Form 1042, and all relevant documents and copies as listed in a above.

c. Repatriated Prisoners of War (RPW).

PES sections must send a copy of each complete medical examination (SF's 88, 93, and attachments) done on a RPW to AL/AOCF, Brooks AFB TX 78235-5301 and Office of Special Studies, NAMI, Code 25, NAS Pensacola, FL 32508-5600.

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

d. Sensitive Medical Data. Transmit reports of medical examination and supporting documents that contain sensitive medical data through medical channels in sealed containers. Only medical personnel open this correspondence.

e. Routing to Certifying and Waiver Authorities:

(1) Initial Medical Examinations for Flying Duty:

(a) Initial medical examinations (three copies) for airman or officer non-rated aircrew duty, special operational duty, and flight nurse training will be submitted for certification according to attachment 3. The certifying authority will certify the SF 88 and two copies of AF Form 1042. The certified SF 88 and allied documents will be filed in the applicant's health record (AF Form 2100 or 2100A series). The certified AF Form 1042 will accompany the applicant's training request.

(b) Initial medical examinations (three copies) for undergraduate flying training, Undergraduate Pilot Training (UPT), Undergraduate Navigator Training (UNT), and Aerospace Medicine Primary (AMP) course training will be provided to the applicant to be included with the training request.

(2) Medical Waiver Examinations for Flying Duty. Regardless of designated waiver authority level, send requests for waivers through command channels. Each level reviews the case and makes recommendations. Disqualifications may be made at any level with notification to waiver authority. Only the waiver authority may grant a waiver. NOTE: Send a copy of disqualifications on rated officers to HQ AFMOA/SGPA.

**1-9. Term of Validity of Reports of Medical Examination.** Reports of medical examination are considered administratively valid as follows:

a. Enlistment. Examination must be completed within 24 months of date of entry on active duty and is done as near as possible to the date of entry on active duty.

b. Commission:

(1) Civilian Applicants. Examination must be completed within 24 months of date of entry on active duty and is done as near as possible to the date of entry on active duty.

(2) Military and AFROTC Applicants:

(a) For enlistment into Professional Officers Course (POC) and for AFROTC scholarship, examination must be within 36 months from the date of the entry.

(b) For commission and entry into active duty in a non-rated status, examination must be within 24 months before entry into active duty.

(3) AFA. Examination must be completed within 24 months before entry on active duty.

(4) Officer Applicants for Indefinite Reserve Status (IRS). Examination must have been done within 24 months from the date of application when required by AFR 36-14.

c. Flying Training. Examination must be within 24 months before entry into training. NOTE: Any change in medical status which may result in disqualification for flying training will be submitted to HQ ATC/SGPS, Randolph AFB TX, for review and certification before the individual is ordered to report for training.

d. Entry Into Flying Training. A flight surgeon will perform a medical screening examination consisting of a medical interview and interval history on all students from all sources upon reporting to the training base or the Flight Screening Program (FSP) at the Officer Training School. Students whose last examination is more than 24 months old at the time they report

to the undergraduate flying training base must have a complete Flying Class I/IA physical. The results must be forwarded to HQ ATC/SG for review and certification.

e. Rating and Flying Status on Completion of Flying Training:

(1) The medical screening examination performed at the time of entry into flying training is valid for completion of training plus 60 calendar days. Under no circumstances will the total period of validity of the medical screening examination exceed 24 months.

(2) The first medical examination following the medical screening will be a complete examination with SFs 88 and 93.

f. Banked Status. UFT graduates awaiting upgrade training are required to maintain Flying Class II qualification.

g. Entry Into Flying Class III and Initial Flying Class II (Flight Surgeon) Duties. The examination performed for entry into Flying Class III and initial Flying Class II (flight surgeon) duties must be done within 24 months before entry into training.

(1) Initial Flying Class II or III examination will not be valid for longer than 24 months.

(2) Personnel whose entry into training is delayed more than 24 months will not be required to undergo another initial flying examination if they maintain a continuous medical clearance. This will require a periodic flying examination, at the proper time, as specified in attachment 2. If the medical clearance is not renewed before expiration, presumption of fitness is lost, and another initial flying physical, properly certified, is required before entry into training.

h. Personnel on Active Duty. Medical examinations for active duty personnel are valid as specified in attachment 2. The validity of the medical examination expires at the end of an individual's birth month. Medical examinations for officers and airmen not on flying status, which are done within 12 months of the 5-year cycle, are valid through the following 5-year cycle. (Example—examination at age 29 is valid until age 35, examination at age 26 is only valid until age 30).

i. Missile Launch Crew, Air Traffic Control, and Space Operations Duty. Medical examinations must be within 24 months before entry into training.

j. USAFR and ANG Members entering EAD With the Regular Air Force. Medical examinations must be completed within 18 months of ei-

ther voluntary or involuntary entry. **NOTE:** USAFR or ANG members entering EAD with the regular Air Force, and who are involuntarily ordered to EAD, cannot be forced to have a physical before entry on active duty. So, members will be scheduled for physicals and scopes of examination according to AFR 28-5. This is to preclude possible civil litigations based on service aggravation connection claims.

**1-10. Foreign Military and North American Treaty Organization (NATO) Personnel.** This paragraph establishes the medical procedures for the exchange aircrews.

a. **Evidence of Clearance.** Flight managers and appropriate commanders require evidence of medical clearance for flying duty on AF Form 1042. Local flight surgeons must prepare AF Form 1042 based on other evidence of medical clearance such as a NATO "medical statement." This must be done before flying.

b. **Medical Qualification for Security Assistance Training Program (SATP) Flying:**

(1) Note that the flight surgeon conducts appropriate physical examinations of foreign students enrolled in flying training courses under the SATP. At the first base of assignment, use the same physical standards applied to US Air Force personnel.

(2) Forward the reports of medical examination on undergraduate flying training students to HQ ATC/SG for certification. Personnel who do not meet the standards will be considered for waiver as with US Air Force students. Students are not permanently disqualified for flying duty for medical reasons until appropriate command surgeon and HQ AFMOA/SGPA review.

c. **Medical Qualification for Rated Foreign Exchange Officers.** Medical records are reviewed on each exchange officer. If the individual can provide evidence of having had an adequate physical examination within the preceding 12 months and qualification under Class II standards, the officer is cleared. Otherwise, medical examination is mandatory. Waiver consideration is stated in attachment 3. Individuals are not permanently disqualified for flying duty for medical reasons until appropriate command surgeon and HQ AFMOA/SGP review.

d. **Medical Qualification of NATO Aircrew Members: For:**

(1) Preexisting conditions with waiver, the originating nation's standards apply.

(2) New medical conditions, the host nation's standards will apply.

(3) Periodic examinations for flying, examining section personnel will be conducted according to the host nation's regulations; and send a copy of the examination to the aeromedical authority of the parent nation. (For US Air Force aircrew members this will be the theater MAJ-COM/SG.)

(4) Grounding exceeding 30-day and permanent medical disqualification, it is not rendered until the parent nation can review the entire case. **NOTE:** The host nation is the nation where the TDY flying duties take place or where the nation has primary aeromedical responsibility. The parent nation is the nation of armed services in which the individual is a member.

**1-11. Medical Examination for Federal Aviation Administration (FAA) Certification.** This paragraph establishes procedures and eligibility to take a medical examination for FAA certificate.

a. **Medical Examination Policy:**

(1) **Authorized To Perform an Examination.** The Federal Aviation Administration (FAA) Directory of Aviation Medical Examiners authorizes each flight surgeon assigned to an installation listed in the directory to perform FAA second class or third class (but not first class) medical examinations and to issue the proper medical certificate.

(2) **Eligible for Examination.** The FAA delegated authority to Air Force to perform FAA medical examinations on active duty and retired personnel of the United States Armed Forces; DoD Reserve Officer Training Corps (ROTC) personnel; members of foreign military services assigned to duties within the continental United States; and military dependents who are members of a military aeroclub. The Air Force performs examinations at the discretion of the MTF commander.

b. **Classes of Medical Certification.** FAA medical standards are in Federal Aviation Regulation, Part 67, and in the Guide for Aviation Medical Examiners published by the FAA Office of Aviation Medicine.

c. **Disposition of Reports:**

(1) Flight medicine personnel send reports of medical examination and supporting documents on all applicants to: DOT/FAA, Manager Aeromedical Certification Branch AAM-300, Civil Aeromedical Institute PO Box 26080, Oklahoma City, OK 73126. The examiner is-

sues FAA Form 8420-2, 8500-2, or 8500-9 as required.

(2) In all cases, the examining facility must maintain the aviation medical examiner (AME) file copy of FAA Form 8500-8 with supporting documentation and dispose of it according to AFR 4-20, volume 2.

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

## Chapter 2

### PHYSICAL PROFILING

**2-1. Purpose of This Chapter.** This chapter, with attachments 4 and 5 sets forth a system of classifying individuals according to functional abilities.

**2-2. Applicability of the Physical Profile System.** The physical profile system applies to the following categories of personnel:

- a. Applicants for appointment, enlistment, and induction into military service.
- b. Active (throughout their military service), USAFR, and ANG members.

**2-3. Purpose of AF Form 422, Physical Profile Serial Report.** The purpose of AF Form 422 is to communicate information to non-medical authorities on the general physical condition of military members. For detailed instruction for completing AF Form 422, see AFP 160-17

**2-4. Establishing the Initial Physical Profile.** It is necessary to verify the initial profile serial of all persons entering active duty.

a. Airmen. Physical Examination and Standards (PES) section personnel will review the physical profile entered on the SF 88, item 76, during basic training, and make any necessary revision using AF Form 422.

b. Officers. PES personnel will screen new officer's medical records at their first permanent duty station, and make any necessary revision using AF Form 422.

**2-5. Episodic Review, Validation, or Revision of Physical Profile Serials.** Review and validate and, or revise the profile serial using AF Form 422 when the following events occur:

- a. At standard or special purpose physical examination, except retirement or separation examination.
- b. On return to normal duty after any illness or injury that significantly affected duty performance or qualification for worldwide duty.
- c. On selection for remote, isolated, or combat zone assignment. See paragraph 7-14.
- d. Every 30 calendar days when a member possesses a 4-T profile.

(1) The CBPO will provide assignment availability code 31, 37, and 81 roster.

(2) PES personnel will notify the health-care provider who initiates MEB action before 4-T expiration, if evaluatee is not expected to return to duty within 1 year.

**2-6. Uses of AF Form 422:**

a. Clearance for Worldwide Duty. A 4-T profile precludes worldwide assignability.  
b. Temporary Occupational Restriction. Use AF Forms 422, 1042, Medical Recommendation for Flying or Special Operational Duty, or DD Form 689, Individual Sick Slip, to inform the member's unit commander or supervisor that the member has an injury or illness which limits normal job performance, to include mobility, for a specified duration. A 4-T profile will not be established unless the injury or illness is not compatible with worldwide assignability and is not expected to resolve within 60 calendar days.

c. Job (AFSC) Retraining:

(1) When a medical defect permanently precludes further employment within a member's AFSC, a medical recommendation for retraining is sent to the servicing CBPO on an AF Form 422 according to AFR 35-1, Military Personnel Classification Policy (Officers and Airmen). The AF Form 422 must include comments that clearly define the medical problem, describe the individual's limitations, and be approved by the DBMS or senior profile officer.

(2) The CBPO will determine the retraining AFSC and notify the senior profile officer. Approval authority will then certify the member medically qualified, or not qualified, for each selected or requested AFSC.

(3) Approval authority for retraining is within the personnel system. Recommendations are ordinarily disapproved and MEB is indicated when the defect:

(a) Is permanent and precludes worldwide assignability.

(b) Existed prior to service (EPTS).

(c) Precludes cross-training to alternate AFSC occupations commensurate with the evaluatee's grade and office.

(d) Temporary Assignment Limitation. A 4-T profile precludes reassignment until the

condition has resolved or MEB processing has been completed.

(1) When a temporary assignment limitation on any officer in the rank of Colonel or above is effected, the MTF must also notify HQ USAF/SG/DP, Washington DC and HQ AFMPC/DPMO, Randolph AFB, TX by message (reference AFR 168-4).

(2) When a member who is given a 4-T profile has an assignment pending (confirmed by CBPO), the healthcare provider must provide the medical facts and circumstances to HQ AFMPC/DPMMS, Randolph AFB TX 78150-6001 via narrative summary or telephone.

e. Drug Abuse Reporting. The Director of Base Medical Services (DBMS) should use AF Form 422 to notify commanders, social actions officers, and other responsible parties of active duty personnel who have been identified as being drug experimenters, users, or addicts. PES personnel should enter the information in the "Individual Defects" section.

**2-7. Use of the Department of the Army (DA) Form 3349.** DA Form 3349, Physical Profile Serial, is acceptable in lieu of AF Form 422. However, review any entry in DA Form 3349 which recommends temporary or permanent geographic or climate assignment restric-

tions. The Army 3 profile is not compatible with worldwide assignability in the Air Force and must be converted to a 4 profile.

**2-8. Strength Aptitude Test (SAT):**

a. AFR 39-1, Airman Classification, establishes a SAT standard for each AFSC.

b. When the CBPO requires a SAT assessment for retraining, it will provide the Physical Examination and Standards (PES) section a letter requesting the SAT. PES section personnel complete the indorsement by reviewing the accession MEPS physical and taking one of the following actions:

(1) Does not retest individuals if the profile "X" factor equals or exceeds the SAT standard for the retraining AFSC unless the medical condition could change the SAT.

(2) If the profile "X" factor entry is blank; contains a numeric character 1, 2, or 3; or is an alpha character less than the SAT standard, considers the SAT results unsatisfactory. A credentialed health care provider should evaluate the patient for ability to undergo retesting. If the individual is cleared for testing, he or she should be sent to the MWR personnel to be administered the SAT. NOTE: AFR 39-4, Airman Retraining Program, outlines additional CBPO responsibilities and contains a copy of the SAT requesting letter mentioned above.

## Chapter 3

### MEDICAL EVALUATION FOR CONTINUED MILITARY SERVICE

#### **3-1. General Information and Guidance:**

a. **Scope.** This chapter sets forth medical conditions and defects that normally preclude continued military service and that will result in MEB processing under AFRs 35-4 and 168-4.

b. **Applicability.** This chapter applies to:

(1) Regular Air Force members on active duty, unless excluded from disability evaluation by AFRs 35-4 and 168-4.

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

(3) USAFR and the ANG members who are:

(a) On EAD unless excluded from disability evaluation by AFR 35-4.

(b) Involuntarily ordered to EAD with the Regular Air Force and who are eligible for fitness evaluation under AFR 35-4.

(c) Reenlisting in the Regular Air Force when no more than 93 calendar days have elapsed between release from EAD with any regular US Armed Service and reenlistment. If more than 93 days have elapsed, chapter 4 applies.

(d) Not on EAD but eligible for fitness evaluation per AFR 35-4.

(4) Air Force ROTC graduates after they assume active duty status. **NOTE:** The Surgeons AFRES, Air Reserve Personnel Center (ARPC), and ANG may use the criteria of this chapter, either alone or in combination with other criteria, to determine:

(a) The qualification of Air Reserve Forces members for continued Reserve service.

(b) If Regular Air Force members are qualified to transfer to duty with the Air Reserve Forces, provided no more than 180 calendar days have elapsed between separation from the Regular Air Force and entry into the Air Reserve Forces.

#### **3-2. Head:**

a. The loss of substance of the skull, with or without prosthetic replacement accompanied by residual signs or symptoms which preclude sat-

isfactory performance of duty or unrestricted station assignability.

b. An unprotected skull defect 3 cm in diameter or larger.

#### **3-3. Mouth, Nose, Pharynx, Larynx, and Trachea:**

##### a. Larynx:

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

(2) Stenosis of the larynx. Of a degree causing respiratory embarrassment.

(3) Obstructive edema. Obstructive edema of the glottis, if recurrent.

##### b. Nose, Pharynx, and Trachea:

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

(2) Sinusitis. Severe and chronic which is suppurative, complicated by polyps, and does not respond to treatment.

(3) Stenosis of trachea.

#### **3-4. Ears and Hearing:**

##### a. Ears:

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

(2) Meniere's syndrome. Sufficient severity and, or frequency to preclude satisfactory military employment despite treatment.

b. Hearing. Hearing loss which precludes safe effective performance of duty (see attachment 4).

#### **3-5. Dental.** Diseases and abnormalities of the jaw or associated tissues which prevent satisfactory performance of duty despite treatment.

#### **3-6. Eyes and Vision.** All ophthalmological cases must include visual acuity and Goldman perimeter charts for central visual acuity.

a. Any disease, injury, infection process, or sequellae involving the eye which is resistant to treatment and, or results in:

(1) Distant visual acuity which cannot be corrected to at least 20/40 in the better eye.

(2) The central field of vision in the better eye is less than 20 degrees from fixation in any direction.

(3) Night blindness of such a degree that the member requires assistance in travel at night.

b. Even if the requirements in a above are met, the following manifestations of eye conditions are disqualifying:

(1) Glaucoma with demonstrable changes in the optic disc.

(2) Retinal detachment which results from organic progressive disease.

(3) Enucleated eye when a prosthesis cannot be properly fitted or work.

(4) Vision correctable only by the use of bilateral contact lenses or uncommon corrective devices, e.g. telescopic lenses.

(5) Aniseikonia when incapacitating signs or symptoms exist that are not easily treatable with standard ophthalmic spectacle lenses.

(6) Binocular diplopia when symptoms are severe, constant, and in a zone less than 20 degrees from the primary position.

(7) Hemianopsia when bilateral, permanent, and based on an organic defect.

### **3-7. Lungs and Chest Wall:**

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

b. Any chronic or recurrent pulmonary disease which precludes satisfactory performance of duty. This may include:

(1) Significant fatigueability or dyspnea on mild exertion supported by appropriate pulmonary function and blood gas studies (see AFR 160-17).

(2) Requirement for an inordinate amount of medical observation or care over prolonged periods.

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

d. Pneumonectomy.

e. Intrinsic asthma or extrinsic asthma, unless due to well defined avoidable precipitant cause.

### **3-8. Heart and Vascular System:**

a. Heart Disease:

(1) Arteriosclerotic heart disease. When associated with congestive heart failure, persistent major rhythm disturbances, repeated angi-

na attacks, or objective evidence of myocardial infarction. The following considerations pertain to myocardial infarction:

(a) Individuals sustaining a myocardial infarct will have MEB processing within 90 calendar days.

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

(c) Treadmill is desired by medical and disability reviewing authorities in adjudication of infarction cases.

(d) For Air Reserve Force member not on EAD and not eligible for disability evaluation under AFR 35-4, the medical unit will initiate AF Form 422 changing the profile to P-4 and restricting the member from participating in any pay or point gaining activities pending final disposition of the member's case by the appropriate Air Reserve surgeon. NOTE: MEBs on cardiac cases must include the New York Heart Association (NYHA) classification.

(2) Paroxysmal supraventricular tachycardia, atrial fibrillation and atrial flutter. If associated with symptomatic organic heart disease, or if not adequately controlled with medication.

(3) Myocarditis and degeneration of the myocardium, if symptomatic.

(4) Pericarditis:

(a) Chronic constrictive pericarditis, unless successful surgery has been performed.

(b) Chronic serous pericarditis.

(5) Rheumatic valvulitis, if symptomatic.

(6) Premature ventricular contractions. When they interfere with the satisfactory performance of duty.

(7) Heart block. Associated with other signs and symptoms of organic heart disease or syncope.

b. Vascular Disease:

(1) Periarteritis nodosa.

(2) Chronic venous insufficiency (Postphlebitic Syndrome). When more than mild and symptomatic despite elastic support.

(3) Raynaud's phenomenon. Manifested by trophic changes of the involved parts characterized by scarring of the skin or ulceration.

(4) Thromboangiitis obliterans. Intermittent claudication of sufficient severity to produce pain and inability to complete a walk of 200 yards or less on level ground at 112 steps per minute without rest or other complications.

(5) Thrombophlebitis. If recurrent symptomatic attacks.

(6) Varicose veins. Severe and symptomatic despite therapy.

(7) Hypertensive cardiovascular disease and hypertensive vascular disease. When one or more of the following exists:

(a) Diastolic pressure consistently more than 110 mmHg following an adequate period of therapy in an ambulatory status.

(b) More than minimal demonstrable changes in the brain.

(c) Symptomatic heart disease.

(d) Significant impairment of renal function.

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

(8) Aneurysm. Aneurysm of any vital, major, or significant vessel (which, if ruptured, can result in sudden, severe or life-threatening manifestations) not correctable by surgery. Any aneurysm corrected by surgery, but with residual symptoms which precludes satisfactory performance of duty.

(9) Reconstructive surgery (including grafts). When:

(a) Prosthetic devices are attached to or implanted for cardiovascular therapeutic purposes, regardless of result.

(b) Residual of surgery of the heart, pericardium, or vascular system results in the inability of the member to satisfactorily perform duty.

(c) Member has undergone coronary vascular surgery, regardless of the result. This includes coronary bypass surgery and coronary angioplasty procedures.

#### NOTES:

- Conditions in (8) and (9) above will have MEB processing within 90 calendar days of surgery regardless of the results.

- The appropriate Air Reserve Forces surgeon will:

- Determine disposition of those Air Reserve Force members who are not on EAD and not authorized disability evaluation under AFR 35-4.

- Assign these members a P-4 profile restricting participation for pay or points pending final disposition of their case.

- Conduct a medical examination and send it to the appropriate Air Reserve Forces surgeon as explained in chapter 8.

- Not conduct an MEB unless directed by the component surgeon.

**3-9. Blood, Blood-Forming Tissue, and Immune System Diseases.** Any of the following diseases and diseases of analogous severity when there is an unsatisfactory response to the therapy or when the therapy or followup requires prolonged, intensive medical supervision:

a. Anemia, chronic.

b. Leukopenia, chronic.

c. Polycythemia.

d. Purpura and other bleeding disorders.

e. Thromboembolic disease.

f. Splenomegaly, chronic, inoperable.

g. Leukemia.

h. Immunodeficiency.

i. Sickle cell disease. These and heterozygous sickling disorders other than sickle cell trait are disqualifying. NOTE: Those individuals with sickling disorders who develop symptoms attributable to the trait must undergo medical board evaluation.

#### 3-10. Abdomen and Gastrointestinal System:

a. Defects and Diseases:

(1) Esophageal:

(a) Achalasia (cardiospasm), manifested by dysphagia requiring repeated dilatation or inability to maintain normal vigor and nutrition.

(b) Esophagitis, persistent and severe.

(c) Diverticulum of the esophagus which causes frequent regurgitation, obstruction, weight loss, and does not respond to treatment.

(d) Stricture of the esophagus which requires an essentially liquid diet, frequent dilatation and hospitalization, or causes difficulty in maintaining weight and nutrition.

(2) Gastritis. Severe, chronic gastritis with repeated symptoms requiring hospitalization and confirmed by gastroscopic examination.

(3) Hernia:

(a) Hiatus hernia with severe symptoms not relieved by dietary or medical therapy or with recurrent bleeding in spite of prescribed therapy.

(b) Other types of hernias if operative repair is contraindicated for medical reasons or if not amenable to surgical repair.

(4) Ulcer. Peptic, duodenal, or gastric with repeated incapacitations or absences from duty because of recurrence of symptoms despite good medical management and supported by labora-

tory and X-ray evidence of activity or severe deformity.

(5) Cirrhosis. Cirrhosis of the liver, jaundice with ascites or demonstrable esophageal varices or history of bleeding from it.

(6) Hepatitis. Chronic, when symptoms persist and there is objective evidence of impairment of liver function beyond a reasonable period of postacute observation.

(7) Amebic Abscess Residuals. Persistent abnormal liver function tests and failure to maintain weight and normal vigor after appropriate treatment.

(8) Pancreatitis, chronic. Recurrent pseudocystitis or frequent abdominal pain requiring hospitalization or causing inordinate lost duty time, or endocrine or exocrine function which prevents satisfactory performance of duty or require permanent station assignment restrictions.

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

(10) Granulomatous enteritis or enterocolitis.

(11) Ulcerative colitis.

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

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

b. Surgery:

(1) Colectomy, partial, when moderate symptoms remain which interfere with satisfactory performance of duty.

(2) Colostomy, when permanent.

(3) Enterostomy, when permanent.

(4) Gastrectomy, total or subtotal with or without vagotomy, or gastrojejunostomy or pyloroplasty with or without vagotomy, when, in spite of good medical management the individual:

(a) Develops incapacitating dumping syndrome.

(b) Develops frequent episodes of incapacitating epigastric distress with characteristic circulatory symptoms or diarrhea.

(c) Continues to demonstrate significant weight loss.

(5) Gastrostomy, when permanent.

(6) Ileostomy, when permanent.

(7) Pancreatectomy, except for partial pancreatectomy for a benign condition which does not result in moderate residual symptoms.

(8) Pancreaticoduodenostomy, pancreaticogastrostomy, and pancreaticojejunostomy, followed by moderate symptoms of digestive disturbance, or requiring insulin.

(9) Proctectomy.

(10) Proctoplexy, proctoplasty, proctorrhaphy, or proctotomy, if fecal incontinence remains after appropriate treatment.

### 3-11. Genitourinary System:

#### a. Genitourinary Conditions:

(1) Cystitis. When complications or residuals of treatment themselves preclude satisfactory performance of duty.

(2) Dysmenorrhea. Not amenable to treatment, and incapacitating.

(3) Endometriosis. Symptomatic and incapacitating despite adequate treatment.

(4) Hypospadias. When surgical correction is unsatisfactory.

(5) Incontinence of Urine. Not amenable to treatment.

#### (6) Kidney:

(a) Calculus in kidney, bilateral and symptomatic.

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

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

(d) Bilateral hydronephrosis, more than mild, bilateral, and causing continuous or frequent symptoms.

(e) Hypoplasia of the kidney, associated with elevated blood pressure or frequent infections which is not correctable by surgery.

(f) Nephritis, chronic, with renal functional impairment.

(g) Nephrosis, other than mild.

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

(7) Menopausal syndrome. Physiologic or artificial, not amenable to treatment and impairs normal performance.

(8) Strictures of the urethra or ureter. Severe and not amenable to treatment.

(9) Urethritis. Chronic, not responsive to treatment and necessitating frequent absences from duty.

b. Genitourinary and Gynecological Surgery:

(1) Cystectomy.

(2) Cystoplasty. If reconstruction is unsatisfactory, or if refractory symptomatic infections persist.

(3) Nephrectomy. When there is significant anatomic or progressive functional abnormality in the remaining kidney.

(4) Nephrostomy or pyelostomy, if drainage persists.

(5) Gonadectomy. Bilateral, when following treatment and convalescent period, there remain incapacitating mental or constitutional symptoms.

(6) Penis. Amputation of.

(7) Ureterointestinal or direct cutaneous urinary diversion.

(8) Ureteroneocystostomy. When both ureters are markedly dilated with irreversible changes.

(9) Ureteroplasty:

(a) When unilateral procedure is unsuccessful and nephrectomy is necessary, consider on the basis of the standard for nephrectomy.

(b) When bilateral and surgical repair is unsuccessful and associated with significant complications or sequelae (for example, marked hydronephrosis or therapeutically refractive pyelonephritis).

(10) Ureterosigmoidostomy.

(11) Ureterostomy. External or cutaneous.

(12) Urethrostomy. When a satisfactory urethra cannot be restored.

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

### 3-12. Neurologic Disorders:

a. Amyotrophic lateral sclerosis.

b. Atrophy. Muscular, myelopathic, including severe residuals of poliomyelitis.

c. Atrophy. Muscular, progressive.

d. Chorea. Chronic and progressive.

e. Friedreich's ataxia.

f. Hepatolenticular degeneration.

g. Seizure disorder:

(1) Seizures incurred after entry to active duty will be processed as follows:

(a) Initial placement of a P-4-T profile with appropriate occupational restrictions is warranted in new cases. MEB processing must be done within 90 calendar days of the first episode. If returned to duty by HQ AFMPC/DPMMM or HQ AFMPC/DPMADS, a reevaluation will be accomplished and sent to HQ AFMPC/ DPMMM not later than 1 year following MEB.

(b) Air Reserve Forces personnel not on EAD and not authorized disability evaluation under AFR 35-4 will be assigned a P-4-T profile restricting participation for pay or points pending final disposition of their case by the component surgeon.

(c) If the individual has insufficient retainability to determine qualification, then PEB referral is indicated.

(d) Individuals who are not well controlled on medication or require such dosages as to cause significant side effects or possess coexisting defects which, in themselves or in the aggregate, cause the member's qualification to be questionable, must be presented to the PEB.

(2) Attacks following omission of prescribed medication or ingestion of alcoholic beverages are not indicative of the controllability of the disorder.

(3) Seizure disorders due to alcohol or drug abuse require prompt PEB referral.

(4) When returned to duty by HQ AFMPC/DPMMM or HQ AFMPC/DPMADS, the MTF profiling officer will take appropriate profile action.

h. Migraine. Manifested by frequent incapacitating attacks or attacks which last for several consecutive days, and unrelieved by treatment.

i. Multiple sclerosis.

j. Myelopathy, transverse.

k. Narcolepsy. When attacks are not controlled by medication.

l. Paralysis agitans.

m. Peripheral nerve conditions such as:

(1) Neuralgia, when symptoms are severe, persistent, and do not respond to treatment.

(2) Neuritis or paralysis due to peripheral nerve injury, when manifested by more than moderate, permanent functional impairment.

n. Syringomyelia.

o. Other neurological conditions. Any other neurological condition, regardless of etiology, when after adequate treatment, there remain residuals, such as persistent severe headaches, weakness or paralysis of important muscle

groups, deformity, incoordination, pain or sensory disturbance, disturbance of consciousness, speech, or mental defects, or personality changes of such a degree as to definitely interfere with the performance of duty.

**3-13. Psychoses, Psychoneuroses, Other Axis I Diagnosis, and Other Mental Conditions.** All psychiatric evaluations must include social and industrial impairment (S & I), per AFR 168-4.

a. **Psychoses.** After a psychotic episode, return to worldwide duty is not authorized without medical board evaluation or HQ AFMPC/DPMMM review.

b. **Psychoneuroses--(Affective Anxiety, Somatiform, Dissociative, Eating, or Psychosexual Disorders).** Severe symptoms, persistent or recurrent, requiring hospitalization or the need for continuing psychiatric support. (Incapacity because of neurosis must be distinguished from weakness of motivation or underlying personality disorder.) These personnel will not be returned to worldwide duty without MEB evaluation or HQ AFMPC/DPMMM review.

c. **Disorders of Intelligence.** Individuals determined to have primary mental deficiency or a special learning defect which interferes with the satisfactory performance of duty are unsuitable and must be referred to their unit commander for consideration of administrative separation.

d. **Other Mental Conditions.** Personality disorders, transient situational reactions, personality disruptions, and habit reactions may render an individual unsuitable rather than unfit because of physical disability.

(1) **Interference with effective duty performance** is dealt with through appropriate administrative channels. Alcoholism, per se, renders an individual unsuitable rather than unfit because of physical disability. Provisions for rehabilitation and disposition are in AFRs 30-2 and 160-36.

(2) **Medical board evaluation** is indicated in those instances when medical complications or sequelae of alcoholism (for example, recurrent jaundice or ascites, esophageal varices, chronic pancreatitis, organic central nervous system (CNS) disorders, etc.) preclude satisfactory performance of duty and worldwide assignability.

(3) **Drug dependency** renders an individual unsuitable rather than unfit because of physical disability. Provisions for rehabilitation and dis-

position are in AFR 30-2. Medical board evaluation is indicated in those instances where drug dependency is the proximate result of a neurotic, psychotic, or organic medical condition.

(4) "Flying phobia" of sufficient magnitude to preclude military air transportation is dealt with administratively unless the condition is the proximate result of a psychotic disorder or a bona fide primary neurotic disorder.

#### **3-14. Extremities:**

##### **a. Upper Extremities:**

(1) Amputation of part or parts of an upper extremity which results in impairment equivalent to the loss of use of a hand.

(2) Joint ranges of motion which do not equal or exceed the following:

##### **(a) For shoulder:**

1. Forward elevation to 90 degrees.
2. Abduction to 90 degrees.

##### **(b) For elbow:**

1. Flexion to 100 degrees.
2. Extension to 60 degrees of flexion.

(3) Dislocating or subluxating shoulder, when not repairable or when surgery is contraindicated.

##### **b. Lower Extremities:**

###### **(1) Amputations:**

(a) Amputation of a toe or toes which precludes the ability to run or walk or to perform duty in a satisfactory manner.

(b) Any loss greater than specified above to include foot, leg, or thigh.

###### **(2) Feet:**

(a) Hallux valgus when moderately severe, with exostosis or rigidity and pronounced symptoms or severe with arthritic changes.

(b) Pes planus, symptomatic, more than moderate with pronation on weight bearing which prevents the wearing of a military shoe, or when associated with trophic changes.

(c) Talipes cavus when severe, with marked discomfort on prolonged standing and walking, metatarsalgia, or which prevents the wearing of a military shoe.

###### **(3) Internal Derangement of the Knee:**

(a) Residual instability following remedial measures if more than moderate in degree or with recurring episodes of effusion or locking, resulting in frequent incapacitation.

(b) If complicated by arthritis (see c(1) below).

(4) **Joint Ranges of Motion.** Motion which does not equal or exceed the measurements listed below:

## (a) Hip:

1. Flexion to 90 degrees.
2. Extension to 0 degrees.

## (b) Knee:

1. Flexion to 90 degrees.
2. Extension to 15 degrees.

(5) Shortening of an Extremity. Shortening of an extremity which exceeds 5 centimeters (2 inches).

## c. Miscellaneous:

## (1) Arthritis:

(a) Arthritis due to infection associated with persistent pain and marked loss of function, with X-ray evidence, and documented history of recurrent incapacity.

(b) Arthritis due to trauma, when surgical treatment fails or is contraindicated and there is functional impairment of the involved joint 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) Rheumatoid arthritis or rheumatoid myositis, with substantiated history of frequent incapacitating episodes supported by objective and subjective findings.

(2) Chondromalacia or Osteochondritis Dissecans. Severe, manifested by frequent joint effusion, more than moderate interference with function, or with severe residuals from surgery.

## (3) Fractures:

(a) Malunion when, after appropriate treatment, there is severe malunion with marked deformity or more than moderate loss of function.

(b) Nonunion when, after an appropriate healing period, the nonunion persists with severe loss of function.

(c) Bone fusion defect when manifested by severe pain or loss of function.

(d) Callus, excessive, following fracture, when functional impairment precludes satisfactory performance of duty and the callus does not respond to adequate treatment.

## (4) Joints:

(a) Arthroplasty, with severe pain, limitation of motion, and limitation of function.

(b) Bony or fibrous ankylosis, with severe pain involving major joints of spinal segments, ankylosis in unfavorable positions, or ankylosis with marked loss of function.

(c) Contracture with marked loss of function and the condition is not remediable by surgery.

(d) Loose bodies within a joint with marked functional impairment complicated by arthritis to such a degree as to preclude favorable results of treatment.

(5) Muscles. Flaccid or spastic paralysis of one or more muscles, producing loss of function which precludes satisfactory performance of military duty.

## (6) Myotonia Congenita.

(7) Osteitis Deformans. Involvement of single or multiple bones with resultant deformities, or symptoms severely interfering with function.

(8) Osteoarthropathy. Hypertrophic, secondary, with severe pain in one or multiple joints and with marked loss of function.

(9) Osteomyelitis Chronic. Recurrent episodes not responsive to treatment or involving the bone to a degree which interferes with stability and function.

(10) Replacement of a Major Joint. Partial or complete replacement of a major joint which results in continued symptoms or limitation of function so as to preclude satisfactory performance of military duty. NOTE: Measure ankylosis and joint motion with a goniometer and conform to methods illustrated in AFR 160-17.

**3-15. Spine, Scapulae, Ribs, and Sacroiliac Joints (See Paragraph 3-14c):**

a. Congenital anomalies such as:

(1) Dislocation of hip.

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

b. Coxa Vara, severe with pain, deformity, and arthritic changes.

c. Herniation of nucleus pulposus, when symptoms and associated objective findings are of such a degree as to require repeated hospitalization or frequent absences from duty.

d. Kyphosis, severe or interfering with function, or causing unmilitary appearance.

e. Scoliosis more than 30 degrees measured by the Cobb method, or loss of normal kyphosis of the thoracic spine, if either are severe or symptomatic or interfering with function or causing unmilitary appearance.

f. Spondylolisthesis or spondylolisthesis, when symptoms and associated objective findings are of such a degree as to require repeated hospitalization or frequent absences from duty.

**3-16. Skin and Cellular Tissues:**

- a. Acne, severe, unresponsive to treatment, and interfering with the satisfactory performance of duty.
- b. Atopic dermatitis, requiring frequent hospitalization.
- c. Cysts and tumors. Refer to paragraph 3-19.
- d. Dermatitis herpetiformis, which fails to respond to therapy.
- e. Eczema, chronic, regardless of type, when there is moderate involvement or when there are repeated exacerbations in spite of continuing treatment.
- f. Elephantiasis or chronic lymphedema, not responsive to treatment.
- g. Epidermolysis bullosa.
- h. Erythema multiform, moderate, severe, chronic, or recurrent.
  - i. Exfoliative dermatitis, chronic, extensive.
  - j. Fungus infections, severe, if not responsive to therapy and resulting in frequent absences from duty.
  - k. Hidradenitis, suppurative, and folliculitis decalvans.
    - l. Hyperhidrosis of the hands and feet when severe or complicated by a dermatitis or infection, either fungal or bacterial, and not amenable to treatment.
    - m. Leukemia cutis and mycosis fungoides.
    - n. Lichen planus, generalized and not responsive to treatment.
    - o. Lupus erythematosus, chronic discoid variety with extensive involvement or when the condition does not respond to treatment.
    - p. Neurofibromatosis, if disfigurement is extensive or when associated with manifestation of other organ system involvement.
    - q. Pemphigus, not responsive to treatment and with moderate constitutional or systemic symptoms.
    - r. Psoriasis or parapsoriasis, extensive and not controllable by treatment or controllable only with potent cytotoxic agents.
    - s. Radiodermatitis, if resulting in malignant degeneration at a site not amenable to treatment.
    - t. Scars and keloids, so extensive they seriously interfere with the function of the body area or they interfere with proper fit and wear of military equipment.
    - u. Tuberculosis of the skin. Refer to paragraph 3-18.

v. Ulcers of the skin, not responsive to treatment after an appropriate period of time or if they result in frequent absences from duty.

w. Urticaria, chronic, severe, and not amenable to treatment.

x. Other skin diseases, if chronic or of a nature which requires frequent medical care or interferes with the satisfactory performance of military duty.

**3-17. Endocrine and Metabolic Conditions:**

- a. Acromegaly, with functional impairment or requiring major replacement therapy.
- b. Adrenal hyperfunction, not responding to therapy.
- c. Adrenal hypofunction.
- d. Diabetes insipidus, requiring antidiuretic hormone replacement therapy.
- e. Diabetes mellitus, when proven to require insulin or oral hypoglycemic drugs, MEB processing will be done within 90 calendar days. Disposition of Air Reserve Forces personnel not on extended active duty and not eligible for disability processing will be determined by the appropriate Air Reserve Forces surgeon.
- f. Gout, with frequent acute exacerbations in spite of therapy, or with severe bone, joint, or kidney damage.
- g. Hyperinsulinism, when caused by a malignant tumor, or when the condition is not correctable.
- h. Hyperparathyroidism, when residuals or complications such as renal or bony defects preclude satisfactory performance of military duty.
- i. Hyperthyroidism, with severe symptoms which do not respond to treatment.
- j. Hypoparathyroidism, with objective evidence and severe symptoms not controlled by maintenance therapy.
- k. Osteomalacia, when residuals after therapy are of such degree or nature as to limit physical activity to a significant degree.

**3-18. Systemic Disease:**

- a. Amyloidosis, generalized.
- b. Dermatomyositis/polymyositis complex.
- c. Leprosy, any type.
- d. Lupus erythematosus, disseminated, chronic.
- e. Myasthenia gravis.
- f. Mycoses, active, not responsive to therapy, or requiring prolonged treatment, or when complicated by disqualifying residuals.
- g. Panniculitis, relapsing, febrile, nodular.

- h. Porphyria.
- i. Sarcoidosis, progressive, with severe or multiple organ involvement and not responsive to therapy (see paragraph 3-7b).
- j. Scleroderma, of the linear type which seriously interferes with the function of an extremity or body area involved or progressive systemic sclerosis including CREST Syndrome (calcinosis, Raynaud's phenomenon, esophageal hypomotility, sclerodactyly, and telangiectasia).
- k. Tuberculosis, active, other than pulmonary.

**3-19. Tumors and Malignant Diseases:**

- a. Malignant neoplasms or residuals thereof.
- b. Benign neoplasms, when the condition prevents the satisfactory performance of duty and the condition is not remediable or a remedial operation is refused. **NOTE:** All members with neoplastic disease must meet an MEB within 90 calendar days of initial diagnosis or as soon as the medical condition has stabilized. Basal cell, squamous cell carcinoma and carcinoma-in-situ of the cervix which have been adequately excised (as evidenced by pathology report, or basal cell carcinoma which has been treated by electrodesiccation and curettage by a dermatologist credentialed to perform the procedure) are exempted from Tumor Board Action (as specified in AFR 160-64) do not require MEB.

**3-20. Sexually Transmissible Diseases:**

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

**3-21. General and Miscellaneous Conditions and Defects:**

- a. The individual is precluded from a reasonable fulfillment of the purpose of his or her employment in the military service.
- b. The individual's health or well being would be compromised if he or she were to remain in the military service.

c. The individual's retention in the military service would prejudice the best interests of the government. Questionable cases will be referred to a MEB for a determination of fitness or to the appropriate Air Reserve Forces surgeon for those Air Reserve Forces members who are not on EAD and not authorized disability processing under AFR 35-4.

d. The individual has an EPTS defect or condition for which corrective surgery is contemplated.

e. The individual requires an indefinite (permanent) excusal above from aerobics.

f. The individual's travel by military air transport is precluded for medical reasons. (See paragraph #3-13 concerning "flying phobia".)

g. The individual has an assignment canceled due to a medical condition. Present to an MEB, or within 10 calendar days, provide narrative summary to HQ AFMPC/DPMMM for review in lieu of MEB.

h. The individual continues to have a 4-T profile 1 year after the defect became disqualifying.

i. The individual has been hospitalized 90 calendar days and return to duty within 3 more months is not expected. MEBs should be accomplished when optimum hospital benefit for disposition purposes is achieved (i.e., when the patient's future qualification for further military service is foreseeable) and should not be delayed until receipt of maximum hospital benefit.

j. The individual refuses required medical, surgical, or dental treatment or diagnostic procedures. See AFR 168-4 for further guidance.

k. The individual requires determination of his or her competency for pay purposes under AFM 177-373, volume I.

l. The individual has had a sanity determination required by the Manual for Courts-Martial and the psychiatric findings indicate the member's suitability for continued military service is questionable.

m. The individual has coexisting medical defects that are thought to be the primary cause of unacceptable behavior or unsatisfactory performance.

## Chapter 4

## MEDICAL STANDARDS FOR APPOINTMENT, ENLISTMENT, AND INDUCTION

## Section A—General Information

**4-1. Purpose and Scope:**

a. This chapter establishes basic physical standards for enlistment, appointment, and induction into the Armed Forces of the United States according to the authority contained in Title 10, United States Code, Section 123. Standards in this chapter correspond to those contained in DoD Directive 6130.3.

b. These standards apply to the Departments of the Army, Navy, Air Force, Marine Corps, and by agreement with the Secretary of Transportation, to the US Coast Guard (hereafter referred to collectively as the "Armed Forces").

c. This chapter sets forth the medical conditions and physical defects that are causes for rejection for military service. The examiner must consider and allow for an examinee's demonstrated ability to adequately perform duties in civilian life which are equivalent to duties required in the military service but take into account the fact the individual may be called upon to serve anywhere in the world, in peacetime and in war.

**4-2. Applicability.** These standards apply to:

a. Applicants for enlistment or commission in the active, ANG, and USAFR components.

(1) For medical conditions or physical defects that EPTS, these standards apply until a member in the Regular Air Force has completed 6 months of active duty.

(2) For medical conditions and physical defects that EPTS, these standards apply until a member in the USAFR or ANG has completed an initial period of active duty for training and returned to their Reserve Component Unit.

b. Applicants for reenlistment in Regular and Reserve components and federally recognized units or organizations of ANG after a period of more than 6 months have elapsed since discharge.

c. USAFR or ANG members or retirees upon voluntary EAD.

d. Indefinite Reserve Status for component (MC, MSC, NC, BSC, Chaplains and Judge Advocate) officers (AFR 36-14).

e. Applicants for a Scholarship or Advanced Course Reserve Officer Training Corps (ROTC), and all other Armed Forces special officer personnel procurement programs.

f. Retention of cadets and midshipmen at the United States Armed Forces academies and students enrolled in the ROTC scholarship program, USUHS, or HPSP.

g. AFROTC graduates whose active duty is delayed under AFR 45-31.

h. All individuals being inducted into the Armed Forces.

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

## Section B—Head and Neck

**4-3. Head:**

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 paragraph 4-22.

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

c. Deformities of the skull 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 elevation or were associated with a laceration of the dura mater or focal necrosis of the brain (see paragraph 4-22).

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 1 square inch (6.45cm<sup>2</sup>) or the size of a 25-cent coin.

**4-4. Neck:**

- 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 the 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 paragraph 4-38.

**Section C—Month, Nose, Sinuses, Pharynx, Trachea, and Larynx****4-5. Mouth:**

- a. Hard palate, perforation of.
- b. Cleft lip, unless satisfactorily repaired by surgery.
- c. Leukoplakia, stomatitis or ulcerations of the mouth, if severe.
- d. Ranula, if extensive. For other tumors see paragraphs 4-39 and 4-42.
- e. Salivary fistula or obstruction of the salivary duct.
- f. 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.

**4-6. Nose and Sinuses:**

- a. Allergic manifestations:
  - (1) Atrophic rhinitis.
  - (2) Allergic rhinitis vasomotor, rhinitis, if moderate or severe and not controlled by oral medications, desensitization, or topical corticosteroid medication.
- b. Anosmia or parosmia.
- c. Choana, atresia or stenosis of, if symptomatic.
- d. Epitaxis, chronic recurrent.

e. Nasal polyps or a history of nasal polyps, unless surgery was performed at least 1 year before examination and there is no evidence of recurrence.

**f. Nasal septum, perforation of:**

(1) Associated with the interference of function, ulceration or crusting, and when the result of organic disease.

(2) If progressive.

(3) If respiration is accompanied by a whistling sound.

g. Sinusitis, acute.

h. Sinusitis, chronic when more than mild:

(1) Evidenced by 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.

**4-7. Pharynx, Trachea, and Larynx:**

- 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.

**4-8. Other Defects and Diseases of the Mouth, Nose, Sinuses, Pharynx, Trachea, and Larynx:**

- 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 (see paragraph 4-40).
- 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.

**Section D—Ears****4-9. Ears:****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 precludes 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 suppurative otitis media of any type.
  - (2) Adhesive otitis media associated with hearing level by audiometric test of 30 decibel (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.
  - (3) Acute or chronic serous otitis media.
  - (4) Presence of attic perforation in which presence of cholesteatoma is suspected.
  - (5) Repeated attacks of catarrhal otitis media; intact greyish, thickened drums.

- (6) History of surgery involving the middle ear, excluding myringotomy.
- (7) Cholesteatoma.
- f. Tympanic Membrane:
  - (1) Any perforation of the tympanic membrane.
  - (2) Surgery to repair perforated tympanic membrane within the past 120 calendar days.
  - (3) Severe scarring of the tympanic membrane associated with hearing level by audiometric test of 30 dB or more average for the speech frequencies (500, 1000, and 2000 cycles per second) in either ear regardless of the hearing level in the other ear.
- g. Other Diseases and Defects of the Ear. Other diseases and defects of the ear which obviously preclude satisfactory performance of duty or which require frequent and prolonged treatment.

**4-10. Hearing.** (See also paragraph 4-9.) The cause for rejection for appointment, enlistment, and induction is a hearing threshold level greater than that described in figure 4-1.

*Audiometers calibrated to the International Standards Organization 1964 (ISO 1964) and the American National Standards Institute 1969 (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 report of medical examination or other medical records will be clearly identified.*

**Acceptable Audiometric Hearing Level for  
Appointment, Enlistment, and Induction  
ISO 1964--ANSI 1969  
BOTH EARS**

*Pure tone at 500, 1000, and 2000 cycles per second of not more than 30 dB on the average (either ear), with no individual level greater than 35 dB at these frequencies; and level not more 45 dB at 3000 cycles per second each ear, and 55 dB at 4000 cycles per second each ear.*

**Figure 4-1. Acceptable Audiometric Hearing Levels.**

## Section E—Dental

### 4-11. Dental:

a. Diseases of the jaw or associated tissues that are not easily remediable, and will incapacitate the individual or otherwise prevent the satisfactory performance of duty. This includes temporomandibular disorders or myofascial pain dysfunction not easily corrected or which would prevent satisfactory performance of duty.

b. Severe malocclusion which interferes with normal mastication or requires early and protracted treatment; or relationship between mandible and maxilla that precludes satisfactory future prostodontic 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 worldwide duty. Dental implants that are no longer functional must not interfere with continuation of wear of the implant prosthesis or prevent removal and replacement with a conventional prosthesis.

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

## Section F—Eyes and Vision

### 4-12. Eyes:

#### a. Lids:

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

(2) Blepharospasm.

(3) Dacryocystitis, acute or chronic.

(4) Destruction of the eyelids, 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. See also paragraph 4-39.

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

(8) Lagophthalmos.

(9) Ptosis interfering with vision.

(10) Trichiasis, severe.

#### b. Conjunctiva:

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

(2) Pterygium:

(a) Recurring after two operative procedures.

(b) Encroaching on the cornea in excess of 3 millimeters, interfering with vision, or if progressive (as evidenced by marked vascularization 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.

(3) Keratitis, acute or chronic.

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

(5) Vascularization or opacification of the cornea from any cause which is progressive or reduces vision below the standards prescribed in paragraph 4-13.

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

#### e. Retina:

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

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

**f. Optic Nerve:**

(1) Congenito-hereditary conditions of the optic nerve or any other CNS 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.

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

**i. Miscellaneous Defects and Diseases:**

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

(a) Temporal	85°
(b) Superior-Temporal	55°
(c) Superior	45°
(d) Superior Nasal	55°
(e) Nasal	60°
(f) Inferior Nasal	50°
(g) Inferior	65°
(h) Inferior Temporal	85°

(2) Absence of an eye.

(3) Asthenopia, severe.

(4) Exophthalmos, unilateral or bilateral, nonfamilial.

(5) Glaucoma, primary or secondary, or preglaucoma as evidenced by intraocular pressure above 25mm Hg, 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 paragraph 4-39.

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

**4-13. Vision:**

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

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

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

(3) In one eye-20/20 and in the other eye-20/400.

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 which is disqualifying; or if refractive error is corrected by orthokeratology or keratorefractive surgery.

d. Contact Lens. Complicated cases requiring contact lenses for adequate correction of vision, such as keratoconus, corneal scar, 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.

**Section G—Lungs and Chest Wall****4-14. Lungs and Chest Wall:**

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, reactive airway disease, exercise induced bronchospasm, except childhood asthma with a trustworthy history of freedom from

symptoms since the 12th birthday. Any use of prophylactic medicine since the 12th birthday is also disqualifying regardless of symptoms.

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-size 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 tissues 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 breast, mastectomy, acute mastitis, chronic cystic mastitis of more than mild degree if symptomatic.

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

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

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

w. Pneumothorax during the year preceding examination if due to simple trauma or surgery; during the 3 years preceding examination if of spontaneous origin. Surgical correction is acceptable if no significant residual disease or de-

formity remains and the pulmonary function tests fall within normal limits. Recurrent spontaneous pneumothorax is disqualifying regardless of cause.

x. Pulmonary embolus, history of.

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

z. Sarcoidosis. See paragraph 4-411.

aa. Significant abnormal findings of the chest wall, lung or lungs, pleura or mediastinum.

ab. Silicone implants, injections, or saline inflated implants in breasts for cosmetic purposes. Encapsulated implants of saline or silicone and teflon, are acceptable if a minimum of 9 months have elapsed since surgery and site is well healed with no complications reported.

ac. Suppurative periostitis or rib, sternum, clavicle, scapula, or vertebra.

ad. Tuberculosis lesions. See paragraph 4-41n.

## Section H—Heart and Vascular System

### 4-15. Heart:

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 artery disease.

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

(1) Supraventricular tachycardia, atrial flutter, atrial fibrillation, 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. Supraventricular tachycardia, atrial flutter, and atrial fibrillation are not disqualifying if there has been no recurrence during the preceding 2 years off all medication.

(2) Left bundle branch block, Mobitz type II second degree atrioventricular (AV) block and third degree AV block. 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 dis-

ease. Accelerated AV conduction (Wolff-Parkinson-White syndrome) and Lown-Ganong-Levine-syndrome are not disqualifying unless associated with an arrhythmia.

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

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 per minute), regardless of cause.

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

#### **4-16. Vascular System:**

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

b. Hypertensive vascular disease, evidenced by 3 consecutive diastolic blood pressure measurements greater than 90 mmHg or 3 consecutive systolic pressures greater than 159 mmHg, irrespective of age; high blood pressure requiring medication.

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

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

#### **4-17. Miscellaneous Cardiovascular Conditions.**

a. Rheumatic fever during the previous 2 years; Sydenham's chorea at any age.

b. Pulmonary or systemic embolization, history of.

### **Section I—Blood and Blood-Forming Tissue Diseases**

#### **4-18. Blood and Blood-Forming Tissue Diseases:**

##### **a. Anemia:**

(1) Blood loss anemia -- until both condition and basic cause are corrected.

(2) Deficiency anemia uncontrolled by medication. Pernicious anemia even if controlled by B-12 injection.

(3) Abnormal destruction of red blood cells (RBC): hemolytic anemia to include enzyme deficiencies, with evidence of ongoing hemolysis; microangiopathic and any other hemolytic anemia, acquired or inherited.

(4) Faulty RBC construction and miscellaneous anemias including hemoglobinopathies, sideroblastic anemias, thalassemia major, and sickle-cell disease. Heterozygous conditions such as G6PD deficiency, thalassemia minor and sickle-cell trait may be acceptable if the hemoglobin is within the examining laboratory's normal limits, Hgb-S is less than Hgb-A and there is no history or evidence of crisis, decreased exercise tolerance or other complications.

(5) Myelophthisic anemia from any cause.

(6) Macroglobulinemia.

(7) Primary refractory anemias; aplastic anemia, paroxysmal nocturnal hemoglobinuria and pure red cell aplasia.

##### **b. Hemorrhagic States:**

(1) Due to inherited or acquired abnormalities in the coagulation system.

(2) Due to quantitative or qualitative platelet deficiency.

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

##### **d. Myeloproliferative Disease:**

(1) Myelofibrosis or myeloid metaplasia.

(2) Primary thrombocythemia.

(3) Polycythemia rubra vera.

(4) DiGuglielmo's syndrome.

(5) Chronic granulocytic leukemia (see Section S).

e. Splenomegaly. Until the cause is remedied.

f. Thromboembolic Disease. Thromboembolic disease except for acute, nonrecurrent thrombophlebitis.

g. Immunodeficiency Diseases. (See paragraph 4-42m).

h. Miscellaneous Conditions. Miscellaneous conditions such as porphyria, hemach-

romatosis, amyloidosis, and postsplenectomy status (except when secondary to causes stated in paragraph 4-19g).

#### **4-19. Abdominal Organs and Gastrointestinal System:**

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 one or more surgical operation for gastric or duodenal ulcer, i.e., partial or total gastric resection, gastrojejunostomy, pyloroplasty, truncal or selective vagotomy (or history of such operative procedures for any other cause or diagnosis).

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

(5) **Congenital abnormalities** of the stomach or duodenum causing symptoms or requiring surgical treatment.

(6) **History of surgical correction** of hypertrophic pyloric stenosis of infancy is not disqualifying if 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 (e.g. 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.** A history of, unless the cause has been corrected.

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.

(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 postcholecystectomy syndrome when symptoms are of such a degree as to interfere with normal performance of duty.

(5) **Cholecystitis,** acute or chronic, with or without cholelithiasis, if diagnosis is confirmed by usual laboratory procedures or medical records.

(6) **Bile duct abnormalities or structures.**

(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.

(2) **Splenectomy,** except when done for the following:

(a) **Trauma.**

(b) **Causes unrelated to diseases of the spleen.**

(c) **Hereditary spherocytosis.**

(d) **Disease involving the spleen** when followed by correction of the condition for at least 2 years.

h. **Tumors.** See paragraph 4-39.

i. **Abdominal Wall:**

(1) **Scars:**

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

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

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

(2) Hernia:

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

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

j. 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.

## Section J—Genitourinary System

### 4-20. Genitalia. (See also paragraph 4-39).

a. Bartholinitis, Bartholin's cyst.

b. Cervicitis, acute or chronic, manifested by leukorrhea.

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 larger than the attendant testicle, or 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 must be obtained and recorded.

h. Menstrual cycle, irregularities of including menorrhagia, if excessive; metrorrhagia; polymenorrhea; amenorrhea, except as noted in g above.

i. New growths of the internal or external genitalia, except a single uterine fibroid, subserous, asymptomatic, less than 3 centimeters in diameter, with no general enlargement of the uterus may be acceptable. (See also paragraph 4-39).

j. Oophoritis, acute or chronic.

k. Ovarian cysts, persistent, clinically significant.

l. Pregnancy. Pregnancy itself is not cause to deny appointment as a regular officer from reserve status or appointment to indefinite reserve status.

m. Salpingitis, acute or chronic.

n. Testicle or testicles. See also paragraph 4-39.

(1) Absence of both testicles.

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

(3) Undescended testicle or testicles.

(o) Urethritis, acute or chronic, other than gonorrhreal urethritis without complications.

p. Uterus, specifically:

(1) Cervical polyps, cervical ulcer, or marked erosion.

(2) Endocervicitis, more than mild.

(3) Generalized enlargement of the uterus due to any cause.

(4) Malposition of the uterus if more than mildly symptomatic.

(5) Pap smears graded Class 2, 3 or 4, (Class 2 smears are acceptable if the diagnosis is benign), or any smear in which the descriptive terms dysplasia, carcinoma-in-situ, or invasive cancer are used.

q. Vagina, such as:

(1) Congenital abnormalities or severe lacerations of the vagina.

(2) Vaginitis, acute or chronic, manifested by leukorrhea.

r. Vulva, such as:

(1) Leukoplakia.

(2) Vulvitis, acute or chronic.

s. 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.

### 4-21. Urinary System. (See paragraphs 4-35 and 4-39).

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

b. Enuresis determined to be a symptom of an organic defect not amenable to treatment. (See also paragraph 4-26).

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, such as:
  - (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 post strenuous exercise) greater than 200 mg/24 hours or a urinary protein to urinary 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, such as:
    - (1) Substantiated history of bilateral renal calculus at any time.
    - (2) Verified history of renal calculus with evidence of stone formation within the preceding 12 months, current symptoms, or positive X-ray for calculus.
    - m. Skenitis.
    - n. Urethra. Stricture of the urethra.
    - 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.

## Section K—Neurological Disorders

### 4-22. Neurological Disorders:

- a. Cerebrovascular conditions. Any history of subarachnoid or intracerebral hemorrhage, embolism, vascular insufficiency, thrombosis, hemorrhage, arteriosclerosis, arteriovenous malformation, or aneurysm 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 disorders, any evidence or history of.
- (1) Basal ganglia disease.
  - (2) Cerebellar and Friedreich's ataxia.
  - (3) Cerbral arteriosclerosis.
  - (4) Dementia.
  - (5) Multiple sclerosis or demyelinating processes.
  - (6) Muscular atrophies and dystrophies of any type.
    - d. Headaches, if they are of sufficient severity or frequency to interfere with normal function.
    - e. Head injury:
      - (1) Applicants with a history of head injury with the following complications are unacceptable at any time:
        - (a) Late post-traumatic epilepsy manifested by generalized or focal seizures.
        - (b) Transient or persistent neurological deficits indicative of parenchymal CNS injury, such as semiparesis or hemianopsia.
        - (c) Evidence of impairment of higher intellectual functions or alterations of personality as a result of injury.
        - (d) Persistent focal or diffuse abnormalities of the electroencephalogram, reasonably assumed to be the direct result of injury.
        - (e) Central nervous system shunt of any type.
      - (2) Applicants with a history of severe head injury are unfit for a period of at least 5 years after which they may be considered fit if complete neurological and neuropsychological evaluation (see table 10-1) show no residual dysfunction or complications. Severe head injuries are defined by one or more of the following:
        - (a) Unconsciousness or amnesia, along or in combination, of 24 hours duration or longer.
        - (b) Depressed skull fracture with or without dural penetration.
        - (c) Laceration or contusion of the dura or brain, or a history of penetrating brain injury, traumatic or surgical.
        - (d) Epidural, subdural, subarachnoid or intracerebral hematoma.
        - (e) CNS infection such as abscess or meningitis within 6 months of head injury.
        - (f) Cerebrospinal fluid rhinorrhea or otorrhea persisting more than 7 days.
        - (g) Early post-traumatic seizure or seizures, which occur within first week after injury and not thereafter. **EXCEPTION:** Seizures at the time of injury or within 15 minutes after injury do not have the same significance and may not be disqualifying.

## (h) Focal neurological signs.

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

(j) Leptomeningeal cysts or arteriovenous fistula.

(3) Applicants with a history of moderate head injury are unfit for a period of at least 2 years after which they may be considered fit if complete neurological evaluation (see table 10-1) shows no residual dysfunction or complications. Moderate head injuries are defined as unconsciousness or amnesia, alone or in combination, of more than 30 minutes but less than 24 hours duration or linear skull fracture.

(4) Applicants with a history of mild head injury as defined by a period of unconsciousness or amnesia, alone or in combination, for less than 30 minutes without linear skull fracture, are unfit for at least 1 month after which they may be acceptable if neurological evaluation (see table 10-1) shows no residual dysfunction or complications.

(5) Persistent post-traumatic sequelae, as manifested by headache, vomiting, disorientation, spatial disequilibrium, personality changes, impaired memory, poor mental concentration, shortened attention span, dizziness, altered sleep patterns, or any findings consistent with organic brain syndrome, are disqualifying until full recovery has been confirmed by complete neurological and neuropsychological evaluation.

f. Hereditary disturbances. Personal or family history of hereditary disturbances, such as multiple neurofibromatosis, Huntington's chorea, hepatolenticular degeneration, acute intermittent porphyria, spinocerbellar ataxia, peroneal muscular atrophy, muscular dystrophy, and familial periodic paralysis. A strong history of such a syndrome, indicating a heredity component, will be cause for rejection in the absence of clinical symptoms or signs since the onset of these illnesses may occur later in adult life.

## g. Infectious diseases, such as:

(1) Meningitis, encephalitis, or poliomyelitis within 1 year before examination, or if there are residual neurological defects which would interfere with satisfactory performance of military duty.

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

h. Narcolepsy, cataplexy, and similar states, authenticated history of.

i. Neuritis, neuralgia, neuropathy, or radiculopathy, authenticated history of, whatever the etiology, unless:

(1) The condition has completely subsided and the cause is determined to be of no future concern.

(2) There are no residual symptoms that could be deemed detrimental to normal function in any practical manner.

j. Paralysis, tremor or weakness, deformity, coordination, 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.

k. Paroxysmal convulsive disorders, disturbances of consciousness, all forms of psychomotor or temporal lobe epilepsy, or history thereof, except under the following circumstances:

(1) No seizure since age 5.

(2) Individuals who have had seizures since age 5 but who, during the 5 years immediately preceding examination for military service, have been totally seizure free and have not been taking any type of anticonvulsant medication for the entire period will be considered on an individual case basis. Documentation in these cases must be from attending or consulting physicians and the original electroencephalogram tracing (not a copy) taken within the preceding 3 months must be submitted for evaluation by the Surgeon General of the Service to which the individual is applying.

## l. Peripheral nerve disorder:

(1) Polyneuritis, whatever the etiology, unless:

(a) Limited to a single episode.

(b) The acute state subsided at least 1 year before examination.

(c) There are no residuals that could be expected to interfere with normal function in any practical manner.

(2) Mononeuritis or neuralgia which is chronic or recurrent, of an intensity that is periodically incapacitating.

(3) Injury of one or more peripheral nerves, unless it is not expected to interfere with normal functions in any practical manner.

m. Any history or evidence of chronic or recurrent diseases, such as myasthenia gravis, polymyositis, muscular dystrophy, familial periodic paralysis, and myotonia congenita.

n. Evidence or history of involvement of the nervous system by a toxic, metabolic or disease process 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.

o. Tremors that will interfere with normal function.

### **Section I—Mental Disorders Diagnostic Concepts and Terms**

*Concepts and terms used in paragraphs 4-23 through 4-28 are in consonance with the Diagnostic and Statistical Manual, Third Edition (DSMIII), American Psychiatric Association, 1980.*

#### **4-23. Disorders With Psychotic Features.**

This 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.

#### **4-24. Affective Disorders (Mood Disorders).** Symptoms, diagnosis, or history of a major mood disorder requiring maintenance treatment or hospitalization.

#### **4-25. Anxiety, Somatoform, Dissociative, or Factitious Disorders (Alternatively May be Addressed as Neurotic Disorders):**

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 for brief duration.

(4) Symptoms of 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 calendar days).

#### **4-26. Personality, Behavior, or Academic Skills Disorders:**

a. Personality or behavior disorders, as evidenced by frequent encounters with law enforcement agencies, antisocial attitudes or behavior which, while not sufficient cause for ad-

ministrative 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 Armed Forces 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 (see paragraph 4-21), occurring beyond early adolescence 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 learning defects secondary to organic or functional mental disorders sufficient to impair capacity to read and understand at a level acceptable to perform military duties.

e. Suicide, history of attempted suicide or other suicidal gestures.

#### **4-27. Psychosexual Conditions:**

a. Homosexual behavior. This includes all homosexual activity except adolescent experimentation or the occurrence of a single episode of homosexual behavior while intoxicated.

b. Transsexualism and other gender identity disorders.

c. Exhibitionism, transvestism, voyeurism and other paraphilias.

#### **4-28. Substance Misuse:**

a. Chronic alcoholism or alcohol addiction or dependence.

b. Drug addiction or dependence.

c. Drug abuse characterized by the:

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

(2) Documented misuse or abuse of any controlled substance (including cannabinoids) requiring professional care within a 1-year period before examination. Use of marijuana or other cannabinoids (not habitual use) or experimental or casual use of other drugs short of dependence may be waived by competent author-

ity as established by the respective Armed Forces 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, with such frequency that it appears that the applicant has accepted the use of or reliance on these substances as part of his or her pattern of behavior. (See also appropriate Armed Forces instructions.)

d. Alcohol abuse. Use of alcoholic beverages which leads to misconduct, unacceptable social behavior, poor work or academic performance, impaired physical or mental health, lack of financial responsibility or a disrupted personal relationship. (See also appropriate Armed Forces instructions.)

## Section M—Extremities

### 4-29. Upper Extremities. (See paragraph 4-31.):

a. Limitation of Motion. An individual will be considered unacceptable if the joint ranges of motion are less than the measurements listed below. See attachment 6.

#### (1) Shoulder:

- (a) Forward elevation to 90 degrees.
- (b) Abduction to 90 degrees.

#### (2) Elbow:

- (a) Flexion to 100 degrees.
- (b) Extension to 15 degrees.

(3) Wrist. A total range of 60 degrees (extension plus flexion). Radial and ulnar deviation combined arch 30 degrees.

#### (4) Hand:

- (a) Pronation to 45 degrees.
- (b) 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 3 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 in b above.

(5) Hyperdactylyia.

(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 paralyses or weakness (either median or ulnar nerves) sufficient to produce physical findings in the hand (e.g., muscle atrophy or weakness).

c. 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).

### 4-30. Lower Extremities. (See paragraph 4-31.):

a. Limitation of Motion. An individual will be considered unacceptable if the joint ranges of motion are less than the measurements listed below. See attachment 6.

#### (1) Hip:

- (a) Flexion to 90 degrees (minimum).
- (b) No demonstrable flexion contracture.
- (c) Extension to 10 degrees (beyond 0).
- (d) Abduction to 45 degrees.
- (e) Rotation 60 degrees (internal and external combined).

#### (2) Knee:

- (a) Full extension.
- (b) Flexion to 90 degrees.

#### (3) Ankle:

- (a) Dorsiflexion to 10 degrees.
- (b) Plantar flexion to 30 degrees.
- (c) Eversion and inversion (total to 5 degrees).

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

#### b. Foot and Ankle:

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

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

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

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

(5) Pes planus, pronounced cases, with decided eversion of the foot and marked bulging of the inner border, due to inward 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 of associated with marked exostosis or bunion which would prevent wearing of military footwear.

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

(9) Effects of disease, injury, or deformity including hyperdactyly which precludes running, are accompanied by disabling pain, or prohibit the wearing of appropriate military foot wear.

(10) Ingrowing toenails, 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 appropriate military foot wear.

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

c. Leg, Knee, Thigh, and Hip:

(1) Dislocated semilunar cartilage, loose or foreign bodies within the knee joint.

(2) Physical findings of an unstable or internally deranged joint.

(3) History of surgical correction of torn semilunar cartilage, loose or foreign bodies within the knee joint during the preceding 6 months. If 6 months or more (6 weeks or more for arthroscopic surgery) have elapsed since operation without recurrence, and any of the following are present: instability of the knee ligaments in anteroposterior, medial or lateral directions in comparison with the normal knee, significant abnormalities noted on x-ray, less than 80 percent strength (as measured by Cybex or similar devices) of the thigh musculature in comparison with the normal side, unacceptable active motion in flexion and extension, persistent effusion or the symptoms of internal de-

rangement. History of surgical correction of knee ligaments during the past 12 months. If more than 12 months have elapsed since surgery without recurrence, if there is evidence of more than mild instability of the knee ligaments in medial, lateral or anteroposterior directions in comparison with a normal knee, weakness or atrophy of the thigh musculature in comparison with the normal side (see 2 above); or if the individual requires bracing or medical treatment with sufficient frequency to interfere with the performance of military duty.

(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 2 years before examination or degenerative changes on X-ray from old hip dislocation.

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

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.

**4-31. Miscellaneous Bone and Joint Conditions and Defects.** (See also paragraphs 4-29 and 4-30.)

a. For arthritis:

(1) Active, subacute or chronic arthritis.

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

(3) Documented clinical history of rheumatoid arthritis, including ankylosing spondylitis.

(4) Traumatic arthritis of a major joint of more than minimal degree.

b. Chondromalacia manifested by authenticated history of chronic pain, joint effusion, interference with function, residuals from surgery, or X-ray changes.

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, symptomatic and more than mild; or if, subsequent to surgery, there is evidence of more than mild instability in comparison with the normal joint, weakness or atrophy in comparison with the normal side, or if the individual requires medical treatment of sufficient frequency to interfere with the performance of military duty.

e. For fractures:

(1) Malunited fractures that interfere significantly with function.

(2) Ununited fractures.

(3) Any old or recent fracture in which a plate, pin, metal rod, wire or screws used for fixation were left in place; for example, an anterior tibial plate.

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 unless successfully treated 2 or more years previously without subsequent recurrent or disqualifying sequelae and demonstrated by both clinical and x-ray evidence.

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 breakdown.

## Section N—Spine, Scapulae, Ribs, and Sacroiliac Joints

### 4-32. Spine and Sacroiliac Joints. (See paragraph 4-31):

a. Arthritis. (See paragraph 4-31.)

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 or curvature of spine from normal alignment, structure, or function (lumbar scoliosis over 20 degrees or dorsal scoliosis over 30 degrees, and kyphosis or lordosis over 55 degrees as measured by the Cobb method or if it;

(1) Prevents the individual from following a physically active vocation in civilian life.

(2) Interferes with the wearing of a uniform or military equipment.

(3) Is symptomatic and associated with positive physical findings and demonstrable by X-ray.

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 of 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 vertebra. A compression fracture, involving less than 25 percent of a single vertebra is not disqualifying if the injury occurred more than 1 year before examination and the applicant is asymptomatic. A history of fractures of the transverse or spinous processes is not disqualifying if the applicant is asymptomatic.

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 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 is disqualifying, even if successfully fused.

1. Weak or painful back requiring external support; that is, corset or brace.

**4-33. Scapulae, Clavicles, and Ribs.** (See paragraph 4-31):

- 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.

**Section O—Skin and Cellular Tissues**

**4-34. Skin and Cellular Tissues:**

- 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.
  - b. Atopic dermatitis. With active or residual lesions in characteristic areas (face and neck, antecubital and popliteal fossae, occasionally wrists and hands), or documented history thereof.
  - c. Cysts:
    - (1) Cysts, other than pilonidal. Of such a size or location as to interfere with the normal wearing of military equipment.
    - (2) Cysts, pilonidal. Pilonidal cysts, if evidenced by the presence of a tumor mass or a discharging sinus.
  - d. Dermatitis factitia.
  - e. Dermatitis herpetiformis.
  - f. Eczema. Any type which is chronic and resistant to treatment.
  - g. Elephantiasis or chronic lymphedema.
  - h. Epidermolysis bullosa, pemphigus.
  - i. Fungus infections. Systemic or superficial types, if extensive and not amenable to treatment.
  - j. Furunculosis. Extensive, recurrent, or chronic.
  - k. Hyperhidrosis of hands or feet. Chronic or severe.
  - l. Ichthyosis. Severe.
  - m. Keloids. Keloid formation, if the tendency is marked or interferes with the wearing of military equipment.
  - n. Leprosy. Any type.
- o. Leukemia cutis: mycosis fungoides, hodgkin's disease. (See paragraph 4-39b(11)(a)2, for additional remarks on Hodgkin's disease and the potential for service qualification.)
  - p. Lichen planus.
  - q. Neurofibromatosis (Von Recklinghausen's Disease).
  - r. Nevi or vascular tumors. If extensive, interfere with function, or exposed to constant irritation.
  - s. Pemphigus or pemphigoid.
  - t. Photosensitivity. Any primary sun-sensitive condition, such as polymorphous light eruption or solar urticaria; any dermatosis aggravated by sunlight such as lupus erythematosus.
  - u. Psoriasis. The actual condition or a verified history thereof.
  - v. Radiodermatitis.
  - w. Scars. Those 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.
  - x. Scleroderma. (See paragraph 4-41.)
  - y. Tattoos which will significantly limit effective performance of military service.
  - z. Tuberculosis. See paragraph 4-41.
  - aa. Urticaria. Chronic.
  - ab. Warts, plantar, which have materially interfered with a useful vocation in civilian life.
  - ac. Xanthoma. If disabling or accompanied by hyperlipidemia.
  - 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.

**Section P—Endocrine and Metabolic Disorders**

- 4-35. Endocrine and Metabolic Disorders:**
- a. Adrenal dysfunction of any degree.
  - b. Cretinism.
  - c. Diabetes mellitus. Any type, including a history of juvenile onset (insulin dependent, type I) is also disqualifying even if there is no current need for insulin and blood sugars are normal.
  - 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.
  - (4) Thyroiditis.
- m. Other endocrine or metabolic disorders which obviously preclude satisfactory performance of duty or which require frequent or prolonged treatment.

#### **Section Q—Height, Weight, and Body Build**

**4-36. Height.** The Military Services will establish the cause for rejection for appointment, enlistment, and induction. The cause for rejection for Air Force male applicants is height less than 60 inches or more than 80 inches. The cause for rejection for Air Force female applicants is height less than 58 inches or more than 80 inches.

**4-37. Weight.** The Military Services will establish the causes for rejection for appointment, enlistment, and induction. Body composition measurements may be used as the final determinant in evaluating an applicant's acceptability. Air Force applicants who exceed the weight in relation to height which is above the limits prescribed in attachment 7. Body fat standards will apply as outlined in attachment 7.

#### **4-38. Body Build:**

- a. Congenital malformation of bones and joints. (See paragraphs 4-29, 4-30, and 4-31).
- 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.

#### **Section R—Tumor and Malignant Diseases**

##### **4-39. Tumors and Malignant Diseases:**

- a. Benign Tumors: Benign tumors of the:
  - (1) Head or face that interfere with function or preclude the wearing of face or gas masks or a helmet.
  - (2) Eyes, ears, or upper airway that interfere with function.
  - (3) Thyroid or other neck structures such as to interfere with function of the wearing of a uniform or military equipment.
  - (4) Breast (male or female), chest, or abdominal wall that would interfere with military duty.
  - (5) Respiratory, gastrointestinal, genitourinary, or musculoskeletal systems that interfere with function or the wearing of a uniform or military equipment.
  - (6) Musculoskeletal system likely to continue to enlarge, be subjected to trauma during military service or show malignant potential.
  - (7) Skin which interfere with function, have malignant potential, interfere with military duty or the wearing of the uniform or military equipment.
- b. Malignant Tumors. Malignant tumors diagnosed by accepted laboratory procedures, and even though surgically removed or otherwise treated, with exceptions as noted. NOTE: Individuals who have a history of childhood cancer and who have not received any surgical or medical cancer therapy for 5 years and are free of cancer will be considered, on a case-by-case basis, for acceptance into the Armed Forces. Applicants must provide complete information about the history and present status of their cancer.
  - (1) Malignant tumors of the auditory canal, eye, or orbit (see paragraph 4-12) 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:

1. Non-Hodgkin's Lymphoma (all types).

2. Hodgkin's disease, active or recurrent. Hodgkin's disease treated with radiation therapy or chemotherapy (or both) and disease free from 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.

## Section S—Sexually Transmitted Disease

**4-40. 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.*

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 4-42.)

b. Complications and permanent residuals of sexually transmitted disease when they are progressive, and 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 4-22.)

## Section T—Systemic Diseases and Miscellaneous Conditions and Defects

**4-41. Systemic Diseases:**

- a. Amyloidosis.
- b. Ankylosing spondylitis.
- c. Eosinophilic granuloma. Eosinophilic granuloma, when occurring as a single localized bony lesion and not associated with soft tissue or other involvement, should not be a cause for rejection once healing has occurred. All other forms of the Histiocytosis X spectrum should be rejected, however.
- d. Lupus erythematosus.
- e. Mixed connective tissue disease.
- f. Polymyositis or dermatomyositis complex.
- g. Progressive systemic sclerosis, including CREST variant.
- 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) Substantial 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 must have received a completed 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 accordance with the guidelines of the American Thoracic Society and US Public Health Service.
    - o. Vasculitis (Bechet's, Wegener's granulomatosis, polyarteritis nodosa).

**4-42. General and Miscellaneous Conditions and Defects:**

a. Allergic manifestations:

(1) Authenticated history of moderate or severe generalized (as opposed to local) allergic reaction (including insect bites or stings) unless subsequent appropriate diagnostic venom testing has demonstrated no allergy exists. Authenticated history severe generalized reaction to common foods (e.g. milk, eggs, beef, and pork).

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.

g. Reactive tests for syphilis such as the rapid plasma reagin (RPR) or Venereal Disease Research Laboratory (VDRL) followed by a reactive, confirmatory Fluorescent Treponemal Antibody Absorption (FTA-ABS) test unless there is a documented history of adequately treated syphilis. In the absence of clinical find-

ings, the presence of a reactive RPR or VDRL followed by a negative FTA-ABS test is not disqualifying if a cause for the false positive reaction can be identified or if the test reverts to a nonreactive status during an appropriate followup period (3 to 6 months).

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

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

j. Industrial solvent and other chemical intoxication, chronic, including carbon disulfide, trichloreethylene, carbon tetrachloride, and methyl cellosolve.

k. Mycotic infection of internal organs.

l. Myositis or fibrositis, severe, chronic.

m. Presence of HIV-I or antibody. Presence is confirmed by repeatedly reactive Enzyme-Linked Immunoassay (ELISA) serological test and positive immunolectrophoresis (Western Blot) test, or other Food and Drug Administration-approved confirmatory test.

## Chapter 5

## MEDICAL STANDARDS FOR AIR TRAFFIC CONTROLLER (ATC) DUTY

**5-1. Medical Standards:**

a. ATCs are not on flying status but must meet special medical standards to be facility rated. Combat controllers are not required to be facility rated to qualify for the 273 XO Air Force specialty code. Medical standards for combat controllers are the same as for Flying Class III. However, if combat controllers are permitted to become facility rated they must meet the special medical standards required for ATCs.

b. The medical conditions listed in chapter 4 and this chapter are cause to reject an examinee for initial ATC duty or continued duty unless a waiver is granted (see attachment 2). Acute medical problems, injuries or their appropriate therapy may be cause for withholding certification for initial training until the problem is resolved. These standards are not all inclusive and other diseases or defects may be cause for rejection based upon the medical judgment of the examining flight surgeon.

c. PES should send questionable cases to MAJCOM/SG for review and certification action.

**5-2. Ear, Nose, and Throat:**

a. Symptomatic Allergic Rhinitis, seasonal and perennial. Allergic rhinitis, controlled solely by desensitization or use of nasal steroid sprays is not disqualifying.

b. Any acute or chronic disease of the middle or inner ear.

c. Any disease or malformation of the nose, mouth, pharynx or larynx that might interfere with enunciation or clear voice communication.

d. Any disturbance of equilibrium.

e. Malformations of the nose which prevent nasal respiration.

f. Any tumor of the sinuses.

**5-3. Hearing:**

a. Hearing loss greater than that specified for H-1 profile for initial selection. Hearing loss greater than that specified for H-2 profile for continued ATC duty. (See attachment 4.)

b. Use of hearing aid.

**5-4. Dental. Same as paragraph 3-5.****5-5. Eye:**

a. Coloboma.

b. Vascular occlusion.

c. Intraocular tension:

(1) Glaucoma, as evidenced by tension of 30 mmHg or greater, or the secondary changes in the optic disc or visual field associated with glaucoma. (See paragraph 10-8.)

(2) Ocular Hypertension (Preglaucoma). Two or more determinations of 22 mmHg or greater but less than 30 mmHg, a difference of 4 mmHg or greater between the two eyes. (See paragraph 10-8.)

d. Any pupillary synechiae.

e. Anisocoria requires clarification and further evaluation by an ophthalmologist.

f. Nystagmus, except end point on convergence testing.

g. Amblyopia.

h. Contact lenses that correct near visual acuity only or that are bifocal, or that are fit with the monovision techniques.

i. Monocularity.

j. Extraocular muscle paralysis or paresis with loss of ocular motility in any direction.

k. Absence of conjugate alignment in any quadrant.

**5-6. Distant Vision:**

a. Uncorrected, worse than 20/100 each eye.

b. Corrected, worse than 20/20 each eye.

**5-7. Near Vision:**

a. Uncorrected, no standard.

b. Corrected vision worse than 20/20 in each eye.

**5-8. Heterotropias and Heterophorias:**

a. Any heterotropia.

b. Heterophorias. More than one prism diopter of hyperphoria, six prism diopters of esophoria, or six prism diopters of exophoria requires a thorough evaluation for other eye pathology by an ophthalmologist for motor and sensory abnormalities. If no other eye pathology is found and all other aspects of the examination are normal, a certificate should be issued.

**5-9. Near Point of Accommodation.** Insufficient accommodation to correctly read official aeronautical charts.

**5-10. Color Vision.** Inability to distinguish aviation signals, red, green, and white.  
NOTE: The X-chrome lens is not acceptable; it does not correct color deficiencies.

**5-11. Depth Perception:**

a. Initial Testing for Air Traffic Control Duty. Failure of the vision test apparatus—near and distant (VTA-ND) screening depth perception test will result in a full ophthalmology or optometry evaluation, to include: ductions, versions, cover test and alternate cover test in 6 cardinal positions of gaze, AO Vectograph Stereopsis Test at 6 meters, AO Suppression Test at 6 meters, Randot Stereopsis Test, and 4 Diopter Base out Prism Test at 6 meters.

b. Continued Air Traffic Control Duty. New failure of the VTA-ND, when passed previously, requires evaluation by an ophthalmologist or optometrist to rule out correctable causes, i.e. refractive error, anisometropia or macular disease. If the ATC has previously failed the VTA-ND and passed the near stereopsis test (Verheoff or Randot), no further workup is required.

**5-12. Visual Fields.** Any visual field defect.

**5-13. Night Vision.** Unsatisfactory night vision as determined by history for initial ATC duty. In trained controllers, this history will be confirmed by the appropriate electrophysiological tests requested by the Aeromedical Consultation Service ophthalmologists. Dark field and empty field myopia due to accommodation are normal physiologic responses.

**5-14. Lungs and Chest Wall:**

- a. Emphysema, if symptomatic.
- b. Pleurisy, either acute fibrinous or with effusion.
- c. Pneumothorax until resolved and it has been determined that no condition is present which would be likely to cause recurrence.
- d. Other diseases or defects of the lungs or chest wall which require the use of medication.

**5-15. Cardiovascular System:**

- a. Myocardial infarction, angina pectoris, or other evidence of coronary heart disease.

b. Any dysrhythmia except sinus arrhythmia or occasional premature atrial contractions (PAC) or premature ventricular contractions (PVC) not due to organic heart disease.

c. Cardiac decompensation.

d. Congenital heart disease accompanied by cardiac enlargement, ECG abnormality, or evidence of inadequate oxygenation.

e. Any heart murmur except functional.

f. Pericarditis, endocarditis, or myocarditis.

g. Aortic stenosis or insufficiency, mitral stenosis or insufficiency.

h. Aneurysm or AV fistula of a major vessel.

i. Peripheral edema, other than simple postural pretibial edema.

j. Peripheral vascular disease.

k. Syncope, threatened or actual during examination.

l. Use of anticoagulant medications.

m. Hypertension, or history of hypertension on antihypertensive medication. Maximum allowable blood pressure by age group after 6 months of unsuccessful non-pharmacological treatment from the date the elevated blood pressure was first identified is:

Age Group	Systolic	Diastolic
Up through 29	140	88
30 through 39	145	90
40 through 49	155	90
50 and Over	160	90

n. Resting pulse rate greater than 100 or less than 50 beats per minute.

o. ECG evidence of conduction defects, to include Wolff-Parkinson-White syndrome with or without a history of paroxysmal atrial tachycardia.

p. Unequivocal ECG evidence to include ventricular strain.

q. History of, or clinical diagnosis of, symptomatic hypertension.

**5-16. Blood, Bloodforming Tissues, and Immune System:**

a. Anemia manifested by a hemoglobin of less than 12 grams per 100 cubic centimeters (gm/100cc) blood.

b. Hemophilia.

c. Polycythemia.

d. Any other disease of the blood or bloodforming tissues which could adversely affect performance.

**5-17. Abdomen and Gastrointestinal System:**

a. Peptic ulcer disease or any complication of peptic ulcer disease. An uncomplicated ulcer that has been inactive for 3 months and does not require medication (except the occasional use of antacids) is not disqualifying.

b. Cholelithiasis.

**5-18. Genitourinary System:**

a. History of recurrent or bilateral renal calculus; or retained renal calculi.

b. Nephrosis.

c. Congenital lesions such as ectopic or horseshoe kidney, unilateral agenesis of kidney, and hypoplasia or dysplasia of kidney.

d. Cystostomy.

e. Neurogenic bladder.

f. Renal transplant.

**5-19. Neurological Disorders:**

a. Any medically unexplained disturbance of consciousness or surgical intervention was necessary to correct the precipitating cause.

b. Any recurring headaches of the vascular, migraine, or cluster (Horton's cephalgia or histamine headache) type or incapacitating tension headaches.

c. Vertigo or dysequilibrium disorders.

d. Cerebrovascular disease to include transient ischemic attack (TIA), cerebral infarction, thrombotic or embolic, or transient global amnesia.

e. Pseudotumor cerebri (benign intracranial hypertension).

f. Hydrocephalus with and without shunts.

g. Demyelinating and autoimmune diseases.

h. Extrapyramidal, hereditary, and degenerative diseases of the nervous system.

i. Infections of the nervous system.

**5-20. Psychiatric Disorders:**

a. An ATC who meets the DSM-III diagnostic criteria for alcohol abuse or alcohol dependence will be restricted from ATC duties until medically disqualified or waived by MAJCOM/SG after the following conditions have been met:

(1) The substance abuse recommendation and treatment (SART) committee (see AFR 30-2) determines that individual has made satisfactory progress and has maintained abstinence without needing medications for a recurrence of 6 months from the date of entering the Track 4 treatment phase of the SART program.

**NOTE:** Any slips during the SART program

will reset the 6-month observation period for waiver consideration.

(2) In the opinion of the flight surgeon, psychiatrist or clinical psychologist, and the unit commander, and based on the SART Treatment and Progress Evaluation, the individual has a low potential for recidivism and can be expected to remain stable under stress.

(3) The individual has no medical complications or sequelae due to past alcohol abuse or dependence.

(4) The individual states in writing that he or she understands the waiver is valid only if total abstinence from alcohol is maintained and that a verifiable break in abstinence once the waiver period has begun will be considered medically disqualifying and not waiverable. To ensure unit commanders are aware of the need to observe individuals with past alcohol problems, new commanders will be briefed on those in their units with waivers when the individual changes assignment or there has been a change of command.

b. The fear of controlling, if a diagnosis of simple phobia (300.29) meets the criteria in DSM III. Only a military psychiatrist or psychologist can make this diagnosis. If a DSM III diagnosis of simple phobia is not established, then fear of controlling is not a medical disqualification, but must be handled administratively.

c. A personality disorder that is severe enough to have repeatedly manifested itself by overt acts disqualifies the individual from ATC duties, but can not be used as a medical reason for separation from active duty (see AFR 36-2 or AFR 39-10).

d. Depressive episodes requiring medication or involving suicidal ideation.

e. All organic brain syndromes.

**5-21. Musculoskeletal, Spine, and Extremities:**

a. Amputation of any extremity or any portion thereof enough to interfere with performance of duties.

b. Any deformity, limitation of motion, or muscle atrophy of the upper or lower extremities sufficient to interfere with duty performance.

c. Active disease of bones and joints, including arthritis.

d. Curvature, ankylosis, or other marked deformity of the spinal column sufficient to interfere with duty performance.

e. Other disturbances of musculoskeletal function, congenital or acquired, sufficient to interfere with duty performance or likely to progress.

**5-22. Endocrine and Metabolic:**

- a. Acromegaly.
- b. Diabetes insipidus.
- c. Hypoglycemia, whether functional or a result of pancreatic tumor.

**5-23. Miscellaneous Causes for Rejection:**

a. Continuous treatment with anti-histaminic, narcotic, barbiturate, mood ameliorating, tranquilizing, motion sickness, steroid, antihypertensive, or ataractic drugs. If any of these medications are used for acute illness, it is the individual's responsibility to not perform air traffic control duties while taking these medications. Base-level flight surgeons should monitor the use of these medications on an acute basis and record such use on AF Form 1042.

b. Exacerbation of any medical condition for which a waiver has been granted.

c. Any malignancy. **NOTE:** Basal cell, squamous cell carcinomas, and carcinoma-in-situ of the cervix which have been adequately excised (as evidenced by pathology report, or basal cell carcinoma which has been treated by electrodesication and curretage by a derma-

tologist credentialed to perform the procedure) and exempted from tumor board action (as specified in AFR 160-64) are not disqualifying.

**5-24. Medical Clearance.** The local flight surgeon must clear any ATC receiving medication, injection, immunization, or treatment (to include dental treatment) which would affect his or her alertness, judgment, equilibrium, vision, speech, or state of consciousness before he or she can assume duty involving control or communication with air traffic.

**5-25. Scope of Examination:**

a. HIV antibody testing is required for all applicants for initial ATC duty. Record the results of cholesterol, HDL, and triglycerides in item 50, SF 88.

b. An adaptability rating for air traffic control (AR-ATC) duty and a reading aloud test (RAT) is required for all applicants for initial ATC duty. Record the results in item 72, SF 88. The RAT and instructions are in AFR 160-13, Medical Examination of Applicants for United States Service Academies, Reserve Officer Training Corps (ROTC) Scholarship Programs, Including the Air Force, Army, and Navy Two- and Three-Year College Scholarship Programs (CSP), and the Uniformed Services University of the Health Sciences (USUHS).

## Chapter 6

## MEDICAL STANDARDS FOR FLYING DUTY

**6-1. General Waiver Information.** The medical conditions listed in chapter 4 and this chapter are cause to reject an examinee for initial flying training (all classes), or continued flying duty (classes II or III) unless a waiver is granted (see paragraph 1-7). Acute medical problems, injuries, or their appropriate therapy may be cause for withholding certification for initial flying training until the problem is resolved. Any condition that in the opinion of the flight surgeon presents a hazard to flying safety, the individual's health, or mission completion is cause for temporary disqualification for flying duties. To be considered waivable, any disqualifying condition should meet the following criteria:

- a. Must not pose a risk of sudden incapacitation.
- b. Must not pose any potential risk for subtle incapacitation that might not be detected by the individual, but could affect alertness, the special senses, or information processing.
- c. Must have resolved or be stable at the time of waiver.
- d. If the possibility of progression or recurrence exists, the first symptoms or signs of such must be easily detectable and cannot, of themselves, pose risk to the individual or the safety of others.
- e. Cannot require exotic tests, regular invasive procedures, or frequent absences to monitor for stability or progression.

**6-2. Medical Examination for Flying:**

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

(1) Flying Class I qualifies for selection, entry into, and during undergraduate pilot training.

(2) Flying Class IA qualifies for selection, entry into, and during undergraduate navigator training.

(3) Flying Class II qualifies rated officers and those physician applicants for Aerospace Medicine Primary training.

(4) Categorical Flying Class II qualifies rated officers for duty in certain restricted aircraft categories.

(a) Flying Class IIA qualifies rated officers for duty in tanker, transport, bomber aircraft.

(b) Flying Class IIB qualifies rated officers for duty in non-ejection seat aircraft.

(c) Flying Class IIC qualifies rated officers for aviation duty as specified in the remarks section of AF Form 1042, Medical Recommendation for Flying or Special Operational Duty, and as annotated on the SF 88. Restriction to a single aircraft type is not permitted. These waivers are coordinated with HQ USAF/XOOT.

(5) Flying Class III qualifies all non-rated personnel.

b. Medical examinations are required when:

(1) Individual applies for initial flying duty (all classes).

(2) Officers holding comparable status in other US military services apply for US Air Force aeronautical ratings.

(3) Personnel, including personnel of the Air Reserve Forces, are ordered to participate in frequent and regular aerial flight.

(4) Flying personnel, including personnel of the Air Reserve Forces, have been suspended from flying status for 12 months or more for medical reasons, applying for return to flying duties.

(5) Flying personnel are ordered to appear before a Flying Evaluation Board (FEB). (See AFR 60-13.)

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

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

(1) Flying personnel have been involved in an aircraft accident (see AFR 127-4).

(2) A commander or flight surgeon considers that a member's medical qualifications for flying duty may have changed.

(3) Flying personnel report to a new base.

d. Only the following medical personnel can perform flying examinations:

(1) Flight surgeons may conduct medical examinations for flying. Departments of the

Army and Navy medical officers trained as flight surgeons are included to the extent of their authorization by their respective departments.

(2) US Air Force flight surgeons on extended active duty may conduct examinations for undergraduate flying training (UFT) (Flying Class I or IA).

#### **EXCEPTIONS:**

1. Air Reserve Forces flight surgeons, performing duty in a active duty medical treatment facility and supervised by the chief of aerospace medicine, may conduct examinations for UFT. These examinations will be reviewed according to the procedures in AFR 160-17.

2. AANG medical units, approved by the ANG Surgeon (NGB/ SG), may conduct medical examinations for UFT. ANGRC/SGP personnel will personally review and certify these examinations for accuracy and completeness before forwarding to Air Training Command.

e. The examining flight surgeon will handle disqualifying defects in the following manner:

(1) Make sure all initial Flying Class I and IA examinations are completed. Send completed SFs 88 and 93 to appropriate certifying authority as explained in attachment 2 through requesting agency, such as CBPO, USAF Recruiting, ROTC Detachment, etc. The examining flight surgeon must completely identify, describe, or document the disqualifying defects and sign SF's 88 and 93.

(2) Discontinue initial Flying Class II, III, or ATC qualification examinations when a disqualifying defect is found, if that defect is unlikely to receive favorable waiver consideration. Complete SF 88 for items 1 through 15, 73, 74, and any items pertaining to the disqualifying defect. Send the abbreviated SF 88 with appropriate signatures and a letter of transmittal to the appropriate waiver authority for review and certification. Notification of CBPO of medical status is required.

(3) Forward a copy of SF 88 on all disqualifications of trained personnel to appropriate MAJCOM/SG for inclusion in the WAVR file.

#### **6-3. Head, Face, Neck, and Scalp (Flying Classes I, IA, II, and III):**

- a. Injuries to the head. (See paragraph 6-25.)
- b. Loss or congenital absence of bony substance of the skull.
- c. Chronic arthritis, complete or partial ankylosis, or recurrent dislocation of the temporomandibular joint.

d. Congenital cysts of branchial cleft origin or those developing from the remains of a thyroglossal duct, with or without fistulous tracts.

e. Chronic draining fistulae of the neck, regardless of cause.

f. Contractions of the muscles of the neck if persistent or chronic. Cicatricial contracture of the neck to the extent it interferes with function or the wear of equipment.

g. Cervical ribs if symptomatic or symptoms can be induced by abduction, scalenus, or costoclavicular maneuvers.

h. Disorders of the thyroid gland. (See paragraph 6-30a(7).)

i. Any anatomic or functional anomaly of head or neck structures, which interfere with normal speech, ventilation of the middle ear, breathing, mastication, swallowing, or wear of aviation or other military equipment.

#### **6-4. Nose, Sinuses, Mouth, and Throat:**

##### **a. Flying Classes II and III:**

(1) Allergic rhinitis, unless mild in degree and considered unlikely to limit the examinee's flying activities. Waivers will be considered if symptoms are controlled by desensitization or topical medication (or both).

(2) Chronic nonallergic or vasomotor rhinitis, unless mild, asymptomatic, and not associated with eustachian tube dysfunction or unless controlled by intermittent topical medication.

(3) Nasal polyps.

(4) Deviations of the nasal septum, septal spurs, enlarged turbinates or other obstructions to nasal ventilation which result in clinical symptoms. Symptomatic atresia or stenosis of the choana.

(5) Epistaxis, chronic, recurrent.

(6) Chronic sinusitis unless mild in degree and considered unlikely to limit the examinee's flying activities.

(7) Recurrent calculi of the salivary glands or ducts.

(8) Deformities, injuries, or destructive diseases of the mouth (including teeth), nose, throat, pharynx, or larynx that interfere with ventilation of the paranasal sinuses and, or middle ear, breathing, speech, or mastication and swallowing of ordinary food.

(9) Atrophic rhinitis.

(10) Perforation of the nasal septum.

(11) Anosmia or parosmia.

(12) Salivary fistula.

(13) Ulcerations, perforation, or extensive loss of substance of the hard or soft palate; extensive adhesions of the soft palate to the pharynx; or complete paralysis of the soft palate. Unilateral paralysis of the soft palate which does not interfere with speech or swallowing and is otherwise asymptomatic is not disqualifying.

(14) Chronic pharyngitis and nasopharyngitis.

(15) Significant abnormalities of the larynx, trachea, and esophagus to include:

(a) Chronic laryngitis. Neoplasm, polyps, granuloma, or ulceration of the larynx.

(b) Aphonia or history of recurrent aphonia if the cause was such as to make subsequent attacks probable. Painful Dysphonia Plicae Ventricularis.

(c) Tracheostomy or tracheal fistula.

(d) Malformations, injuries or diseases of the esophagus, such as ulceration, diverticulum, varices, stricture, achalasia, pronounced dilation, or peptic esophagitis.

b. Flying Classes I and IA. In addition to the above:

(1) A verified history of allergic, nonallergic, or vasomotor rhinitis, after age 12.

(2) Any surgical procedure for sinusitis, polyposis or hyperplastic tissue. Waiver may be considered if recovery is complete and individual has been asymptomatic for 1 year.

#### **6-5. Ears:**

##### a. Flying Classes II and III:

(1) History of surgery involving the middle ear, excluding cholesteatoma in (8) below. Residual of mastoid surgery.

(2) Inability to perform the VALSALVA maneuver.

(3) Perforation of the tympanic membrane. Surgery to repair perforated tympanic membrane is disqualifying until healing is complete.

(4) Tinnitus when associated with active disease.

(5) Abnormal labyrinthine function.

(6) Recurrent episodes of vertigo with or without nausea, vomiting, tinnitus, and hearing loss.

(7) Any conditions that interfere with the auditory or vestibular functions.

(8) Cholesteatoma or history of surgical removal of cholesteatoma. Small cholesteatomas, confined to the middle ear or removed entirely without significant loss of the posterior ear ca-

nal wall may be considered for waiver on a case-by-case basis.

(9) Atresia, tuberosity, severe stenosis or tumors of the external auditory canal which prevents an adequate view of the tympanic membrane or effective therapeutic access to the entire external auditory canal.

b. Classes I and IA. In addition to the above:

(1) History of radical mastoidectomy.

(2) History of abnormal labyrinthine function, unexplained or recurrent vertigo.

(3) Surgical repair of perforated tympanic membrane within the last 120 calendar days.

**6-6. Hearing,Flying Class II and III.** Hearing loss greater than H-1 profile. See attachment 4. Progressive pure tone hearing losses greater than or equal to 30dB at 2000Hz require a full audiologic evaluation by a certified military audiologist; losses equal or greater than 50dB at 2000Hz require as ACS evaluation. In-flight hearing test (as described in SAM-TR-73-29) are required for all initial waivers and any renewal if there has been any changes in hearing.

#### **6-7. Dental:**

##### a. Flying Classes II and III:

(1) Personnel who have active orthodontic appliances need not have appliances removed for physical qualification. After consultation with the treating orthodontist, the local flight surgeon may qualify the individual for flying duties if there is no effect on speech or the ability to wear equipment with comfort.

(2) Severe malocclusion which interferes with normal mastication or requires protracted treatment.

(3) Diseases of the jaw or associated structures such as cysts, tumors, chronic infections, and severe periodontal conditions which could interfere with normal mastication, until adequately treated.

b. Classes I and IA. In addition to the above:

(1) Dental defects such as carious teeth, malformed teeth, defective restorations, or defective prostheses, until corrected.

(2) Anticipated or ongoing treatment with fixed orthodontic appliances.

**6-8. Eye, Classes I, IA, II, and III:****a. Lids:**

(1) Any condition of the eyelids which impairs normal eyelid function or comfort or potentially threatens visual performance.

(2) Ptosis which interferes with vision in any field of gaze or direction.

**b. Conjunctiva:**

(1) Conjunctivitis, chronic, seasonal.

(2) Trachoma, unless healed without scarring.

(3) Xerophthalmia.

(4) Pterygium which encroaches on the cornea more than 1 mm, interferes with vision.

**c. Cornea:**

(1) Chronic keratitis.

(2) Corneal ulcer of any kind, including history of recurrent corneal ulcers or recurrent corneal erosions.

(3) Vascularization or opacification of the cornea, from any cause, when it is progressive, interferes with vision or causes refractive problems.

(4) Corneal dystrophy of any type, including keratoconus of any degree.

(5) History of radial keratotomy or other surgical or laser procedures accomplished to modify the refractive power of the cornea is not waivable.

**d. Uveal Tract.** Chronic or recurrent inflammation of the uveal tract (iris, ciliary body, or choroid), except for healed traumatic iritis.

**e. Retina/Vitreous:**

(1) History of detachment of the retina.

(2) Degenerations and dystrophies of the retina and, or macula, macular cysts and holes. All types of pigmentary degenerations (primary and secondary).

(3) Retinitis, chorioretinitis, or other inflammatory conditions of the retina, unless sin-

gle episode which has healed, is expected not to recur, and does not interfere with vision.

(4) Angiomatoses, phakomatoses, retinal cysts and other conditions which impair vision.

(5) Hemorrhages, exudates or other retinal vascular disturbances.

(6) Vitreous opacities or disturbances which may cause loss of visual acuity.

**f. Optic Nerve:**

(1) Optic neuritis, of any kind, including retrobulbar neuritis, papillitis, neuroretinitis, or a documented history of same.

(2) Papilledema.

(3) Optic atrophy (primary or secondary).

**g. Lens:**

(1) Aphakia, unilateral or bilateral.

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

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

(4) Pseudophakia (intraocular lens implant).

**h. Other Defects and Disorders:**

(1) Asthenopia, if severe.

(2) Exophthalmos, unilateral or bilateral.

(3) Nystagmus of any type, except endpoint on convergence testing.

(4) Diplopia.

(5) Visual field defects, any type, including hemianopsia.

(6) Loss of normal pupillary reflexes.

(7) Retained intraocular foreign body.

(8) Absence of an eye.

(9) Anophthalmos or microphthalmus.

(10) Any traumatic, organic, or congenital disorder of the eye or adnexa, not specified above, which threatens to permanently impair visual function.

**6-9. Vision and Refraction.** See table 6-1.

**TABLE 6-1****VISION STANDARDS OF AVIATION DUTY**

Flying Class	Vision Limits for Each Eye				Refraction Limits			
	Distant Vision		Near Vision		Any Meridian	Astigmatism	Anisometropia	Contact Lenses
	Uncorrected	Corrected	Uncorr	Corr				
I Civilian	20/20	-	20/20	-	+2.00 -0.25	0.75	2.00	See note 1
I Others (See Note 2)	20/70	20/20	20/20	-	+2.00 -1.50	1.50	2.00	
IA	20/200	20/20	20/40	20/20	+2.00 -1.50	2.00	2.50	
II Pilot	20/400	20/20 (See note 3)		20/20	+2.00 -1.50	2.00	2.50 (See note 4)	(See note 5, 6, and 7.)
II/III	20/400	20/20 (See note 3)		20/20	+5.50 -5.50 (See note 8)	3.00	3.50 (See note 3)	(See note 3, 6, and 7.)

**NOTES:**

1. Use of polymethyl methacrylate (PMMA) or gas permeable (hard) contact lenses within 3 months before the examination or soft contact lenses 1 month before examination is prohibited.
2. These medical standards will apply for Air Force Academy and ROTC cadets at the time of the Air Force commissioning examination, and for US Air Force active duty members and applicants from the Reserve and Guard components during the initial Flying Class examination. By direction of the CSAF, no waivers will be considered.
3. Individuals found on routine examination to be 20/20 in one eye and 20/25 in the other but correctable to 20/20 O. U. may continue flying until the appropriate corrective lenses arrive. These lenses must be ordered by the most expeditious means.

4. Anisometropias greater than Flying Class II or III standards may be considered for waiver if the VTA-ND stereopsis is normal and the aviator has no asthenopic symptoms due to poor fusion, control, or diplopia.
5. Complex refractive errors that can be corrected only by contact lenses are disqualifying.
6. All aircrewmembers are prohibited from using contact for treatment of medical conditions unless they have been specifically prescribed and issued by the ACS.
7. Optional wear of contact lenses for aircrewmembers is outlined in attachment 9.
8. Waivers may only be considered when the individual has normal ophthalmological examination to include retina and possesses plastic lens spectacles which correct them to 20/20 in both eyes and meet the US Air Force standards for commercially obtained spectacles for aircrew duties.

**6-10. Heterophoria and Heterotropia:****a. Flying Class III:**

- (1) Esophoria greater than 15 prism diopters.
- (2) Exophoria greater than 8 prism diopters.
- (3) Hyperphoria greater than 2 prism diopters.
- (4) Heterotropia greater than 15 prism diopters.

**b. Flying Class I, IA, and II:**

- (1) Esophoria greater than 10 prism diopters.
- (2) Exophoria greater than 5 prism diopters.
- (3) Hyperphoria greater than 1.5 prism diopters.
- (4) Heterotropia, including microtropias.
- (5) Point of convergence (PC) greater than 70 mm.

(6) History of extraocular muscle surgery is cause for complete evaluation of ocular motility by an ophthalmologist to look for residual heterophorias, heterotropias (including microtropias), and motor/sensory problem.

**6-11. Near Point of Accommodation:**

- a. Flying Classes II and III. No standards.
- b. Flying Classes I and IA. Near point of accommodation less than minimum for age specified in attachment 8.

**6-12. Color Vision, Classes I, IA, II, and III.** Five or more incorrect responses, including failures to make responses within 2 seconds, in reading the 14 test charts of the standard color vision test set (VTS-CV) administered under the standard color perception testing easel light. Even though the VTS-CV has been failed, passing the Farnsworth Lantern (FALANT) is acceptable for all flying class III. (See AFR 160-17.) Flight surgeon applicants with defective color vision may be considered for IIA waiver.

**6-13. Depth Perception:**

- a. Flying Class III. No standard unless specified in chapter 7.
- b. Flying Class I, IA and II-Flight Surgeon Applicant. Failure of the vision test apparatus-near and distant (VTA-ND) screening depth perception test will be considered for waiver only after a full ophthalmology or optometry evaluation, to include: ductions, versions, cover

test and alternate cover test in primary and 6 cardinal positions of gaze, AO Vectograph Stereopsis Test at 6 meters, AO Suppression Test at 6 meters, Randot Stereopsis Test, and 4 Dioptric Base out Prism Test at 6 meters. These tests are designed to identify motility disorders, especially microtropias and monofixation.

**c. Flying Class II and III-Inflight Refuellers.** New failure of the VTA-ND, when passed previously, requires evaluation by an ophthalmologist or optometrist to rule out correctable causes, i.e. refractive error, anisometropia or macular disease. If the aviator has previously failed the VTA-ND and passed the near stereopsis test (Verheoff or Randot), no further workup is required.

**6-14. Field of Vision:****a. Flying Classes II and III:**

(1) Contraction of the normal visual field in either eye of 15 degrees or more in any meridian.

(2) Scotoma which is due to active pathological process.

(3) Any scotoma that is the result of a healed lesion unless the resulting deficit will not compromise flying safety or mission completion.

**b. Flying Classes I and IA.** In addition to the above, any demonstrable scotoma other than physiologic.

**6-15. Night Vision, Classes I, IA, II, and III.** Unsatisfactory night vision as determined by history for classes I and IA. In trained aviators, this history will be confirmed by the appropriate electrophysiological tests requested by the Aeromedical Consultation Service ophthalmologists. Dark field and empty field myopia due to accommodation are normal physiologic responses.

**6-16. Red Lens Test:****a. Flying Classes II and III.** No standards.

**b. Flying Classes I and IA.** Any diplopia or suppression during the Red Lens Test which develops within 20 inches of the center of the screen is considered a failure. Complete evaluation of ocular motility by a qualified ophthalmologist who will render an opinion as to the reason for the failure. (See AFR 160-17.)

**6-17. Intraocular Tension, Flying Classes I, IA, II, and III:**

a. Glaucoma. As evidenced by tension 30 mmHg or greater, or the secondary changes in the optic disc or visual field associated with glaucoma (see paragraph 10-8).

b. Ocular Hypertension (Preglaucoma).

Two or more determinations of 22 mmHg or greater but less than 30 mmHg, or 4 mmHg or more difference between the two eyes. (See paragraph 10-8.) **NOTE:** Abnormal pressures obtained by a "puff" tonometer should be verified by applanation or Schiotz tonometry.

#### **6-18. Lungs and Chest Wall:**

a. Flying Classes II and III:

(1) Pulmonary tuberculosis, including tuberculous pleuritis or pleurisy of unknown etiology with positive tuberculin test, unless the disease has remained inactive for at least 1 year after completion of an adequate course of anti-tuberculous therapy and clinical tests for active disease are negative. Surgical treatment of tuberculosis is disqualifying for a period of 1 year after surgery and until absence of residual effects is substantiated by normal pulmonary function and exercise tolerance testing.

(2) History of a recurrent spontaneous pneumothorax.

**NOTES:**

1. A single episode of spontaneous pneumothorax will not require waiver if PA inspiratory and expiratory chest radiograph and thin-cut CT-scan, show full expansion of the lung and no demonstrable pathology which would predispose to recurrence.

2. Recurrent pneumothorax. Waiver can only be considered after surgical correction and demonstration of normal pulmonary function after an observation period of 6 months.

(3) Pulmonary blebs or bullae, unless corrected by surgical treatment, recovery is complete, and pulmonary function tests are normal. Blebs or bullae which clearly communicate with the bronchial tree and otherwise do not require surgery may be considered for waiver upon recommendation by a pulmonary specialist.

(4) Bronchiectasis, unless corrected by surgical treatment, recovery is complete, and pulmonary function tests are normal.

(5) Sarcoidosis. Waiver may be considered if the disease has been demonstrated to be inactive and no evidence of other organ system involvement (See Chapter 10).

(6) Pleural effusion.

(7) Empyema, residual sacculation or unhealed sinuses of the chest wall following surgery for empyema.

(8) Chronic bronchitis if pulmonary function is impaired to such a degree as to interfere with duty performance or to restrict activities.

(9) Asthma of any degree, or a history of asthma, reactive airway disease, intrinsic or extrinsic bronchial asthma, exercise-induced bronchospasm, or IgE (Immunoglobulin E) mediated asthma, except a history of childhood asthma with a trustworthy history of complete freedom from symptoms since the 12th birthday.

(10) Bullous or generalized pulmonary emphysema, demonstrated by pulmonary function tests.

(11) Cystic disease of the lung. Waiver may be considered after surgical resection and a normal pulmonary evaluation.

(12) Silicosis or extensive pulmonary fibrosis with functional impairment or abnormal pulmonary function tests.

(13) History of lung abscess. Waiver may be considered when treatment is complete and pulmonary function and exercise tolerance tests normal.

(14) Chronic mycotic infection of the lung. Residuals of infection, including cavitation, except for scattered nodular parenchymal and hilar calcifications.

(15) Foreign body in the trachea, bronchus, lung, or chest wall.

(16) Chronic adhesive (fibrous) pleuritis of sufficient extent to interfere with pulmonary function and exercise tolerance.

(17) History of bi-lobectomy, lobectomy or multiple segmental resections if there is significant reduction of vital capacity, timed vital capacity, or maximum breathing capacity, or if there is residual pulmonary pathology.

(18) Suppurative periostitis, osteomyelitis, caries, or necrosis of the ribs, sternum, clavicle, scapulae, or vertebrae.

(19) Congenital malformation or acquired deformities which reduce the chest capacity or diminish respiratory or cardiac functions to a degree which interferes with vigorous physical exertion or produce disfigurement when the examinee is dressed.

(20) Chronic cystic mastitis.

(21) History of pulmonary embolus.

(22) Silicone injections or saline or silicone filled implant encapsulation in breast or chest.

b. Flying Classes I and IA. In addition to the above:

(1) History of spontaneous pneumothorax.

A single episode may be considered for waiver after 3 years if pulmonary evaluation shows complete recovery with full expansion of the lung and no demonstrable pathology that would predispose to recurrence.

(2) Chronic adhesive pleuritis which produces any findings except minimal blunting of the costophrenic angles.

(3) History of sarcoidosis.

#### **6-19. Cardiovascular System:**

a. Flying Classes II and III:

(1) History of cardiac surgery. Waiver may be considered for atrial septal defect, ventricular septal defect and patent ductus arteriosus which have been surgically repaired without evidence of any residual defects.

(2) Heart pump failure, regardless of cause.

(3) Hypertrophy or dilatation of the heart verified by echocardiogram, unless evaluation demonstrates it to be normal physiological response to athletic conditioning.

(4) Persistent tachycardia with a resting pulse rate of more than 100.

(5) Elevated blood pressure (measured in the sitting position) as follows:

(a) In applicants for flying training or initial flying duty (measured in the sitting position) evidenced by average systolic pressure greater than 140 mmHg, or average diastolic pressure of greater than 90 mmHg obtained from the 5-day blood pressure check outlined in paragraph 10-3. History of elevated blood pressure requiring chronic medication for control.

(b) In trained flying personnel evidenced by:

1. Average systolic blood pressure greater than 140 mmHg or average diastolic blood pressure greater than 90 mmHg.  
**NOTE:** Asymptomatic personnel with average systolic blood pressure ranging between 141 mmHg and 160 mmHg, or average diastolic blood pressure ranging between 91 mmHg and 100 mmHg, may remain on flying status for up to 6 months (from the date the elevated blood pressure was first identified) while undergoing non-pharmacological intervention. If blood pressure is not controlled by non-pharmacological intervention at the end of that period, the individual must be placed in DUTY NOT INVOLVING FLYING (DNIF) status. (Refer to

paragraph 6-32a(4) for procedures to follow when maintenance medication is required.)

2. Any elevation in blood pressure due to secondary metabolic or pathologic causes until the underlying cause has been corrected, provided the primary condition is not disqualifying.

(6) Orthostatic or symptomatic hypotension.

(7) Pericarditis, myocarditis, or endocarditis, or history of these conditions.

(8) Major congenital abnormalities and defects of the heart and vessels, unless corrected by surgery without residuals or complications. Uncomplicated dextrocardia and other minor asymptomatic abnormalities, such as minor ventricular septal defect, or atrial septal defect may be acceptable. A minimum recovery period of 6 months following surgery is mandatory before consideration together with repeat studies including invasive testing as applicable, demonstrating functional correction.

(9) Acute rheumatic fever; a verified history of rheumatic fever or chorea within the previous 2 years; recurrent attacks of rheumatic fever or chorea at any time; evidence of residual cardiac damage.

(10) Coronary artery disease, symptomatic or asymptomatic. History of myocardial ischemia. Coronary artery disease strongly suspected by symptoms or tests for myocardial ischemia or infarction unless ruled out by angiography. History of coronary artery surgery or other intervention is not waivable.

(11) History of major dysrhythmia, symptomatic or asymptomatic. Major dysrhythmias include atrial tachycardia, flutter, or fibrillation, sustained supraventricular tachycardia, ventricular tachycardia or fibrillation, multifocal premature ventricular contractions, and asystole. **NOTE:** The following dysrhythmias require ACS evaluation before waiver consideration: atrial fibrillation or flutter, sustained or recurrent supraventricular tachycardia, ventricular tachycardia (three or more consecutive premature beats, including multifocal atrial tachycardia), and frequent supraventricular or ventricular pairs. The following dysrhythmias require ACS review of local non-invasive evaluation before waiver consideration: non-sustained supraventricular tachycardia, multifocal ventricular premature ectopy, ventricular premature R wave on preceding T wave, ventricular or supraventricular pairing, bigeminy, trigeminy, or quadrigeminy.

(12) Verified history of electrocardiographic evidence of major conduction defects, such as Mobitz II second degree A-V block, third degree A-V block, Wolff-Parkinson-White (WPW) syndrome, or Lown-Ganong-Levin syndrome. First degree A-V block, complete right bundle-branch block, Mobitz I second degree A-V block (Wenckebach) and WPW pattern, are acceptable without waiver if complete cardiac evaluation reveals no underlying disease.

(13) Anterior and posterior hemi-fascicular block and left bundle branch block may be considered for waiver if complete cardiology evaluation reveals no underlying disease.

(14) History of any organic valvular disorders of the heart including mitral valve prolapse (MVP) and those improved by surgery. NOTE: Rated personnel found to have MVP may be considered for waiver by HQ AFMOA/SGPA following ACS evaluation. Nonrated aircrew members with MVP may be considered for waiver by the waiver authority specified in attachment 2 following complete local cardiac evaluation, to include echocardiogram and Holter monitor studies, if there is no history of tachyarrhythmia, conduction defect, chest pain syndrome, near syncope, syncope, or orthostatic symptoms and no hemodynamically significant mitral regurgitation.

(15) Resting ECG findings considered to be "borderline," or known to be serial changes from previous records unless a cardiac evaluation reveals no underlying disease.

(16) All electrocardiographic tracings read as abnormal. Waiver will not be considered until evaluation recommended by ACS has been completed.

(17) Borderline or abnormal noninvasive cardiac studies. NOTE: For rated officers, send copies of any ECG, echocardiogram, Holter monitor, thallium scan, and ETT-TM to the ECG library file.

(18) History of recurrent thrombophlebitis or thrombophlebitis with persistent thrombus, evidence of circulatory obstruction, or deep venous incompetence in the involved veins.

(19) Varicose veins with complications or if more than mild.

(20) Peripheral vascular disease, including Raynaud's disease, thromboangiitis obliterans, erythromelalgia, arteriosclerotic, or diabetic vascular disease.

(21) Aneurysm of any vessel or history of correction by surgery.

(22) Syphilitic heart disease.

(23) Significant traumatic heart disease. Surgical correction may be acceptable if no residual cardiac abnormalities are noted after a 3-6 month observation period.

(24) Hypersensitive carotid sinus.

(25) Arteritis of any artery.

(26) Inadequate arterial blood supply to any extremity.

b. Flying Classes I and IA. In addition to the above:

(1) Complete right bundle-branch block if associated with underlying heart disease.

(2) Wolff-Parkinson-White electrocardiographic findings.

(3) History of cardiac surgery including all modalities of bypass tract ablation.

(4) Any significant congenital abnormality. Atrial septal defect, ventricular septal defect or patent ductus arteriosus may be considered for waiver after surgical repair if no residual dysfunction or abnormalities are present after 6 month observation period.

(5) History of documented supraventricular or ventricular tachydysrhythmias including fibrillation, flutter, tachycardia (three or more consecutive premature ectopic beats including multifocal atrial tachycardia), or incapacitation from a dysrhythmia or cardiac arrest.

(6) Any major vascular synthetic graft.

(7) Elevated blood pressure (see a(5) above)

#### **6-20. Blood, Blood-Forming Tissue, and Immune System Diseases. Flying Classes I, IA, II, and III:**

a. Hematocrit values outside the range of 38 to 50 percent for men and 36 to 47 percent for women should be evaluated. The lowest permissible hematocrit for certification is 32 percent. Decreasing hematocrit values, even within the range of normal, may be an indication for workup. Loss of 200cc or more of blood is disqualifying for at least 72 hours following the loss (includes blood donors).

b. Anemia of any etiology.

c. Myelophthisic anemia, myeloma, macroglobulinemia, leukemias and lymphomas.

d. Polycythemia. Waivers will not be favorably considered if the hematocrit is above 55 percent.

e. Hemoglobinopathies and thalassemias.

(1) Homozygous hemoglobin abnormalities.

(2) Sickle cell disease or heterozygous sickling disorders other than sickle cell trait.

(3) Sickle cell trait if the individual has a history of symptoms associated with a sickling disorder or symptomatology attributable to intravascular sickling during decompression in an altitude chamber. Review and certification by proper authority (see attachment 3) is required for all aircrew members with sickle cell trait after evaluation as outlined in paragraph 10-11.

**f. Hemorrhagic states and thromboembolic disease:**

- (1) Coagulopathies such as hemophilia.
- (2) Thromboembolic disease, except for acute, non-recurrent conditions.

(3) Thrombocytopenia or thrombocytosis. Platelet counts less than 100,000/mm<sup>3</sup> or greater than 400,000/mm<sup>3</sup> should be evaluated. Thrombocytosis greater than 750,000/mm<sup>3</sup> is disqualifying. Qualification is appropriate if there is temporary, secondary (reactive) thrombocytosis of less than 750,000/mm<sup>3</sup> that has resolved and platelet counts have been consistently normal.

(4) Platelet dysfunctions.

g. Leukopenia (Granulocytopenia). White blood cell counts should fall within the range of 3,500 to 12,000 cells/mm<sup>3</sup>--counts in the range of 750 to 3500/mm<sup>3</sup> should be fully evaluated. Granulocyte counts of less than 750/mm<sup>3</sup> are disqualifying.

h. All leukemias and other myeloproliferative disorders.

i. All lymphomas including mycosis fungoides and Sezary syndrome.

j. Plasma cell dyscrasias.

(1) Multiple myeloma.

(2) Macroglobulinemia.

k. Immunodeficiency syndromes, primary or acquired. Confirmed presence of Human Immunodeficiency Virus (HIV) or antibody. HQ AFMOA/SGPA retains waiver authority for all flying classes.

l. Generalized lymphadenopathy or splenomegaly until the cause is corrected.

**6-21. Abdomen and Gastrointestinal System:**

**a. Flying Classes II and III:**

(1) Gastrointestinal hemorrhage or history of, regardless of cause. Waiver may be considered for any condition that is clearly attributable to a specific, nonpersistent cause.

(2) Single or recurrent uncomplicated peptic ulcers may be considered for waiver after

healing is complete and there is freedom from symptoms without medication.

(3) Peptic ulcer complicated by hemorrhage, obstruction or perforation. Waiver will not be considered unless the following conditions pertain:

(a) Freedom from symptoms for 6 months.

(b) Healing demonstrated by endoscopy.

(c) Absence of continuing need for medications, except sucralfate (see paragraph 6-32a(4)(k).)

(d) Absence of cirrhosis, esophageal varices, neoplasm, erosive gastritis, hiatal hernia and esophagitis, gastric varices or other evidence of portal hypertension and vascular abnormalities (e.g. familial telangiectasia, angiodysplasia).

(e) Appropriate preventive lifestyle changes have been documented.

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

(5) Viral hepatitis until clinical recovery is complete, serum transaminases are normal, tests of synthetic function (especially prothrombin time) are normal and physical activity is not limited.

(6) Wounds, injuries, scars, or weakness of the muscles of the abdominal wall which are sufficient to interfere with function.

(7) Sinus or fistula of the abdominal wall.

(8) Chronic or recurrent esophagitis including reflux esophagitis. Waiver may be considered after healing is complete, there is freedom from symptoms, and no need for maintenance medications.

(9) Chronic gastritis.

(10) Congenital abnormalities of the bowel if symptomatic or requiring surgical treatment. History of intestinal obstruction if due to any chronic or recurrent disease. Surgery to relieve childhood pyloric stenosis or intussusception is not disqualifying if there is no residual dysfunction.

(11) Crohn's disease (regional enteritis).

(12) Malabsorption syndromes (see paragraph 6-30a(13)).

(13) Irritable bowel syndrome.

(14) Ulcerative colitis or proctitis or verified history of same.

(15) Chronic diarrhea, regardless of cause.

(16) Megacolon.

(17) Diverticulitis, symptomatic diverticulosis, or symptomatic Meckel's diverticulum.

(18) Any chronic liver disease whether congenital or acquired. Marked enlargement of the liver from any cause. Hepatic cysts. Congenital hyperbilirubinemias, e.g. Gilbert's disease, do not require waiver if asymptomatic.

(19) Chronic cholecystitis.

(20) Cholelithiasis.

(21) Sphincter of Oddi dysfunction or bile duct abnormalities or strictures.

(22) Pancreatitis or history of same. Congenital anomalies or disease of the pancreas.

(23) Chronic enlargement of the spleen.

(24) Splenectomy, for any reason except the following:

(a) Trauma to an otherwise healthy spleen.

(b) Hereditary spherocytosis.

(c) Disease involving the spleen when followed by correction of the condition.

(d) Causes unrelated to disease of the spleen.

(25) History of gastroenterostomy, gastrointestinal bypass, stomach stapling, or surgery for relief of intestinal adhesions.

(26) Symptomatic esophageal motility disorders.

(27) History of partial resection of the large or small intestines for chronic or recurrent disease.

b. Flying Class I and IA. In addition to the above, history of peptic ulcer, except single episodes clearly related to medication ingestion.

#### **6-22. Perianal and Rectum, Flying Classes I, IA, II, and III:**

a. Proctitis, chronic or symptomatic.

b. Stricture or prolapse of the rectum.

c. Hemorrhoids which cause marked symptoms or internal hemorrhoids which hemorrhage or protrude intermittently or constantly until surgically corrected.

d. Fecal incontinence.

e. Anal fistula.

f. Ischiorectal abscess.

g. Chronic anal fissure.

h. Symptomatic rectocele.

i. Pilonidal cyst if there is a history of inflammation or discharging sinus in the 2 years preceding examination. Surgery for pilonidal cyst or sinus is disqualifying until the wound is healed, there are no referable symptoms, and no further treatment or medication is required.

#### **6-23. Genitourinary System, Flying Class I, IA, II and III:**

a. History of recurrent or bilateral renal calculus. Waiver may be considered for Flying Class II and III if excretory urography reveals no congenital or acquired anomaly, renal function is normal, and parathyroid adenoma or other metabolic abnormality (i.e., hypercalcuria, hyperoxaluria, hyperuricosuria, or cysteinuria) has been excluded, corrected, or controlled.

b. Retained renal calculus. Waiver may be considered for Flying Class II and III under the following circumstance:

(1) Retained calculus located in the renal parenchyma or in a calyceal diverticulum may be considered for an unrestricted flying waiver, provided metabolic and renal function are normal.

(2) Retained calculus located in a papillary duct or any more distal portion of the collecting system may be considered for a Flying Class IIA waiver, provided metabolic and renal function are normal.

c. Proteinuria under normal activity (at least 48 hours poststrenuous exercise) greater than 200 mg in 24 hours. Waiver may be considered for fixed and reproducible orthostatic proteinuria when the urinary protein to urinary creatinine ratio on a randomly collected urine (not first morning void) is less than or equal to 0.2. It is not necessary to collect a 24 hour urine specimen.

d. Persistent or recurrent hematuria.

e. Cylindruria, hemoglobinuria, or other findings indicative of significant renal disease.

f. Chronic nephritis.

g. Stricture of the urethra.

h. Urinary fistula.

i. Urinary incontinence.

j. Absence of one kidney. Functional impairment of either or both kidneys.

k. Horseshoe kidney.

l. Chronic pyelitis or pyelonephritis.

m. Renal ptosis (floating kidney) causing impaired renal drainage, hypertension or pain.

n. Hydronephrosis or pyonephrosis.

o. Polycystic kidney disease.

p. Chronic cystitis.

q. Amputation of the penis.

r. Hermaphroditism.

s. Hypertrophy of the prostate gland with urinary retention, abscess of the prostate gland, or chronic prostatitis.

t. Epispadias or hypospadias with unsatisfactory surgical correction.

u. Hydrocele.

- v. Large or painful left varicocele. Any right varicocele unless significant underlying pathology has been excluded by urological evaluation.
- w. Undescended testicle. Absence of both testicles.
- x. Chronic orchitis or epididymitis.
- y. Urinary diversion.
- z. Major abnormalities and defects of the genitalia such as a change of sex, a history thereof, or complications (such as adhesions or disfiguring scars) residual to surgical correction of these conditions.

#### **6-24. Pelvic:**

##### a. Flying Classes II and III:

(1) Pregnancy or other symptomatic enlargement of the uterus due to any cause. Pregnancy waivers for trained flying personnel may be requested under the following guidelines: the request is voluntary and must be initiated by the crewmember with concurrence by the squadron commander, flight surgeon, and obstetrician. Physiological training is waived during pregnancy; flying is restricted to pressurized multi-crew, multi engine, non-ejection seat aircraft; and crewmembers will be released from all mobility commitments. The waiver will only be valid for the 13th through 24th week of gestation.

(2) Chronic symptomatic vaginitis.

(3) Chronic salpingitis or oophoritis.

(4) Symptomatic uterine fibroids.

(5) Ovarian cysts.

(6) All symptomatic congenital abnormalities of the reproductive system.

(7) Dysmenorrhea, if incapacitating to a degree which necessitates recurrent absences of more than a few hours from routine duty.

(8) Gross irregularity of the menstrual cycle. Menorrhagia, metrorrhagia, polymenorrhea, or amenorrhea (except as noted in (9) below).

(9) Menopausal syndrome, either physiologic or surgical, if manifested by more than mild constitutional or psychological symptoms.

(10) Endometriosis, if symptomatic or controlled medically.

(11) Malposition of the uterus, if symptomatic.

(12) Vulvitis, chronic.

b. Flying Class I and IA. In addition to above, endometriosis or a history thereof.

#### **6-25. Neurological Disorders:**

##### a. Flying Classes II and III:

(1) Infections of the CNS.

(2) Single or multiple episodes of seizures of any type (grand mal, petit mal, focal, etc.).

(3) Disturbances of consciousness:

(a) An isolated episode of vasovagal syncope associated with venipuncture (or similar benign precipitating event) which is less than 1 minute in duration, without loss of continence, and followed by rapid and complete recovery without sequelae does not require waiver if thorough neurological and cardiovascular evaluation by a flight surgeon reveals no abnormalities.

(b) Physiological loss of consciousness (LOC) caused by reduced oxygen tension, general anesthesia, or other medically induced LOC (excluding vasovagal syncope) does not require waiver provided there is full recovery without sequelae.

(c) High G loss consciousness (G-LOC) during a centrifuge run does not require waiver for continued flying duty unless there are neurologic sequelae or evidence that the G-LOC occurrence is associated with coexistent disease or anatomic abnormality. Inflight G-LOC caused by an improperly performed anti-G straining maneuver or a disconnect of the anti-G protective gear will not be disqualifying and will be managed as a physiological incident. The local flight surgeon will complete appropriate post-incident medical evaluation and report the incident per AFR 127-4.

(d) All other loss or alteration disturbance of consciousness. For rated personnel, waiver will be considered by HQ AFMOA/SGPA only after evaluation at ACS. For non-rated personnel, waiver is at MAJCOM discretion. NOTE: Flying training applicants and students with a history of syncope evaluated according to paragraph 10-14 and certified qualified for Flying Class I or IA by HQ ATC/SG do not require a waiver for Flying Class II for the same history of syncope.

(4) Decompression sickness with neurological involvement or history thereof. Consideration for waiver may be given following medical evaluation by an Air Force hyperbaric qualified physician.

(5) Recurring headaches of the vascular, migraine, or cluster (Horton's cephalgia or histamine headache) type or incapacitating tension headaches.

(6) Electroencephalographic abnormalities:

(a) Truly epileptiform abnormalities to include generalized, lateralized, or focal spikes, sharp waves, spike-wave complexes, and sharp and slow wave complexes during alertness, drowsiness, or sleep are disqualifying. Benign transients such as Small Sharp Spikes (SSS) or Benign Epileptiform Transients of Sleep (BETS), wicket spikets, 6 Hertz (Hz) (phantom) spike and wave, rhythmic temporal theta of drowsiness (psychomotor variant), and 14 or 6Hz positive spikes are not disqualifying.

(b) Generalized, lateralized, or focal continuous polymorphic delta activity or intermittent rhythmic delta activity (FIRDA or OIRDA) during the alert state is disqualifying unless the etiology of the abnormality has been identified and determined not to be a disqualifying disorder.

(7) History of head injury.

(a) Head injury associated with any of the following are not waivable:

1. Post-traumatic seizures. (Seizures at the time of injury or within 5 minutes after injury may be considered for waiver.)

2. Persistent neurological deficits indicative of significant parenchymal CNS injury, such as hemiparesis or hemianopsia.

3. Evidence of impairment of higher intellectual functions or alterations of personality as a result of injury.

4. Cerebrospinal fluid shunts.

(b) Severe head injury. Head trauma associated with any of the complications listed below may be considered for Flying Class II and III waiver in 5 years (see table 10-1).

1. Radiographic evidence of retained metallic or bony fragments.

2. Leptomeningeal cysts, aerocele, brain abscess, or arteriovenous fistula.

3. Unconsciousness or amnesia or the combination of the two exceeding 24 hours' duration.

4. Depressed skull fracture (the inner table indented by more than the thickness of the skull) with or without dural penetration.

5. Traumatic or surgical laceration or contusion of the dura mater or the brain, or a history of penetrating brain injury.

6. Focal neurological signs.

7. Epidural, subdural, subarachnoid, or intracerebral hematoma. A small epidural collection of blood found only on CT-scan or magnetic resonance imaging (MRI) and without

evidence of parenchymal injury either on the imaging study or on neurological examination, followed to resolution without surgery, may be considered for waiver at two years as in the moderate head injury group.

8. CNS infection such as abscess or meningitis within 6 months of head injury.

9. Cerebrospinal fluid rhinorrhea or otorrhea persisting more than 7 calendar days.

(c) Moderate head injury. Head trauma associated with the below criteria may be considered for waiver in 2 years (see table 10-1).

1. Unconsciousness for a period greater than 30 minutes but less than 24 hours.

2. Amnesia for a period of greater than 1 hour but less than 24 hours. (Waiver contingent on a completely normal neurological and neuropsychological evaluation to include computerized tomography (CT) scan.)

**EXCEPTION:** Waiver may be considered after 6 months of observation if a normal CT-scan was obtained within 2 calendar days of injury.

(d) Mild head injury. Head trauma which does not meet criteria for more severe injury may be considered for waiver after 1 month (see table 10-1).

(e) Head trauma with no loss of consciousness, amnesia, or abnormal findings on examination, does not require waiver.

(f) 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, but may be considered for waiver when full recovery has been confirmed by complete neurological and neuropsychological evaluation. Neuropsychological testing to assure cognitive, intellectual and psychomotor capacities sufficient for US Air Force aviation duty will be performed as outlined in table 10-1.

(g) Craniotomy and skull defects.

(h) Neurosyphilis in any form (meningo-vascular, tabes dorsalis, or general paresis).

(i) Narcolepsy, cataplexy, and similar states.

(j) Injury of one or more peripheral nerves unless it is not expected to interfere with normal function in any practical manner.

(k) History of subarachnoid hemorrhage, embolism, vascular insufficiency, thrombosis,

hemorrhage, arteriosclerosis, arteriovenous malformation, or aneurysm involving the CNS.

(13) History of tumor involving the brain or its coverings or surgical correction of the same, except surgical correction of tumors of the spinal cord occurring 5 years before examination, if there is no residual and no complications or sequelae are expected.

(14) Personal or family history of hereditary disturbances such as multiple neurofibromatosis, Huntington's chorea, hepatolenticular degeneration, acute intermittent porphyria, spinocerebellar ataxia, peroneal muscular atrophy, muscular dystrophy, and familial periodic paralysis. A strong familial history of such a syndrome, indicating a hereditary component, in the absence of clinical symptoms or signs, may be considered for waiver.

(15) Evidence or history of degenerative or demyelinating process such as multiple sclerosis, dementia, basal ganglia disease, or Friedreich's ataxia.

(16) History or evidence of such defects as basilar invagination, hydrocephalus, premature closure of the cranial sutures, meningocele, and cerebral or cerebellar agenesis if there is evidence of impairment of normal functions or if the process is expected to be progressive.

(17) Verified history of neuritis, neuralgia, neuropathy, or radiculopathy, whatever the etiology, unless:

(a) The condition has completely subsided and the cause is determined to be of no future concern.

(b) There are no residual which could be deemed detrimental to normal function in any practical manner.

(18) Polyneuritis, whatever the etiology, unless:

(a) Limited to a single episode.

(b) The acute state subsided at least 1 year before examination.

(c) There are no residual which could be expected to interfere with normal function in any practical manner.

(19) History or evidence of chronic or recurrent diseases, such as myasthenia gravis, polymyositis, or myotonia disorder.

(20) Evidence or history of involvement of the nervous system by a toxic, metabolic or disease process if there is any indication such involvement is likely to interfere with prolonged normal function in any practical manner or is

progressive or recurrent, or if there is a significant neurological residual which would interfere with aviation duties.

(21) Tremors, chorea, dystonia or other movement disorders which will interfere with normal function.

b. Flying Classes I and IA. In addition to the above, paroxysmal convulsive disorders. Seizures associated with febrile illness before 5 years of age may be acceptable with waiver if recent neurological evaluation, MRI, and 24 hour electroencephalogram (EEG) are normal.

#### 6-26. Psychiatric Disorders:

a. Flying Classes II and III:

- (1) Eating disorders.
- (2) Gender identity disorders.
- (3) Organic mental disorders.

(4) Alcohol dependence or abuse (DSM III-R) or any disease the proximate cause of which is alcoholism. These conditions may be waived by MAJCOM/SG if the following conditions have been met:

(a) The substance abuse recommendation and treatment (SART) committee (see AFR 30-2) determines that individual has made satisfactory progress and has maintained abstinence without needing medications for a period of 6 months from the date of entering the Track 4 treatment phase of the SART program.

**NOTE:** Any slips during the SART program will reset the 6-month observation period for waiver consideration.

(b) In the opinion of the flight surgeon, psychiatrist, clinical psychologist, clinical social worker, flying unit commander, and based on the SART Treatment and Progress Evaluation, the individual has a low potential for recidivism and can be expected to remain stable under stress.

(c) The individual has no medical complications or sequelae due to past alcohol abuse or dependence.

(d) The individual states in writing that he or she understands the waiver is valid only if total abstinence from alcohol is maintained and that a verifiable break in abstinence once the waiver period has begun will be considered medically disqualifying and not waivable. To ensure flying unit commanders are aware of the need to observe individuals with past alcohol problems, new commanders will be briefed on those in their units with waivers for this condition when the individual changes assignment or there has been a change in command.

(5) All other drug abuse or use as defined in AFR 30-2. These conditions are not waiverable.

(6) Schizophrenia.

(7) Delusional disorder.

(8) Psychotic disorders not elsewhere classified. A brief reactive psychosis, a psychosis secondary to a mood disorder, or a psychotic event associated with a toxic or infectious process may be waiverable after review by HQ AF-MOA/SGPA.

(9) Bipolar disorder.

(10) Depression disorders including major depression, dysthymia and depression not otherwise specified.

(11) Anxiety disorders. Non-phobic fear of flying is considered an administrative not medical problem.

(12) Somatoform disorders.

(13) Dissociative disorders.

(14) Sexual paraphilias are not medically disqualifying; however, individuals meeting diagnostic criteria will be dealt with administratively.

(15) Sexual dysfunctions and sexual disorders not otherwise specified are not medically disqualifying unless in association with another Axis I disorder.

(16) Sleep disorders need not be disqualifying unless representing distress in the individual of such magnitude to warrant somatic treatment greater than 30 days duration, or if associated with another Axis I disorder other than an adjustment disorder.

(17) Factitious disorders.

(18) Impulse control disorders not elsewhere classified.

(19) Adjustment disorders of more than 60 days duration.

(20) Psychological factors affecting physical conditions.

(21) Personality disorders are not medically disqualifying; however, if social and occupational, administrative or legal ramifications are operant, a psychiatric evaluation may be warranted to clarify suitability for future flying or other duty. **NOTE:** When evaluating aircrew members for conditions listed above, the local flight surgeon should consult the most appropriate mental health professional. In cases where psychopharmacological intervention may be indicated, toxic/metabolic etiologies are considered, or the case is to be submitted to higher headquarters for formal disqualification, consultation by a board eligible or board certified psychiatrist is required.

(22) History of attempted suicide or suicidal behavior may be waiverable by HQ AF-MOA/SGPA on rated personnel or MAJCOM on nonrated personnel after at least 1 year of treatment and observation.

b. Flying Classes I and IA. In addition to the above:

(1) History of any of the above diagnoses excluding verifiable simple adjustment disorders not requiring hospitalization.

(2) History of attempted suicide.

(3) History of psychosis in the family of origin (father, mother, or siblings).

(4) Unsatisfactory adaptability rating for military aviation.

(5) History of persistent learning disability.

(6) Evidence of any condition causing serious chronic impairment of educational goals or chronic behavioral difficulties requiring hospitalization or prolonged treatment.

## **6-27. Extremities, Flying Classes I, IA, II, and III:**

### **a. General Conditions:**

(1) Arthritis of any type of more than minimal degree, which interferes with the ability to follow a physically active lifestyle, or may reasonably be expected to preclude the satisfactory performance of flying duties.

(2) Documented history or findings of rheumatoid arthritis.

(3) Active osteomyelitis or a verified history of osteomyelitis, unless inactive with no recurrences during the 2 years before examination, and without residual deformity sufficient to interfere with function.

(4) Osteoporosis.

(5) Osteochondromatosis or multiple cartilaginous exostoses.

(6) Disease or injury, or congenital anomaly of any bone or joint, with residual deformity, instability, pain, rigidity, or limitation of motion if function is impaired to such a degree it will interfere with training, physically active lifestyle, or flying duties.

(7) Unreduced dislocation; substantiated history of recurrent dislocations or subluxations of a major joint if not satisfactorily corrected.

(8) Instability of a major joint if symptomatic and more than mild, or if subsequent to surgery there is evidence of instability, weakness, or significant atrophy.

- (9) Malunited fractures which interfere significantly with function.
- (10) Symptomatic ununited fractures.
- (11) Any fracture in which a plate, pin, or screw was used for fixation if the fixation devices remain in place and are easily subject to trauma.
- (12) Muscular paralysis, paresis, contracture, or atrophy if progressive or of sufficient degree to interfere with the performance of flying duties.
- (13) Demonstrable loose body in any joint (includes osteocartilaginous or metallic foreign objects).
- (14) Synovitis with persistent swelling or limitation of motion.
- (15) Osteonecrosis.
- (16) Chondromalacia, if symptomatic or there is verified history of joint effusion, interference with function, or residuals from surgery.
- (17) Joint replacement.
- (18) Myotonia congenita.
- (19) Scars, extensive, deep or adherent to the skin and soft tissues or neuromas of an extremity which are painful, interfere with movement, preclude the wearing of equipment, or show a tendency to breakdown.
- (20) Symptomatic amputation stump (neuroma, bone spur, adherent scar or ulceration).
- b. Upper Extremity:
  - (1) Absence or loss of more than one-third of the distal phalanx of either thumb.
  - (2) Absence or loss of the distal and middle phalanx of an index, middle, or ring finger of either hand, irrespective of the absence or loss of the little finger.
  - (3) Absence or loss of more than the distal phalanges of any two of the following fingers of either hand: index, middle, or ring.
  - (4) Absence of any portion of the hand or upper extremity in excess of above.
  - (5) Resection of a joint other than that of a finger.
  - (6) Hyperdactylyia.
  - (7) Scars and deformities of the fingers or hand which impair circulation, are symptomatic, or impair normal function to such a degree as to interfere with the satisfactory performance of flying duties.
  - (8) Healed disease or injury of the wrist, elbow or shoulder with residual weakness or symptoms of such a degree as to preclude satisfactory performance of duty. Grip strength of

less than 75 percent of predicted normal when compared with the normal hand (non-dominant is 80 percent of dominant grip).

- (9) Limitation of motion (less than specified): shoulder—forward elevation to 90 degrees, or abduction to 90 degrees; elbow—flexion to 100 degrees, or extension to 15 degrees; wrist—a total range of 60 degrees extension plus flexion; radial ulnar deviation a total combined arc of 30 degrees; hand pronation to the first quarter of the normal arc, supination to the first quarter of the normal arc; fingers—inability to clench fist, pick up a pin or needle, and grasp an object; thumb—inability to touch tips of at least three fingers.

**NOTE:** See attachment 6 for measurements.

c. Lower Extremity:

- (1) Loss of either great toe or loss of any two toes on the same foot.
- (2) Amputation or absence of any portion of the foot or lower extremity in excess of c(1) above.
- (3) Clubfoot of any degree.
- (4) Rigid or spastic flatfoot. Flatfoot, tarsal coalition.
- (5) Weak foot with demonstrable eversion of the foot, valgus of the heel, or marked bulging of the inner border due to inward rotation of the astragalus regardless of the presence or absence of symptoms.
- (6) Elevation of the longitudinal arch (pes cavus) if of enough degree to cause subluxation of the metatarsal heads and clawing of the toes. Obliteration of the transverse arch associated with permanent flexion of the small toes.
- (7) Any condition, disease, or injury to feet or toes which results in disabling pain, distracting discomfort, inability to satisfactorily perform military aviation, or precludes wear of proper military footgear.
- (8) Verified history of congenital dislocation of the hip, osteochondritis of the hip (Legg-Perthes disease), or slipped femoral epiphysis of the hip with X-ray evidence of residual deformity or degenerative changes.
- (9) Verified history of hip dislocation within 2 years of examination or degenerative changes on X-ray from old hip dislocation.
- (10) Difference in leg length of more than 2.5 cm (from anterior superior iliac spine to the distal tip of the medial malleolus).
- (11) Dislocation of semilunar cartilages or loose foreign bodies within the knee joint. History of surgical correction of same within the preceding 6 months; if more than 6 months have

elapsed without recurrence, and there is instability of the knee ligaments in lateral or anteroposterior directions in comparison with the normal knee, or abnormalities noted on X-ray; if there is significant atrophy or weakness of the thigh musculature in comparison with the normal side; or if there is not acceptable active motion in flexion and extension (which is, flexion to 90 degrees and full extension); or if there are other symptoms of internal derangement or a condition which would interfere with the performance of flying duties.

(12) Osteochondritis dissicans of the knee or ankle if there are X-ray changes.

(13) Osteochondritis of the tibial tuberosity (Osgood-Schlatter disease) if symptomatic or with obvious prominence of the part and X-ray evidence of separated bone fragments.

(14) Limitation of motion (less than specified): hip-flexion to 90 degrees, or extension to 10 degrees (beyond 0) abduction to 45 degrees, rotation to 60 degrees (internal and external combined); knee-full extension, or flexion to 90 degrees; ankle-dorsiflexion to 10 degrees, or plantar flexion to 30 degrees eversion and inversion combined to 5 degrees; toes-stiffness which interferes with walking, marching, running, or jumping. NOTE: See attachment 6 for measurements.

#### **6-28. Spine and Other Musculoskeletal:**

##### **a. Flying Classes II and III:**

(1) History of disease or injury of the spine or sacroiliac joints, either with or without objective signs, which has prevented the examinee from successfully following a physically active lifestyle.

(2) Arthritis of the spine, all types.

(3) Granulomatous disease of the spine, active or healed.

(4) Scoliosis of more than 25 degrees as measured by the Cobb method.

(5) Abnormal curvature of the spine of any degree in which there is a noticeable deformity when the examinee is dressed, in which pain or interference with function is present, or which is progressive.

(6) Symptomatic spondylolisthesis or spondylosis.

(7) Symptomatic herniated nucleus pulposus with sciatica or history of surgery or chemonucleolysis for that condition.

(8) Fractures or dislocations of the vertebrae. A compression fracture involving less than 25 percent of a single vertebra is waiver-

able when the injury is well healed and asymptomatic. More extensive compression fractures may be considered for categorical IIB waiver. History of fractures of the transverse processes is not disqualifying if asymptomatic.

(9) Spina bifida when more than one vertebra is involved, if there is dimpling of the overlying skin, or a history of surgical repair for spina bifida.

(10) Juvenile epiphysitis with any degree of residual change indicated by x ray or kyphosis.

(11) Weak or painful back requiring external support.

(12) Recurrent disabling low back pain due to any cause.

(13) Fusion involving more than two vertebrae. Any surgical fusion.

b. Flying Classes I and IA. Herniated nucleus pulposus or history of same.

#### **6-29. Skin:**

##### **a. Flying Classes II and III:**

(1) Any chronic skin disorder which is severe enough to cause recurrent grounding from flying duties, or is aggravated by or interferes with the wearing of military equipment.

(2) Extensive, deep, or adherent scars which interfere with muscular movements, with the wearing of military equipment, or show a tendency to breakdown.

(3) Atopic dermatitis with active or residual lesions in characteristic areas or a verified history of it.

(4) Dermatitis herpetiformis.

(5) Eczema which is chronic and resistant to treatment.

(6) Fungus infections of the skin, systemic or superficial, that interferes with duty performance or the wear of life support equipment.

(7) Furunculosis which is extensive, recurrent or chronic.

(8) Hyperhidrosis if chronic or severe.

(9) Leukemia cutis; mycosis fungoides; Hodgkin's disease.

(10) Lichen planus.

(11) Neurofibromatosis.

(12) Photodermatosis unless due to medication.

(13) Psoriasis, unless mild and considered unlikely to limit the individual's ability to complete his/her duties. Mild psoriasis or psoriasis controlled with topical steroids may be considered for waiver.

(14) Scleroderma.

(15) Xanthoma if symptomatic or accompanied by hypercholesterolemia or hyperlipoproteinemia.

(16) Chronic urticaria.

b. Flying Classes I and IA. In addition to above, Psoriasis or verified history of same.

### **6-30. Endocrine and Metabolic:**

a. Flying Classes II and III:

(1) Adiposogenital dystrophy (Frohlich's syndrome).

(2) Adrenal dysfunction of any degree, including pheochromocytoma.

(3) Cretinism.

(4) Diabetes insipidus.

(5) Diabetes mellitus. Waivers may be requested when the individual's fasting plasma glucose is 140 milligrams per deciliter or less, the two hour post prandial plasma glucose is 175 milligrams per deciliter or less, and the glycohemoglobin is in the normal range established for the laboratory performing the test, provided oral hypoglycemic medications or insulin are not required.

(6) Gigantism or acromegaly.

(7) Thyroid disorders:

(a) Goiter if associated with pressure symptoms, or if enlargement is of such degree as to interfere with wearing of a military uniform or military equipment.

(b) Hyperthyroidism or thyrotoxicosis.

(c) Thyroiditis, acute and subacute.

(8) Gout, unless controlled by approved medication (see paragraph 6-32a(4).)

(9) Hyperinsulinism, confirmed, symptomatic.

(10) Parathyroid dysfunction.

(11) Hypopituitarism.

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

(13) Nutritional deficiency diseases (including sprue, beriberi, pellagra, and scurvy) which are more than mild and not readily amenable to therapy or in which permanent pathological changes have been established.

(14) Other endocrine or metabolic disorders which obviously preclude satisfactory performance of military service or which will require frequent or prolonged treatment.

(15) Hypercholesterolemia alone is not necessarily disqualifying. Those flying personnel who meet one or more of the following criteria for hyperlipidemia, or whose risk factors are of significant concern should have an ECG and

aeromedical summary forwarded to MAJC-OM/SG and ACS.

(a) Repeated serum cholesterol greater than 300 mg/dl.

(b) Repeated serum cholesterol from 230 to 300 mg/dl and a total cholesterol/high density lipoprotein (HDL) cholesterol ratio greater than 6.0, or low density lipoprotein (LDL) value greater than 160 mg/dl.

(16) Osteopenia.

(17) Hypoglycemia from any endogenous source.

b. Flying Classes I and IA. In addition to the above:

(1) Diabetes mellitus. Persistent glucosuria from any cause including fasting renal glucosuria is disqualifying. Glucosuria postprandially or during glucose loading challenge is not disqualifying in the absence of any renal disease or history of recurrent genitourinary infections. However, this finding requires evaluation as outlined in AFR 160-12.

(2) Any confirmed (repeated) serum cholesterol in excess of 230 mg/dl with one or both of the following criteria present:

(a) HDL cholesterol equal to or less than 15 percent of total cholesterol.

(b) Total cholesterol greater than 300 mg/dl.

(3) Gout.

### **6-31. Height and Weight:**

a. Flying Class III:

(1) Height same as flying training standard.

(2) Weight:

(a) For initial qualification a weight in relation to height applies. Body fat standards will be considered for individual within 10 pounds or exceeding maximum allowable weight. (See attachment 7.)

(b) For trained personnel refer to AFR 35-11. Additional weight restrictions may apply in certain ejection systems.

b. Flying Class II:

(1) Height less than 64 inches or more than 77 inches.

(2) Weight for trained personnel refer to AFR 35-11. NOTE: Personnel found to be overweight or overfat during a Flying II or III physical, will be referred to their unit commander by letter for appropriate action under AFR 35-11.

c. Flying Class I:

(1) Height less than 64 inches or more than 77 inches.

(2) Sitting height greater than 40 inches or less than 34 inches. (See AFP 160-17 for method of measurement).

(3) Weight in relation to height applies and body weight may not exceed 232 pounds. Body fat standards will be considered for individual within 10 pounds or exceeding maximum allowable weight. (See attachment 7.)

d. Flying Classes 1A and Initial II (Flight Surgeon):

(1) Height less than 64 inches or more than 77.

(2) Sitting height greater than 40 inches or less than 33 inches. (See AFP 160-17 for method of measurement).

(3) Weight in relation to height applies and body weight may not exceed 232 pounds. Body fat standards will be considered for individual within 10 pounds or exceeding maximum allowable weight. (See attachment 7.)

#### **6-32. Systemic and Miscellaneous Causes for Rejection.**

a. Flying Classes II and III:

(1) Nonhematological malignancies. History or presence of malignant tumor, cyst or cancer of any sort. Review by tumor board, medical evaluation board, and Armed Forces Institute of Pathology (AFIP) are required before initial waiver can be considered. Neoplasms of the lung which have been adequately excised may be considered for waiver after a minimum of 5 years has elapsed, there is no evidence of active disease, and individual has continued to be a non-smoker. Basal cell and squamous cell carcinomas and carcinoma-in-situ of the cervix which have been adequately excised (as evidenced by pathology report, or basal cell carcinoma which have been treated by electrodessication and curettage by a dermatologist credentialed to perform this procedure), are exempted from tumor board action but must be reported to tumor registry and are not disqualifying. NOTE: Tumor board followup requirements will be addressed in aeromedical summary on any waiver renewal.

(2) Airsickness in flying personnel is not cause for medical disqualification unless there is medical evidence of organic or psychiatric pathology. If airsickness is of such chronicity or severity as to interfere with the performance of flying duties by a rated officer, his or her potential for further use in rated duties will be addressed by a Flying Evaluation Board (see AFR 60-13). Copies of these cases will be sent

through medical channels to HQ AFMOA/SGPA for review before convening a board. Airsickness experienced by nonrated personnel (other than UPT or UNT students) while enrolled in flying courses is medically disqualifying if it is of such severity or chronicity as to interfere with the performance of flying duties. Final determination of medical qualification in these cases will be made by the MAJ-COM/SG.

(3) Medication use in aircrew not requiring waiver action. The use of medications will usually be cause for medical disqualification for flying duty until the grounding condition has been resolved, the medication is no longer required and the effects of the drugs have dissipated. The flight surgeon must clear (by recording an entry on SF 600) and complete a AF Form 1042 on any individual who has received medications or treatment (to include dental) which would affect state of consciousness, judgment, alertness, equilibrium, coordination, vision or speech, before the individual resumes any duty involving flying or other special operational duties.

(a) Disqualification following administration of immunobiologics is not required unless, in the opinion of the attending flight surgeon, the physical effects might be expected to present a hazard to flying safety.

(b) Aircrew members will not fly for at least 8 hours after receiving a local or regional anesthetic agent.

(c) Isoniazid for prophylactic therapy of tuberculin converters who do not have active tuberculosis will not be disqualifying after a minimum of 7 days observation while on the medication. Monthly visits with the flight surgeon are required while taking the medication.

(d) Oral contraceptives, implantable timed release progestin, estrogen alone or with progestin as replacement therapy, will not be disqualifying after a minimum of 30 days of side effect-free observation while on the medication. Any change in oral contraceptive regimen or change to a preparation with a higher estrogen or progestin content will require an additional 30-day observation period while in a grounded status.

(e) Medications which may be used without medical consultation:

1. Skin antiseptics, topical antifungals, 1 percent Hydrocortisone cream, or benzoyl peroxide for minor wounds and skin diseases which do not interfere with the perfor-

mance of flying duties or wear of personal equipment.

2. Single doses of aspirin or acetaminophen to provide analgesia for minor self-limiting conditions.

3. Antacids for mild isolated episodes of epigastric distress.

4. Hemorrhoidal suppositories.

5. Bismuth subsalicylate for mild afibrile cases of diarrhea.

6. Afrin or neosynephrine nasal sprays may be used by aircrew as "get me down" should unexpected ear or sinus block occur during flight. These should be prescribed by a flight surgeon with instructions that they not be used to treat symptoms of head congestion existing prior to flight.

(f) Medication prescribed by a flight surgeon which may be used without removal from flying duty once the potential for idiosyncratic reaction has been excluded:

1. Chloroquine phosphate or primaquine phosphate for antimalarial prophylaxis.

2. Scopolamine alone or in combination with dextroamphetamine or ephedrine for airsickness in flying trainees. Use is limited to three flights accompanied by an instructor.

3. Doxycycline (100 mg) administered twice a day for 5 days may be used to treat mild diarrhea. Doxycycline may also be used for prophylaxis against diarrhea in personnel deployed to problem areas. One hundred milligrams should be administered daily during the period of exposure and for at least 2 days following exposure, with the total period of use not to exceed 2 weeks. However, before using doxycycline, crewmembers should first be ground tested with a 100 mg dose and observed for 72 hours.

4. Topical antibiotics for control of acne.

5. Topical Retin-A for control of acne as long as local irritation does not interfere with wear of the life-support equipment.

6. Topical Zovirax.

7. Completion of a course of oral penicillin, erythromycin, or cephalexin, specifically for streptococcal pharyngitis, once infectious process is asymptomatic.

8. Completion of a course of erythromycin, cephalexin, oxacillin or dicloxacillin, specifically for soft tissue infections, once infection is asymptomatic, given no interference

with duty performance or the wear of military equipment.

9. Vaginal creams or suppositories for treatment of vaginitis once asymptomatic.

10. Completion of a course of sulfamethoxazole-trimethoprim, tetracycline, ampicillin, doxycycline for treatment of acute urinary tract infections or prostatitis, once symptoms have abated.

11. Temazepam, if such use is essential for the safe execution of an operational mission and only after MAJCOM coordination and approval.

(4) Maintenance medication requiring waiver. Those medications for conditions listed below may be waived by the MAJCOM surgeon (or Chief, Aeromedical Services for airmen with aviation service code 9C). The use of other medications, singly or in combination (except as specified in 5 below) requires review by HQ AF-MOA/SGPA, Bolling AFB DC 20332-6188 for rated officers and by the MAJCOM surgeon for non-rated flying personnel. All waiver requests must document the medication is well tolerated without side effects and has controlled the medical condition for which it was prescribed.

(a) Chlorothiazide or hydrochlorothiazide for control of hypertension.

(b) Triamterene for control of hypertension.

(c) Probenecid for treatment of gout or hyperuricemia.

(d) Allopurinol for treatment of gout or hyperuricemia.

(e) Combination therapy of: a and b; a and c; a and d. **NOTE:** Consider combination drug therapy for a waiver only after failure of other measures such as diet, weight reduction, and single drug therapy.

(f) Epinephrine derivatives without added action agents, or betablockers (timolol, levobunolol, betaxolol), all for topical use only, to control glaucoma.

(g) Synthroid or dessicated thyroid United States pharmacopeia (USP) for treatment of thyroid hypofunction or for thyroid suppression.

(h) Tetracycline, erythromycin, doxycycline in standard doses for acne management.

(i) Sulfamethoxazole-trimethoprim, tetracycline, ampicillin, doxycycline for chronic genitourinary infectious or prostatitis once asymptomatic.

(j) Folic acid in the treatment of sprue.

(k) Sucralfate (1 gram twice daily) for prevention of recurrent, uncomplicated duodenal ulcers. Waivers will be considered after 7 days observation while on the medication.

(l) Topical flunisolide or beclomethasone or cromolyn nasal spray for control of mild to moderate allergic rhinitis, non-allergic rhinitis, or vasomotor rhinitis. Observation for control of the rhinitis (usually 7 to 14 calendar days) is required.

(m) Griseofulvin for treatment of fungal infections may be considered for IIA waiver by HQ AFMOA/SGPA.

(n) Clomiphene citrate for treatment of infertility.

(o) Cholestyramine or colestipol hydrochloride for control of hypercholesterolemia. Lovastatin and Gemfibrozil may be considered for categorical IIA waiver, by HQ AFMOA/SGPA, if failure and/or patient intolerance of the other cholesterol lowering medications has been documented. Waiver will be considered after appropriate ground trial reveals no idiosyncratic reactions and a satisfactory response to the therapy is documented.

(p) Oral potassium supplements in conjunction with diuretic therapy.

(5) Any allergic condition which requires desensitization therapy.

(6) Eosinophilic granuloma.

(7) Gaucher's disease.

(8) Schuller-Christian disease.

(9) Letterer-Siwe's disease.

(10) Chronic metallic poisoning.

(11) Residual of cold injury, such as deep-seated ache, paresthesia, hyperhidrosis, easily traumatized skin, cyanosis, ankylosis, amputation of any digit, or cold urticaria.

(12) Heat pyrexia (heat stroke or heat exhaustion) if a reliable history indicates an abnormally lowered heat tolerance threshold.

(13) History of malignant hyperthermia.

(14) Syphilis, congenital or acquired. A history of primary or secondary syphilis is not disqualifying provided:

(a) The examinee has no symptoms of disease.

(b) There are no signs of active disease and no residual thereof.

(c) Serologic VDRL testing rules out re-infection.

(d) There is a verified history of adequate antiluetic treatment.

(e) There is no evidence or history of CNS involvement.

(15) Parasitic infestation, all types.

(16) History of sensitivity or a demonstrated sensitivity of sufficient severity to require permanent exemption from any immunization required by AFR 161-13.

(17) Other congenital or acquired abnormalities, defects or diseases which preclude satisfactory performance of military duty or which require frequent and prolonged treatment.

(18) Benign tumors which interfere with function or the wear of equipment and tumors which are likely to enlarge or be subjected to trauma during military service or show malignant potential.

(19) Miscellaneous conditions such as porphyria, hemochromatosis, amyloidosis.

(20) Inflammatory idiopathic diseases of connective tissue.

(21) Lupus erythematosus (acute, subacute, or chronic) or any other dermatosis aggravated by sunlight.

(22) Vasculitis.

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

(24) Extrapulmonary tuberculosis.

(25) Sarcoidosis if more than mild or if other organs are involved.

b. Flying Classes I and IA. In addition to the above:

(1) Motion sickness experienced in aircraft, automobiles, or watercraft after the age of 12 with any significant frequency. Any history of motion sickness will be completely explored.

(2) History of malignancy except childhood malignancy considered cured may be considered for waiver on a case-by-case basis.

## Chapter 7

## MEDICAL STANDARDS—MISCELLANEOUS CATEGORIES

**7-1. Attendance at Service Schools.** Applicants for all types of training courses must be free of any abnormal physical or mental condition which is likely to interfere with successful completion of the course. While in training, the member must remain medically qualified for worldwide service. Certain technical training courses and Air Force specialty classifications impose additional requirements. (see AFRs 36-1, 39-1 and 50-5.)

**7-2. Inflight Refueling Operation Duty.**

Individuals must meet standards for Flying Class III and the standards listed below:

- a. Corrected near and distant visual acuity of 20/20 in each eye with ordinary spectacles.
- b. Heterophoria at 20 feet:
  - (1) Esophoria. 10 prism diopters or less.
  - (2) Exophoria. 5 prism diopters or less.
  - (3) Hyperphoria. 1 prism diopter or less.
  - (4) Heterotropia, including microtropias.
- c. Normal depth perception, as defined for Flying Class I.
- d. Sufficient freedom from disease and deformities of the nose, mouth, and throat to ensure easily understood voice-radio communication.
- e. Certification and waiver authority is MAJCOM of assignment for active duty personnel. HQ AFRES/SGP and ANGRC/SGP are certification and waiver authority for personnel assigned their commands. HQ ATC/SG is certification authority for nonprior service applicants (see attachment 3).

**7-3. Space Operations Duty.** Personnel entering Space Operations Duty (Air Force Specialty Code 20XX and 277X0) must meet the medical standards for Appointment, Enlistment, and Induction (chapter 4), as well as the requirements outlined below:

- a. Causes for Rejection:
  - (1) Defective color vision:
    - (a) Successful completion of the FALANT is satisfactory, if the examinee cannot pass the VTS-CV.
    - (b) In the case of trained space operations duty personnel who fail all tests, an on-the-job color vision test will be performed. The flight surgeon will observe the examinee at the actual job site during an exercise. If the examinee can promptly and accurately recognize all

colors required for safe job performance, the flight surgeon will make the following notation in item 73, SF 88, "Color Vision: Fails VTS-CV and FALANT. Passes on-the-job color vision test. Certified color safe."

(c) Certification of color qualification will be reviewed with any job change and at the time of each physical examination.

(2) Hearing. A hearing profile less than "1" for initial selection. Trained space operators who do not meet at least H-2 standards should receive an onsite operational hearing evaluation analogous to the inflight evaluation required for aircrew.

(3) Any defect in speech which would interfere with clear enunciation.

(4) Any medical condition, the natural history of which is to incapacitate an individual suddenly and without warning.

(5) Any psychiatric condition which would result in a psychiatric profile less than S-1, or in the opinion of the examining flight surgeon would interfere with space operations duty with particular attention to a fear of heights, closed or confined spaces.

(6) Character and behavior disorders when manifested by a history of repeated or severe behavioral difficulties:

(a) Alcoholism as defined in AFR 160-36.

(b) History of attempted suicide.  
**NOTE:** Disorders of this nature are cause for medical disqualification for initial selection for training. Thereafter, such disorders may be cause for administrative elimination from the career field. If the individual is found to be medically qualified, then a recommendation will be made regarding appropriate administrative action, such as reclassification or elimination from service.

(7) Corrected visual acuity must be 20/20 bilaterally, for distance and near.

(8) Any condition requiring recurrent use of medication which could affect mental alertness, physical coordination, or lead to sudden incapacitation.

(9) Allergic rhinitis or vasomotor rhinitis if more than mild, or if it requires medication for control. Hyposensitization procedures are acceptable providing no other medication is required and continuous or seasonal control has

been demonstrated. NOTE: All allergy disorder histories must be fully explained.

(10) Unsatisfactory adaptability rating for space operations duty (ARSpace Operations Duty) on initial selection. (See AFR 160-17.)

b. Certification for Training. Medical examinations for all applicants for space operations duty require certification by HQ ATC/SGPS before entering training.

c. Waivers for Continued Space Operations Duty:

(1) Waivers for minor deviations from the above standards may be requested when, in the opinion of the examining flight surgeon, such defects will not be aggravated or complicated by space operations duty and will not constitute an undue hazard to the individual or compromise the mission. Waiver authority is the MAJCOM/SG.

(2) Personnel with any of the conditions listed in paragraph 1-7d(1) are not to be returned to duty until review and certification of the medical case has been accomplished by the MAJCOM/SG.

(3) Use of maintenance medication listed in paragraph 6-32a(3) and (4) applies. Such use will be considered disqualifying until the member has completed an adequate trial period (minimum of 7 days except for use of oral contraceptives which requires 30 days). Return to duty may be accomplished locally, however, an aeromedical summary must be forwarded immediately to the MAJCOM/SG.

(4) Use of any other maintenance medication is considered disqualifying, and an individual will not be returned to duty until review and certification of the case has been accomplished by the MAJCOM/SG. Waivers for maintenance medication will be considered only after the individual has completed an adequate trial period free from adverse side effects and the medical condition is successfully stabilized.

d. Continuation of Space Operations Duty:

(1) When space operations members report to a new base for duty, PES personnel will perform an informal examination, using SF 600, Health Record-Chronological Record of Medical Care, only as extensive as considered necessary to ensure the individual is qualified to perform their duties.

(2) When it comes to the attention of Flight Medicine that a member's qualification has changed Flight Medicine personnel will notify his or her unit.

(3) PES personnel will complete AF Form 1446, within the 3-month period preceding the last day of the birth month on all years that a space operations member is not scheduled for a complete medical examination. This requirement applies to students undergoing training and applicants who have been certified for training but not yet entered training.

(4) If available, a flight surgeon should perform medical examinations for continued space operations duty, and for certification retention for training for such duties. In those cases where a flight surgeon is not available, and the physical is not performed by a flight surgeon, the physical must be sent to the MAJCOM/SG for review and certification.

**7-4. Missile Launch Crew Duty.** Medical examinations for all applicants for missile launch crew duty (AFSC 18XX) must be certified by MAJCOM/SG before entry into training.

a. Cause for Rejection, Applicants. The medical standards in chapter 4, and the requirements outlined below, are cause to reject an applicant for missile launch crew duty:

(1) Defective color vision. Five or more incorrect responses, including failures to make responses within 2 seconds, in reading the 14 test charts of the standard color vision test set (VTS-CV) administered under the standard color perception testing easel light. Even though the VTS-CV has been failed, passing the Farnsworth Lantern (FALANT) is acceptable. (See AFR 160-17.)

(2) Hearing loss greater than that specified for H-1 profile in attachment 4.

(3) Defect which would interfere with wearing oxygen equipment, protective head gear, or other safety equipment.

(4) Defect in speech which would interfere with clear enunciation over a radio communication system.

(5) Medical condition, the natural history of which is to incapacitate an individual suddenly and without warning.

(6) Mental disorders:

(a) Any mental disorder which would result in a psychiatric profile less than S-1.

(b) Any history of mental disorder occurring after age 12, including:

1. Claustrophobia.

2. Alcoholism as defined in AFR 160-36.

3. History of attempted suicide or suicidal gesture.

(c) Any psychiatric condition which, in the opinion of the examining flight surgeon would interfere with missile duty.

(7) History of seizure disorder after age 5.

(8) Corrected distant vision worse than 20/20 in the better eye or corrected near vision worse than 20/20 in one eye and 20/30 in the other.

(9) Use of medication:

(a) Any recurrent use of medication that could affect mental alertness, physical coordination, or lead to sudden incapacitation is disqualifying and waiver will not be considered.

(b) Any use of other types of maintenance medication will require waiver action by the MAJCOM/SG.

**EXCEPTION:** Maintenance medications listed in paragraph 6-32a(4), or antibiotics, are acceptable and do not require waiver action provided the medication is well tolerated without side effects and has controlled the medical condition for which it was prescribed.

(10) Allergic rhinitis or vasomotor rhinitis if more than mild, or if it requires the use of medication for control. Any history of allergic rhinitis will be fully evaluated to determine the extent of the condition before submission of the physical examination for certification or waiver. If allergy evaluation reveals that allergic or vasomotor rhinitis is more than mild, or requires medication for control, the individual will be disqualified. A waiver may be formally requested by a flight surgeon with complete evaluation. Waivers for topical corticosteroids or immunotherapy (or both) will be considered provided no other medication is required and continuous or seasonal control is demonstrated.

(11) Unsatisfactory adaptability rating for missile duty (AR-Missile Duty). (See AFR 160-17.)

(12) Head injuries:

(a) Head injury of a mild degree (paragraph 4-22e(4)) with a normal neurological examination (table 10-1) does not require waiver action.

(b) Head injury of a moderate or severe degree (paragraph 4-22e(2) or (3)) will require waiver action after normal neurological testing as required for commissioning (table 10-1).

b. Continuation of Missile Launch Duty:

(1) When missile launch crewmembers report to a new base for duty, an informal examination, using SF 600, will be accomplished only as extensive as considered necessary to ensure

the individual is qualified to perform their duties.

(2) When the flight surgeon becomes aware that a member's qualification has changed, he or she notifies the unit.

(3) PES personnel should complete AF Form 1446, within the 3-month period preceding the last day of the birth month on all years that a missile launch crew member is not scheduled for a complete medical examination. This requirement applies to students undergoing training and applicants who have been certified for training but not yet entered training.

(4) If available, a flight surgeon should perform medical examinations for continued missile launch crew duty, and for certification retention for such duties. In those cases where a flight surgeon is not available, the physical must be sent to the MAJCOM/SG for review and certification.

**7-5. Ground Launched Cruise Missile (GLCM) Duty.** Personnel selected for initial assignment to a GLCM unit must meet the medical standards for appointment, enlistment, and induction (chapter 4), as well as the requirements outlined below:

a. Additional Causes for Rejection:

- (1) Any condition in chapter 3.
- (2) Physical profile less than 2 2 2 2 1.
- (3) Dental Class 2, 3, or 4.

(4) Allergic rhinitis, unless mild in degree and not requiring desensitization or maintenance antihistamine therapy.

(5) History of seizure disorder.

(6) Use of maintenance medications other than antibiotics and oral contraceptives.

b. Medical Examination Requirements. Personnel identified for an initial or return assignment to GLCM duty must undergo a complete physical examination to include completion of SFs 88, 93, and 520 and AF Form 422. In addition, AF Form 1042, will be completed for 18XX personnel.

c. Certification and Waiver Authority for Initial Selection for Training. All physical examinations performed in support of the GLCM selection process will be formally certified.

(1) The MAJCOM/SG will certify all 18XX personnel. The MAJCOM/SG will certify other GLCM personnel who require waivers.

**NOTE:** Prepare and certify waiver or certification requests according to paragraph 1-7.

(2) The Director of Base Medical Services (DBMS) will certify all other GLCM personnel

not requiring waiver. At those medical facilities where the DBMS is not a Medical Corps officer, the Chief, Aerospace Medicine will prepare the certification. (Forward controversial or questionable cases to the MAJCOM/SG for appropriate disposition.) SF 88 and AF Form 422 are the forms used in the certification process.

**d. Continued GLCM Duty:**

(1) Trained GLCM personnel who are selected for return to GLCM duty after a lapse of more than 1 year are required to undergo the processing procedures outlined c(1) and (2) above.

(2) Waivers for minor deviations from the selection standards may be requested from the MAJCOM/SG of assignment when, in the opinion of the examining physician, such defects will not be aggravated or complicated by GLCM duty and will not constitute an undue hazard to the individual or a compromise to the mission.

(3) GLCM personnel other than 18XX personnel are required to undergo a complete medical examination within 6 months before the end of the birth month every 5 years starting at age 25. **NOTE:** An initial selection examination taken within the 12 months before the 5 year cycle will remain valid through the first cycle (example, examination at age 24 is valid until age 30).

(4) PES personnel should complete AF Form 1446 within the 6-month period preceding the last day of the birth month on all years a GLCM 18XX member is not scheduled for a complete medical examination.

**7-6. Weapons Controllers:**

a. Standards. The medical standards for air weapons controllers (17XX) are the standards for Flying Class III. Minimum scope of the medical examination is outlined in attachment 3.

b. Frequency. Medical examinations will be performed according to attachment 3 for all officers and airmen on flying status.

c. Certification and Waiver Authority:

(1) Medical examination of applicants for training leading to AFSC 17XX will be reviewed and certified for such training by MAJCOM/SG of current assignment.

(2) Waivers may be granted for training and subsequent duty in the AFSC.

(3) Certification and waiver authority is prescribed in attachment 2.

**d. Removal From Duty:**

(1) When a controller is found by proper medical authority to be temporarily medically disqualified for duty, he or she is prohibited from participating in ground or airborne duty by local administrative action. AF Form 1042 will be used for these actions.

(2) Controllers will be cleared by a flight surgeon before resuming duty following a period of incapacitation.

(3) Waiver for "ground duty only" may be requested from the appropriate MAJCOM/SG. MAJCOM/SG coordination with MAJCOM/DP is required for restricted waivers.

(4) The medical examination documents of controllers found to have medical conditions requiring permanent removal from duty will be forwarded to the individual's MAJCOM/SG. Medical personnel should not make a recommendation to reclassify an AWC (AFSC 17XX) who is disqualified, for flying class III and ground duty, until HQ AFMPC/DPMMM has reviewed the case. The MAJCOM/SG should forward all such cases directly to HQ AFMPC/DPMMM, Randolph AFB TX 78150-6001. HQ AFMPC/DPMMM will coordinate with DPMROO2 and provide further utilization information or direct reclassification action.

**7-7. Parachute Duty.** The medical standards for applicants for parachute duty training and subsequent parachute duty are the same as those for Flying Class III.

**7-8. Marine Diving Duty.** Personnel must meet medical standards for Flying Class III and the standards listed below:

a. Vision of 20/100 or better, each eye, near and distant, without correction; correctable to 20/20 each eye.

b. Weight not in excess of that specified in attachment 7.

c. Ability to hold breath for 60 seconds subsequent to deep breathing.

d. No abnormality whatsoever of the cardiovascular, respiratory, or gastrointestinal systems.

e. No tendency to excessive flatulence.

f. No history of surgery or injury involving entrance into thoracic, pericardial, or abdominal cavities in the previous 6 months, or cranial cavity at any time.

g. No abnormality of the extremities which would reduce normal strength, stability and

dexterity, including loss of any digit or digit segment, of either hand.

h. Satisfactory adaptability rating (AR) for Diving Duty. (See AFR 160-17.)

i. Satisfactory orthostatic tolerance test.  
j. No history or recurrent episodes of pain diagnosed as the bends.

k. No unrepaired dental problem which might promote aerodontalgia.

l. No history of spontaneous pneumothorax, lung overpressure accidents (during or following decompression), or any episode of CNS decompression sickness, chokes, or vasomotor decompression sickness.

m. Waiver authority is MAJCOM/SG of assignment. NOTE: Marine divers will be restricted from diving duty for 48 hours following operative dental procedures.

**7-9. Hyperbaric Chamber Duty.** Personnel must meet the medical standards for Flying Class III and the standards listed below:

- a. No tendency to excessive flatulence.
- b. No history of surgery or injury involving entrance into thoracic, pericardial, or abdominal cavities in the previous 6 months, or cranial at any time.
- c. Satisfactory AR for Hyperbaric Chamber Duty. (See AFR 160-17.)
- d. No history of recurrent episodes of pain diagnosed as the bends.
- e. No unrepaired dental problem which might promote aerodontalgia.

f. No history of spontaneous pneumothorax, lung overpressure accidents (during or following decompression) or any episode of CNS decompression sickness, chokes, or vasomotor decompression sickness. Consideration for waiver may be given following medical evaluation by an Air Force hyperbaric qualified physician.

g. A normal chest X-ray within the past 12 months will be required unless the individual is currently performing duties requiring a flying class II or III physical examination.

h. Waivers for deviations from the above standards may be requested from the appropriate MAJCOM/SG. Consultation with the USAF Hyperbaric Center, Brooks AFB TX 78235-5000, before granting such waivers by MAJCOM/SG is recommended. NOTE: Hyperbaric chamber personnel will be restricted from duty for 48 hours following operative dental procedures.

**7-10. Physiological Training:**

a. Physiological training personnel (AFSC 916X and 911X0) must meet the medical standards for Flying Class III.

b. Clearance to complete physiologic training:

(1) Military personnel performing aviation duty must have a current class I, IA, II, or III physical on record.

(2) Military personnel requiring passenger training only will be required to complete items 23, 28, 29, 31, 41, 50 (hemoglobin (Hgb)), 51, 52, 57a, 58a, and 77 of SF 88. This abbreviated examination must be accomplished within 90 calendar days of requested training. NOTE: AF Form 1042 will be issued as satisfactory evidence of completion of the requirements outlined in a, b, or c above.

(3) US Air Force, Army or Navy ROTC cadets must present evidence of satisfactory completion of SF 88, or DD Form 2351, DOD Medical Examination Review Board (DOD-MERB) Report of Medical Examination, accomplished within 36 months of the scheduled physiological training. NOTE: AF Form 1042, will not be required of this group of trainees, but any current medical problems must be cleared by the local flight surgeon.

(4) Civilians undergoing physiological training will be required to present a current FAA medical certificate or a valid AF Form 1042 obtained as outlined in c above.

c. The following conditions are disqualifying for physiological training:

- (1) Inability to valsalva.
- (2) Intercurrent or chronic obstructive ear, nose, throat, sinus or pulmonary disease.
- (3) Loss of 200 cc or more of blood is disqualifying for at least 72 hours following the loss.
- (4) Sickle cell disease or heterozygous sickling disorders other than sickle cell trait.
- (5) Sickle cell trait if there is a history of symptoms associated with sickling disorder. Symptomatology attributable to intravascular sickling during decompression in an altitude chamber is also disqualifying.
- (6) History of migraine, neurocirculatory decompression sickness, claustrophobia, organic heart disease, or symptomatic hiatal hernia.
- (7) Inguinal hernia.
- (8) Pregnancy.

**7-11. Survival Training Instructor Duty-Selection and Retention.** The Survival

Training Instructor course is physically demanding and requires the ability to withstand daily running up to 5 miles, 50 pushups, mountain climbing, heat and cold exposure, hiking and backpacking with a weight up to 70 pounds. A standard medical examination recorded on SFs 88 and 93 specifically for survival instructor duty is required at the time of application. The MMPI, MCMI, and Shipley-Hartford Institute of Living Scale psychological tests are required as part of the application examination.

a. Selection. The causes for rejection are:

- (1) Any condition listed in chapter 4.
- (2) Profile less than P-1, U-1, L-1, H-1, E-1, S-1, except that uncorrected distant vision will not be less than 20/100 each eye corrected to 20/20.
- (3) Speech impediment which interferes with clear enunciation.
- (4) History of recurrent or chronic back pain.
- (5) Scoliosis over 25 degrees measured by the Cobb method. Any other abnormal curvature of the spine of any degree in which there is a noticeable deformity, or in which there is pain, or interference with function, or which is progressive.
- (6) Spondylolysis or spondylolisthesis, if symptomatic.
- (7) History of recurrent knee pain or chondromalacia of the patella. A history of knee surgery requires an orthopedic evaluation and a demonstrated ability of at least 1 year strenuous physical activity not requiring a brace.
- (8) History of recurrent shin splints.
- (9) History of recurrent ankle sprains.
- (10) History of foot pain.
- (11) History of stress fractures.
- (12) History of any vertebral fractures, except that for history of a healed, asymptomatic fracture of the transverse process is not disqualifying.
- (13) History of surgery involving a major joint requires an orthopedic evaluation.
- (14) History of frost bite or heat exhaustion.
- (15) History of reactive airway disease or exercise induced breathing difficulties.
- (16) Allergy to stinging insects, pollen, trees, grasses, or dust unless desensitized and controlled on maintenance dosage.
- (17) Deficient night and color vision. Color perception is acceptable if the individual can properly identify the colors on a military topographic map.
- (18) Food aversions, insect or snake phobias.

(19) Character and behavior disorders.

(20) History of alcohol or drug abuse.

(21) History of suicidal gesture or attempt.

(22) Intolerance to close or confined spaces.

(23) Mental health condition that indicates the applicant will be unable to accept constructive criticism or unable to function in a high stress environment.

b. Retention. A trained and experienced survival instructor will be considered using these standards as a guide, but continued duty will be dependent upon the member's demonstrated ability and performance.

c. Waivers. Minor deviations from the above standards may be requested for survival instructor duty when, in the opinion of the reviewing authority, such defects will not interfere with the rigorous training program, nor be aggravated by outdoor activities in extreme weather conditions, nor constitute an undue hazard to the instructor or to his or her students.

d. Certification and Waiver Authority.

The HQ ATC/SGPS is the medical certification and waiver authority for selection and retention of survival instructors and trainees.

**7-12. Military Training Instructor (MTI) Duty.** MTIs have the primary responsibility for conducting basic military training to nonprior service Air Force personnel. They instruct, supervise, counsel, and inspect indoors and outdoors under all kinds of environmental situations. Consequently, MTIs are under tremendous mental and physical stress. MTI applicants need to be adequately evaluated to identify potential medical and psychological conditions which would make them unfit or unsuitable for MTI duty.

a. The CBPO will refer each MTI applicant to the PES section for:

(1) Medical records review.

(2) Physician Interview and examination.

Additionally, an interview and recommendation by a psychiatrist or psychologist specifically for MTI duty is mandatory, if such a specialist is assigned to the local medical facility. The results of the interview and examination will be recorded in the applicant's outpatient health records on SF 600, Chronological Record of Medical Care.

(3) Current physical profile assessment to be recorded on AF Form 422 with the statement indicating the applicant was interviewed and

examined by a physician and psychiatrist or psychologist.

b. Specific causes for rejection are:

- (1) Physical profile less than 121221.
- (2) Speech impediment which interferes with clear enunciation.
- (3) History of injury to, or defects of, the spinal column, major bones, or joints which have caused recurring symptoms.
- (4) History of symptomatic defects of the foot including pes planus, bunions, hallux valgus, hammer toes, plantar warts, recurring ingrown toenails, and pes cavus.
- (5) History, or current evidence, of a psychiatric condition.

(6) Personality disorder which precludes the applicant from accepting criticism, supervising large groups of students, or functioning effectively in a high stress situation.

(7) Asthma or emphysema.

(8) Weight outside the standards according to height.

(9) Any other medical or psychiatric condition which, in the opinion of the examiner, contraindicates duty in a physically and psychologically demanding environment.

c. Annually, a mental health provider will interview MTIs and their health records to insure their medical fitness for continuation as an MTI. An AF Form 422 will serve as the annual medical certification for continued duty.

d. HQ ATC/SG is the final medical review authority in the MTI selection and retention process.

### **7-13. Duty Requiring Use of Night Vision Goggles (NVG):**

a. Aircrew members who wear the modified version (cutaway) of the AN/PVS-5a NVG or the ANVIS NVG in the performance of their duties will have no additional vision standards. The corrected visual acuity standards for each flying class will permit a visual acuity of at least 20/50 while wearing NVG. Personnel who are required to wear NVG will be examined initially and periodically according to Aerospace Medicine Consultant Center Report 85-3, Night Vision Manual for the Flight Surgeon. Those who cannot demonstrate at least 20/50 vision while wearing NVG will be referred to optometry or ophthalmology for further evaluation. Each aircrew member who requires corrective lenses in order to meet the visual acuity standards for flying, and who are required to wear NVG in the performance of their flying duties

will be provided special safety glasses or contact lenses which will be worn when using NVG. Special safety glasses with lenses ground to the appropriate correction for spherical or astigmatic refraction can be obtained in the following manner:

- (1) If the aircrew member has not had a refraction done within the past year, do a current refraction.
- (2) Send the current prescription and a letter requesting special safety glasses with plastic lenses to AL/AOCO, Brooks AFB TX 78235-5301.

(3) Return one complete pair of glasses per prescription to the requester.

(4) Give the glasses to the aircrew member with instructions to wear them only when using NVG and to protect the lenses from marring or scratching.

b. Aircrew members who are required to wear the unmodified version (full faceplate) of the AN/PVS-5a NVG, and who are also required to wear spectacles in the performance of their duties, must meet the following additional vision requirements:

- (1) Refractive error of no more than plus 2.00 or minus 6.00 diopters in any meridian.
- (2) Astigmatism requiring no more than 1.00 diopter of cylinder.
- (3) If unable to meet either of the above two requirements, the individual must be able to wear MAG-1 combat spectacles with the full faceplate NVG. MAG-1 combat spectacles with plastic or polycarbonate lenses can be ordered from Aeromedical Consultation Service. Follow the procedures outlined in a(1) and (2) above. Specify MAG-1 combat spectacles in the letter.

(4) If the individual is unable to meet the above requirements, he or she may be referred for a full aeromedical consultation evaluation and the possible fitting of contact lenses.

### **7-14. Remote or Isolated Duty:**

a. Verification of Medical Acceptability. Personnel who are alerted for assignment to areas where unaccompanied tour length is 17 months or less and accompanied tour length is 24 months, as indicated in AFR 36-20, will be sent to the PES for verification of medical acceptability for assignment. This verification will consist of:

- (1) Individual medical records review.
- (2) Verifying the existing physical profile.

(3) Doing a periodic medical examination if an examination will be due during the assignment tour.

(4) Doing an audiometric examination if the individual is currently in, and subject to routine monitoring under, the Hearing Conservation Program.

(5) Annotating SF 600 that the review and appropriate actions have been taken.

**NOTES:**

1. The periodic medical examination and audiometric examination are not required to be accomplished if the assignment is to an installation or base which has a USAF medical treatment facility with a physical examination and standards section.

2. The purpose of this evaluation is to make sure any individual selected for assignment to a remote or isolated duty station may reasonably be expected to effectively complete the tour of duty. Personnel qualified for WWD may not be acceptable for remote or isolated duty assignments. Individuals in need of extensive and prolonged medical or dental care are not

acceptable. Known conditions which could produce catastrophic or life threatening illness should not be assigned to remote or isolated duty. Personnel with the diagnosis of asthma require a medical evaluation by an internist, allergist, or pulmonary medicine physician to determine suitability for remote or isolated duty assignments. Those with asthma will be presented to a medical evaluation board. See b(2) below for disposition.

b. Disposition:

(1) Qualified for Worldwide Service. The CBPO will be notified of the individuals clearance using the short-tour clearance form in AFR 35-17, attachment 17.

(2) Qualification for Worldwide Service Questionable:

(a) PES personnel will prepare an AF Form 422, according to chapter 2, and the DBMS or designated profile officer will sign and review it before sending it to the CBPO.

(b) PES personnel will determine the individual's qualification according to chapter 3.

## Chapter 8

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

**8-1. Purpose of This Chapter.** This chapter implements DoD Directive 1205.9, 6 October 1960, as required by 10 U.S.C. 1004(a). It establishes procedures for accomplishing, reviewing, certifying, and administratively processing medical examinations on Air Reserve Component members not on extended active duty (EAD) who are assigned to the Ready Reserve and Standby Reserve. Use AFRES Sup 1 to AFR 160-43 with this regulation when working cases on AFRES unit assigned members.

#### **8-2. Terms Explained:**

a. **Air Reserve Component (ARC).** Unit and individual members of the Air National Guard (ANG) and US Air Force Reserve (USAFR).

b. **ARC Members of the Ready Reserve:**

(1) **Air National Guard.** Administered by ANGRC/SGP, Andrews AFB, D.C. 20331-6008.

(2) **US Air Force Reserve Unit.** Administered by HQ AFRES/SGP, Robins AFB, GA 31098-6001.

(3) **Individual Mobilization Augmentee (IMA).** Administered by HQ ARPC/ SGS, Denver, CO 80280-5000.

(4) **Reinforcement Designee (RD).** Category H Reserve member. Administered by HQ ARPC/SGS, Denver CO 80280-5000.

c. **ARC of the Standby Reserve.** Nonaffiliated and inactive status Reserve members. Administered by HQ ARPC/SGS, Denver CO 80280-5000. These members may be ordered to EAD only in time of war or national emergency declared by the Congress.

**8-3. Medical Standards Policy.** Each ARC individual will be medically qualified for deployment and worldwide duty according to chapter 3. **NOTE:** Assignment Limitation Code "C" may be authorized for IMAs with certain medical conditions which limit their qualification for worldwide duty as outlined in AFR 35-41, volume I.

#### **8-4. Specific Responsibilities:**

a. **Commander or Supervisor.** Each ARC commander or active force supervisor ensures an ARC member is medically qualified for worldwide duty (AFR 35-41, volume II). The com-

mander and supervisor of the ARC member who receives medical information will submit the information or documentation to the servicing medical facility for review and fitness for duty determination.

b. **ARC Member.** Each ARC member is responsible for promptly reporting a disease, injury, and an operative procedure or hospitalization not previously reported to his or her commander or supervisor. Any concealment or claim of disability made with the intent to defraud the government may result in legal action and possible discharge from the ARC. Refusal to comply with requests for medical information will result in processing under paragraph 8-14.

c. **Air Force Health Care Providers.** They will review medical documentation submitted by an ARC member's commander or supervisor to determine fitness for duty. Air Force medical service personnel will record any injury or disease incurred or contracted by ARC members during any training period on appropriate medical forms since the injury or disease may be the basis for a claim against the government. This may require initiation of a Line of Duty Determination, if prescribed by AFR 35-67, AFRES Supp 1 to AFR 35-67 or ANGR 35-67.

#### **8-5. General Responsibilities:**

a. Establish health and dental records for each ARC member under the provisions of AFR 35-44. Their contents and maintenance are described in AFRES 162-1 and AFR 168-4. File a medical examination (SF 88 and 93 as required, and all supporting documents) on an ARC member found medically qualified for worldwide duty in the member's health record.

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

(2) Send original IMA medical examinations to HQ ARPC/SGS, Denver, CO 80280-5000.

b. Send ARC members found medically disqualified and questionable cases to:

(1) ANGRC/SGP, Andrews AFB, DC 20331-6008, for ANG members.

(2) HQ AFRES/SGP, Robins AFB GA 31098-6001, for unit member.

(3) HQ ARPC/SGS, Denver CO 80280-5000, for IMAs.

c. Make sure members assigned to the Retired Reserve because of medical disqualification who desire removal from this section meet the following criteria:

(1) Disqualifying defect must be repaired or resolved.

(2) Chapter 4 standards must be satisfied if assigned to the Retired Reserve for more than 12 months.

(3) Review and certification by HQ ARPC/SG, verifying member is medically qualified to return to duty.

d. Have unit assigned members who want to reenlist but have not completed a medical examination or annual medical certificate in the past 12 months complete AF Form 895, Annual Medical Certificate. Individuals with changes in medical status will be scheduled by their commander or supervisor for a medical examination to determine eligibility for reenlistment.

e. Annually, prepare an ARPC Form 69 on RDs not participating for pay or points. Members who feel their medical qualification is in question must attach medical documentation to the ARPC Form 69 and return the form to HQ ARPC/DSFS, Denver, CO 80280-5000.

f. Forward medical examinations on general officers or colonels serving in general officer positions found medically disqualified, or who have questionable medical status, according to instructions in attachment 2.

g. Refer personnel found to be overweight during a periodic medical examination to their unit commander by letter for appropriate action under AFR 35-11.

#### **8-6. Voluntary EAD:**

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

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

c. ARC members must meet medical qualification standards in chapter 4.

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

#### **8-7. Involuntary EAD—45-Day-Active Duty Tour:**

a. An ARC member who has a current medical examination according to attachment 3 may be involuntarily ordered to EAD for a period of 45 calendar days.

b. The medical records of the ARC member must be reviewed for disqualifying defects according to chapter 3. Members found medically disqualified or questionably qualified for worldwide duty will be evaluated before entry on EAD.

c. An ARC member who fails to report for the medical examination will be processed according to paragraph 8-14.

#### **8-8. Involuntary EAD or Mobilization.** An ARC member ordered to EAD due to mobilization will be medically processed according to AFR 28-5.

**8-9. Annual Training (AT) or Active Duty for Training (ADT) or Inactive Duty for Training (IDT).** Commanders will ensure members reporting for duty are medically qualified under current directives. Members found medically disqualified or questionable for worldwide duty will be evaluated for fitness for duty and released from duty by his or her commander pending final disposition by HQ AFRES/SGP, HQ ARPC/SGS, or ANGRC/SGP. Members who believe their medical condition has changed significantly during an AT, ADT, or IDT will report to a medical facility before release from tour. A line of duty determination will be accomplished according to AFR 35-67, AFRES Supp 1 to AFR 35-67 or ANGR 35-67 on ARC members suffering from injury or disease incurred or contracted during AT, ADT, or IDT.

#### **8-10. Inactive Duty for Training:**

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

b. If a member reports for duty and does not consider him/herself medically qualified, the member must be scheduled by the ARF commander or active duty supervisor for a medical evaluation during the IDT period. If the member is not qualified for worldwide duty, a medical evaluation will be sent to HQ AFRES/SGP, HQ ARPC/SGS, OR ANGRC/SGP as appropriate. The member is excused from training pending a review of the case. For ANG members, the

State Air Surgeon may grant an interim waiver for IDT in the likelihood the member will be returned to duty.

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

#### **8-11. Medical Examination:**

a. Medical personnel must perform a medical examination according to chapter 1 and AFP 160-17 and consult AFRES Sup 1 to AFR 160-43 when doing medical examinations on AFRES unit assigned members.

b. Medical personnel should complete a Type II dental examination during periodic physicals. ARC flying personnel will require this examination every 2 years (SF 88). Bite wing radiographs will be done at the discretion of the examining dental officer for diagnostic assistance.

c. ARC unit members must complete AF Form 895 within 12 months of the date of their last medical certificate for those years in which a medical examination was not required.

(1) Unit or ANG members with positive responses made on AF Form 895, will require the ARC unit member to interview with a senior medical technician (SMT) as soon as possible, but not later than the UTA following completion of the AF Form 895. This interview may be conducted by telephone.

(a) The SMT annotates his or her findings in the member's medical record on SF 600. The member must provide all supporting civilian medical and dental documentation for inclusion in their medical and dental records.

(b) If the SMT determines the member has a chronic or current medical condition or has questionable qualifications, the SMT refers the case to a military physician for review and disposition.

(c) The medical unit will notify the ARC CBPO and commander when a member cannot continue the UTA because of a medical condition. AF Form 422 is the form of notification.

d. IMA's must notify their commander or supervisor of positive responses on AF Form 895. The commander or supervisor will schedule the member for a fitness for duty evaluation to determine medical qualification for worldwide duty. The member should be released from duty pending final disposition by HQ ARPC/SGS.

#### **8-12. Scheduling Periodic Medical Examination.** See attachment 2.

a. ARC unit and ANG members' medical examinations are scheduled at USAFR or ANG medical units. If this is not possible, they are scheduled periodically at DoD medical treatment facilities. ARC members may make their own appointments if more practical. A periodic medical examination is normally scheduled during a training period.

b. IMA members schedule periodic medical examinations after they receive a certified request for the examination from HQ ARPC/SGS. HQ ARPC/DPRC notifies IMA flying personnel of examination requirements. IMAs are normally assigned and attached to active duty units for training. It is normal for them to schedule their periodic medical examinations with active units. After IMAs have received a scheduled date from the MTF, they must contact HQ ARPC/SGS to forward a copy of their most recent SFs 88,93, and 603, HIV screening results, and any significant interval history to the MTF. If they do not receive medical information within 72 hours before the examination, the MTF must contact HQ ARPC/SGS to obtain the information. MTFs should make every effort to perform the medical examination in 1 day.

c. A civilian physician or dentist may perform a medical or dental examination at government expense if prior approval has been obtained from ANGRC/SG for ANG members, from HQ AFRES/SGP for unit USAFR members, or from HQ ARPC/SGS for IMAs.

#### **8-13. Medical Evaluations To Determine Fitness for Duty:**

a. The commander or supervisor must schedule medical evaluations to determine medical and dental qualification for continued worldwide duty (Fitness for Duty) for the following reasons:

(1) Notification or awareness of a change in the member's medical status.

(2) ARC member feels he or she is medically disqualified for worldwide duty.

b. The commander or supervisor notifies the ARC member, in writing, to report for the medical evaluation. This evaluation must not be deferred for more than 90 calendar days.

c. The medical evaluation must be reported on the SF Form 502, Medical Record - Narrative Summary for all ARC members. SFs 88 and 93 and AF 618 are also required for this evaluation on ANG members only. The narrative summary

must show a clear picture of the disease or injury, and:

- (1) Date and circumstances of occurrence.
- (2) Response to treatment.
- (3) Current clinical status.
- (4) Proposed treatment.
- (5) The extent to which the condition interferes with the performance of duty (conflict and war).
- (6) Prognosis.
  - d. A member who is unable to travel must submit a report from his or her attending physician to his or her commander or supervisor who, in turn, will submit the report to the servicing medical treatment facility for review and determination of fitness for duty.
  - e. Medical personnel will forward the medical evaluations on:
    - (1) ARC unit members and ANG members found questionably or disqualified for continued worldwide duty to HQ AFRES/SGP or ANGRC/SGP.
    - (2) IMAs to HQ ARPC/SGS for review and disposition.

**8-14. Failure To Comply.** ARC members who fail to complete a required medical requirement (i.e., periodic medical examination, dental, immunizations, etc.) will be placed on 4T profile. The servicing medical unit will write the ARC member's commander stating the reserve member in question failed to appear for a military formation and request appropriate administrative action. The medical unit will also request that the commander provide a date when the member would be expected to complete his or her medical requirement. No further action is required by the medical unit.

- a. ARC members on flying status who fail to complete a required medical examination will be suspended from flying status per AFR 60-13.
- b. ARC members with known medical or dental conditions who refuse to comply with a request for medical information or medical evaluation will be considered medically unfit for continued military duty. Cases such as these will be processed according to paragraph 8-13b.

**Chapter 9****MEDICAL EXAMINATION-PERFORMING AND RECORDING**

**9-1. Important Aspects of Taking a Medical History.** One of the most important tasks on the physical examination is the accurate writing and recording of the examinee's medical history. An item of medical history often determines the examinee's qualification for the type of physical examination being taken. Although an important part of the physical examination, the correct writing and recording of a medical history is also one of the most difficult. An understanding of anatomy and physiology as well as diseases and disorders are needed so that the right questions may be asked to obtain all the necessary information.

**9-2. Medical History.** Prepare an SF 93, Report of Medical History, and attach it to SF 88, Report of Medical Examination, when performing examinations are done for the following purposes:

- a. Entry into active military service.
- b. Appointment or enlistment in the US Air Force or its Reserve forces.
- c. Retirement or separation from active military service.
- d. When an examination is sent for higher authority review.
- e. When considered desirable by the examining physician; for example, when there has been an interval history of significant illness or injury.
- f. Examination of an ARF member.

**9-3. Interval Medical History.** A complete medical history is not required on every physical examination. It is only required when preparing SF 93. When preparing an SF 93, record only significant items of medical history since

the last physical examination. This is called the interval medical history.

a. Record any medical condition that required the examinee to see a physician more than once, required hospitalization, or required excusal, grounding, or suspension from flying status as part of the interval medical history. Obtain the information concerning the interval medical history by asking the person and by reviewing the examinee's medical records.

b. Record the interval medical history on SF 88, item 73.

c. After recording the interval medical history, record the following denial statement: "Examinee denies, and review of medical records fails to reveal, any other significant medical or surgical history since last examination (enter the date of that examination here in parentheses)."

d. If the examinee had no interval medical history, record the above statement, omitting the word "other."

**9-4. Medical Examinations.** Record the results of complete medical examinations on SF 88 according to AFP 160-17 standard format.

**9-5. AF Form 1446, Medical Examination-Flying Personnel.** Use AF Form 1446 to record findings when a complete examination is not required. Use this form for the medical examinations performed on officers and airmen on flying status, space operations duty, missile launch crew duty, weapons controller duty, physiological training duty, hyperbaric chamber duty, marine diving duty, air traffic control duty, and parachute duty. (See attachment 3, notes 2 and 5.)

## Chapter 10

### SPECIAL EVALUATION REQUIREMENTS

**10-1. About This Chapter.** This chapter establishes minimum guidelines for cases submitted to certification and waiver authorities that should include appropriate followup and documentation of potentially disqualifying conditions.

**10-2. Artificial Dentures.** During dental evaluation, document the satisfactorily restoration of masticatory function, appearance, and clear speech. Note that a complete dental prosthesis must satisfactorily demonstrate adequate phonetics, retention, stability, interocclusal space, and occlusion. Oral tissues supporting the prosthesis must be in good health.

**10-3. Blood Pressure, Elevated, Finding or History of:**

a. The diagnosis of hypertension or the assessment of control is based on the average of sitting blood pressure readings obtained on 5 different days. If the blood pressure is persistently elevated, medical consultation is indicated (see AFR 160-17).

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

**10-4. Concussion.** See paragraph 10-6.

**10-5. Dizziness or Fainting Spells, History of.** See paragraph 10-14.

**10-6. Head Trauma in Flying Personnel.** Minimum observation periods and evaluation requirements are listed in table 10-1. **NOTE:** The severity of injury is a governing factor.

**10-7. Hepatitis, History of, in the Past 6 Months.** Hepatitis B surface antigen (HbsAg) and serum glutamic-oxaloacetic transaminase (SGOT).

**10-8. Intraocular Tension:**

a. Routine determination of intraocular tension by tonometry is outlined in attachment 2. Refer examinees with the following intraocular tensions to a qualified ophthalmologist for consultation:

(1) Two or more current determinations of 22 mmHg or higher.

(2) A difference of 4 mmHg or greater between right and left eyes.

b. For personnel who are required to meet medical standards for flying, a ocular hypertension (preglaucoma) group will be identified. This group will include those flying personnel whose intraocular pressure exceeds the limits in "a" above, but who have no visual field defect or optic disc or nerve fiber layer changes, and whose pressure is below 30 mmHg.

c. When ophthalmological consultation results in a diagnosis of glaucoma, any type, or the need for medication (either topical or systemic) to control intraocular tension, the condition is disqualifying for all categories. Refer to the MAJCOM/SG, personnel who are required to meet medical standards for flying, after an effective therapeutic regime has been established and if the flight surgeon and ophthalmologist agree there are no apparent aeromedical reasons to justify continued suspension from flying duties for evaluation. Refer individuals with glaucoma to the Aeromedical Consultation Service, Brooks AFB TX for evaluation. Effective therapy is defined as an intraocular pressure of 21 mmHg or less and no adverse visual or systemic effects from medications. At a minimum, ophthalmology followup (military or civilian) is required every 6 months. Personnel who require systemic medication will not be considered for a flying waiver.

d. The initial ophthalmology and all subsequent ophthalmology evaluations should include, where appropriate, a dilated examination of the disc with a stereoscopic magnifying lens (Hruby, Goldman, 90D), visual fields, applanation tonometry, and stereo 35 mm disc photos (when available).

**10-9. Malocclusion, Teeth.** Report of examination by a dentist with comment as to whether incisal and masticatory functions are

adequate for an ordinary diet, plus a comment on the degree of facial deformity with the jaw in natural position and whether there is interference with speech.

#### 10-10. Serologic Test for Syphilis (STS)

**Positive.** Repeat test and obtain a careful and complete venereal disease history. If second STS (RPR or VDRL) is positive, additional diagnostic tests, such as FTA-ABS, should be done to rule out active syphilis.

**10-11. Sickle Cell Trait.** Confirm positive sickle cell screening tests on personnel performing flying duty or required to meet flying medical standards by hemoglobin electrophoresis. A one-time certification, by the proper certification authority in attachment 2, is required for all flying personnel and flying training appli-

cants with sickle cell trait. For the purpose of maintaining a central registry of US Air Force flying personnel with sickling disorders, the certification authority will notify HQ AFMOA/SGPA, Bolling AFB DC, 20332-6188, when an individual with sickle cell trait is certified for flying duty. Include the following information: name (last, first, MI), rank, SSN, flying class, percent of hemoglobin-S, and certification date.

#### 10-12. Skull Fracture, History of, in Past 10 Years. (See table 10-1.)

**10-13. Sarcoidosis.** The local evaluation should include radiograph of the chest (hilar, pulmonary function testing, Holter monitor, ophthalmology evaluation, and pertinent laboratories (CBC, liver function studies, ACE

TABLE 10-1

## EVALUATION FOR RISK OF HEAD INJURY SEQUELAE

Degree of Head Injury	Minimum Observation Time	Evaluation Requirements
Mild  (see paragraph 6-25a (7)(d) for criteria)	1 month	Enlistment, Induction, Appointment: -Complete Neurological Examination by a Physician Flying Class I, IA, II, III: -Complete Neurological and Mental Status Examination by a Flight Surgeon
Moderate  (see paragraph 6-25a (7)(c) for criteria)	2 years	Enlistment, Induction, Appointment, Flying Class I, 1A, II, III: -Complete Neurological Evaluation by a Neurologist or Internist -CT Scan -Neurological Evaluation (Consists of the following tests, as a minimum: MMPI; Halstead -Rectan; and WAIS-R)
Severe  (see paragraph 6-25a (7)(b) for criteria)	5 years for closed head trauma  10 years for penetrating head trauma	Enlistment, Induction, Appointment, Flying Class II, III: -Complete Neurological Evaluation by a Neurologist or Neurosurgeon -CT Scan -Neurological Evaluation (Consists of the following tests, as a minimum: MMPI; Halstead -Rectan; and WAIS-R) -If above are normal, then aeromedical consultation service evaluation (Flying Classes II & III ONLY)

level, serum calcium, 24-hour urine calcium). Disqualify those with definite myocardial, neurologic or systemic sarcoidosis. Submit waiver request to the MAJCOM after the above evaluation is normal. Perform reevaluation with the above testing every 2 years unless clinically indicated at a shorter interval. Refer aviators to the ACS for standard indications in this regulation or if there is the possibility of cardiac or systemic sarcoidosis.

**10-14. Syncope, History of.** In evaluating a syncopal event, a good history is the single most important element in the package which is sent to the reviewing authority. Include in the history a detailed description of the event itself, with particular attention to prodromal symptoms, if present, duration of unconsciousness, and speed of full cognitive recovery. Address any triggering stimuli, e.g. venipuncture, prolonged standing, flashing lights etc. Mention any contributing factors, e.g. alcohol, sleep deprivation, illness etc.

**10-15. The Aerospace Medicine Consultant Service (ACS).** Located at Brooks AFB, TX the ACS was established to evaluate aviators with difficult, obscure, or borderline medical problems as well as aircrew members being considered special flight operations.

a. **Referral Requirement.** Persons who may be referred to ACS include:

(1) Active duty personnel on flying or persons removed from flying duty for medical reasons, after approval by their MAJCOM Surgeon. Medical disqualification and suspension from flying for more than 3 years require HQ AFMOA/SGPA approval. Forward all requests through the MAJCOM/ SG.

(2) Air National Guard and Air Force Reserve personnel who have been approved by HQ AFMOA/SGPA for such consultation. Under these circumstances, personnel are issued orders for the time required for travel and consultation. Only HQ AFRES/SG and the Chief, National Guard Bureau (NGB/CF) have the authority to issue orders and provide funds for their respective personnel.

(3) US Army and Navy personnel with approval of AAMA, Fort Rucker, AL or Naval Aeromedical Research Institute, Pensacola, FL, respectively and concurrence from ACS.

(4) Military personnel of foreign countries assigned to and present for duty in the continen-

tal United States (CONUS), after HQ AFMOA/SGPA approval.

b. **Referral Procedures:**

(1) **Initial Evaluations.** The referring flight surgeon prepares a referral package as specified in paragraph 1-8a. The patient's current SF 88 (if not more than 6 months old) may be used in place of a new SF 88. When the ACS scheduler requests records of special studies (including electrocardiogram (ECG), echocardiogram, electroencephalogram (EEG), Holter monitors, magnetic resonance imaging (MRI), all x-rays, etc.), and consultations, send them by certified mail.

(2) **Reevaluations.** For flyers who return to the ACS for reevaluation, include the following forms in the aeromedical package: a current SF 88 or AF Form 1446 and current aeromedical summary (minimum 3 copies); AF Form 1042, Medical Recommendations for Flying or Special Operational Duty; and three copies of the previous year's complete physical and supporting documents when submitting AF Form 1446.

(3) **Scheduling Procedures.** The approving authority sends the request to Aeromedical Consultation Service, Brooks AFB TX 78235-5301. The ACS then notifies the base flight surgeon of the appointment date and furnishes reporting instructions. The military treatment facility making the referral publishes the temporary duty (TDY) orders and provides the funds to support the TDY. The orders should state that the TDY is for aeromedical evaluation, and that 10 calendar days of TDY, in addition to travel time, is authorized. Orders must not direct travel by aeromedical evacuation aircraft only. All medical and dental records, including inpatient records, outpatient records (AF Form 2100 series) are to be sent by certified mail with enough time to arrive at the ACS 10 calendar days before the scheduled appointment. The ACS will return all records by certified mail.

c. **Consultation Procedures.** The ACS makes a thorough evaluation of the referred problem, conducts specialized studies and confirmatory examinations, and makes disposition recommendations to the certification or waiver authority. ACS must send a written consultation report with recommendation to the certification or waiver authority within 30 workdays after the evaluation has been completed. The unit flight surgeon must brief the examinee on details of the findings and recommendations in the consultation report. Final review and dispo-

sition of each case rests with the certification or waiver authority specified attachment 2.

d. Distribution of Reports. The ACS combines referral documents with copy of the consultation report and sends the complete package to the certification or waiver authority. In addition, the ACS distributes one copy to every report to the following:

- (1) Individual consultant service for retention.
- (2) Examinee's Health Record (AF Form 2100 series).
- (3) Referral medical facility, if other than recipient of the AF Form 2100.
- (4) MAJCOM/SG, HQ AFRES/SG, or ANGRC/SGP.

## Chapter 11

### OCCUPATIONAL HEALTH EXAMINATIONS

**11-1. Why Occupational Examinations are Done.** Occupational health examinations are done to assess the health status of individuals as it relates to their work. The examinations are conducted to assist in maintaining a fit force essential to mission readiness, and to make sure the Air Force meets its obligation under the Occupational Safety and Health Act of 1970 (29 U.S.C. 6686) to promote good health in its workers.

**11-2. Who Receives These Examinations.**

These examinations are done on workers, military and civilian (including foreign nationals), who are assigned to workplaces identified by the Bioenvironmental Engineering Section (BES) and validated by the Aerospace Medicine Council as designated potential occupational health risk areas (Air Force Occupational Safety and Health (AFOSH) Standard 161-17).

**11-3. Collateral Responsibilities.** The conduct of occupational health examinations requires the cooperation of several agencies, namely, the BES, Aerospace Medicine Council, Military Public Health (MPH) Section, Physical Examination and Standards (PES) Section, Consolidated Base Personnel Office (CBPO), and the Consolidated Civilian Personnel Office (CCPO).

a. The BES identifies those workplaces where assigned workers may require occupational health examinations.

b. The Aerospace Medicine Council reviews BES recommendations concerning workplaces where workers require occupational health examinations and decides on the scope of such examinations.

c. The MPH monitors scheduling and results of the examinations.

d. The PES schedules and performs occupational health examinations.

e. The CBPO and CCPO provide and update occupational health examination scheduling products.

**11-4. Types of Examinations:**

a. Preplacement or Baseline. These are specific tests and examinations done to establish

and document baseline data for future use in evaluating potential occupational exposures.

b. Special Purpose Periodic. These are specific tests and examinations done at intervals to evaluate and document the health effects of occupational exposures. The frequency and extent of these assessments are determined from the type of health risk, results of workplace monitoring, and recorded findings of previous health examinations. These examinations may range from a complete physical examination to selected biological screening tests.

c. Termination. These are specific tests and examinations to assess pertinent aspects of the worker's health, normally done upon termination of employment (separation or retirement). Documented examination results may be beneficial in assessing the relationship of a future medical problem to work or exposures in the workplace. Additionally, termination examinations may be required for individuals being reassigned from hazardous to nonhazardous duties or by a specific AFOSH standards. AFOSH standard 161-10, Health Hazards Control for Laser Radiation, requires examination upon termination and permanent change of station or permanent change of assignment from laser related duties.

**11-5. Examination Requirements.** The Aerospace Medicine Council determines the scope of these examinations locally, after considering all relevant exposure factors and regulatory guidance. AFOSH Standard 161-17 outlines examinations required by Air Force publications and lists resource material that can assist in making decisions on the appropriateness of examinations. Additional guidance is published in DoD Manual 6055.5 (AFOSH Standard 161-17), Occupational Health Surveillance Manual.

**11-6. Records Required.** Prepare and dispose of the following forms as outlined in AFOSH Standard 161-17 and AFR 4-20, volume 2:

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

b. AF Form 2768, Supplemental History. Used to record information concerning the examinee's health and occupation, past and present.

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

d. AF Form 2770, Assessment and Disposition. Used to provide a written medical opinion concerning the fitness of the examinee and to notify the individual and the individual's supervisor of the determination. NOTE: It also serves to fulfill the provisions of AFR 40-716 when it is determined a civilian worker is not qualified, temporarily or permanently, to perform assigned current duties.

e. SF 78, Certificate of Medical Examinations. Provides a listing of functional and environmental factors essential to the examination and placement of civilian workers. Examiner records findings and conclusions on this form and returns the completed document to the responsible CCPO. NOTE: For those personnel who will be employed to perform duties requiring occupational health examination,

the CCPO will send a copy of page 1, parts A, B, and C to the medical treatment facility records section. MTF personnel use this copy of the SF 78 to establish individual medical records.

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

g. DD Form 2216, Hearing Conservation Data. Used to record the results of periodic and followup audiometry for individuals routinely exposed to hazardous noise. NOTE: Before using this form, make sure a reference audiogram is already filed in the individual's health record.

h. AF Form 1671, Detailed Hearing Conservation Data Followup. Used to record the results of detailed followup audiometric monitoring.

i. SF 520, Electrocardiographic Record. Used to record the results of ECG when indicated.

**11-7. Consultations.** If during the accomplishment of these examinations the health care provider suspects an individual's illness may be job-related, the practitioner notes pertinent historical and clinical data on SF 513, Medical Record-Consultation Sheet, and sends it to the MPH (AFR 161-33).

#### BY ORDER OF THE SECRETARY OF THE AIR FORCE

OFFICIAL

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Director of Information Management

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## LIST OF ABBREVIATIONS

ACS—Aeromedical Consultation Service	DC—Dental Corps
ADT—Active duty tour	DEROS—Date Eligible for Return from Overseas
AFA—Air Force Academy	DODD—Department of Defense Directive
AFIP—Armed Forces Institute of Pathology	DODMERB—Department of Defense Medical Examination Review Board
AFELM—Air Force Element	DOS—Date of separation
AFMPC—Air Force Manpower and Personnel Center	DPA-V—Depth perception apparatus Verhoeff
AFROTC—Air Force Reserve Officer's Training Corps	DSM—Diagnostic and Statistical Manual
AFSC—Air Force Specialty Code	EAD—Extended active duty
AL/AOC—Armstrong Laboratory/Aerospace Medicine Directorate, Clinical Sciences Division	ECG—Electrocardiogram
AL/AOCAB—Armstrong Laboratory/Aerospace Medicine Directorate, ECG Library	ELISA—Enzyme-linked immunosorbent assay
AL/AOCI—Armstrong Laboratory/Aerospace Medicine Directorate, Flight Medicine	ENT—Ear, nose, and throat
AL/AOCO—Armstrong Laboratory/Aerospace Medicine Directorate, Ophthalmology	EPTS—Existed prior to service
AME—Aviation Medicine Examiner	ETS—Expiration of term of service
AMP—Aerospace Medicine Primary	FAA—Federal Aviation Administration
ANG—Air National Guard	FALANT—Farnsworth lantern test
ANGRC—Air National Gaurd	FAR—Federal Air Regulation
ANSI—American National Standards Institute	FMO—Flight Management Officer
AR—Adaptability Rating	FTS-ABS—Fluorescent treponemal antibody absorption
ARC—Air Reserve Component	GLC—High G induced loss of consciousness
AR-Missile Duty—Adaptability Rating-Missile Duty	G6PD—Glucose 6 phosphate dehydrogenase
ARF—Air Reserve Forces	HDL—high density lipoprotein
ARMA—Adaptability Rating Military Aviation	HPSP—Health Professions Scholarship Program
ARPC—Air Reserve Personnel Center	HIV—Human Immunodeficiency Virus
ASMRO—Armed Services Medical Regulating Officer	HOSM—Host Operations System Management
ATC—Air Training Command	IDT—Inactive duty for training
AV—Atrioventricular	IMA—Individual mobilization augmentee
AWOL—Absent Without Official Leave	ISO—International Standards Organization
BES—Bioenvironmental Engineering Section	LAS—Limited assignment status
BSC—Biomedical Sciences Corps	LOC—Loss of consciousness
CBPO—Consolidated Base Personnel Office	LOD—Line of duty
CCPO—Consolidated Civilian Personnel Office	MAJCOM—Major command
cm—Centimeter	MC—Medical Corps
CNS—Central Nervous System	MEB—Medical Evaluation Board
CONUS—Continental United States	MEPS—Military Entrance Processing Station
CSAF—Chief of Staff United States Air Force	mm—Millimeter
CT—Cover test	mmHg—Millimeters of mercury
DAF—Department of the Air Force	MPH—Military Public Health
DAFSC—Duty Air Force Specialty Code	MSC—Medical Service Corps
dB—Decibel	MTF—Medical Treatment Facility
DBMS—Director of Base Medical Services	MVP—Mitral Valve Prolapse
	NATO—North Atlantic Treaty Organization
	NC—Nurse Corps
	NIBH—Not indicated by history
	NOK—Next of kin
	NVG—Night vision goggles
	OTS—Officer Training School
	OU—Oculi Unitas (both eyes)
	PA—Physician's Assistant
	PC—Point of convergence

**PCA**—Permanent change of assignment  
**PCS**—Permanent change of station  
**PEB**—Physical Evaluation Board  
**PEBRH**—Physical Evaluation Board Referral Hospital  
**PES**—Physical Examination and Standards  
**PFT**—Pulmonary function test  
**PMMA**—Polymethyl Methacrylate  
**RBC**—Red blood cell  
**RD**—Reinforcement designees  
**ROTC**—Reserve Officer Training Corps  
**RPR**—Rapid plasma reagent  
**SSN**—Social security number  
**STS**—Serologic test for syphilis

**TDY**—Temporary duty  
**UNT**—Undergraduate navigator training  
**UPT**—Undergraduate pilot training  
**USAFR**—US Air Force Reserve  
**USUHS**—Uniformed Services University of Health Sciences  
**VASCI**—Veterans administration spinal cord injury  
**VDRL**—Venereal Disease Research Laboratory  
**VTA-ND**—Vision test apparatus, near and distant  
**VTS-CV**—Vision test set, color vision  
**WAVER**-File—Centralized waiver repository

## PERIODIC MEDICAL EXAMINATION AND SCOPE CRITERIA

TABLE 1

PERIODIC MEDICAL EXAMINATION AND SCOPE CRITERIA			
Category	Frequency	Qualification Criteria	Special Studies (See note 1)
A. All officers and airmen on flying status, weapons controller duty, physiological training duty, hyperbaric chamber and parachute duty. Rated officer performing missile launch crew duty or air traffic controllers.	Annually, within 3 months preceding the last day of the birth month. (See notes 1, 2, 3, 4, and 5)	Flying Class II or III or Air Traffic Controller Duty (see chapter 5).	Baseline ECG on record, at age 35 (or first complete physical thereafter), and with each complete physical thereafter. Rectal examination with occult blood testing with each complete physical after 39. Tonometry examination for rated officers on each complete physical after age 29, all others after age 39. Females will undergo a pelvic and breast examination and papanicoloau smear, annually.
B. All officers and airmen not only flying status, nonrated missile launch crew and space operations duty personnel. (See note 6.)	Within 6 months preceding the last day of the birth month 25, 30, 35, 40, 43, 46, 49, 52, 55, 58, 61. (See notes 1, 4, 6, 7 and 8.)	Worldwide duty, or paragraph 7-3 or 7-4	Base line ECG on record, at age 35 (or first complete physical thereafter), and with each complete physical thereafter. Rectal examination with occult blood testing with each complete physical after 39. Tonometry examination for rated officers on each complete physical after age 39. Females will undergo a pelvic and breast examination and papanicoloau smear, annually.
C. General officers. (See note 9.)	Annually, within 3 months of the last day of the birth month. (See notes 1, 2, 3, 4, and 9.)	Flying Class II, or III, or worldwide duty, as appropriate.	Same as all officers and airmen on flying status.

## NOTES:

- Take lipid measurements (cholesterol, HDL-cholesterol and triglycerides), provide counseling regarding risk factors for coronary artery disease and give written evaluation results to the examinee with each complete medical examination. Risk factors for coronary artery disease in the ANG and AFRES is limited to flying personnel as specified in paragraph 9-7. Order an electrocardiogram with the examination at age 35 and with each complete examination thereafter.
- Complete SF 88 and 93 on all physical done for purposes noted in paragraph 9-2 and every 3 years. Complete AF Form 1446, Medical Examination-Flying Personnel each year a complete examination is not required. For general officers on flying status, the AF Form 1446 (on alternate years) is optional at the member's dis-

cretion; therefore, if the AF Form 1446 is not done, a complete examination is required.

- Complete SF 88 and 93 if the individual is in training leading to the award of a rating or flying/special operational duty Air Force Specialty Code. Make sure the first examination following training and arrival at the permanent duty station is a complete examination if the initial flying duty application examination beyond term of validity. The majority of personnel with aviation service code 7J, 7K, 7L or 7T are between ages 45-49. Therefore, they personnel will be examined at the specified age and issued a 2-year medical clearance until age 49. At age 49 and annually thereafter, they will receive a complete examination and be issued a one year clearance.

- Require female personnel to have an annual pelvic and breast examination and a papanicoloau smear. Request these examina-

tions be completed not later than 1 year from date of last examination. Require a baseline mammogram at age 40 and at 3-year intervals thereafter or more frequent if indicated and at age 50, annually thereafter.

5. Complete AF Form 1446 within a 6-month period preceding the last day of the birth month on all years a missile launch crewmember or space operations duty member is not scheduled for a complete medical examination.

6. Note that the MAJCOM/SG may waive the requirement for periodic nonflying examinations when assignments are located away from reasonably accessible medical treatment facilities.

7. Require Reserve component members to receive a physical examination every 4 years

which will be scheduled according to the procedures in AFM 30-130, volume I, Base Level Military Personnel System.

8. Require air traffic controllers being assigned to remote or isolated duty to complete a physical examination 60 calendar days before their departure date. This examination will be valid for the duration of their assignment regardless of birth date plus 60 days following DROS.

9. Require ANG officers being considered for promotion to general or promotion within the general officer ranks to undergo a physical examination for promotion within 6 months of the recognition board. Forward a copy of all routine and periodic physical examinations done on ANG general officers and selectees to: ANGRC/SGP, Mail Stop 18, Andrews AFB MD 20331-6008.

## CERTIFICATION OR WAIVER AUTHORITY CRITERIA

TABLE 1

## CERTIFICATION OR WAIVER AUTHORITY CRITERIA

Category	Certification Authority	Waiver Authority (See note 1)
1. Flying Class I and IA	ATC/SG	ATC/SG (See note 2)
2. Flying Class II (See note 3 and 4) a. Rated Officers (See note 5) b. Medical officers before Aerospace Medicine Primary (AMP) training	MAJCOM/SG (See note 6) AFMPC/DPMMM (ATC/SG) USAFSAM/AF (See note 7)	MAJCOM/SG (See note 6) HQ AFMOA/SGPA
3. Flying Class III (See note 8) a. Officers (See notes 4 and 5) b. Airmen (Aviation Service Code 9D and 9E, AFR 60-1) c. Airmen, other (Aviation Service Code 9C, AFR 60-1) d. Physiological Training and Hyperbaric Medicine Personnel e. Nurses before flight nurse training	MAJCOM/SG (See note 9) MAJCOM/SG (See notes 8 and 9) Chief, Aeromedical Services (See note 11)  MAJCOM/SG AMC/SG, AFRES/SGP, ANGRC/SGP	MAJCOM/SG (See note 9) MAJCOM/SG (See notes 8 and 9) Chief, Aeromedical Services (See note 11)  MAJCOM/SG AMC/SG, AFRES/SG, ANGRC/SGP
4. Flying Class II and III, for all conditions listed in paragraph 1-7d(1). a. Rated officers (See notes 3 and 4) b. All other officers and airmen.	HQ AFMOA/SGPA MAJCOM/SG	HQ AFMOA/SGPA MAJCOM/SG
5. Air Traffic Control and Combat Control Duty (officers and airmen).	MAJCOM/SG	MAJCOM/SG
6. Weapons Controller (17XX)	MAJCOM/SG (See note 9)	MAJCOM/SG
7. Missile Launch Crew Duty	MAJCOM/SG	MAJCOM/SG
8. Continued Missile Launch Crew Duty	MAJCOM of Assignment/SG	MAJCOM of Assignment/SG
9. Space Operations Duty Applicants	ATC/SG	ATC/SG
10. Continued Space Operations Duty	AFCOM/SG	AFCOM/SG
11. Air Force Commission a. Reserve, initial appointment (See note 15) (1) Extended Active Duty - Line, DCNC, BSC, MSC (2) Extended Active Duty - MC, Chaplain (3) Extended Active Duty - Judge Advocate (JA) (4) AFRES (Line and all components) (5) ANG (Line and all components) (6) General Officers (Colonels serving in general officer positions) a) IMA b) Unit member and Air Reserve Technicians (ART) c) ANG b. Regular, initial appointment (See note 15) (1) Line (2) USAFA cadets c. Regular appointment of Reserve officers (AFR 36-5)	ATC/SG AFMPC/DPMMM AFMPC/DPMMM AFRES/SGP, ARPC/SGS ANGRC/SGP  ARPC/SGS AFRES/SGP  ANGRC/SGP  ATC/SG USAFA/SG  DBMS (See note 10)	ATC/SG AFMPC/DPMMM AFMPC/DPMMM AFMPC/DPMMM AFMPC/DPMMM HQ AFMOA/SGPA (See note 14) AFRES/SGP  ANGRC/SGP  ATC/SG USAFA/SG  AFMPC/DPMMM

**TABLE 1. (Continued)**

Category	Certification Authority	Waiver Authority (See note 1)
d. Indefinite Reserve Status (AFR 36-13)	DBMS (See note 10)	AFMPC/DPMMM
e. Recall to Active Duty (1) Line and Component (2) ANG (3) Reserve	AFMPC/DPMMM ANGRC/SGP ARPC/SGP, AFMPC/DPMMM	AFMPC/DPMMM AFMPC/DPMMM AFMPC/DPMMM
12. AF Enlistment: a. Initial enlistment of airmen b. Recall to Active Duty: (1) ANG (2) Reserve (3) Retired	EPS  ANGRC/SGP ARPC/SGS, AFMPC/DPMMM ARPC/SGS	AFMPC/DPMMM AFMPC/DPMMM AFMPC/DPMMM
13. USUHS	DODMERB	AFMPC/DPMMM
14. HPSP a. Civilian b. Active Duty, Line, ROTC	ATC/SG AFMPC/DPMMM	ATC/SG AFMPC/DPMMM
15. US Air Force Academy Applicants	DODMERB	USAFA/SG
16. Air Force ROTC Program Applicants	DODMERB	ATC/SG
17. PALACE CHASE and PALACE FRONT	DBMS	ANGRC/SGP, AFRES/SGP, ARPC/SGS

**NOTES:**

1. All questionable or controversial cases that cannot be resolved will be sent to higher levels of command for review and decision. For cases in which HQ AFMOA/SGPA is waiver authority, interim waiver authority by subordinate commands is specifically denied.
2. HQ AFMOA/SGPA is the ultimate waiver authority for Flying Classes I and IA. Authority is delegated to ATC/SG to grant waivers to applicants for undergraduate flying training and individuals undergoing flying training.
3. Authority to grant and renew waiver for categorical Flying Class II with suffixes A, B, or C is retained by HQ AFMOA/SGPA excepted as indicated in paragraph 1-7d(1).
4. Certification and waiver authority for US Air Force flying personnel assigned to the National Aeronautics and Space Administration (NASA) is NASA. Upon completion of NASA tour and return to US Air Force control, these personnel will be required to meet US Air Force medical standards and requirements.
5. Rated flying personnel who are medically disqualified for rated duty (Class II) may be granted waivers, by the MAJCOM of assign-

ment, to perform nonrated duty (Class III). Close coordination with the individual's servicing host operations systems management (HOSM) office, by the base flight surgeon, is required for these waivers.

6. HQ AFMC/SG has final authority on all primary and alternate US Air Force Test Pilot School applicants except for conditions listed in paragraph 1-9e(1).

7. AFRES/SG, APRC/SG, or NGB/SG, as appropriate, is the certification authority for assigned personnel who apply for the AMP course. Applicants are processed through the appropriate surgeon's office and all training quotas are assigned by the respective office. HQ AFMPC/DPMMM does not process applications for AFRES, ARPC, or ANG personnel.

8. Enlisted retraining applicants for flying duty (Class III), who are currently medically qualified and performing flying duty in AFSC 11XXX or one with an "A" prefix, do not require additional review and certification or reexamination prior to retraining unless the individual is applying for AFSC 112X0, 115X0, 273X0 or the individual is on a medical waiver. Applicants for 112X0, 115X0, 273X0 and those

on a medical waiver will require a current and complete examination, and certification by proper authority. Certification authority for personnel on a medical waiver is the projected command of assignment.

9. Applicants for airmen and officers aircrew duty.

a. Certification authority is the current command of assignment.

b. Waiver authority is the command of assignment or as indicated; 273X0, HQ AMC/SG or HQ AFSOC/SG; 117X0 and 118XX, HQ ACC/SG.

c. HQ ATC/SG is certification authority for nonprior service applicants examined by MEPS who have guaranteed enlisted aircrew AFSCs before they come on active duty and for individuals undergoing basic training who are selected for enlisted aircrew AFSCs including 111XO and 112XO.

10. At those medical facilities commanded by an officer other than a Medical Corps officer, the certification and waiver authority reverts to the MAJCOM Surgeon.

11. For noncrew members (aviation service code 9C) with diagnosis of alcoholism, waiver or

certification authority is retained by MAJC-OM/SG and will not be delegated below that level.

12. Waiver of certification authority for those conditions listed in paragraph 1-6e(1)(k), (l) and (u) is retained by AFMOA/SGPA.

13. HQ ATC/SG is the certification authority for nonprior service applicants examined by MEPS who have guaranteed AFSC 272XO or 273X0 before active duty and for individual undergoing basic training who are selected for training into AFSC 272XO or 273X0. Officer accessions and commissioning through USAFA or AFROTC who are entering AFSC 16XX and 17XX the certification authority is ATC/SG. NGB/SG is certification authority for Air National Guard personnel who apply for 272X0, 273X0, 16XX, or 17XX duty.

14. Officers commissioned through AFROTC whose entry on extended active duty (EAD) has been delayed under AFR 45-31, certification authority is HQ ARPC/SG and waiver authority is HQ AFMPC/DPMMM.

15. HQ AFMOA/SGPA notifies HQ USAF/REPS of disposition.

## HEARING STANDARDS

**1. H-1 Profile.** The H-1 profile will be used to qualify applicants for Flying Classes I and IA, initial Flying Class II and III, Air Force Academy and AFROTC selection, initial selection for missile launch crew duty, air traffic controller duty, other special duty as required by this regulation, and potentially noise-hazardous career fields as noted in AFR 39-1, Airman Classification. Civilian and military applicants for these occupational categories who do not meet the H-1 profile will be considered for waiver following a detailed evaluation by an Air Force or civilian audiologist as outlined in the Air Force Hearing Conservation Program directive.

**Maximum Audiometric Loss (Unaided Acuity)**  
ISO 1964/ANSI S3.6 Standards

Frequency	(Hz)	500	1000	2000	3000	4000	6000
Each Ear	(dB)	25	25	25	*	*	*

\*No more than a total of 270 decibel (dB) loss for both ears at 3000, 4000, and 6000 Hz. (Average of 45 dB for the six thresholds.)

**2. H-2 Profile.** Required for continued Flying Classes II and III:

**Maximum Audiometric Loss (Unaided Acuity)**  
ISO 1964/ANSI S3.6 Standards

Frequency	(Hz)	500	1000	2000	3000	4000	6000
Better Ear	(dB)	30	30	30	-	-	-
Worse Ear	(dB)	30	50	50	-	-	-

**3. H-3 Profile.** Required for reenlistment 6 months or less after separation and for active duty personnel. Any hearing loss greater than H-2, but whose remaining auditory acuity, unaided or aided, permits reasonable fulfillment of the purpose of the member's employment on active duty in some occupational capacity commensurate with his or her grade will be deemed H-3 and qualified for worldwide service and continued active duty.

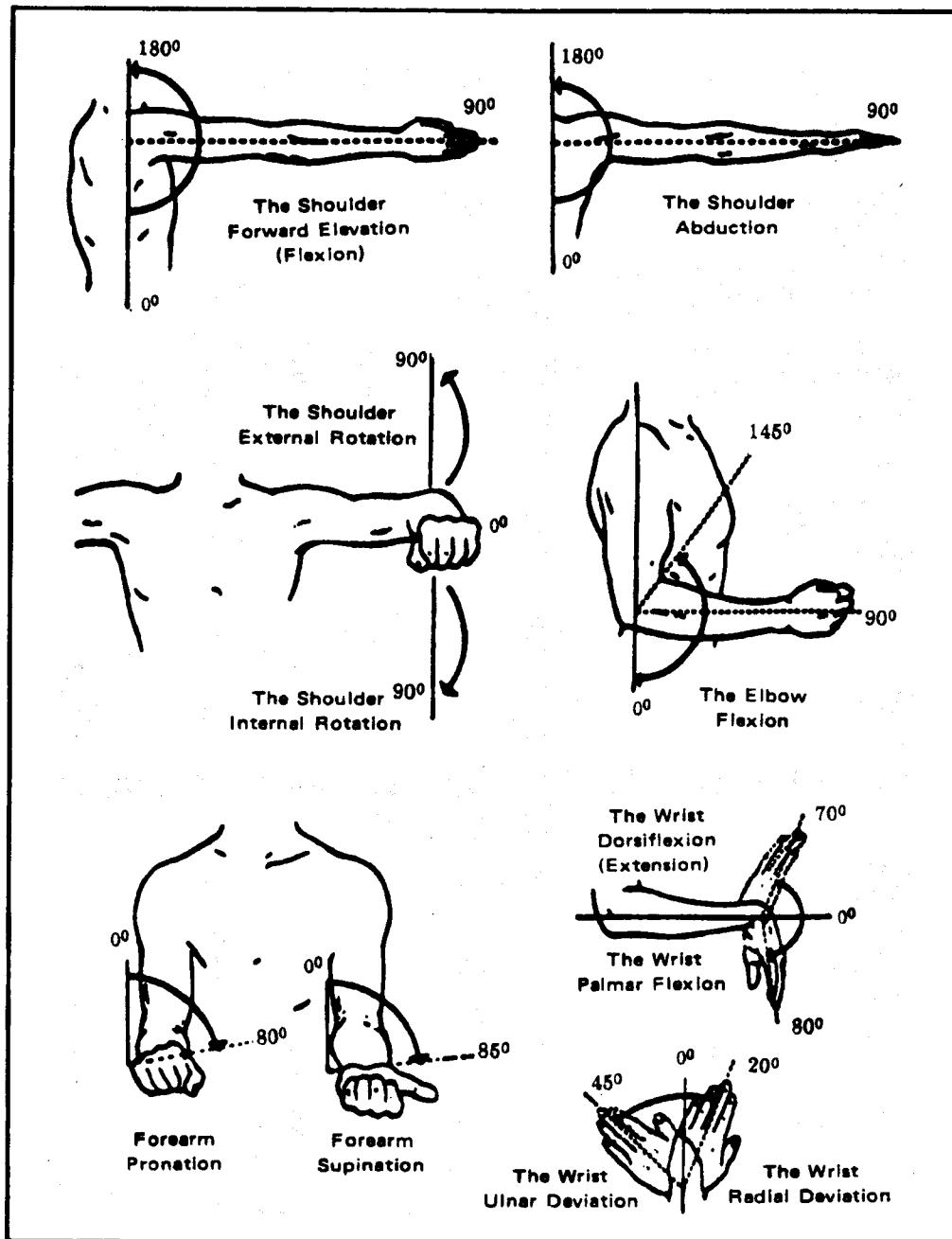
**4. H-4 Profile, Active Duty Personnel.** Any hearing with which, despite maximal benefit from a hearing aid, the members are unable to perform the duties of their office, grade, or rank in such a manner as to reasonably fulfill the purpose of their employment on active duty. Unless the hearing loss is temporary (1 year or less), the members' qualification for worldwide service will be deemed questionable and their case records will be promptly referred for Medical Evaluation Board processing.

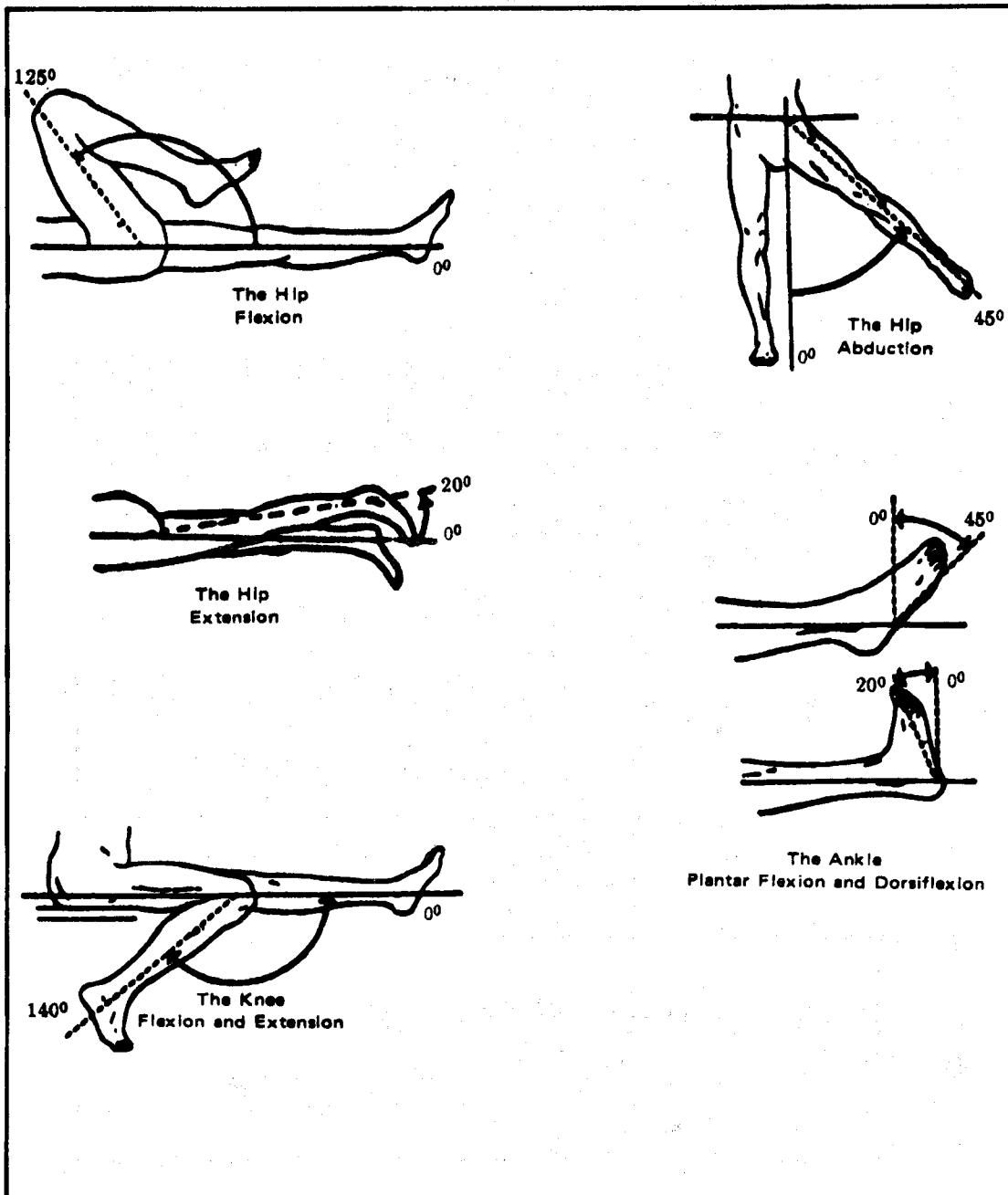
**NOTE:** Refer to the Air Force Hearing Conservation Program when noting a significant shift in measured hearing threshold, even though such a shift may not result in a profile change. ISO 1964 and ANSI S3.6 values are identical for all practical purposes as used in this regulation. Also, see appropriate personnel directives for specific AFSC requirements.

## PHYSICAL PROFILE SERIAL CHART

Profile Serial	P Physical Condition	A Physical Condition	L Lower Extremities	H Hearing-Ears	E Vision; Eyes	S Neuropsychiatric
1	Free of any significant organic defect or systemic disease.	Bones, joints, and muscles normal. Must be capable of performing long marches and continuous standing over prolonged periods. No defects which disqualify for running, climbing, and digging.		Attachment 4.	Minimum vision of 20/200 correctable to 20/200 in each eye.	No psychiatric disorder.
2	Presence of minimally significant organic defect(s) or systemic disease or diseases.	Slightly limited mobility of joints, muscular weakness, or other musculoskeletal defects which do not prevent moderate marching, climbing, running, digging, or prolonged effort.			Vision correctable to 20/400 in one eye and 20/70 in the other, or 20/30 in one eye and 20/100 in the other eye and 20/400 in the other.	Individual has mild transient psychoneurotic reactions.
3	Significant defect or defects and/or disease or diseases under good control, and not requiring regular and close medical support. Capable of all basic work commensurate with rank and position	Defects causing moderate interference with function, yet capable of sustained effort for short periods.			Vision correctable to limits less than E-2, provided the better eye is at least 20/40 or correctable vision in the worst eye.	Individual has a mild chronic psychoneurosis, moderate transient psychoneurotic reaction. This category may be assigned to individuals with a transient reaction if returned to duty by MEB action or following HQ AFMPC/DPM/M review.*
4	Medically unacceptable for worldwide duty or qualification questionable, including remote and isolated duty chapters 3 or 8 of this regulation. Use 4 profile only with "m" or "l" suffix for members on extended active duty and USAFR or ANG personnel eligible under AFR 36-4.	Organic defect or defects systemic and infectious disease or diseases with examples of diabetes mellitus, hypertension, arthritis, dental malocclusion, endocrinopathies, neoplasms.	Strength, range of movement, and efficiency of feet, legs, pelvic girdle, lower back and lumbar vertebrae.	Auditory acuity.	Correctable vision worse than 20/40 in the better eye.	All psychosis transient or chronic, except those due to infection or toxic substances, and severe neurologic disturbance, transient or chronic.

\*Medically Qualified Worldwide Duty.

**UPPER EXTREMITY MOVEMENT**

**LOWER EXTREMITY MOVEMENT**

## HEIGHT AND WEIGHT TABLES

<b>Height</b>	<b>Men</b>	<b>Women</b>			
in	cm	Minimum	Maximum	Minimum	Maximum
58	147.32	98(44.54)	149(67.72)	88(39.99)	126(57.27)
59	149.86	99(44.99)	151(68.62)	90(40.90)	128(58.18)
60	152.40	100(45.45)	153(69.54)	92(41.48)	130(59.09)
61	154.94	102(46.36)	155(70.45)	95(43.18)	132(60.00)
62	157.48	103(46.81)	158(71.81)	97(44.09)	134(60.90)
63	160.02	104(47.27)	160(72.72)	100(45.45)	136(61.81)
64	162.56	105(47.72)	164(74.54)	103(46.81)	139(63.18)
65	165.10	106(48.18)	169(76.81)	106(48.18)	144(65.45)
66	167.64	107(48.63)	174(79.09)	108(49.09)	148(67.27)
67	170.18	111(50.45)	179(81.36)	111(50.45)	152(69.09)
68	172.72	115(52.27)	184(83.63)	114(51.81)	156(70.90)
69	175.26	119(54.09)	189(85.90)	117(53.18)	161(73.18)
70	177.80	123(55.90)	194(88.18)	119(54.09)	165(75.00)
71	180.34	127(57.72)	199(90.45)	122(55.45)	169(76.81)
72	182.88	131(59.54)	205(93.18)	125(56.81)	174(79.09)
73	185.42	135(61.36)	211(95.90)	128(58.18)	179(81.36)
74	187.96	139(63.18)	218(99.09)	130(59.09)	185(84.09)
75	190.50	143(65.00)	224(101.81)	133(60.45)	190(86.36)
76	193.04	147(66.81)	230(104.54)	136(61.81)	196(89.09)
77	195.58	151(68.63)	236(107.27)	139(63.18)	201(91.36)
78	198.12	153(69.54)	242(110.00)	141(64.09)	206(93.63)
79	200.66	157(71.36)	248(112.72)	144(65.45)	211(95.90)
80	203.20	161(73.18)	254(115.45)	147(66.81)	216(98.18)

(Weight in parentheses in Kilograms)  
 (Body fat requirements are located in AFR 35-11)

**NOTE:** All individuals within 10 pounds or who exceed their maximum allowable weight (MAW) will be administered the body fat measurement (BFM) and denied qualification if they fail to meet the BFM. Individuals who fail to qualify under the BFM will not be qualified if they subsequently fall below 10 pounds of their MAW unless they meet BFM standards. Individuals who exceed their MAW, but qualify by BFM may be qualified for accession or flying training. These weight standards also apply to individuals whose training has been delayed.

**ACCOMODATIVE POWER**

(Minimum for Age)

Age	Diopters	Age	Diopters
17	8.8	32	5.1
18	8.6	33	4.9
19	8.4	34	4.6
20	8.1	35	4.3
21	7.9	36	4.0
22	7.7	37	3.7
23	7.5	38	3.4
24	7.2	39	3.1
25	6.9	40	2.8
26	6.7	41	2.4
27	6.5	42	2.0
28	6.2	43	1.5
29	6.0	44	1.0
30	5.7	45	0.6
31	5.4		

**OPTIONAL USE OF SOFT CONTACT LENSES BY USAF AIRCREW**

**9-1. Policy.** USAF aircrews may use optional soft contact lenses (SCL) for the correction of distance vision without waiver provided the vision requirements of chapter 6 are met. Aircrew members wearing SCL for medical reasons will need a waiver. The administration of the SCL program is the responsibility of the local flight medicine section. Optional SCL may be provided at government expense at the discretion of the squadron commander or at private expense. Details of the program are in "Aircrew Instructions for Soft Contact Lens (SCL) Use."

**9-2. Aircrew Responsibilities.** Aircrew members requiring SCL will visit their flight surgeon for briefing and assessment. They will receive mandatory instructions for SCL use and will be required to sign as having received and understood the instructions. The certificate of understanding will be filed in the members medical record. The aircrew member is personally responsible for arranging followup and for maintaining the currency of their SCL and spectacle prescriptions.

**9-3. Flight Surgeon Responsibilities:**

- a. Briefing the aircrew member and making sure the aircrew member understands the contents of the "Aircrew Instructions for Soft Contact Lens (SCL) Use."
- b. Filing the certificate of understanding in the members medical record.
- c. Reporting to MAJCOM/SGPA all SCL-related incidents and DNIF days.
- d. Monitoring compliance with "Guidelines for Eye Clinics on the Fitting and Care of SCL for USAF Aircrew."

**9-4. Fitting Arrangements.** The local medical treatment facility will provide fitting and followup for aircrew members whose lenses are supplied at government expense. Aircrew members who purchase their own lenses will undergo initial screening by the flight surgeon and will be given a copy of "Guidelines for Eye Clinics on the Fitting and Care of SCL for USAF Aircrew" to hand carry to the private optometrist.

**9-5. Medical Limitations.** To wear SCL in flight without a waiver, aircrew members must satisfy the following criteria:

- a. Demonstrate visual acuity of 20/20 OS and OD with SCL.
- b. Demonstrate visual acuity of 20/20 OS and OD with spectacles immediately after removing SCL.
- c. Have corneal astigmatism less than or equal to 2.0 diopters.
- d. Have no evidence of active or chronic disease or structural abnormality of conjunctiva, lids or cornea.

\* U.S. G.P.O.:1993-311-773:87132

