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Aerospace Medicine

MEDICAL EXAMINATIONS AND STANDARDS VOLUME 3-FLYING AND SPECIAL OPERATIONAL DUTY

COMPLIANCE WITH THIS PUBLICATION IS MANDATORY

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This instruction implements AFPD 48-1, *Aerospace Medical Program* and Department of Defense Directive (DoDD) 1332.18, *Separation or Retirement for Physical Disability*, and DoDD 6130.3, *Physical Standards for Appointment, Enlistment and Induction*, May 1994, DoDI, 6130.4, *Medical Standards for Appointment, Enlistment, or Induction in the Armed Forces,* Jan 2005, DoDD 5154.24, *Armed Forces Institute of Pathology (AFIP)*. It establishes procedures, requirements, recording, and medical standards for medical examinations given by the Air Force. It prescribes procedures and references the authority for retiring, discharging, or retaining members who, because of physical disability, are unfit to perform their duties. This instruction applies to all applicants for military service, scholarship programs, Air National Guard and the Air Force Reserve. Active duty flight medicine offices will use the Air Force Reserve Command (AFRC) supplement to this instruction when managing units assigned Reserve Members and will maintain a copy of the AFRC Supplement when Reserve units are located on the same base.

This instruction requires the collection and maintenance of information protected by the Privacy Act of 1974 and the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Authority to collect and maintain records prescribed in this outlined in Title 10, United States Code, Section 8013 and Executive Order, 9397. Privacy Act System Notice F044 AFSG G, Aeromedical Information Management and Waiver Tracking System (AIMWTS), applies. Ensure that all records created as a result of processes prescribed in this publication are maintained in accordance with AFMAN 37-123, *Management of Records* and disposed of in accordance with the *Air Force Records Disposition Schedule (RDS)* located at **https://afrims.af.mil**. The reporting requirement in this volume are exempt from licensing according to AFI 33-324, paragraph 2.11.10, *The Information Collections and Reports Management Program; Controlling Internal, Public, and Interagency Air Force Information Collections*. Send comments and suggested improvements on AF Form 847, *Recommendation for Change of Publicatio*n, through channels, to AFMOA/SGPA, 110 Luke Avenue, Room 405, Bolling AFB, DC 20032-7050. **Attachment 1** is a list of references and supporting information.

SUMMARY OF CHANGES

A bar (|) indicates a revision from the previous edition.

Chapter 1

MEDICAL STANDARDS

1.1. Medical Standards for Ground Based Controller Duty:

1.1.1. Applicability. The standards in **Attachment 2** apply to all ground based aircraft controllers including air traffic controllers, weapons controllers/directors, sensor operators and ground based operators of man-portable, non-weapon delivering small UAV (MP-UAV) unless other AFSC specific standards apply., weapons directors, non-flying sensor operations, ground based operators of man-portable, and non-weapon delivering small UAV (unless other AFSC specific standards apply).

1.1.1.1. Individuals required to perform frequent and regular aerial flights must also meet Flying Class III standards in **Attachment 4** for Air Battle Managers, **Attachment 4** for Air Weapons Controllers/Directors (AFSC 1C5X1D), and **Attachment 4** for Combat Controllers, **Attachment 4** for sensor operators required to perform frequent and regular aerial flights, **Attachment 4** for Unmanned Aerial Vehicle (UAV) operator and **Attachment 5** for Pararescuemen.

NOTE: Individuals required to perform frequent and regular aerial flights must also meet Flying Class III standards IAW **Attachment 4**.

1.1.2. Rejection. The medical conditions listed in **Attachment 2, Attachment 4** and **Attachment 5** and AFI48-123V2, Attachment 2 are cause to reject an examinee for initial controller duty or continued duty unless a waiver is granted. Acute medical problems, injuries, or their appropriate therapy are cause for withholding certification of initial training or temporarily restricting the individual from controller duties until the problem is resolved. These standards are not all inclusive, and other diseases, or defects, can be cause for rejection based upon the medical judgment of the examining flight surgeon.

1.1.3. Acute Conditions. Acute conditions which impair safe and effective performance of duty are cause for temporary removal from controlling duties using AF Form 1042, *Medical Recommendation for Flying or Special Operational Duty,* IAW **Chapter 3**.

1.2. Space and Missile Operations Duty (SMOD):

1.2.1. Applicability. The medical conditions listed in **Attachment 3** and in AFI48-123V2, **Attachment 2** are cause to reject an examinee for initial SMOD duty (AFSCs 13SX and 1C6XX) and any individual of another AFSC assigned to operational crew duty maintaining mission ready or equivalent status.

1.2.2. The medical conditions listed in **Attachment 3** and AFI48-123V2, Attachment 2 are cause to reject SMOD personnel for continued duty unless a waiver is granted.

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

1.2.4. Acute Conditions. Acute conditions which impair safe and effective performance of duty are cause for temporary removal from SMOD duties using AF Form 1042 IAW **Chapter 3**.

1.3. Medical Standards for Flying Duty:

1.3.1. General Waiver Information. The medical conditions listed in **Attachment 4** and **Attachment 5** and in AFI48-123V2, Attachment 2 and Attachment 3, and AFI48-123V4, Attachment 5 are cause to reject an examinee for flying training (all classes), or continued flying duty (classes II or III) unless a waiver is granted. Acute medical problems, injuries, or their appropriate therapy are cause for withholding certification for flying training, or temporarily restricting the individual from flying until the problem is resolved, using AF Form 1042 IAW **Chapter 3.** These standards are not all inclusive, and other diseases, or defects, can be cause for rejection based upon the judgment of the examining flight surgeon. Any condition, that in the opinion of the flight surgeon presents a hazard to flying safety, the individual's health, or mission completion, is cause for temporary disqualification for flying duties. To be considered waiverable, any disqualifying condition should meet the following criteria:

1.3.1.1. Not pose a risk of sudden incapacitation.

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

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

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

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

1.3.1.6. Must be compatible with the performance of sustained flying operations.

1.3.2. Medical Examination for Flying:

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

1.3.2.1.1. Flying Class I qualifies for selection into MFS, and once MFS is passed, commencement of undergraduate pilot training (UPT).

1.3.2.1.2. Flying Class IA qualifies for selection and commencement of undergraduate navigator training (UNT).

1.3.2.1.3. Flying Class II qualifies undergraduate flight training students, rated officers, and physicians.

1.3.2.1.3.1. Categorical Flying Class II qualifies rated officers for duty in certain restricted aircraft categories. HQ USAF/A3OT will be given formal notification and require coordination of these waivers. Granting categorical waivers does not guarantee operational utilization. Restrictions for FCIIA and FCIIB will be documented in the remarks section of the AF Form 1042.

1.3.2.1.3.2. Flying Class IIA qualifies rated officers for duty in low-G aircraft (tanker, transport, bomber, T-43, T-1, or remotely piloted aircraft (RPA)).

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

1.3.2.1.3.4. Flying Class IIC qualifies rated officers for aviation duty as specified in the remarks section of AF Form 1042, as annotated on the Aeromedical Summary (AMS), or

SF 88, *Report of Medical Examination*, or DD Form 2808, *Report of Medical Examination*, and as noted in Aeromedical Information Management Waiver Tracking System (AIMWTS). Example: Restricted to remotely piloted aircraft (RPA) duties only.

1.3.2.1.4. Flying Class III qualifies individuals for non-rated duties in Aviation Service Code (ASC) 9D, 9E, 9W and other relevant ASCs.

1.3.2.1.5. Physiologic training/operational support standards (**Attachment 5**) qualify individuals for nonrated duties in ASC 9C.

NOTE: USAFA cadets participating in USAFA cadet airmanship program, see **A5.12.**

1.3.2.2. Medical examinations are required when:

1.3.2.2.1. Individual applies for initial flying duty (all classes) except as specified in AFI48-123V4, Attachment 2, note 7.

1.3.2.2.2. Officers holding comparable status in other US military services apply for Air Force aeronautical ratings (FC II, SF 88/DD Form 2808, SF 93, *Report of Medical History*, DD Form 2807-1, *Report of Medical History*, etc.).

1.3.2.2.3. Personnel, including personnel of the ARC, are ordered to participate in frequent and regular aerial flight (FC II/III, SF 88/DD Form 2808, SF 93, /DD Form 2807-1, etc.).

1.3.2.2.4. Flying personnel, including personnel of the ARC, are suspended from flying status for 12 months or more for medical reasons, applying for return to flying duties (FC II/III, SF 88, DD Form 2808/SF 93, DD Form 2807-1, etc. for ARC, and Preventive Health Assessment (PHA) with AMS for Active Duty Air Force).

1.3.2.2.5. Flying personnel are ordered to appear before a Flying Evaluation Board (FEB). (See AFI 11-401, *Aviation Managemen*t.) (Use FC II/III, SF 88, DD Form 2808/SF 93, DD Form 2807-1, etc. for ARC, and PHA with AMS for Active Duty Air Force.)

NOTE: Air sickness may be managed IAW AFI48-123V4, paragraph 1.2.19. If no underlying medical pathology and unresponsive to the measures discussed in AFI48-123V4, paragraph 1.2.19, this becomes an administrative function.

1.3.2.2.6. All members on flying status, annually, usually within 3 months preceding the last day of the birth month. See AFI48-123V1, Attachment 2 for specific variations and details.

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

NOTE: If the break is less than 12 months, the local flight surgeon clears the member for flying duty. If the break has been greater than 12 months, forward to the gaining MAJCOM/SG for review and certification. All waivers must go to the gaining MAJCOM/SG. Refer to AFI 11-402 for further information.

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

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

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

1.3.2.3.3. Flying personnel report to a new base.

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

1.3.2.3.4.1. Complete all Flying Class I and IA Undergraduate Flight Training (UFT) examinations, regardless of the nature of disqualifying defect. Send completed SF 88/DD Form 2808 and SF 93/DD Form 2807-1, and all allied documents to the appropriate certifying authority or requesting agency, such as Military Personnel Flight (MPF), Air Force Recruiting, Air Force Reserve Officer's Training Corps (AFROTC) Detachment, etc. The examining flight surgeon completely identifies, describes, or documents the disqualifying defects and enters demographics and disqualifying diagnosis into AIMWTS, brief AMS with pertinent information, signs, dates and forwards to HQ Air Education and Training Command (AETC)/SGPS for disposition.

1.3.2.3.4.2. Complete initial Flying Class II or III, ground based controller, air vehicle operator, or space and missile operation duty examination. When a disqualifying defect is likely to receive favorable waiver consideration, send complete waiver package (see paragraph **2.2.**) to the appropriate waiver authority. Enter waiver requests and disqualifications into AIMWTS, then sign and send to the appropriate approval/waiver authority.

1.3.2.3.4.3. Forward aeromedical disqualifications to the MAJCOM/SG for review and disposition. Local medical facilities do not have disqualification certification authority. MAJCOM/SG will notify AFMOA/SGPA of disqualified cases (rated members only). AFMOA/SGPA will notify FAA of medical disqualification for rated members only.

1.4. Medical Standards for Miscellaneous Categories. The medical standards for the following categories are contained in **Attachment 5**:

1.4.1. Attendance at service schools.

1.4.2. Parachute duty.

1.4.3. Marine diving duty and hyperbaric chamber duty (includes Self-Contained Underwater Breathing Apparatus (SCUBA) for pararescue and combat control duty).

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

1.4.5. Survival Training Instructor duty, selection and retention.

1.4.6. Military Training Instructor (MTI) duty.

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

1.4.8. Remote or isolated duty.

1.4.9. Hypobaric Chamber Training and duty.

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

1.4.11. Static Line Parachute Duty.

1.4.12. Incentive and Orientation Flights.

1.4.13. United States Air Force Academy (USAFA) incentive flight, student parachute, cadet jumpmaster, student soaring, and cadet soaring instructor pilot duties.

Chapter 2

FLYING AND SPECIAL OPERATIONAL DUTY WAIVERS

2.1. Waiver of Medical Conditions. The individuals and organizations with authority to grant a waiver for medically disqualifying defects are listed in AFI48-123V4, Attachment 2, Certification & Waiver Authority. Certification, or waiver of medical standards, can only be performed by a credentialed flight surgeon. Controversial or questionable cases, and cases that fall outside of the parameters set by this instruction, will be referred to AFMOA/SGPA at the discretion of the MAJCOMs. **Members who do not meet medical standards for continued military service must be presented to Medical Evaluation Board (MEB)/Physical Evaluation Board (PEB) prior to any aeromedical waiver consideration**.

2.1.1. Initiating Waivers. Forward all relevant medical information through AIMWTS to the waiver authority. Special requirements for flying waivers are contained in paragraph **1.3.**

2.1.2. Term of Validity of Waivers:

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

2.1.2.2. An expiration date is placed on a waiver for any conditions that may progress or require periodic reevaluation.

2.1.2.3. Waivers are valid for the specified condition. Any exacerbation of the condition, or other changes in the patient's medical status, automatically invalidates the waiver, and they are placed Duties Not Involving Flying (DNIF) until the medical evaluation is complete, and a new waiver is requested.

2.1.2.4. If a condition resolves and member is qualified by appropriate standards, or the condition no longer requires a medical waiver, and individual has no other conditions requiring medical waiver, retire the waiver using AIMWTS with concurrence of waiver granting authority. The individual who retires the waiver must annotate reason and MAJCOM point of contact for concurrence in "Reason for Retirement" block, before signing in AIMWTS.

2.1.3. Flying Duty. Waiver Authority for Rated Officers. AFMOA/SGPA retains waiver authority as follows:

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

NOTE: Consult AFI48-123V4, Attachment 2, Certification & Waiver Authority, for delegation of waiver authority to MAJCOM/ SG.

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

2.1.3.2. All initial waivers for conditions listed in AFI48-123V2, Attachment 2, Medical Standards for Continued Military Service.

2.1.3.3. All initial waivers for conditions referred to the ACS, except for those as listed at Note 3, AFI48-123V4, Attachment 2, Certification & Waiver Authority. MAJCOM/SG may grant initial and may renew waivers, if the following two criteria are met: the aviator meets entry criteria into an established ACS clinical management/study group(s) and a waiver is recommended by the ACS. Controversial cases will be forwarded to AFMOA/SGPA.

2.1.3.3.1. MAJCOM/SGs will not grant/renew waivers for members of active ACS study groups without consulting the ACS.

2.1.3.4. All cases where the ACS recommends medical disqualification in accordance with AFI48-123V4, Attachment 2, Certification & Waiver Authority.

2.1.3.5. All initial waivers for maintenance medication, except those listed in "Official Air Force Approved Aircrew - Quick Reference List", updated quarterly by AFMOA (approved by AF/SGOP).

2.1.3.6. All flying waivers and disqualifications on general officers, regardless of diagnosis.

2.1.3.7. All initial categorical IIC waivers except as delegated to MAJCOM/SG, see AFI48-123V4, Attachment 2, Notes.

2.1.3.7.1. Renewal of IIC waivers originally granted by AFMOA/SGPA, except as delegated to MAJCOM/SG, see AFI48-123V4, Attachment 2, Notes.

2.1.3.8. Any controversial condition that in the opinion of the MAJCOM/SG warrants an AFMOA/SGPA decision.

2.1.4. Delegation of Waiver Authority for Flying and SOD Personnel:

2.1.4.1. Command surgeons may delegate waiver authority to another command surgeon or to a Residency Trained Aerospace Medicine specialist (RAM, AFSC 48A3/48A4). The senior flight surgeon serving as the installation SGP may be used in the event that a RAM is not available. MAJCOM/SGPs provide AFMOA/SGPA a copy of all delegation letters.

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

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

2.1.4.2.1. Certification and waiver authority for 9C aircrew is listed in AFI48-123V4, Attachment 2.

2.1.5. Centralized Flying Waiver Repository (WAVR File):

2.1.5.1. AIMWTS will serve as the centralized flying waiver repository.

2.1.5.2. All flying medical waiver actions will be recorded in AIMWTS.

2.1.5.3. Flying waivers that are no longer required due to personnel separation and/or retirement must be "retired" in AIMWTS.

2.1.6. Waivers for Enlisted Occupations:

2.1.6.1. The medical service does not make recommendations for medical waivers for entry or retention in non-flying or special operations duty AFSCs for those who fall below qualification standards imposed by personnel directives. Senior Profile Officers or physical standards experts should consult with the Air Force Career Field Managers to determine if a waiver request is appropriate. Medical waivers will not be granted to allow an individual disqualified from one AFSC to enter another AFSC, when the defect is disqualifying for both AFSCs.

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

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

2.2.1. Waiver for Flying or Special Operational Duty.

2.2.1.1. Waiver requests for all initial flying and SOD examinations will be submitted using AIMWTS and Physical Examining and Processing Program (PEPP). Supporting documents must be uploaded as attachments into these applications as listed in paragraph **2.2.1.2.** and forwarded to the reviewing/certification authority.

NOTE: PHA**,** SF 600, *Health Record, Chronolgical Record of Medical Care*, SF 88 or DD Form 2808 must be accomplished according to the frequency in AFI48-123V1, Attachment 2 and is irrespective of waiver action. However, this document is not required for waiver submission for trained aviators unless specifically requested by the waiver authority. Utilize the aeromedical summary format when requesting waivers for trained aircrew or for aircrew in training. Do not accomplish SF 88, DD Form 2808, or PHA solely for the purpose of a waiver submission unless flight surgeon deems necessary, or directed by other authority. See AFPAM 48-133, paragraph 10.9.

2.2.1.2. All waiver requests referred to AFMOA/SGPA must be submitted to the MAJCOM/SG. MAJCOM/SG must provide a recommendation on the case to AFMOA/SGPA through AIMWTS. These requests should include as a minimum:

2.2.1.2.1. Aeromedical Summary with other supporting documents pertinent to the case included as attachments within AIMWTS.

2.2.1.2.2. If applicable, AF Form 618, *Medical Board Report*, indicating the member has been returned to duty. The MEB/PEB Air Force Personnel Center (AFPC)/DPAMM instructions including Review in Lieu of (RILO) recommendation and Assignment Limitation Code C status must also be included.

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

2.2.1.2.4. SF 515, *Medical Record-Tissue Examination*, in cases of malignancy (initial waiver request).

2.2.1.2.5. AFIP opinion, in cases of malignancy (initial waiver request). Specimens will be sent to: AFIP, 6825 16th St NW, Building 54, Washington DC 20306-6000. DSN 662-2100.

NOTE: Website is **www.afip.org** and form to utilize is AFIP Form 288-R, *Contributors Consultation Request Form***.**

2.2.1.3. Active flyers or special operational duty personnel awaiting the results of an MEB for an obviously disqualifying (non-waiverable, permanent) condition, may be disqualified without awaiting actual results of MEB in order to facilitate other administrative actions (i.e. re-training).

2.2.2. The following are required for ARC:

2.2.2.1. Cover letter.

2.2.2.2. Aeromedical Summary. This should be the AMS accomplished in AIMWTS. If AIMWTS is not available at the facility, then a hard copy is required.

2.2.2.3. AFIP opinion in cases of malignancy (initial waiver request).

2.2.2.4. Any other relevant documentation.

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

2.2.3. Flying Waiver Renewal. The examiner prepares relevant documentation using AIMWTS.

2.2.4. Repatriated Prisoners of War (RPW). Public Health sends a copy of each medical examination (SF 88/DD Form 2808, SF 93/DD Form 2807-1, or DD Form 2697, *Report of Medical Assessment*, and attachments) to USAFSAM/AFC, 2507 Kennedy Circle, Brooks City Base TX 78235-5116, and to the Office of Special Studies, NOMI, Code 25, NAS Pensacola, FL 32508-5600.

NOTE: Include "RPW" on Report of Medical History form, as an additional purpose for examination.

2.2.5. Routing of Dispositions:

2.2.5.1. The certifying authority certifies the AMS in AIMWTS.

2.2.5.1.1. TRAINED ASSETS: Flight Medicine prints and files the certified AMS document in the health record; then prepares, files, and forwards the AF Form 1042.

2.2.5.1.2. INITIAL FLYING WAIVERS: Public Health (Flight Medicine for the ARC) prints and files the certified AMS document in the health record. Provides initial medical examinations for UPT, UNT, and Aerospace Medicine Primary (AMP) course training to the applicant to include with the training request. AMP course attendees must hand carry AF Form 1042 to USAFSAM.

2.2.5.1.3. MAJCOM/SGPA notifies AFMOA/SGPA of disqualifications on rated officers.

2.2.5.1.4. If certified disqualified (trained asset): A flight surgeon will advise the member they are medically disqualified from their flying or special operational duty, and provide the member with the AF Form 422, *Physical Profile Serial Report,* for use in retraining actions with the Military Personnel Flight. Document the notification of disqualification in the health record. The member's unit should also be notified of the member's disqualification from special operational duty. The AF Form 1042 or AF Form 422 may be used, with appropriate comments in the remarks section of the AF Form 1042 of the member's permanent disqualification from special operational duty.

Chapter 3

MEDICAL RECOMMENDATION FOR FLYING OR SPECIAL OPERATIONAL DUTY

3.1. General. Use AF Form 1042 to convey updates and changes to medical qualification for flying or special operational duty.

3.1.1. Applicability. Applies to each Air Force Medical Treatment Facility (MTF) or ARC medical squadron providing support for flying or special operational duty personnel. ***Flying or special operational duty personnel are defined as any Air Force member with an ASC, AFSC or duty position that must meet special entry and continuing medical qualifications as defined in Attachment 2, Attachment 3, Attachment 4 and Attachment 5.***

3.1.2. Flight surgeons will determine aeromedical dispositions. Non-flight surgeon medical providers may ground flying or special operational duty personnel. The flight surgeon must document review and disposition of all non-flight surgeon medical providers' entries in the member's medical record. A grounding AF Form 1042 initiated by a non-flight surgeon medical provider must be countersigned and dated by the flight surgeon. Host Aviation Resource Management (HARM) Office will act upon AF Form 1042 based upon actual flight surgeon signature date.

3.2. Prepare a new AF Form 1042 when an individual is:

3.2.1. Found temporarily medically unfit—described as DNIF, Duties Not to Include Controlling (DNIC) or Duties Not to Include Alert (DNIA).

3.2.2. Determined by a flight surgeon to be fit for return to flying status (RTFS) or special operational duty.

3.2.3. Medically qualified by appropriate review authority following disqualification.

3.2.4. Medically qualified for continued flying/special operational duty following medical examinations.

3.2.5. Medically qualified by flight surgeon for Incoming Clearance to a new base. This new clearance will supersede any previous incoming clearances that should be removed from the record at this time.

3.2.6. To temporarily "ground" or clear aircrew following involvement in any class of aircraft mishap.

3.2.7. To permanently medically disqualify a member for flying or special operational duty.

3.2.7.1. Only after MAJCOM or higher authority certifies examination in AIMWTS, permanent disqualification authority is the same for waiver actions as noted in AFI48-123V4, Attachment 2. Also, refer to paragraph **1.3.2.3.4.3.**.

NOTE: An AF Form 1042 does not need to be accomplished with the expiration of a flying PHA. The HARM Office will take appropriate administrative action if a new AF Form 1042 is not received by the end of the member's birth month.

3.3. Form Completion:

3.3.1. AF Form 1042 must contain the date the individual is actually found qualified.

3.3.2. Date of the flight surgeon signature will serve as the date the action was accomplished.

3.3.3. If the examination cannot be completed prior to expiration due to reasons beyond the member's control, the examining flight surgeon may request a medical waiver from the appropriate MAJCOM/SGP using AIMWTS. If granted, a new AF Form 1042 should be accomplished to reflect the extension and sent to the member's HARM Office.

3.3.4. Flyers and special operational duty personnel unavailable for PHA due to deployment in support of national emergencies may be granted an extension to the expiration date of an annual flight PHA of up to six months at the direction of AFMOA/SGPA, or their delegated authority. Once national emergency is identified, the member, their unit, and the home base MTF will make every effort to complete the PHA prior to deployment. PHAs may be accomplished up to 6 months prior to the last day of the member's birth month. Member will have 45 days upon return to home base to complete extended PHA clearance. (See, AFI48-123V4, Table A2.1, Note 1.)

3.3.5. See AFI48-123V4, Table A2.1 for authorized variations and other applicable term of validity requirements.

3.4. Inactive Flyers. Do not complete an AF Form 1042 for individuals in inactive aviation service categories who are not involved in flying duties, if the medical condition is minor, does not require a medical waiver, and is expected to resolve within 30 days. Inactive flyers with ASCs of 6J, 7J, 8J, or 9J do not require aeromedical disposition (i.e., DNIF, waiver processing, ACS evaluation, etc.). Refer to AFI 11-401. Aeromedical issues will be addressed when, and if, the member requests return to active flying status at a later date. AFI48-123V2, Attachment 2 applies to these members. Care should be taken to ensure the member's Aviation Service Codes are correct prior to applying AFI48-123V2, Attachment 2 standards.

3.5. AF Form 1042 Distribution:

3.5.1. Original to patient's health record. For transient personnel, send the original and 2 copies to the individual's home Medical Treatment Facility Flight Surgeons Office for distribution.

3.5.2. One copy to the local HARM Office (within 1 duty day) for flying personnel, or to the unit commander or supervisor for other personnel.

3.5.3. One copy to the member's unit.

3.5.3.1. The medical unit must notify the member's unit of any grounding or return to flying actions by telephone as soon as possible.

3.5.4. One copy to the member.

NOTE: Flying PHA performed by a non-AF flight surgeon requires review and certification by parent MAJCOM/SG.

3.6. Disposition of Expired AF Form 1042:

3.6.1. Grounding actions such as DNIF, DNIC, DNIA dispose of when superseded by an AF Form 1042 for RTFS action.

3.6.2. Remove previous Initial Base clearances when superseded by a new Initial Base clearance AF Form 1042. Do not remove last PHA clearance on completing a newly assigned member's Initial Base clearance.

3.6.3. Remove previous PHA clearances when superseded by a new PHA clearance AF Form 1042. Do not remove last Initial Base clearance on completing a PHA clearance.

3.6.4. Do not remove AF Form 1042 recording a member's RTFS following a period of DNIF from the outpatient medical record. These should remain a permanent part of a member's medical record.

NOTE: The remarks section of the AF Form 1042 can be used for local special purpose determinations, i.e., "May perform Supervisor of Flying (SOF) duties," with the determination based upon the flight surgeon's assessment of the member's mental alertness and physical capabilities. The Remarks section of any AF Form 1042 leaving the MTF will not have member's diagnosis or other protected health care information written or otherwise affixed in accordance with HIPAA rules. Commanders should be advised to contact the flight surgeons office if more details about a member's condition are required.

3.7. Record of Action. The flight surgeon office maintains a monthly log of restrictions and re-qualifications on AF Form 1041, *Medical Recommendation for Flying or Special Operational Duty Log*, and disposes of AF Form 1041 as specified by Air Force Records Disposition Schedule. Use the AF Form 1041 log to track personnel who are in DNIF, DNIC, or DNIA status. AF Form 1041 is now included within Preventive Health Assessment and Individual Medical Readiness (PIMR) (See AFI 48-101.)

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

Chapter 4

MEDICAL CLEARANCE FOR JOINT OPERATIONS OR EXCHANGE TOURS

4.1. Medical Clearance for Joint Operations:

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

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

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

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

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

4.2. Joint Training:

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

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

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

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

4.2.5. In cases of irreconcilable conflict, host service decision takes precedence (consult with MAJCOM/SGPA for further guidance).

Chapter 5

NORTH ATLANTIC TREATY ORGANIZATION (NATO) AND OTHER FOREIGN |MILITARY PERSONNEL

5.1. North Atlantic Treaty Organization (NATO) Personnel:

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

5.2. Evidence of Clearance. Definitions: The host nation is the nation where Temporary Duty (TDY) flying duties take place, or the nation with primary aeromedical responsibility. The parent nation is the nation of whose armed services the individual is a member.

5.2.1. Local (Host) MTF flight surgeons prepare AF Form 1042 based on the standards of medical fitness for flying duties issued by the parent country.

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

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

5.2.2.1. Pre-existing conditions, waived by the parent NATO nation will be accepted by the USAF as long as health or safety is not compromised. Pre-existing conditions waived by non-NATO parent nations will be accepted IAW the agreement between USAF and parent nation.

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

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

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

5.3. Medical Qualification of NATO Aircrew Members:

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

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

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

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

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

5.4.2. Forward reports to HQ AETC/SGP for certification or waiver consideration.

5.4.3. Disqualification decisions should be discussed with AFMOA/SGPA and appropriate parent nation liaison.

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

Chapter 6

MEDICAL EXAMINATION FOR FEDERAL AVIATION ADMINISTRATION (FAA) CERTIFICATION

6.1. Medical Examination for FAA Certification.

6.1.1. Availability. MAJCOM/SGs and ANG/SG determine whether FAA examinations are available in their facilities.

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

6.1.2.1. 4N0 technicians may assist with para-professional portion of FAA exam only if certified by the FAA.

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

6.1.3.1. Active duty and ARC members of the United States Armed Forces.

6.1.3.2. Department of Defense (DoD) Reserve Officer Training Corps (ROTC) personnel.

6.1.3.3. Members of foreign military services assigned to duties within the Continental United States (CONUS).

6.1.3.4. Military retirees or dependents of active duty who are members of a military aero club.

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

6.1.4.1. FAA second or third class examinations may be performed IAW AFI 48-101 in Air Force facilities. Beneficiaries (see paragraph **6.1.3.**) seeking FAA certificates should normally only require FAA Third Class Certificate to meet the requirements for civil private or student pilot medical certification. Second Class Certificates should not normally be granted unless there is a specific training need of the member. (See FAR, Part 67 for details.) The SGP must ensure appropriate local guidelines are in place to meet these requirements.

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

6.1.4.3. Air Force facilities may not conduct FAA Class I Certificate examinations.

6.1.5. Disposition of Reports:

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

6.1.5.2. In all cases, the examining facility maintains the file copy of FAA Form 8500-8, *Application for Airman Medical Certificate or Airman Medical & Student Pilot Certificate,* with supporting documentation and disposes of it according to current directives.

6.1.6. Supply of FAA Medical Forms and Publications. To obtain FAA forms, use FAA Form 8500-33, *Medical Forms and Stationary Requisition*, or write to DOT/FAA, AAM-410, Civil Aerospace Medical Institute, P.O. Box 25082, Oklahoma City, OK 73125-9944.

Chapter 7

AEROMEDICAL CONSULTATION SERVICE

7.1. The Aeromedical Consultation Service (ACS) Conducts Specialized Aeromedical Evaluations.

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

7.1.1.1. Active Duty Air Force and ARC personnel on flying status, or as requested by the MAJCOM or AFMOA/SGPA. Persons medically disqualified when approved by the MAJCOM surgeon or AFMOA/SGPA.

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

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

7.1.1.4. At the discretion of the MAJCOM or AFMOA/SGPA, initial ACS evaluations of inactive flyers only if reassignment to active flying is pending.

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

7.1.1.6. Military personnel of foreign countries when approved by the State Department and AFMOA/SGPA.

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

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

7.2. Referral Procedures.

7.2.1. Initial Evaluations: The referring flight surgeon prepares an aeromedical summary utilizing the AIMWTS program. Once ACS evaluation is approved by either MAJCOM/SGPA or AFMOA/SGPA, MTFs will send original records of special studies mentioned in the aeromedical summary. i.e., ECG tracings, echocardiogram tape, EEG tracings, Holter monitor tracings, Magnetic Resonance Imaging (MRI) film, all x-ray films and specialty consultations, etc., to the ACS electronically, or by certified mail (whichever is appropriate and feasible).

NOTE: The appropriate mailing address is: USAFSAM/FECA, 2507 Kennedy Circle, Brooks City-Base TX 78235-5116.

7.2.2. Re-evaluations: These will be accomplished under the same guidelines as initial evaluations. Supporting documentation will be forwarded only at the request of the ACS. ACS re-evaluations will be coordinated with the MAJCOM/SG or AFMOA/SGPA, using AIMWTS.

7.3. Scheduling Procedures

7.3.1. The approval authority will forward the request to the ACS utilizing AIMWTS.

7.3.2. The ACS notifies the MTF of the appointment date and furnishes reporting instructions. The ACS will make every effort to schedule appointments as soon as possible after waiver authority

request. The ACS will only reschedule appointments due to mission essential reasons. Any requested documentation should be forwarded in sufficient time to reach the ACS 10 days prior to appointment.

7.3.3. Members scheduled for ACS evaluations will be briefed by the referring local flight surgeon regarding ACS requirements and reporting instructions. This responsibility will not be delegated.

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

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

7.3.6. Send health records, by certified mail to arrive at the ACS 10 days before the scheduled appointment. A hand carried copy of the medical record is acceptable only in its entirety.

7.4. Consultation Procedures.

7.4.1. The ACS evaluates and makes recommendations to the waiver authority. The ACS is not a waiver authority.

7.4.2. The preliminary ACS report and recommendation called the Patient Status Worksheet (PSW) is sent electronically to the waiver authority within 3 workdays of the ACS date of recommendation. AIMWTS is updated with the ACS recommendation at this time.

7.4.3. If an in-person ACS evaluation is not required, the ACS will make recommendations via an aeromedical letter to the waiver authority. The ACS enters this into AIMWTS.

7.5. Distribution of Reports.

7.5.1. The final ACS report and recommendation called the Patient Status Report (PSR) is sent electronically to the waiver authority within 60 workdays following member's departure. The ACS will also attach the PSR into AIMWTS.

7.6. Medical Flight Screening. MFS is managed by the ACS and conducted at two sites: the ACS and the USAFA.

7.6.1. MFS uses additional advanced medical screening techniques (list of screening tests approved by AFMOA/SGPA and maintained at ACS) to ensure pilot candidates who have already passed their FCI physical are in compliance with standards described in this instruction and any superseding USAF policy. All UPT applicants must complete and successfully pass MFS or receive a waiver prior to starting UPT.

7.6.2. MFS Certification & Waiver Authority.

7.6.2.1. HQ AETC/SGPS is the certification and waiver authority for MFS. HQ AETC/SGPS may forward controversial cases to AFMOA/SGPA as required.

GEORGE P. TAYLOR, JR, Lt General, USAF, MC, CFS
Surgeon General

Attachment 1

GLOSSARY OF REFERENCES AND SUPPORTING INFORMATION

References

Executive Order 9397, *Numbering System For Federal Accounts Relating To Individual Persons*

Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Rule

Privacy Act System Notice FO44, Aircrew Standards Case File

Title 10, United States Code, Section 8013, *Secretary of the Air Force*

14 Code of Federal Regulations (CFR) Part 67, FAA Airman Medical Standards and Certification

STANAG 3526, *Interchangeability of NATO Aircrew Medical Categories*

DoDD 1332.18, *Separation or Retirement for Physical Disability*

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

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

AFPD 48-1, *Aerospace Medical Program*

AFI 10-248, *Fitness Program*

AFI 11-202 Vol 3, *General Flight Rules*

AFI 11-401, *Aviation Management*

AFI 11-403, *Aerospace Physiological Training Program*

AFI 33-324, *The Information Collections and Reports Management Program; Controlling Internal, Public, and Interagency Air Force Information Collections*

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

AFI 48-101, *Aerospace Medical Operations*

AFI 48-123 Vol 1*, Medical Examinations and Standards – General Provisions*

AFI 48-123 Vol 2*, Medical Examinations and Standards – Accessions, Retention and Administration*

AFI 48-123 Vol 4*, Medical Examinations and Standards – Special Standards and Requirements*

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

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

AFMAN 37-123, *Management of Records*

AFPAM 48-133, *Physical Examination Techniques*

AFRC 48-101, *Respiratory Protection Program*

Air Force Records Disposition Schedule (AFRDS)

AFSPCI 10-1202, *Crew Operations*

SAM TR73-29, *Materials and Procedures for In-flight Assessment of Auditory Function in Aircrewmen*

Alcohol Abuse-Dependence Waiver Guide

Aircrew Waiver Guide

Official Air Force Approved Aircrew - Quick Reference List

AR 40-501, *Standards of Medical Fitness*

FAA Guide for Aviation Medical Examiners

Diagnostic and Statistical Manual of Mental Disorders (DSM), American Psychiatric Association

AL-SR-1992-0002, *Night Vision Manual for Flight Surgeon*s

National Fire Protection Association 1582, *Standard on Comprehensive Occupational Medical Program for Fire Departments*

National Fire Protection Association Technical Implementation Guides (TIGs)

Abbreviations and Acronyms

ACS—Aeromedical Consultation Service

AETC—Air Education and Training Command

AFIP—Armed Forces Institute of Pathology

AFI—Air Force Instruction

AFMOA—Air Force Medical Operation Agency

AFMOA/SGPA—Air Force Medical Operation Agency, Aerospace Medicine Directorate

AFPC—Air Force Personnel Center

AFRC—Air Force Reserve Command

AFROTC—Air Force Reserve Officer's Training Corps

AFSC—Air Force Specialty Code

AIMWTS—Aeromedical Information Management Waiver Tracking System

AME—Aviation Medical Examiner

AMP—Aerospace Medicine Primary or Airsickness Management Program

AMS—Aeromedical Summary

ANG—Air National Guard

AR-SMOD—Adaptability Rating for Space and Missile Operations Duty

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

ARMA—Adaptability Rating Military Aviation

ASC—Aviation Service Code

AV—Atrioventricular

BMR—Basic Mission Ready

CMR—Combat Mission Ready

CNS—Central Nervous System

dB—Decibel

DCS—Decompression Sickness

DF—Dean of Faculty

DNIA—Duties Not to Include Alert

DNIC—Duties Not Including Controlling

DNIF—Duties Not Involving Flying

DoD—Department of Defense

DODD—Department of Defense Directive

DODMERB—Department of Defense Medical Examination Review Board

DOT—Department of Transportation

DSM—Diagnostic and Statistical Manual

ECG—Electrocardiogram

EEG—Electroencephalogram

ENT—Ear, Nose, and Throat

FAA—Federal Aviation Administration

FALANT—Farnsworth lantern test

FAR—Federal Air Regulation

FSO—Flight Surgeon's Office

GBC—Ground Based Controller

G-LOC—G induced loss of consciousness

HDL—High-density lipoprotein

HIV—Human Immunodeficiency Virus

HIPAA—Health Insurance Portability and Accountability Act

HARM—Host Aviation Resource Management Office

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

ICD—International Classification of Disease

IMA—Individual Mobilization Augmentee

IOP—Intraocular Pressure

LASEK—Laser Epithelial Keratomileusis

LASIK—Laser-Assisted In Situ Keratomileusis

LOC—Loss of consciousness

MAJCOM—Major Command

MC—Medical Corps

MEB—Medical Evaluation Board

MFS—Medical Flight Screening

mm—Millimeter

MPF—Military Personnel Flight

MP-UAV—Man-Portable Unmanned Aerial Vehicle

MRI—Magnetic Resonance Imaging

MTF—Medical Treatment Facility

MTI—Military Training Instructor

NATO—North Atlantic Treaty Organization

NOMI—Naval Operational Medicine Institute

NVG—Night vision goggles

OTC—Over the Counter

OU—Oculi Unitas (both eyes)

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

PC—Point of convergence

PCE—Primary Care Element

PCM—Primary Care Manager

PDS—Pigmentary Dispersion Syndrome

PEB—Physical Evaluation Board

PGS—Pigmentary Glaucoma Suspect

PHA—Preventive Health Assessment

PIP—Pseudoisochromatic Plates

PRK—Photorefractive Keratectomy

PSR—Patient Status Report

RAT—Reading Aloud Test

RDS—Records Disposition Schedule

RK—Radial Keratotomy

ROTC—Reserve Officer Training Corps

RPA—Remotely Piloted Aircraft

RPW—Repatriated Prisoner of War

RTFS—Return to Flying Status

SATP—Security Assistance Training Program

SCL—Soft Contact Lenses

SCUBA—Self-contained Underwater Breathing Apparatus

SMOD—Space and Missile Operations Duty

SUPT—Specialized Undergraduate Pilot Training

TDY—Temporary Duty

TPSK—Topographical Pattern Suggestive of Keratoconus

UAV—Unmanned Aerial Vehicle

UFT—Undergraduate Flight Training

UNT—Undergraduate Navigator Training

UPT—Undergraduate Pilot Training

USAFA—United States Air Force Academy

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

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

Attachment 2

MEDICAL STANDARDS FOR GROUND BASED CONTROLLER DUTY

A2.1. Conditions in AFI48-123V2, Attachment 2, Medical Standards for Continued Military Service also apply. For conditions listed in AFI48-123V2, Attachment 2, ensure an MEB has been performed and final disposition made prior to submission of a waiver request.

Applicability. The standards in this attachment apply to all ground based aircraft controller (GBC) including air traffic controllers, weapons controllers, combat controllers/directors, sensor operators and ground based operators of man-portable, non-weapon delivering small UAV (MP-UAV) unless other AFSC specific standards apply. Combat Controllers (AFSC 1C5X1D) must also meet the FC III requirements in Attachment 4 and the parachute duty requirements in Attachment 5.

A2.2. Ear, Nose, and Throat.

A2.2.1. Symptomatic allergic rhinitis (477.0), seasonal or perennial not controlled by use of topical nasal steroids or cromolyn.

A2.2.2. Any disease or malformation of the nose, mouth, pharynx or larynx that might interfere with enunciation or clear voice communication.

A2.2.3. Any disturbance of equilibrium.

A2.2.4. Obstructions of the nose from any cause which prevent nasal respiration.

A2.3. Hearing (All hearing defects are coded with ICD-9 code 389).

A2.3.1. Hearing loss greater than that specified for H-1 profile for initial selection. Hearing loss greater than that specified for H-2 profile for continued controller duty.

A2.3.2. Use of hearing aid.

A2.4. Eye.

A2.4.1. Monocularity.

A2.4.2. Intraocular pressure.

A2.4.2.1. Glaucoma (365), as evidenced by pressure of 30 mmHg or greater, or the secondary changes in the optic disc or visual field associated with glaucoma (365).

A2.4.2.2. Ocular hypertension (preglaucoma). Two or more determinations of 22 mmHg or greater but less than 30 mmHg, or a difference of 4 mmHg or greater between the two eyes.

A2.4.3. Nystagmus (379.50), except on versional end points.

A2.4.4. Contact lenses that correct near visual acuity only or that are bifocal, or that are fit with the monovision techniques.

A2.4.5. Diplopia (368.2) in any field of gaze, either constant or intermittent, including history of.

A2.4.6. History of refractive surgery of any type to include radial keratotomy (RK) or any other surgical or laser procedures, intraocular contact lenses, or corneal implants (INTACS), accomplished to modify the refractive power of the cornea or for any other reason, such as phototherapeutic keratec-

tomy (PTK). Certain corneal refractive surgery procedures, including laser-assisted in situ keratomileusis (LASIK) (P11.7) or Photorefractive Keratectomy (PRK) (P11.7), and laser epithelial keratomileusis (LASEK) (P11.7) are also disqualifying for entry to the Air Force and certain occupations (i.e. flying or other special duty positions). Waiver criteria are listed in the corresponding Aircrew Waiver Guide and AF/SG corneal refractive surgery policy letters (located on the AFMS Knowledge Junction).

NOTE: Some occupations, such as combat controllers must also meet flying class III standards, and as such, PRK (P11.7) and may be disqualifying for those standards, but not GBC medical standards alone.

A2.4.7. Extraocular muscle paralysis or paresis with loss of ocular motility in any direction.

A2.4.8. Absence of conjugate alignment in any quadrant.

A2.5. Distant Vision.

A2.5.1. Uncorrected, worse than 20/400 each eye.

A2.5.2. Corrected, worse than 20/20 each eye.

A2.6. Near Vision.

A2.6.1. Uncorrected, no standard.

A2.6.2. Corrected vision worse than 20/20 in each eye.

A2.7. Heterotropias and Heterophorias.

A2.7.1. Any heterotropia.

A2.7.2. Heterophorias. More than 1.5 prism diopter of hyperphoria, 10 prism diopters of esophoria, or 6 prism diopters of exophoria requires a thorough evaluation for other eye pathology motor and sensory abnormalities, by an optometrist and ophthalmologist. Paragraph **A4.12.2.1.** applies; also, see paragraph **A4.12.**.

A2.8. Defective Color Vision (368.5). Color vision testing must be performed and recorded monocularly under approved and standardized illuminant (i.e., Illuminant C). Five or more incorrect responses in either eye (including failure to make responses in the allowed time interval (no more than 5 seconds)) in reading the **14 test plate versions** of one of the following Pseudoisochromatic Plates (PIP) sets is considered a failure: Dvorine, the original version of the AO (excludes Richmond PIP version), or Ishihara. See Aircrew Waiver Guide.

NOTE: Test scores should be recorded as number correct/total number presented. Documentation of results must also be recorded monocularly (Example: PIP OD: 12/14, OS: 13/14 Passes). No other PIP versions, such as Richmond PIP, or Beck Engraving versions, or other tests for color vision (368.5), are authorized for qualification purposes. The Farnsworth lantern test (FALANT) has been dropped as a USAF qualifying test.

A2.9. Depth Perception. No standard.

A2.10. Visual Fields. Any visual field defect.

A2.11. Night Vision. Unsatisfactory night vision as determined by history for initial controller duty. In trained controllers, this history is confirmed, when clinically required, by the appropriate electrophysiological tests requested by the Aeromedical Consultation Service ophthalmologists.

A2.12. Cardiovascular System.

A2.12.1. History of myocardial infarction, angina pectoris, or other evidence of coronary heart disease including silent ischemia.

A2.12.2. History of dysrhythmia with symptoms of hemodynamic compromise.

A2.12.3. Symptomatic valvular heart disease or asymptomatic moderate to severe valvular disease associated with hypertrophy, chamber enlargement, or ventricular dysfunction (see AFI48-123V2, Attachment 2).

A2.12.4. Aneurysm or Atrioventricular (AV) fistula of a major vessel.

A2.12.5. Hypertension, or history of hypertension on antihypertensive medication. Hypertension is evidenced by average systolic blood pressure greater than 140 mmHg or average diastolic blood pressure greater than 90 mmHg. Patients may be followed initially as in paragraph **A4.18.**

A2.12.6. Resting pulse rate greater than 110 or less than 45 beats per minute.

A2.12.7. ECG evidence of significant conduction defects, to include Wolff-Parkinson-White syndrome.

A2.13. Blood, Blood-forming Tissues, and Immune System.

A2.13.1. Anemia of any etiology.

A2.13.2. Blood donation: 8 hr restriction from controller duty following blood donation (formal flight surgeon restriction not required).

A2.14. Abdomen and Gastrointestinal System.

A2.14.1. Gastrointestinal hemorrhage (578) or history of, regardless of cause.

A2.14.2. Peptic ulcer disease or any complication of peptic ulcer disease. An uncomplicated ulcer that has been inactive for 3 months and does not require medication (except the occasional use of antacids) is not disqualifying.

A2.14.3. Cholelithiasis.

A2.15. Genitourinary System.

A2.15.1. History of recurrent or bilateral renal calculus.

A2.15.2. Retained renal calculus, except parenchymal.

A2.15.3. Cystostomy.

A2.15.4. Neurogenic bladder.

A2.15.5. Renal transplant.

A2.16. Neurological Disorders.

A2.16.1. History of any medically unexplained disturbance of consciousness or where surgical intervention was necessary to correct the precipitating cause.

A2.16.2. History of any of the following types of headaches:

A2.16.2.1. Recurrent headaches of the vascular, migraine, or cluster (Horton's cephalgia or histamine headache) type.

A2.16.2.2. A single incapacitating headache of any type (e.g., loss of consciousness, aphasia, ataxia, vertigo or mental confusion).

A2.16.2.3. Headaches of any type which are of sufficient severity to likely interfere with controlling duties.

A2.16.2.4. Acephalgic migraines.

A2.16.3. History of recurrent vertigo or dysequilibrium disorders.

A2.16.4. Cerebrovascular disease to include transient ischemic attack (TIA), cerebral infarction, thrombotic or embolic, or transient global amnesia.

A2.16.5. Demyelinating and autoimmune diseases.

A2.16.6. Extrapyramidal, hereditary, and degenerative diseases of the nervous system.

A2.16.7. Infections of the nervous system.

A2.17. Psychiatric Disorders. (Reference most current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM), American Psychiatric Association.)

A2.17.1. Alcohol dependence or abuse or any disease the proximate cause of which is alcoholism. Waiver may be considered when all of the requirements in **Attachment 4.25.1.5.** are met and documented.

A2.17.2. Unsatisfactory adaptability rating for ground based controller duties.

A2.17.3. Anxiety disorders.

NOTE: Fear of controlling which does not meet the DSM criteria for a disorder is handled administratively.

A2.17.4. History of attempted suicide or suicidal behavior.

A2.17.5. Mood disorders including bipolar disorder, major depression, dysthymia and depression not otherwise specified.

A2.17.6. All organic mental disorders.

A2.17.7. Any personality disorder, or mental condition that may render the individual unable to safely perform controller duties. A personality disorder that is severe enough to have repeatedly manifested itself by overt acts disqualifies the individual from controller duties. Also, see AFI48-123V2, Attachment 2.13.4.

A2.18. Musculoskeletal, Spine, and Extremities. Any disease, condition, or deformity of the musculoskeletal system, which may impair duty performance or access to control facilities, is likely to progress, or which requires frequent use of analgesic or anti-inflammatory medication for control.

A2.19. Endocrine and Metabolic.

A2.19.1. Diabetes insipidus.

A2.19.2. Hypoglycemia, whether functional or a result of pancreatic tumor.

A2.19.3. Thyroid disorders.

A2.19.4. Other endocrine or metabolic disorders which preclude satisfactory performance of controller duties.

A2.20. Medication.

A2.20.1. Use of any medication whose known actions may affect alertness, judgment, cognition, special sensory function, mood, or coordination. See "Official Air Force Approved Aircrew - Quick Reference List", updated quarterly by AFMOA (approved by AF/SGOP) for list of approved medications.

A2.21. Miscellaneous.

A2.21.1. Exacerbation of any medical condition for which a waiver has been granted.

A2.21.2. HIV (Human Immunodeficiency Virus) antibody testing is required for all applicants for initial controller duty. Record the results of cholesterol, high-density lipoprotein (HDL), and triglycerides in item 19F or item 42, SF 88 or appropriate block in DD Form 2808.

A2.21.3. An adaptability rating for control duty (AR-CD) and a reading aloud test (RAT) is required on all applicants for initial controller duty. Record the results in item 41, SF 88 or item 72a, DD Form 2808. The RAT and instructions are in AFJI 36-2018, *Medical Examination of Applicants for United States Service Academies, Reserve Officer Training Corps (ROTC) Scholarship Programs, Including Two and Three-Year College Scholarship Programs (CSP), and the Uniformed Services University of Health Sciences (USUHS).*

A2.21.4. Air traffic controllers assigned to remote sites where required interval medical examinations are not available are authorized no more than a 6 month deferral period to allow mission completion. This deferred period is effective only while assigned to the remote site. Members must ensure currency once assigned to an installation with medical facilities capable of performing examinations. Also, complete an audiometric examination if the individual is on the hearing conservation program.

A2.22. FAA Certificate. Civilian contract Air traffic controllers performing controller duty on Air National Guard (ANG), Air Force Reserve, or Active Duty Air Force installations shall have a Class II FAA certifying physical examination performed by a designated civilian AME in accordance with 14 CFR Part 67 (FAA Airman Medical Standards and Certification). Federally employed air traffic controllers may have Class II FAA examinations performed only by those AMEs designated by the FAA Regional Flight Surgeon to perform controller examinations. Applications for Statements of Demonstrated Ability (SODA), or waivers, will be processed through the Mike Monroney Aeronautical Center per the Guide for Aviation Medical Examiners.

Attachment 3

SPACE AND MISSILE OPERATIONS DUTY (SMOD)

AFSC 13S and 1C6 and any individual of another AFSC assigned to operational crew duty maintaining mission ready or equivalent status

A3.1. Conditions in AFI48-123V2, Attachment 2, Medical Standards for Continued Military Service also apply. For conditions listed in AFI48-123V2, Attachment 2, ensure an MEB has been performed and final disposition made prior to submission of a waiver request.

A3.2. Vision.

A3.2.1. Defective Color Vision (368.5). Color vision testing must be performed and recorded monocularly under approved and standardized illuminant (i.e., Illuminant C). Five or more incorrect responses in either eye (including failure to make responses in the allowed time interval (no more than 5 seconds)) in reading the **14 test plate versions** of one of the following PIP sets: Dvorine, the original version of the AO (excludes Richmond PIP version), or Ishihara. See Aircrew Waiver Guide.

NOTE: Test scores should be recorded as number correct/total number presented. Documentation of results must also be recorded monocularly (Example: PIP OD: 12/14, OS: 13/14 Passes). No other PIP versions, such as Richmond PIP, or Beck Engraving versions, or other tests for color vision, are authorized for qualification purposes. The FALANT has been dropped as a USAF qualifying test.

A3.2.2. Corrected visual acuity worse than 20/20 in the better eye near and distant.

NOTE: Individuals found on routine examination to be less than 20/20 in the better eye in either near or distant, or both, but correctable to at least 20/20 near and distant in one eye may continue to perform Space and Missile Operations duties until the appropriate corrective lenses arrive. These lenses must be ordered by the most expeditious means.

A3.3. Hearing. A hearing profile less than H-2 for initial selection or less than H-3 for continued SMOD duty.

A3.4. Head and Neck.

A3.4.1. Any disease or malformation of the nose, mouth, pharynx, or larynx that might interfere with enunciation or clear voice communication as demonstrated by the reading aloud test.

A3.5. Neuropsychiatric. See most current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM), American Psychiatric Association.

A3.5.1. Psychiatric profile other than S-1 and S-1 profile with a psychiatric diagnosis.

A3.5.2. History of claustrophobia.

A3.5.3. Alcohol dependence (303) or abuse (305) or any disease the proximate cause of which is alcoholism. Waiver may be considered when all of the requirements in **Attachment 4.25.1.5.** are met and documented.

A3.5.4. Any psychiatric condition, or history thereof, which, in the opinion of the examining flight surgeon, would interfere with the performance of space and missile operations crew duty. Also see AFI48-123V2, Attachment 2.13.4.

A3.5.5. Headaches.

A3.5.5.1. Initial applicants: History of recurrent headaches of the vascular, migraine, or cluster type (including acephalgic migraines).

A3.5.5.2. Trained personnel: Recurrent headaches of the vascular, migraine, or cluster type (including acephalgic migraines) confirmed by neurologist evaluation.

A3.5.5.3. A single incapacitating headache of any type (i.e., loss of consciousness, aphasia, ataxia, vertigo or mental confusion).

A3.5.6. Unsatisfactory AR-SMOD.

A3.5.7. History of attempted suicide, or suicidal behavior (300.9).

A3.5.8. History of seizures within the past 5 years, or usage of medications to control seizures within the past 5 years.

A3.5.9. Head injuries.

A3.5.9.1. Head injury of a mild degree (**Attachment A4.24.**) with a normal neurological examination by a flight surgeon does not require waiver action.

A3.5.9.2. Head injury of a moderate or severe degree (**Attachment A4.24.**) will require waiver action as delineated in AFI48-123V4, Table 1.2.1. The minimum observation period for SMOD is six months for moderate head injury and two years for severe head injury. All evaluation requirements as delineated in AFI48-123V4, Table 1.2.1. apply.

A3.6. Medication.

A3.6.1. Prescription Medications.

A3.6.1.1. Personnel may not perform SMOD Combat Mission Ready (CMR) or Basic Mission Ready (BMR) duties (AFSPCI 10-1202, paragraphs 1.3 and 1.4.) while using any medication whose known common adverse effect or intended action(s) affect alertness, judgment, cognition, special sensory function, mood or coordination.

A3.6.1.2. CMR and/or BMR SMOD personnel prescribed medication with these known actions must be placed in Duties Not Involving Controlling (DNIC), or DNIA, status while under their effect. If chronic or long-term use of such medications is required, a medical waiver must be accomplished and reviewed by HQ AFSPC/SGPA for disposition.

A3.6.1.3. For all SMOD medication use, all clinical practice and standard of care guidelines must be adhered to, and appropriately documented, before during and after prescribing such medication to SMOD personnel (example: monitoring liver function tests for personnel prescribed some statins, etc.).

A3.6.1.4. SMOD personnel in non-CMR/BMR positions do not require DNIA/DNIC action for medications unless the underlying medical condition requires medical waiver action or the medication may affect alertness, judgment, cognition, special sensory function, mood or coordination

and the medication use is anticipated as a long term maintenance medication. In such cases waiver work up and application is required.

A3.6.2. Over the Counter (OTC) medications and Supplements:

A3.6.2.1. FDA-approved OTC medications and commercially available (in the United States) substances, to include herbal and nutritional supplements, may generally be used by SMOD personnel without Flight Surgeon approval, provided the product is used in accordance with manufacturers' directions for its intended use.

A3.6.2.2. SMOD personnel are required to consult with the Flight Surgeon whenever:

A3.6.2.2.1. The member is within 12 hours of reporting SMOD duties and will be using the product for the very first time; or

A3.6.2.2.2. The member has questions about a product's use or potential side effects; or

A3.6.2.2.3. The member experiences adverse reactions which may affect the member's ability to perform duties.

A3.7. General.

A3.7.1. Any medical condition, the natural history of which is to incapacitate an individual suddenly and without warning.

A3.7.2. Exacerbation of any medical condition for which a waiver has been granted.

A3.8. Continuation of Space and Missile Operations Duty.

A3.8.1. Only a Flight Surgeon may make determinations or recommendations concerning a SMOD crewmember's ability to perform or not perform combat or basic mission ready crew duties.

A3.8.1.1. When a crew member receives care by a non-flight surgeon provider, the member should be seen immediately by a flight surgeon for appropriate aeromedical disposition. If a flight surgeon is not immediately available, the member should be temporarily removed from space and missile duties until seen by a flight surgeon or the visit is reviewed by a flight surgeon.

A3.8.2. AF Form 1042 actions (additional guidance on disposition of the AF Form 1042 can be found in **Chapter 3**).

A3.8.2.1. Initial certification: Certified physical and copy of qualifying AF Form 1042 in Part 3 of medical record.

A3.8.2.1.1. Training: All 13S and 1C6 must have qualifying SMOD physical examination certified, as appropriate, by AETC/SG, AFSPC/SGPA, Local Waiver Authority, or appropriate ARC/SG.

A3.8.2.2. Initial base clearance. Upon reporting to a new base, for duty or training, a complete medical records review and informal examination (using SF 600, *Health Record, Chronological Record of Medical Care*) will be conducted by a flight surgeon to ensure the member is medically qualified to perform SMOD (additional guidance on disposition of the AF Form 1042 can be found in **Chapter 3**).

A3.8.2.3. Waivers: Copy of certified waiver in Part 3 of medical record and copies of AF Form 1042 to unit commander and in Part 3 of medical record.

A3.8.2.4. Routine Medical Care or Services.

A3.8.2.4.1. Active/Operational SMOD (13S or 1C6 performing Basic or Combat Mission Ready, or any individual of another AFSC assigned to operational crew duty maintaining mission ready or equivalent status): DNIA/DNIC for any disqualifying medical conditions, medication use or treatments, short or long term, for the period of time that the condition or treatment will last. Copy of DNIA/DNIC AF Form 1042 to individuals' commander and copy in Part 3 of medical record. When condition is resolved or treatment completed Return to Controlling Duties AF Form 1042 to individual's commander and copy in Part 3 of medical record.

A3.8.2.4.2. Inactive/Non-operational 13S and 1C6. Do not DNIA/DNIC for temporary medical conditions or medication treatment. No AF Form 1042 action required. For long term or potentially disqualifying medical conditions or medication treatments, DNIA/DNIC is required. Copy of AF Form 1042 to individual's commander and copy in Part 3 of medical record. If condition or treatment is long term and/or disqualifying, begin waiver process.

A3.8.3. Preventive Health Assessment (PHA) is covered in **Chapter 3**.

A3.9. Additional Testing.

A3.9.1. HIV antibody testing is required for all applicants for initial duty. Record the results of cholesterol, HDL, and triglycerides in item 19F or item 42, SF 88, or in appropriate block in DD Form 2808.

A3.9.2. An AR-SMOD and a reading aloud test (RAT) is required on all applicants for initial duty. Record the results in item 41, SF 88 or item 72a in DD Form 2808. The RAT and instructions are contained in AFJI 36-2018 and AFPAM 48-133.

A3.10. Pregnancy.

A3.10.1. Pregnancy is not necessarily disqualifying for space and missile duties. It may be appropriate to remove an individual from crew duties if she is experiencing some side effects from her pregnancy (e.g. hyperemesis, preeclampsia). The following guidelines should be used for routine pregnancy.

A3.10.1.1. Missileers - remove from alert duty after 24 weeks gestation.

A3.10.1.2. Spacelift Operators and Space Warning Operators - remove from shift duty after 32 weeks gestation.

A3.10.1.3. Satellite Command and Control and Space Surveillance Operators - remove from shift duty after 36 weeks gestation.

Attachment 4

MEDICAL STANDARDS FOR FLYING DUTY

A4.1. Conditions listed in AFI 48-123V2, Attachment 2, Medical Standards for Continued Military Service and AFI 48-123V2, Attachment 3, Appointment, Enlistment, and Induction apply. For conditions listed in AFI 48-123V2, Attachment 2, ensure a MEB has been performed and final disposition made prior to submission of a flying waiver request. When a crewmember receives care by a non-flight surgeon provider, the member should be seen immediately by a flight surgeon for appropriate aeromedical disposition. If a flight surgeon is not immediately available, the member will be removed from flying duties until seen by a flight surgeon or the visit reviewed by a flight surgeon.

A4.2. Head, Face, Neck, and Scalp (Flying Classes I, IA, II, and III).

A4.2.1. Injuries to the head (see paragraph **A4.24.**).

A4.2.2. Loss or congenital absence of bony substance of the skull (756.0 or 738.1).

A4.2.3. Chronic arthritis, complete or partial ankylosis, or recurrent dislocation of the temporomandibular joint.

A4.2.4. Congenital cysts (744.4) of branchial cleft origin or those developing from the remains of a thyroglossal duct, with or without fistulous tracts.

A4.2.5. Chronic draining fistulae of the neck, regardless of cause.

A4.2.6. Contractions (723) 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.

A4.2.7. Cervical ribs (756.2) if symptomatic or symptoms can be induced by abduction, scalenus, or costoclavicular maneuvers.

A4.2.8. Any anatomic or functional anomaly of head or neck structures, which interfere with normal speech, ventilation of the middle ear, breathing, mastication, swallowing, or wear of aviation or other military equipment.

A4.3. Nose, Sinuses, Mouth, and Throat.

A4.3.1. Flying Classes II and III.

A4.3.1.1. Allergic rhinitis (477.0), unless mild in degree and considered unlikely to limit the examinee's flying activities.

A4.3.1.2. Chronic nonallergic or vasomotor rhinitis, unless mild, asymptomatic, and not associated with eustachian tube dysfunction.

A4.3.1.3. Nasal polyps (471).

A4.3.1.4. Deviations of the nasal septum, septal spurs, enlarged turbinates or other obstructions to nasal ventilation which result in clinical symptoms. Symptomatic atresia or stenosis of the choana.

A4.3.1.5. Epistaxis (784.7), chronic, recurrent.

A4.3.1.6. Chronic sinusitis (473) unless mild in degree and considered unlikely to limit the examinee's flying activities.

A4.3.1.7. Recurrent calculi of the salivary glands or ducts.

A4.3.1.8. Deformities, injuries, or destructive diseases of the mouth (including teeth), nose, throat, pharynx, or larynx that interfere with ventilation of the paranasal sinuses and, or middle ear, breathing, easily understood speech, or mastication and swallowing of ordinary food.

A4.3.1.9. Atrophic rhinitis.

A4.3.1.10. Perforation of the nasal septum (478.1).

A4.3.1.11. Anosmia or parosmia (781.1).

A4.3.1.12. Salivary fistula (527.4).

A4.3.1.13. Ulcerations, perforation, or extensive loss of substance of the hard or soft palate; extensive adhesions of the soft palate to the pharynx; or complete paralysis of the soft palate. Unilateral paralysis of the soft palate which does not interfere with speech or swallowing and is otherwise asymptomatic is not disqualifying.

A4.3.1.14. Chronic pharyngitis (462) and nasopharyngitis (472.2).

A4.3.1.15. Chronic laryngitis. Neoplasm, polyps, granuloma, or ulceration of the larynx.

A4.3.1.15.1. Aphonia or history of recurrent aphonia, if the cause was such as to make subsequent attacks probable. Painful dysphonia plicae ventricularis.

A4.3.1.15.2. Tracheostomy (V44.0) or tracheal fistula (530.84).

A4.3.1.15.3. Malformations, injuries or diseases of the esophagus, such as ulceration, diverticulum, varices, stricture, achalasia, pronounced dilation, or peptic esophagitis.

A4.3.1.16. History of sleep apnea or other clinical sleep disorders, regardless of prior treatment.

A4.3.2. Flying Classes I and IA. In addition to the above:

A4.3.2.1. A verified history of allergic (477.0), nonallergic (472.0), or vasomotor rhinitis, after age 12.

A4.3.2.2. Any surgical procedure for sinusitis, polyposis or hyperplastic tissue. See Aircrew Waiver Guide.

A4.4. Ears.

A4.4.1. Flying Classes II and III.

A4.4.1.1. History of surgery involving the middle ear, excluding cholesteatoma (See **A4.4.1.9.**).

A4.4.1.2. History of mastoid surgery.

A4.4.1.3. Inability to perform the valsalva maneuver.

A4.4.1.4. Perforation of the tympanic membrane. Surgery to repair perforated tympanic membrane is disqualifying until healing is complete and hearing is normal.

A4.4.1.5. Tinnitus when associated with active disease.

A4.4.1.6. Abnormal labyrinthine function.

A4.4.1.7. Recurrent episodes of vertigo with or without nausea, vomiting, tinnitus, and hearing loss.

A4.4.1.8. Any conditions that interfere with the auditory or vestibular functions.

A4.4.1.9. Cholesteatoma (385.3), or history of surgical removal of cholesteatoma.

A4.4.1.10. Atresia (744.02), tuberosity, severe stenosis (380.5) 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.

A4.4.2. Classes I, IA, II (flight surgeon applicants) and III (initial applicants). In addition to **A4.4.1.**

A4.4.2.1. Applicants must demonstrate satisfactory performance of the Reading Aloud Test (RAT).

A4.4.2.2. History of radical mastoidectomy.

A4.4.2.3. History of abnormal labyrinthine function, unexplained or recurrent vertigo.

A4.4.2.4. Surgical repair (P19) of perforated tympanic membrane (384.2) within the last 120 calendar days.

A4.5. Hearing (all hearing defects are coded with ICD-9 code 389).

A4.5.1. Flying Class II and III. Hearing loss greater than H-1 profile, or asymmetric hearing loss, requires work-up by an audiologist (audiology evaluation for initial waiver and waiver renewals must have been accomplished within 12 months of submission to waiver authority). Waivers are required for H-3 hearing loss or greater. Indefinite waivers are not authorized.

A4.5.1.1. For trained assets an H-2 profile alone does not require waiver. However, an evaluation sufficient to rule-out conductive or retrocochlear pathology should be conducted. This includes full audiologic evaluation and, where appropriate, referral for Ear, Nose, and Throat (ENT) consultation. Referral to ENT may be at the discretion of the audiologist or referring facility. Restriction from flying is not required during work-up.

A4.5.1.2. H-3 profile requires waiver.

A4.5.1.2.1. For members with new H-3 profiles (i.e., those whose hearing has recently changed to H-3, and who have not been previously worked-up), restriction from flying is appropriate.

NOTE: Members with long-standing, stable H-3 not previously evaluated by an audiologist and/or ENT, require work-up and waiver, but need not be restricted from flying, unless in the opinion of the flight surgeon they represent a danger to flying safety.

A4.5.1.2.2. Interim waiver may be granted by MAJCOM/SG after determination of acceptable hearing proficiency (occupational aircrew hearing assessment), pending complete audiology evaluation (indefinite waivers are not authorized).

A4.5.1.2.3. For actively flying personnel, validate hearing proficiency in one of two ways prior to issuance of medical waiver for H-3 profile:

A4.5.1.2.3.1. Inflight hearing test as described in SAM TR73-29, *Materials and Procedures for In-flight Assessment of Auditory Function in Aircrewmen,* and reproduced within AFPAM 48-133.

A4.5.1.2.3.2. Written validation, signed by the flying squadron commander or operations officer, of the adequacy of the member's hearing to perform safely in assigned aircrew duties in the flying environment. This validation should be supplemented by the assigned flight surgeon's written memorandum for record stating that speech discrimination levels, according to examination by audiologist, are adequate for the performance of flying duties.

A4.5.1.2.4. Waiver is contingent upon complete audiologic and where appropriate, ENT evaluation.

NOTE: The audiologist must rule out conductive and retrocochlear disease. The audiologist may defer ENT evaluation.

A4.5.1.2.5. The occupational aircrew hearing assessment is deferred for inactive flyers. They may receive a Flying Class IIC waiver specifying the completion of the occupational aircrew hearing assessment before return to active flying. The pending requirement for operational hearing evaluation upon return to cockpit duties must be entered on the AF Form 1042.

A4.5.2. Asymmetric hearing loss (greater than, or equal to, 25 decibel (dB) difference, comparing left and right ear, at any two consecutive frequencies) requires full audiological work-up with further clinical evaluation as indicated, and requires a waiver (indefinite waivers are not authorized). Restriction from flying is not required during work-up. Also, see Aircrew Waiver Guide.

A4.5.3. The following tests are suggested as a complete audiologic evaluation:

A4.5.3.1. Pure tone air and bone conduction thresholds.

A4.5.3.2. Speech reception thresholds.

A4.5.3.3. Speech discrimination testing, to include high intensity discrimination.

A4.5.3.4. Immittance audiometry.

A4.5.3.5. Tympanograms.

A4.5.3.6. Ipsilateral and contralateral acoustic reflexes (levels not exceeding 110 dB HL).

A4.5.3.7. Acoustic reflex decay (500 and 1000 Hz, with levels not exceeding 110 dB HL).

A4.5.3.8. Otoacoustic emissions (transient evoked or distortion product).

A4.5.4. The following tests may be required if indicated by those listed in **A4.5.3.**

A4.5.4.1. Auditory brainstem response.

A4.5.4.2. MRI.

NOTE: Audiology reevaluation is required for waiver renewals if a shift of greater than 10 dB is noted from the "baseline" audiogram in any one frequency from 1,000 Hz to 4,000 Hz. Additionally, audiology evaluations submitted to the waiver authority must have been accomplished within 12 months. These rules apply to all hearing waivers.

A4.5.5. Initial Flying Class FCI/IA, II and III must be H1 for selection.

A4.6. Dental.

A4.6.1. Flying Classes II and III.

A4.6.1.1. Personnel wearing orthodontic appliances need not have appliances removed for physical qualification. After consultation with the treating orthodontist, the local flight surgeon may qualify the individual for flying duties if there is no effect on speech or the ability to wear equipment with comfort.

A4.6.1.2. Severe malocclusion (524) which interferes with normal mastication or requires protracted treatment.

A4.6.1.3. Diseases of the jaw or associated structures such as cysts, tumors, chronic infections, and severe periodontal conditions which could interfere with normal mastication, until adequately treated.

A4.6.1.4. Aircrew members who have a significant dental defect which may be expected to cause a dental emergency during flight will be grounded. ARC members are managed IAW AFI 48-123V2, Chapter 5.14.1.

A4.6.2. Classes I and IA. In addition to those listed at **A4.6.1.** to **A4.6.1.4.**:

A4.6.2.1. Dental defects such as carious teeth, malformed teeth, defective restorations, or defective prosthesis, until corrected.

A4.6.2.2. Anticipated or ongoing treatment with fixed orthodontic appliances.

A4.7. Eye, Flying Classes I, IA, II, and III.

A4.7.1. Lids/Adnexa.

A4.7.1.1. Any condition of the eyelids which impairs normal eyelid function or comfort, or potentially threatens visual performance (374.4).

A4.7.1.2. Epiphora, nasolacrimal duct obstruction.

A4.7.1.3. Ptosis, any, except benign etiologies which are not progressive and do not interfere with vision in any field of gaze or direction.

A4.7.1.4. Dacryocystitis, acute or chronic (375.30).

A4.7.1.4.1. Dacryostenosis.

A4.7.2. Conjunctiva.

A4.7.2.1. Conjunctivitis, chronic (372.1), allergic (372.14).

A4.7.2.2. Trachoma, unless healed without visually significant scarring.

A4.7.2.3. Xerophthalmia (372.53).

A4.7.2.4. Pterygium (372.4) which encroaches on the cornea more than 1mm or interferes with vision, or is progressive, or causes refractive problems.

A4.7.3. Cornea.

A4.7.3.1. Keratitis (370), chronic or acute, including history of.

A4.7.3.2. Corneal ulcers (370.0) or recurrent corneal erosions.

A4.7.3.3. Vascularization (370.6) or opacification (371) of the cornea from any cause.

A4.7.3.4. History of traumatic corneal laceration unless it does not interfere with vision, nor is likely to progress.

A4.7.3.5. Corneal dystrophy of any type (371.5), including Keratoconus (371.6) of any degree.

NOTE: UPT applicants who demonstrate a Topographical Pattern Suggestive of Keratoconus (TPSK) (371.6) without other clinical findings of keratoconus (371.6), may be eligible for waiver. Applicants must be evaluated at MFS. Test results from outside agencies, or civilian sources will not be used for waiver or initial qualification determination. Members identified with TPSK who are granted a medical waiver will be entered into the ACS TPSK Study/Management Group. Participation in this study/management group is **mandatory** for waiver. **Reevaluation at the ACS will be required for waiver renewal.** See Aircrew Waiver Guide.

A4.7.3.6. History of refractive surgery of any type, to include RK or any other surgical or laser procedures, intraocular contact lenses, or corneal implants (INTACS), accomplished to modify the refractive power of the cornea or for any other reason, such as phototherapeutic keratectomy (PTK). Certain corneal refractive surgery procedures, including LASIK (P11.7) or PRK (P11.7), and laser epithelial keratomileusis (LASEK) (P11.7) are also disqualifying for entry to the Air Force and certain occupations (i.e. flying or other special duty positions). Waiver criteria are listed in the corresponding Aircrew Waiver Guide and AF/SG corneal refractive surgery policy letters (available on the AFMS Knowledge Junction).

A4.7.3.7. Corneal Refractive Therapy (CRT) active or a history of these procedures.

A4.7.3.8. Lamellar (P11.7) or penetrating keratoplasty (corneal transplant) (P11.6).

A4.7.4. Uveal Tract. Acute, chronic or recurrent inflammation of the uveal tract (iris, ciliary body, or choroid), except for healed traumatic iritis.

A4.7.5. Retina/Vitreous.

A4.7.5.1. Retinal detachment (361) and history of same.

A4.7.5.2. Degenerations (362), scarring, and dystrophies of the retina (759.6), including lattice degeneration, retinoschisis (361.1) and all types of central and peripheral pigmentary degenerations.

A4.7.5.3. Degenerations and dystrophies of the macula, macular cysts, and holes.

A4.7.5.4. Retinitis, chorioretinitis, or other inflammatory conditions of the retina, unless single episode which has healed, and is expected not to recur or progress, and does not impair central or peripheral vision.

A4.7.5.5. Angiomatoses (759.6), phakomatoses, retinal cysts (361.1) and other conditions which impair or may impair vision.

A4.7.5.6. Hemorrhages, exudates or other retinal vascular disturbances.

A4.7.5.7. Vitreous opacities or disturbances which may cause loss of visual acuity.

A4.7.6. Optic Nerve.

A4.7.6.1. Congenito-hereditary conditions that interfere or may interfere with central or peripheral vision.

A4.7.6.2. Optic neuritis (377.3), of any kind, including retrobulbar neuritis, papillitis, neuroretinitis, or a documented history of same.

A4.7.6.3. Papilledema (377.0).

A4.7.6.4. Opticatrophy (primary or secondary) or optic pallor.

A4.7.6.5. Optic nerve cupping greater than 0.4 or an asymmetry between the cups of greater than 0.2, unless proven to be physiologic after comprehensive evaluation by an eyecare specialist. This evaluation should include local diurnal pressure checks and visual field testing.

A4.7.6.6. Optic neuropathy.

A4.7.6.7. Optic nerve head drusen.

A4.7.7. Lens.

A4.7.7.1. Aphakia (379.31), unilateral or bilateral.

A4.7.7.2. Dislocation of a lens, partial or complete.

A4.7.7.3. Opacities (366), cataracts (366.9), or irregularities of the lens, which interfere with vision, or are considered to be progressive.

A4.7.7.4. Pseudophakia (intraocular lens implant).

A4.7.7.5. Posterior and/or anterior capsular opacification.

A4.7.7.6. Intraocular contact lenses.

A4.7.8. Other Defects and Disorders.

A4.7.8.1. Asthenopia (368.13), if severe.

A4.7.8.2. Exophthalmos (376), unilateral or bilateral.

A4.7.8.3. Nystagmus (379.50) of any type, except on versional end points.

A4.7.8.4. Diplopia (368.2) in any field of gaze, either constant or intermittent, including history of.

A4.7.8.5. Visual field defects, any type, including hemianopsia.

A4.7.8.6. Abnormal pupils or loss of normal pupillary reflexes (367.5), with the exception of physiological anisocoria.

A4.7.8.7. Retained intraocular foreign body (360).

A4.7.8.8. Absence of an eye (743.00).

A4.7.8.9. Anophthalmos (743.00) or microphthalmus.

A4.7.8.10. Any traumatic, organic (360), or congenital disorder of the eye or adnexa (376), not specified above, which threatens, or potentially threatens, to intermittently or permanently impair visual function.

A4.7.8.11. Migraine or its variants, to include acephalgic migraine (see paragraph **A4.24.**).

A4.7.8.12. History of any ocular surgery to include lasers of any type.

A4.8. Vision and Refraction.

Table A4.1. VISION & REFRACTIVE ERROR STANDARDS

Vision Limits for Each Eye Refraction Limits								
Flying Class	**Distant Vision**		**Near Vision**		**Any Meridian**	**Astig-matism**	**Aniso-metropia**	**Spectacles/ Contact Lenses** Notes: 1,3,5,6,7
	Uncorr	Corrected	Uncorr	Corrected				
I Notes: 2,10,12,13	20/70	20/20	20/30	20/20	+2.00 -1.50	1.50	2.00	Note 1, 13
IA Notes: 2,10,12,13	20/200	20/20	20/40	20/20	+3.00 -2.75	2.00	2.50	Note 1, 13
II (Pilot)	20/400	20/20 Notes: 3,11	-	20/20 Note: 3,9	+3.50 -4.00	2.00	2.50 Note 4	Note 1, 13
II/III (Non-pilot)	20/400	20/20 Notes: 3,12	-	20/20 Note: 3,9	+5.50 -5.50 Note 8	3.00	3.50 Note 4	Note 1, 13

NOTES:

1. Use of hard, rigid, or gas permeable (hard) contact lenses within 3 months before the examination or soft contact lenses 1 month before all initial flying examinations is prohibited. Document SF 88/DD Form 2808 appropriately to ensure this requirement has been met.
2. These medical standards apply for USAFA, AFROTC cadets at the time of AF commissioning physical, AF active duty members, civilian applicants for flying training, and applicants from the Reserve and Guard components during the initial flying physical.
3. Individuals found on routine examination to be 20/20 in one eye and 20/25 with current corrective lenses, but are correctable to 20/20 O.U. and who have normal stereopsis 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 OVT (or VTA) stereopsis is normal and the aviator has no asthenopic symptoms due to poor fusional control, or diplopia (368.2).

5. Complex refractive errors that can be corrected only by contact lenses are disqualifying.
6. All aircrew members are prohibited from using contact lenses for treatment of medical conditions unless they have been specifically prescribed and issued or approved by the ACS.
7. Optional wear of contact lenses for aircrew members is outlined in **Attachment 7**.
8. Waivers may only be considered after the individual has a normal ophthalmological examination, to include a dilated fundus exam, and possesses plastic lens spectacles which correct them to 20/20 in each eye and meets the USAF standards for approved spectacles for aircrew duties (see **Attachment 7**).
9. Near vision should be corrected to 20/20 at the nearest cockpit working distance.
10. The Air Force Chief of Staff retains Exception To Policy (ETP) authority for vision and refractive limits for UFT applicants.
11. Flying Class II/III aviators should be refracted to their best corrected visual acuity. Use of spectacles to correct aircrew to better than 20/20 if possible, should be encouraged, but is at the discretion of the crewmember. For continued flying qualification use refraction required to achieve 20/20.
12. For qualification purposes, cycloplegic refraction readings should be recorded for that required to read the 20/20 line in each eye. However, continue refraction to best visual acuity and report the best achievable corrected visual acuity as a clinical baseline. (Thus, acuity and refractive error numbers may not correlate). Cycloplegic refractions that cannot achieve the 20/20 line will need clinical evaluation or re-evaluation. Cycloplegic Policy: For qualification purposes, a cycloplegic refraction should be done using 1% cyclopentolate (Cyclogel®), two drops, 5-15 minutes apart. Examination will be performed no sooner than one hour after the last drop and within two hours of the last drop of cyclopentolate. If the cyclopentolate does not appear to dilate the pupil sufficiently, another agent or a new bottle of cyclopentolate on another day should be considered.
13. Crewmembers who wear corrective spectacles or contact lenses must carry a spare set of clear prescription spectacles on their person while performing aircrew duties, see AFI 11-202, Vol 3, paragraph 6.3. The only approved spectacle frame for USAF aircrew and other contract personnel flying USAF aircraft is the Improved Aircrew Spectacle (IAS) frame referred to as the Air Force Flight (AFF) frame by the DoD Optical Fabrication Enterprise. No other frames are authorized. The former approved aircrew spectacle, the HGU-4/P, can be worn until replaced with the new IAS. Additionally, only 15 percent (N-15) transmittance neutral density gray spectacle lenses are approved for flying duty (**Attachment 7**).

A4.9. Heterophoria and Heterotropia.

A4.9.1. Flying Class III, except Inflight Refuelers.

A4.9.1.1. Esophoria greater than 15 prism diopters.

A4.9.1.2. Exophoria greater than 8 prism diopters.

A4.9.1.3. Hyperphoria greater than 2 prism diopters.

A4.9.1.4. Heterotropia greater than 15 prism diopters, at near or distance.

A4.9.2. Flying Class I, IA, II, II-Flight Surgeons, Inflight Refuelers and any other individuals required to perform scanner duties. If any of these are exceeded, then paragraph **A4.12.2.1.** applies.

NOTE: For the purposes of this AFI, scanner duties are defined by the requirement to assist with safety clearance checks of their aircraft from outside obstacles.

A4.9.2.1. Esophoria greater than 10 prism diopters, at near or distance.

A4.9.2.2. Exophoria greater than 6 prism diopters, at near or distance.

A4.9.2.3. Hyperphoria greater than 1.5 prism diopters, at near or distance.

A4.9.2.4. Heterotropia, including microtropias, at near or distance.

A4.9.2.5. Point of convergence (PC) greater than 100mm.

NOTE: Accomplish and record PC measurements only at the time of initial Flying Class I, IA, II-Flight Surgeon, and III - Inflight Refueler applicant exams. The PC is no longer required on periodic examinations.

A4.9.2.6. History of extraocular muscle surgery or strabismus therapies is disqualifying and requires complete evaluation of ocular motility by a competent eye care professional to look for residual heterophorias, heterotropias (including microtropias), and motor sensory problems. Paragraph **A4.12.2.1.** applies.

A4.10. Near Point of Accommodation.

A4.10.1. Flying Classes II and III. No standards.

A4.10.2. Flying Classes I and IA. Near point of accommodation greater than minimum for age specified in **Attachment 6**.

A4.11. Color Vision (368.5).

A4.11.1. Classes I, IA. Color vision deficit or anomaly of any degree or type.

A4.11.1.1. All Flying Class I applicants must pass definitive color vision testing during MFS. Established color vision testing during MFS is determined by the following tests approved by AF/SG.

A4.11.1.1.1. PIP I (minimum passing score 10/14 OU tested monocularly).

A4.11.1.1.2. PIP II (minimum passing score 9/10 tested monocularly).

A4.11.1.1.3. PIP III (minimum passing score 9/10 tested monocularly).

A4.11.1.1.4. F2 Pass or Fail.

A4.11.1.2. All Flying Class IA applicants must possess normal color vision as demonstrated by passing the approved PIP I.

A4.11.2. Flying Class II/III: Must possess normal color vision as demonstrated by passing the approved PIP I.

A4.11.2.1. FS Applicants with color vision defects (failing the PIP I plates) may be considered for a FCIIA waiver only. FCIIA waiver authority is delegated to HQ AETC/SG. Controversial cases will be referred to AFMOA/SGPA.

A4.11.2.2. Trained FC II aircrew, other than flight surgeons, who fail the PIP I and were previously qualified for aviation duties based on a past history of passing either the FALANT and/or the Color Threshold Tester (CTT) require a FCIIC waiver. A formal ophthalmologic evaluation must be accomplished to determine the type and degree of color vision defect. The aviator will be limited to his current airframe unless a functional cockpit assessment has been devised for the new aircraft. AFMOA/SGPA is waiver authority IAW AFI 48-123 V4, Attachment 2.

A4.11.2.3. Color vision screening done at base level must be performed monocularly under an approved and standardized illuminant (i.e., MacBeth easel lamp with a 100 watt light bulb or a True Daylight AE lamp from Richmond Products). Five or more incorrect responses in either eye (including failure to make responses in the allowed time interval (no more than 5 seconds)) in reading the 14 test plates of one of the following Pseudoisochromatic Plate (PIP) tests, Dvorine, the original version of the AO (excludes Richmond PIP version), or Ishihara, is considered a failure. No other PIP versions, such as the Richmond PIP, or Beck Engraving versions, or other tests for color vision are authorized. Test scores should be recorded as number of correct/total number presented. The FALANT is not authorized. See Aircrew Waiver Guide.

A4.11.2.4. Aircrew with defective color vision are not authorized to wear the yellow High Contrast Visor (HCV) or any other colored visor, corrective lenses or contacts. However, aircrew may wear issued sunglasses and laser eye protection.

A4.12. Depth Perception/Stereopsis.

A4.12.1. Initial Flying Class I, IA, II, and III. All will be tested. Failure of either of the following screening depth perception tests: the Vision Test Apparatus (VTA-DP), or its newer replacement, the Optec Vision Tester (OVT) is disqualifying for Inflight Refueler Applicants, Combat Controller Applicants, and any other aircrew required to perform scanner duties (as defined in the **Note** accompanying **A4.9.2.**), or defined by the MAJCOM and career field manager as performing duties requiring normal depth perception. Those FC III personnel who fail depth perception testing, and are not required to possess normal depth perception for the performance of their duties, may receive a MAJCOM waiver for depth perception.

A4.12.1.1. Failure without optical correction (unless the candidate is emmetropic) must be retested with correction in place, regardless of level of uncorrected visual acuity. Failure with best-corrected visual acuity is disqualifying, but may be considered for waiver only after completion of a local preliminary motility evaluation by an ophthalmologist or optometrist, and review by both AETC and the ACS.

A4.12.1.1.1. A locally performed macular examination and the subsequent preliminary motility evaluation must include **all** of the following:

A4.12.1.1.1.1. Ductions, versions, cover test and alternate cover test in primary and 6 cardinal positions of gaze.

A4.12.1.1.1.2. AO Vectograph Stereopsis Test at 6 meters (4 line version).

A4.12.1.1.1.3. AO Suppression Test at 6 meters.

A4.12.1.1.1.4. Randot or Titmus Stereopsis Test.

A4.12.1.1.1.5. Red Lens Test.

A4.12.1.1.1.6. 4 Diopter Base out Prism Test at 6 meters.

NOTE: These tests are designed to identify and characterize motility/alignment disorders, especially microtropias and monofixation syndrome. The results of these tests done locally are considered to be preliminary, but will be used by waiver authorities to determine whether a candidate should be permanently disqualified without any waiver consideration, to identify if there are easily correctable causes (i.e., spectacles), and to determine whether further evaluation is required. These cases will be reviewed by HQ AETC/SGPS and the ACS.

A4.12.2. Flying Class II, and III-Inflight Refuelers. A new failure of the VTA-DP or OVT requires evaluation by an optometrist or ophthalmologist to determine the cause of the failure, and to rule out correctable causes, i.e., refractive error and anisometropia. If the aviator is still unable to pass the VTA or OVT with proper optical correction, then all of the motility tests listed in **A4.12.1.1.1.** must be accomplished as a prerequisite for any further waiver consideration. The results of these tests done locally are considered to be preliminary, but will be used by waiver authorities to determine whether a candidate should be permanently disqualified without any waiver consideration, to identify if there are potentially correctable causes, and to determine whether further evaluation is required. These cases will be reviewed by the appropriate waiver authorities and the ACS to determine the further course of action.

A4.12.2.1. Initial Flying Class III, AFSC Specific requirement. 1A0, 1A1, 1A2 (if they fail, they become AC-130 gunship loadmasters only), 1A7 (if they fail, they go to fixed wing only) all require depth perception. AFSCs 1A3, 1A4, 1A5, 1A6, 1A8, 1T2, 1C1 do not require depth perception.

A4.12.2.2. If the trained aviator has previously failed the VTA or OVT, and has previously been evaluated, and has either, normal motility, or a stable previously diagnosed and waivered motility disorder, and can pass another stereopsis test, such as the Titmus or Randot, no further work-up is required.

NOTE: Despite history of a long standing problem, apparent stability, and a documented waivered stereopsis or motility disorder, if the local flight surgeon still feels that the degree of depth perception or stereopsis in a trained aviator may not be compatible with the present aircraft or duties of assignment, further work-up will be required. In such cases, consultation with the appropriate waiver authority and the ACS is required.

A4.13. Field of Vision.

A4.13.1. Flying Classes I, IA, II and III.

A4.13.1.1. Contraction of the normal visual field in either eye to within 30 degrees of fixation in any meridian.

A4.13.1.2. Central scotoma, whether active or inactive, including transitory migraine related or any other central scotoma which is due to active pathological process.

A4.13.1.3. Any peripheral scotoma, other than physiologic.

A4.14. Night Vision, Flying Classes I, IA, II, and III. Unsatisfactory night vision is determined by history for initial flying. In trained aviators, this history is confirmed, when clinically required, by the appro-

priate electrophysiological tests requested by the Aeromedical Consultation Service ophthalmologists. Dark field and empty field myopia due to accommodation are normal physiologic responses.

A4.15. Red Lens Test.

A4.15.1. Flying Classes II and III (except Inflight Refuelers, and scanners): No standards.

A4.15.2. Flying Classes I, IA, and III-Inflight Refuelers, and Scanners (as defined in the **Note** at **A4.9.2.**): Any diplopia (368.2) or suppression during the Red Lens Test which develops within 20 inches of the center of the screen (30 degrees) is considered a failure. If failed, a complete preliminary local evaluation of ocular motility/alignment by a qualified ophthalmologist or optometrist as described in **A4.12.1.1.1.** is then required. The results of these tests done locally are considered to be preliminary, but will be used by waiver authorities and the ACS to determine whether a candidate should be permanently disqualified without any waiver consideration, to identify if there are potentially correctable causes, and to determine whether further evaluation is required. The Red Lens Test will be repeated for Flying Class I at MFS.

A4.16. Intraocular Pressure, Flying Classes I, IA, II, and III.

A4.16.1. Glaucoma (365). As evidenced by intraocular pressures of 30 mmHg or greater, or the secondary changes in the optic disc or visual field associated with glaucoma (365). Trained aircrew with glaucoma require consultation (review or evaluation) with the ACS prior to waiver consideration.

NOTE: Pigmentary dispersion syndrome (PDS) is not medically disqualifying for flying (includes Initial Flying Classes) unless associated with elevated intraocular pressures above 22 mmHg. PDS without IOP elevation should be referred to a competent local eyecare provider for monitoring. PDS with elevated IOP, referred to as Pigmentary Glaucoma Suspect, (PGS) requires local ophthalmology evaluation. A confirmed diagnosis of PGS is disqualifying for all initial Flying Classes. Trained aircrew with PGS require consultation (review or evaluation) with the ACS prior to waiver consideration.

A4.16.2. Ocular hypertension (Preglaucoma). Two or more determinations of 22 mmHg or greater, but less than 30 mmHg, or 4 mmHg or more difference between the two eyes. (See AFI 48-123V4, paragraph 1.2.5.)

NOTE: Abnormal pressures obtained by a noncontact (air puff) tonometer or Schiotz must be verified by applanation.

A4.17. Lungs and Chest Wall.

A4.17.1. Flying Classes II and III.

A4.17.1.1. Pulmonary tuberculosis (011.9), including tuberculous pleuritis or pleurisy of unknown etiology with positive tuberculin test.

A4.17.1.2. History of spontaneous pneumothorax (512). A single episode of spontaneous pneumothorax does not require waiver if PA inspiratory and expiratory chest radiograph and thin-cut CT-scan show full expansion of the lung and no demonstrable pathology which would predispose to recurrence.

A4.17.1.3. Pulmonary blebs or bullae (492.0), unless corrected by surgical treatment, recovery is complete, and pulmonary function tests are normal.

A4.17.1.4. Bronchiectasis (494), unless corrected by surgical treatment, recovery is complete, and pulmonary function tests are normal.

A4.17.1.5. Sarcoidosis (135).

A4.17.1.6. Pleural effusion (511.9).

A4.17.1.7. Empyema (510.9), residual sacculation or unhealed sinuses of the chest wall following surgery for empyema.

A4.17.1.8. Chronic bronchitis (491.9), if pulmonary function is impaired to such a degree as to interfere with duty performance or to restrict activities.

A4.17.1.9. Asthma (493) 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.

A4.17.1.10. Bullous or generalized pulmonary emphysema (492), demonstrated by pulmonary function tests.

A4.17.1.11. Cystic disease of the lung (518.89).

A4.17.1.12. Silicosis (502) or extensive pulmonary fibrosis (515) with functional impairment or abnormal pulmonary function tests.

A4.17.1.13. History of lung abscess (513.0).

A4.17.1.14. Chronic mycotic infection of the lung (112.4). Residuals of infection, including cavitation (011.2), except for scattered nodular parenchymal and hilar calcifications.

A4.17.1.15. Foreign body in the trachea, bronchus (934), lung, or chest wall.

A4.17.1.16. Chronic adhesive (fibrous) pleuritis (511.0) of sufficient extent to interfere with pulmonary function and exercise tolerance.

A4.17.1.17. History of bi-lobectomy (P32.4), lobectomy (P32.4), 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.

A4.17.1.18. Suppurative periostitis, osteomyelitis, caries, or necrosis of the ribs, sternum, clavicle, scapulae, or vertebrae.

A4.17.1.19. Congenital malformation or acquired deformities, which reduce the chest capacity, or diminish respiratory or cardiac functions, to a degree which interferes with vigorous physical exertion or produce disfigurement when the examinee is dressed.

A4.17.1.20. Chronic cystic mastitis (610.1).

A4.17.1.21. History of pulmonary embolus (415.19).

A4.17.1.22. Silicone implants, injections, or saline inflated implants in breasts for cosmetic purposes.

A4.17.1.23. Sleep apnea (780.57) and other clinical sleep disorders.

A4.17.2. Flying Classes I and IA. In addition to the above:

A4.17.2.1. History of spontaneous pneumothorax (512). 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.

A4.17.2.2. Chronic adhesive pleuritis (511.0) which produces any findings except minimal blunting of the costophrenic angles.

A4.17.2.3. History of sarcoidosis (135.0).

A4.18. Cardiovascular System.

A4.18.1. Flying Classes II and III.

A4.18.1.1. History of cardiac surgery or catheter-based therapeutic intervention.

A4.18.1.2. Heart pump failure, regardless of cause.

A4.18.1.3. Hypertrophy or dilatation of the heart verified by echocardiogram, unless evaluation demonstrates it to be normal physiological response to athletic conditioning.

A4.18.1.4. Persistent tachycardia (785.1) with a resting pulse rate of more than 100.

A4.18.1.5. Elevated blood pressure (measured in the sitting position) as follows:

A4.18.1.5.1. Average systolic pressure greater than 140 mmHg, or average diastolic pressure of greater than 90 mmHg obtained from the 3-day blood pressure check.

NOTE: Asymptomatic personnel with average systolic blood pressure ranging between 141 mmHg and 160 mmHg, or average diastolic blood pressure ranging between 91 mmHg and 100 mmHg, may remain on flying status for up to 6 months (from the date the elevated blood pressure was first identified) while undergoing non-pharmacological intervention to achieve acceptable values. (For hypertension treated with medication, refer to Aircrew Waiver Guide for details on waiver work-up and required information.)

A4.18.1.5.2. History of elevated blood pressure requiring chronic medication for control.

A4.18.1.5.3. 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.

A4.18.1.5.4. Orthostatic or symptomatic hypotension, or recurrent vasodepressor syncope.

A4.18.1.5.5. Pericarditis (420), myocarditis (422), or endocarditis, or history of these conditions.

A4.18.1.5.6. Any significant congenital abnormalities of the heart and vessels (746), unless corrected by surgery without residuals or complications. A minimum recovery period of 6 months following surgery is mandatory before waiver is considered together with repeat studies, including invasive testing as applicable, demonstrating functional correction. Uncomplicated dextrocardia and minor atrial and ventricular septal defects may be acceptable without surgical correction.

A4.18.1.5.7. Acute rheumatic fever; a verified history of rheumatic fever or chorea within the previous 2 years; recurrent attacks of rheumatic fever or chorea at any time; evidence of residual cardiac damage.

A4.18.1.5.8. Coronary artery disease, symptomatic or asymptomatic. History of myocardial ischemia. Coronary artery disease strongly suspected by symptoms or tests for myocardial ischemia or infarction unless ruled out by angiography (other definitive evaluation of coronary patency and function will be considered on a case-by-case basis). History of coronary artery surgery or other intervention among select aircrew positions may be waiverable, after a minimum recovery period of 6 months. ACS review and evaluation are required. See Aircrew Waiver Guide.

A4.18.1.5.9. History of symptomatic major dysrhythmia. Asymptomatic major dysrhythmias require ACS review. Major dysrhythmias include supraventricular tachycardia (427.0), atrial flutter or fibrillation, ventricular tachycardia or fibrillation, and asystole.

A4.18.1.5.10. Verified history of major electrocardiographic conduction defects, such as Mobitz II second-degree A-V block (426.12), third degree A-V block (426.0), left bundle branch block (LBBB) (426.2), Wolff-Parkinson-White (WPW) pattern/syndrome (426.7), or Lown-Ganong-Levine (LGL) syndrome (426.81). LBBB and WPW pattern may be waiverable after ACS evaluation; either WPW or LGL syndrome may be waivered after correction and ACS evaluation. See Aircrew Waiver Guide.

A4.18.1.5.11. Right bundle branch block (426.4), left anterior fascicular block, and left posterior fascicular block may be waiverable after local cardiologic evaluation and ACS review. See Aircrew Waiver Guide.

A4.18.1.6. History of valvular heart disease to include pulmonic, mitral, and tricuspid valvular regurgitation greater than mild, aortic regurgitation greater than trace, and any degree of valvular stenosis. Mitral Valve Prolapse (MVP) and bicuspid aortic valve are also medically disqualifying. See Aircrew Waiver Guide.

A4.18.1.7. Any other resting 12-lead ECG findings considered to be borderline or abnormal by ECG Library review, or known to be serial changes from previous records, unless a cardiac evaluation as directed by the ECG Library reveals no underlying disqualifying disease. Refer to the "Disposition for ECG findings" found in the AFMS Knowledge Exchange for guidance whether the aviator/aircrew should be DNIF pending evaluation results and final recommendation from the ECG Library or ACS.

A4.18.1.8. Borderline or abnormal noninvasive cardiac studies.

NOTE: For rated officers, copies of any study when accomplished for any reason, (i.e., ECG, holter monitor, thallium scan, ETT-TM, or echocardiogram video tape) **MUST** be forwarded to the ECG Library for review.

A4.18.1.9. History of recurrent thrombophlebitis (451.9) or thrombophlebitis with persistent thrombus, evidence of circulatory obstruction, or deep venous incompetence in the involved veins.

A4.18.1.10. Varicose veins with complications, or if more than mild.

A4.18.1.11. Peripheral vascular disease (443), including Raynaud's disease (443.0), thromboangiitis obliterans, erythromelalgia, arteriosclerotic, or diabetic vascular disease.

A4.18.1.12. Aneurysm of any vessel or history of correction by surgery.

A4.18.1.13. Syphilitic heart disease.

A4.18.1.14. History of significant traumatic heart disease.

A4.18.1.15. Hypersensitive carotid sinus.

A4.18.1.16. Arteritis (446) of any artery.

A4.18.1.17. Inadequate arterial blood supply to any extremity.

A4.18.1.18. Vasculitis.

A4.18.2. Flying Classes I and IA. In addition:

A4.18.2.1. Wolff-Parkinson-White electrocardiographic pattern; may be waiverable for flying training, after ACS review/evaluation, if corrected by catheter ablation or surgery. See Aircrew Waiver Guide.

A4.18.2.2. Any major vascular synthetic graft.

A4.18.2.3. Elevated blood pressure, other than sitting (see **A4.18.1.5.** for sitting).

A4.19. Blood, Blood-Forming Tissue, and Immune System Diseases. Flying Classes I, IA, II and III:

A4.19.1. Anemia of any etiology. Hematocrit values less than 38 for men or 36 for women should be evaluated; decreasing hematocrit values, even if in the normal range, may also be an indication for workup. Waiver for trained aircrew is permissable for stable anemia not due to an otherwise disqualifying condition, as long as the hematocrit does not fall below 32 percent.

A4.19.2. Loss of 200 cc or more of blood is disqualifying for at least 72 hours. Platelet phoresis is disqualifying for 72 hours. See Aircrew Waiver Guide.

A4.19.3. Polycythemia; a hematocrit above 50 in men, or above 47 in women, should be evaluated. Waiver is not favorably considered if the hematocrit is above 55 percent.

A4.19.4. Hemoglobinopathies and thalassemias.

A4.19.4.1. Homozygous hemoglobin abnormalities.

A4.19.4.2. Sickle cell disease or heterozygous sickling disorders other than sickle cell trait.

A4.19.4.3. Sickle cell trait if the individual has a history of symptoms associated with a sickling disorder or symptomology attributable to intravascular sickling during decompression in an altitude chamber. Review and certification by proper authority (see AFI48-123V4, Attachment 2, Certification & Waiver Authority) is required for all aircrew members with sickle cell trait after evaluation as outlined in AFI 48-123V4, paragraph 1.2.7.

A4.19.5. Hemorrhagic states and thromboembolic disease:

A4.19.5.1. Coagulopathies.

A4.19.5.2. Thromboembolic disease, except for acute, non-recurrent conditions.

A4.19.5.3. Thrombocytopenia or thrombocytosis. Platelet counts less than 100,000/mm 3 or greater than 400,000 mm 3 are disqualifying and should be evaluated. Transient elevation of platelet counts due to acute illness (acute phase reactant) does not require waiver. See Aircrew Waiver Guide.

A4.19.5.4. Platelet dysfunctions.

A4.19.6. Leukopenia (granulocytopenia). White blood cell counts should fall within the range of 3,500 to 12,000 cells/mm 3 -- counts in the range of 750 to 3500 cells/mm 3 should be fully evaluated. Granulocyte counts of less than 750 cells/mm 3 are not waiverable.

A4.19.7. All leukemias and other myeloproliferative disorders.

A4.19.8. All lymphomas, including mycosis fungoides and Sezary syndrome.

A4.19.9. Plasma cell dyscrasias.

A4.19.9.1. Multiple myeloma.

A4.19.9.2. Macroglobulinemia.

A4.19.10. Immunodeficiency syndromes, primary or acquired. Confirmed presence of HIV or antibody. AFMOA/SGPA retains waiver authority for all flying classes. See Aircrew Waiver Guide.

A4.19.11. Generalized lymphadenopathy or splenomegaly, until the cause is corrected.

A4.20. Abdomen and Gastrointestinal System.

A4.20.1. Flying Classes I, IA, II and III.

A4.20.1.1. Gastrointestinal hemorrhage (578), or history of, regardless of cause. Waiver may be considered for any condition that is clearly attributable to a specific, nonpersistent cause. See Aircrew Waiver Guide.

A4.20.1.2. Peptic ulcer disease, active or refractory.

A4.20.1.3. Peptic ulcer complicated by hemorrhage, obstruction or perforation.

A4.20.1.4. Hernia, other than small asymptomatic umbilical or hiatal.

A4.20.1.5. History of viral hepatitis, with carrier status (070), persistent transaminase elevation, or evidence of chronic active or persistent hepatitis.

A4.20.1.6. Wounds, injuries, scars, or weakness of the muscles of the abdominal wall which are sufficient to interfere with function.

A4.20.1.7. Sinus or fistula of the abdominal wall.

A4.20.1.8. Chronic or recurrent esophagitis (530.1) including reflux esophagitis.

A4.20.1.9. Chronic gastritis (535).

A4.20.1.10. Congenital abnormalities of the bowel if symptomatic or requiring surgical treatment. History of intestinal obstruction if due to any chronic or recurrent disease. Surgery to relieve childhood pyloric stenosis or intussusception is not disqualifying, if there is no residual dysfunction.

A4.20.1.11. Crohn's disease (555) (regional enteritis).

A4.20.1.12. Malabsorption syndromes (see **A4.29.**).

A4.20.1.13. Irritable bowel syndrome (564.1).

A4.20.1.14. Ulcerative colitis (556), or proctitis (556) or verified history of same.

A4.20.1.15. Chronic diarrhea (787.91), regardless of cause.

A4.20.1.16. Megacolon.

A4.20.1.17. Diverticulitis, symptomatic diverticulosis, or symptomatic Meckel's diverticulum (751.0).

A4.20.1.18. Any chronic liver disease (571.3) whether congenital or acquired. Marked enlargement of the liver from any cause (789.1). Hepatic cysts (573.8). Congenital hyperbilirubinemias, i.e. Gilbert's disease, do not require waiver if asymptomatic. See Aircrew Waiver Guide.

A4.20.1.19. Chronic cholecystitis.

A4.20.1.20. Cholelithiasis (574).

A4.20.1.21. Sphincter of oddi dysfunction, or bile duct abnormalities or strictures.

A4.20.1.22. Pancreatitis (577.1), or history of same.

A4.20.1.23. Congenital anomalies, disease of the spleen. Chronic enlargement of the spleen.

A4.20.1.24. Splenectomy, for any reason except the following:

A4.20.1.24.1. Trauma to an otherwise healthy spleen.

A4.20.1.24.2. Hereditary spherocytosis.

A4.20.1.25. History of gastroenterostomy, gastrointestinal bypass, stomach stapling, or surgery for relief of intestinal adhesions.

A4.20.1.26. Symptomatic esophageal motility disorders (including Gastroesophageal Reflux Disease (530.81)) not controlled by infrequent OTC antacids.

A4.20.1.27. History of partial resection of the large or small intestines for chronic or recurrent disease.

A4.21. Perianal, Rectum, and Prostate: Flying Classes I, IA, II, and III.

A4.21.1. Proctitis, chronic, or symptomatic.

A4.21.2. Stricture (569.2) or prolapse (569.1) of the rectum.

A4.21.3. Hemorrhoids which cause marked symptoms, or internal hemorrhoids which hemorrhage (455) or protrude intermittently or constantly, until surgically corrected.

A4.21.4. Fecal incontinence (787.6).

A4.21.5. Anal fistula (565).

A4.21.6. Ischiorectal abscess.

A4.21.7. Chronic anal fissure.

A4.21.8. Symptomatic rectocele.

A4.21.9. Pilonidal cyst, if there is a history of inflammation or discharging sinus in the 2 years preceding examination. Surgery for pilonidal cyst or sinus is disqualifying until the wound is healed, there are no referable symptoms, and no further treatment or medication is required.

A4.21.10. Chronic prostatitis, prostatic hypertrophy, with urinary retention or abscess of the prostate gland.

A4.22. Genitourinary System: Flying Class I, IA, II and III.

A4.22.1. History of recurrent or bilateral renal calculus. Uncomplicated single episode of renal calculus does not require waiver, but should be evaluated. See Aircrew Waiver Guide.

A4.22.2. Retained renal calculus. A subset of retained calculus may be considered for waiver. See Aircrew Waiver Guide.

A4.22.3. Proteinuria under normal activity (at least 48 hours post strenuous exercise) greater than 200 mg in 24 hours. Waiver may be considered for fixed and reproducible orthostatic proteinuria when the urinary protein to urinary creatinine ratio on a randomly collected urine (not first morning void) is less than or equal to 0.2. It is not necessary to collect a 24 hour urine specimen.

A4.22.4. Persistent or recurrent hematuria.

A4.22.5. Cylindruria, hemoglobinuria, or other findings indicative of significant renal disease.

A4.22.6. Chronic nephritis.

A4.22.7. Stricture of the urethra.

A4.22.8. Urinary fistula.

A4.22.9. Urinary incontinence.

A4.22.10. Absence of one kidney.

A4.22.11. Functional impairment of either or both kidneys.

A4.22.12. Horseshoe kidney.

A4.22.13. Chronic pyelitis or pyelonephritis.

A4.22.14. Renal ptosis (floating kidney) causing impaired renal drainage, hypertension, or pain.

A4.22.15. Hydronephrosis, or pyonephrosis.

A4.22.16. Polycystic kidney disease.

A4.22.17. Chronic cystitis.

A4.22.18. Amputation of the penis.

A4.22.19. Hermaphroditism.

A4.22.20. Epispadias or hypospadias with unsatisfactory surgical correction.

A4.22.21. Hydrocele, unless small and asymptomatic.

A4.22.22. Large or painful left varicocele. Any right varicocele, unless significant underlying pathology has been excluded.

A4.22.23. Undescended testicle. Absence of both testicles.

A4.22.24. Chronic orchitis, or epididymitis.

A4.22.25. Urinary diversion.

A4.22.26. 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.

A4.23. Pelvic.

A4.23.1. Flying Classes I, IA, II and III.

A4.23.1.1. Pregnancy or other symptomatic enlargement of the uterus due to any cause. Flight surgeons shall educate female pilots during annual PHAs that pregnancy is disqualifying. 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 obstetrical provider. Physiological training is waived during pregnancy; flying is restricted to pressurized multi-crew, multi-engine, non-ejection seat aircraft; and crewmembers are released from all mobility commitments. The waiver is valid for the 13th through 24th week of gestation. See Aircrew Waiver Guide.

NOTE: Refer to AFRCI 48-101 for further guidance on unit assigned reservists.

A4.23.1.2. Chronic symptomatic vaginitis.

A4.23.1.3. Chronic salpingitis or oophoritis.

A4.23.1.4. Symptomatic uterine fibroids.

A4.23.1.5. Symptomatic ovarian cysts.

A4.23.1.6. All symptomatic congenital abnormalities of the reproductive system.

A4.23.1.7. Dysmenorrhea, if incapacitating to a degree which necessitates recurrent absences of more than a few hours from routine duty.

A4.23.1.8. Gross irregularity of the menstrual cycle. Menorrhagia, metrorrhagia, polymenorrhea, or amenorrhea is symptomatic, and interferes with performance of duties.

A4.23.1.9. Menopausal syndrome, either physiologic or surgical, if manifested by more than mild constitutional or psychological symptoms.

A4.23.1.10. Endometriosis.

A4.23.1.10.1. Symptomatic or controlled medically.

A4.23.1.10.2. History of, is disqualifying for FC I/IA.

A4.23.1.11. Malposition of the uterus, if symptomatic.

A4.23.1.12. Vulvitis, chronic.

A4.24. Neurological Disorders.

A4.24.1. Flying Classes II and III.

A4.24.1.1. Infections of the Central Nervous System (CNS).

A4.24.1.2. Seizure of any type (grand mal, petit mal, focal, etc.).

A4.24.1.3. Disturbances of consciousness (not due to head injury).

A4.24.1.3.1. An isolated episode of neurocardiogenic syncope associated with venipunture, or prolonged standing in the sun (or similar benign precipitating event) which is less than 1 minute in duration, without loss of continence, and followed by rapid and complete recovery

without sequelae, does not require waiver if thorough neurological and cardiovascular evaluation by a flight surgeon reveals no abnormalities. See Aircrew Waiver Guide.

A4.24.1.3.2. Physiological loss of consciousness (LOC) caused by reduced oxygen tension, general anesthesia, or other medically induced LOC (excluding vasovagal syncope) does not require waiver provided there is full recovery without sequelae.

A4.24.1.3.3. High G loss of consciousness (G-LOC) during a centrifuge run does not require waiver for continued flying duty, unless there are neurologic sequelae, or evidence that the G-LOC occurrence is associated with coexistant disease or anatomic abnormality. Inflight G-LOC caused by an improperly performed anti-G straining maneuver, or a disconnect of the anti-G protective gear is not disqualifying, and is managed as a physiological incident. The local flight surgeon completes appropriate post-incident medical evaluation and reports the incident according to applicable directives. See Aircrew Waiver Guide.

A4.24.1.3.4. All other loss or disturbance of consciousness. For rated personnel, waivers are considered by AFMOA/SGPA, only after evaluation at ACS. For non-rated personnel, waiver is at MAJCOM discretion. See Aircrew Waiver Guide.

NOTE: Flying training applicants and students with a history of syncope and/or loss of consciousness, evaluated according to AFI 48-123V4, Table 1.2.1., and certified acceptable for Flying Class I or IA by HQ AETC/SG, do not require an additional waiver for flying Class II for the same history of syncope.

A4.24.1.4. History of any of the following types of headaches.

A4.24.1.4.1. Recurrent headaches of the vascular, migraine, or cluster (Horton's cephalgia or histamine headache) type.

A4.24.1.4.2. A single incapacitating headache of any type (e.g. loss of consciousness, aphasia, ataxia, vertigo or mental confusion).

A4.24.1.4.3. Headache of any type which are of sufficient severity to likely interfere with flying duties.

A4.24.1.4.4. Acephalgic migraines.

A4.24.1.5. Electroencephalographic abnormalities.

A4.24.1.5.1. Truly epileptiform abnormalities to include generalized, lateralized, or focal spikes, sharp waves, spike-wave complexes, and sharp and slow wave complexes during alertness, drowsiness, or sleep are disqualifying. Benign transients such as Small Sharp Spikes (SSS) or Benign Epileptiform Transients of Sleep (BETS), wicket spikes, 6 Hertz (Hz) (phantom) spike and wave, rhythmic temporal theta of drowsiness (psychomotor variant), and 14 and 6Hz positive spikes are not disqualifying.

A4.24.1.5.2. Generalized, lateralized, or focal continuous polymorphic delta activity or intermittent rhythmic delta activity (FIRDA or OIRDA) during the alert state is disqualifying, unless the etiology of the abnormality has been identified and determined not to be a disqualifying disorder.

A4.24.1.6. History of head injury.

A4.24.1.6.1. Head injuries associated with any of the following are not waiverable:

A4.24.1.6.1.1. Post-traumatic seizures (Exception: seizures at the time of injury).

A4.24.1.6.1.2. Persistent neurological deficits indicative of significant parenchymal CNS injury, such as hemiparesis or hemianopsia.

A4.24.1.6.1.3. Evidence of impairment of higher intellectual functions or alterations of personality as a result of injury.

A4.24.1.6.1.4. Cerebrospinal fluid shunts.

A4.24.1.6.2. Severe head injury. Head trauma associated with any of the complications listed below may be considered for Flying Class II and III waiver in 5 years (see AFI 48-123V4, Table 1.2.1.).

A4.24.1.6.2.1. Unconsciousness or amnesia, or the combination of the two equal to, or exceeding, 24 hours duration.

NOTE: In cases which are defined as severe only due to the duration of loss of consciousness or amnesia, and are otherwise minimal, mild, or moderate, a waiver at 2 years may be considered if the evaluation requirements in AFI 48-123V4, Table 1.2.1. are met.

A4.24.1.6.2.2. Radiographic evidence of retained metallic or bony fragments.

A4.24.1.6.2.3. Leptomeningeal cysts, aerocele, brain abscess, or arteriovenous fistula.

A4.24.1.6.2.4. Depressed skull fracture (the inner table indented by more than the thickness of the skull) with, or without, dural penetration.

A4.24.1.6.2.5. Traumatic or surgical laceration or contusion of the dura mater or the brain, or a history of penetrating brain injury.

A4.24.1.6.2.6. Focal neurological signs.

A4.24.1.6.2.7. Epidural, subdural, subarachnoid, or intracerebral hematoma.

NOTE: A small epidural collection of blood found only on CT-scan or MRI, and without evidence of parenchymal injury either on the imaging study or on neurological examination, followed to resolution without surgery, may be considered for Flying Class II or III waiver at two years as in the moderate head injury group. For SMOD, this finding does not change the minimum observation period for severe head injury as stated in AFI 48-123V4, Table 1.2.1.

A4.24.1.6.2.8. CNS infection, such as abscess or meningitis, within 6 months of head injury.

A4.24.1.6.2.9. Cerebrospinal fluid rhinorrhea, or otorrhea, persisting more than 7 calendar days.

A4.24.1.6.3. Moderate head injury. Head trauma associated with the following criteria may be considered for Flying Class II or III waiver in 2 years (see AFI 48-123V4, Table 1.2.1.).

A4.24.1.6.3.1. Unconsciousness for a period of 30 minutes or greater, but less than 24 hours.

A4.24.1.6.3.2. Amnesia for a period of 1 hour or greater, but less than 24 hours. (Waiver contingent on a completely normal neurological and neuropsychological evaluation to include computerized tomography (CT) scan.) See Aircrew Waiver Guide.

Exception: Waiver may be considered after 6 months of observation if a normal CT-scan was obtained within 2 calendar days of injury.

NOTE: In cases which are defined as moderate only due to the duration of loss of consciousness or amnesia and are otherwise minimal, mild, a waiver at 6 months may be considered if the evaluation requirements in AFI 48-123V4, Table 1.2.1.are met.

A4.24.1.6.4. Mild head injury. Head trauma, which does not meet criteria for more severe injury, may be considered for waiver after l month (see AFI 48-123V4, Table 1.2.1.).

A4.24.1.6.5. Head trauma with no loss of consciousness, amnesia, or abnormal findings on examination, does not require waiver.

A4.24.1.6.6. 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.

A4.24.1.7. Craniotomy and skull defects.

A4.24.1.8. Neurosyphilis in any form (meningovascular, tabes dorsalis, or general paresis).

A4.24.1.9. Narcolepsy, cataplexy, and similar states.

A4.24.1.10. Injury of one or more peripheral nerves, unless it is not expected to interfere with normal function in any practical manner.

A4.24.1.11. History of subarachnoid hemorrhage, embolism, vascular insufficiency, thrombosis, hemorrhage, arteriosclerosis, arteriovenous malformation, or aneurysm involving the CNS.

A4.24.1.12. History of tumor involving the brain or its coverings.

A4.24.1.13. 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.

A4.24.1.14. Probable evidence, or history, of degenerative or demyelinating process such as multiple sclerosis, dementia, basal ganglia disease, or Friedreich's ataxia.

A4.24.1.15. 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.

A4.24.1.16. Verified history of neuritis, neuralgia, neuropathy, or radiculopathy, whatever the etiology, unless:

A4.24.1.16.1. The condition has completely subsided, and the cause is determined to be of no future concern.

A4.24.1.16.2. There is no residual which could be deemed detrimental to normal function in any practical manner.

A4.24.1.17. Polyneuritis, whatever the etiology, unless:

A4.24.1.17.1. Limited to a single episode.

A4.24.1.17.2. The acute state subsided at least 1 year before examination.

A4.24.1.17.3. There is no residual, which could be expected to interfere with normal function in any practical manner.

A4.24.1.18. History or evidence of chronic or recurrent diseases, such as myasthenia gravis, polymyositis, or myotonia disorder.

A4.24.1.19. 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.

A4.24.1.20. Tremors, chorea, dystonia, or other movement disorders which could interfere with aviation or normal function.

A4.24.2. Flying Classes I and IA. In addition to the above, paroxysmal convulsive disorders. Seizures associated with febrile illness before 5 years of age may be acceptable with waiver if recent neurological evaluation, MRI, and EEG including awake and sleep samples are normal. See Aircrew Waiver Guide.

A4.24.2.1. History of severe head injury is usually not waiverable, and may not be considered until at least 10 years post injury. See Aircrew Waiver Guide.

A4.25. Psychiatric Disorders. (Reference most current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM), American Psychiatric Association).

A4.25.1. Flying Classes II and III.

A4.25.1.1. Eating Disorders.

A4.25.1.2. Gender Identity Disorders.

A4.25.1.3. Mental Disorders due to a General Medical Condition.

A4.25.1.4. Delirium, Dementia, and Amnestic Disorders, and Other Cognitive Disorders.

A4.25.1.5. Alcohol Dependence or Abuse. These conditions may be waived by MAJCOM/SGPA for a period no greater than three years, in accordance with the requirements in **A4.25.1.5. to A4.25.1.5.4.** and the current Alcohol Abuse-Dependence Waiver Guide. In order to be considered for waiver, two conditions must be met: individual must have "demonstrated recovery" (defined in **A4.25.1.5.1.**) as determined and documented by the MTF Alcohol & Drug Abuse Prevention & Treatment (ADAPT) Program treatment team; and the individual must comply with post-treatment aftercare program requirements (see **A4.25.1.5.2.**). Also, see Aircrew Waiver Guide.

A4.25.1.5.1. Demonstrated recovery is defined as: successfully completed American Society of Addiction Medicine (ASAM) indicated treatment; maintained a positive attitude and unqualified acknowledgement of their alcohol disorder; and remained abstinent without the need for medication.

A4.25.1.5.2. Post-treatment Aftercare Program Requirements. The member must document participation in an organized alcohol recovery program (Alcoholics Anonymous (AA) or other program approved by the USAF Substance Abuse Prevention & Treatment Program Manager) and meet with the designated professionals for the following specified timeframes:

Table A4.2. AFTERCARE PROGRAM MEETING TIMEFRAMES

Professional/Meetings	First Year	Second/Third Year	Fourth Year
Flight Surgeon	Monthly	Quarterly	Annually
ADAPT	Monthly	Monthly	N/A
Psychiatrist, Psychologist, Social Worker	Annually	Annually	N/A
Organized alcohol recovery program (e.g. Alcoholics Anonymous)	3x weekly	1x weekly	Recommended (not required)

NOTES:

1. The flight surgeon has primary responsibility for collecting and submitting the required documentation for waiver submission. The ADAPT representative collects and maintains alcohol recovery program attendance documentation. Temporary modification of aftercare program requirements because of operational demands must be documented by the flight surgeon.
2. Initial waiver may be requested after "demonstrated recovery" (as defined in **A4.25.1.5.1.**) and successful completion of 90 days in the post-treatment aftercare program.

A4.25.1.5.3. Non-compliance or Aftercare Failure. The following pertain to any member in denial of an alcohol problem, failing to abstain, or not compliant with all aftercare requirements: ground the member; and re-evaluation by flight surgeon, ADAPT, and Alcohol Treatment Facility to determine potential for re-treatment. If member is determined to have potential for re-treatment, follow the initial waiver and aftercare program processes. If member is determined not to have potential for re-treatment, an AMS should be submitted for permanent disqualification. A second waiver request for Alcohol Dependence or Abuse (**A4.25.1.5.**) may be considered in accordance with initial waiver requirements, but requested no sooner than 12 months from the last date that non-compliance with the post-treatment aftercare program was documented. Second waiver requests are considered on a case-by-case basis only, and waiver authority for these individuals is AFMOA/SGPA.

A4.25.1.5.4. As part of the waiver package, the individual states in writing that they understand the waiver is valid, only if total abstinence from alcohol is maintained, and that a verifiable break in abstinence, once the waiver period has begun, is considered medically disqualifying. This written statement, kept in the medical records, must be accomplished at the initial waiver request, and re-accomplished each time a waiver renewal is requested.

A4.25.1.6. All other substance-related disorders.

A4.25.1.7. Schizophrenia and other Psychotic Disorders.

A4.25.1.8. Mood Disorders.

A4.25.1.8.1. Depressive disorders including major depression, dysthymia, cyclothymia, and depression, not otherwise specified.

A4.25.1.8.2. Bipolar disorder.

A4.25.1.9. Anxiety Disorders. If the flight surgeon determines that the problem is due to a non-phobic "fear of flying" or (in a trainee) a "manifestation of apprehension," then the disposition is considered administrative and not medical.

A4.25.1.10. Somatoform Disorders.

A4.25.1.11. Dissociative Disorders.

A4.25.1.12. Sexual paraphilias are not medically disqualifying; however, individuals meeting diagnostic criteria are dealt with administratively.

A4.25.1.13. Sexual dysfunctions and sexual disorders, not otherwise specified are not medically disqualifying unless in association with another Axis I disorder.

A4.25.1.14. Sleep disorders, if of such magnitude to warrant somatic treatment greater than 30 days duration, or if associated with an Axis I disorder other than an adjustment disorder.

A4.25.1.15. Factitious Disorders.

A4.25.1.16. Impulse Control Disorders, not elsewhere classified.

A4.25.1.17. Adjustment Disorders of more than 60 days duration.

A4.25.1.18. Unsatisfactory adaptability rating for military aviation (ARMA). Maladaptive personality traits (not meeting diagnostic criteria for a personality disorder), or a pattern of maladaptive behavior that significantly interferes with safety of flight, crew coordination, or mission completion. In the absence of maladaptive personality adjustment, traits, or behavior patterns, motivational issues are managed administratively.

A4.25.1.19. Psychological Factors Affecting Medical Condition.

A4.25.1.20. Personality disorder that is severe enough to repeatedly manifest itself by significant interference with safety of flight, crew coordination, or mission completion; but can not be used as a medical reason for separation from active duty. Refer to AFI 48-123V2, paragraph 2.12.

A4.25.1.21. History of attempted suicide or suicidal behavior.

A4.25.2. Flying Classes I and IA. In addition:

A4.25.2.1. History of any of the diagnoses listed at **A4.25.1.**, excluding verifiable simple adjustment disorders not requiring hospitalization.

A4.25.2.2. History of schizophrenia in both parents, or bipolar disorder in both parents.

A4.25.2.3. Unsatisfactory adaptability rating for military aviation.

A4.25.2.4. History of persistent learning disorder.

A4.25.2.5. Evidence of any condition causing serious chronic impairment of educational goals, or chronic behavioral difficulties requiring hospitalization or prolonged treatment.

A4.26. Extremities, Flying Classes I, IA, II, and III.

A4.26.1. General Conditions.

A4.26.1.1. Arthritis of any type of more than minimal degree, which interferes with the ability to follow a physically active lifestyle, or may reasonably be expected to preclude the satisfactory performance of flying duties.

A4.26.1.2. Documented history or findings of rheumatoid arthritis.

A4.26.1.3. Active osteomyelitis, or a verified history of osteomyelitis, unless inactive with no recurrence during the 2 years before examination, and without residual deformity sufficient to interfere with function.

A4.26.1.4. Osteoporosis.

A4.26.1.5. Osteochondromatosis or multiple cartilaginous exostoses.

A4.26.1.6. Disease or injury, or congenital anomaly of any bone or joint, with residual deformity, instability, pain, rigidity, or limitation of motion, if function is impaired to such a degree it interferes with training, physically active lifestyle, or flying duties.

A4.26.1.7. Unreduced dislocation; substantiated history of recurrent dislocations or subluxations of a major joint, if not satisfactorily corrected.

A4.26.1.8. Instability of a major joint, if symptomatic and more than mild, or if subsequent to surgery there is evidence of instability, weakness, or significant atrophy.

A4.26.1.9. Malunited fractures which interfere significantly with function.

A4.26.1.10. Symptomatic nonunion of fractures.

A4.26.1.11. Any retained orthopedic fixation device that interferes with function or easily subject to trauma.

A4.26.1.12. Muscular paralysis, paresis, contracture, or atrophy, if progressive, or of sufficient degree to interfere with the performance of flying duties.

A4.26.1.13. Demonstrable loose body in any joint (includes osteocartilaginous or metallic foreign objects).

A4.26.1.14. Synovitis with persistent swelling or limitation of motion.

A4.26.1.15. Osteonecrosis.

A4.26.1.16. Chondromalacia, if symptomatic, or there is verified history of joint effusion, interference with function, or residuals from surgery.

A4.26.1.17. Joint replacement.

A4.26.1.18. Myotonia congenita.

A4.26.1.19. Scars, extensive, deep or adherent to the skin and soft tissues or neuromas of an extremity which are painful, interfere with movement, preclude the wearing of equipment, or show a tendency to breakdown.

A4.26.1.20. Symptomatic amputation stump (neuroma, bone spur, adherent scar or ulceration).

A4.26.2. Upper Extremity.

A4.26.2.1. Absence of any segment of the hand or digits.

A4.26.2.2. Resection of a joint other than that of a finger.

A4.26.2.3. Hyperdactylia.

A4.26.2.4. Scars and deformities of the fingers, or hand, which impair circulation, are symptomatic, or impair normal function to such a degree as to interfere with the satisfactory performance of flying duties.

A4.26.2.5. Healed disease or injury of the wrist, elbow or shoulder with residual weakness or symptoms of such a degree as to interfere with the satisfactory performance of flying duty. Grip strength of less than 75 percent of predicted normal when compared with the normal hand (non-dominant is 80 percent of dominant grip).

A4.26.2.6. Limitation of motion.

A4.26.3. Lower Extremity.

A4.26.3.1. Amputation or absence of any portion of the foot, or lower extremity, in excess of 1 of the 2nd through 5th toes.

A4.26.3.2. Clubfoot of any degree.

A4.26.3.3. Rigid or spastic flatfoot, symptomatic flatfoot, tarsal coalition.

A4.26.3.4. Weak foot with demonstrable eversion of the foot, valgus of the heel, or marked bulging of the inner border due to inward rotation of the talus regardless of the presence or absence of symptoms.

A4.26.3.5. Elevation of the longitudinal arch (pes cavus), if of enough degree to cause subluxation of the metatarsal heads and clawing of the toes. Obliteration of the transverse arch associated with permanent flexion of the small toes.

A4.26.3.6. Any condition, disease, or injury to feet or toes which results in disabling pain, distracting discomfort, inability to satisfactorily perform military aviation, or precludes wear of proper military footgear.

A4.26.3.7. Verified history of congenital dislocation of the hip, osteochondritis of the hip (Legg-Perthes disease), or slipped femoral epiphysis of the hip with X-ray evidence of residual deformity or degenerative changes.

A4.26.3.8. Verified history of hip dislocation within 2 years of examination, or degenerative changes on X-ray from old hip dislocation.

A4.26.3.9. Difference in leg length of more than 2.5. centimeter (from anterior superior iliac spine to the distal tip of the medial malleolus).

A4.26.3.10. Weak Knee. Dislocation of semilunar cartilages or loose foreign bodies within the knee joint; or residual instability of the knee ligaments; or significant atrophy or weakness of the thigh musculature in comparison with the normal side; or limited range of motion or other symptoms of internal derangement; or a condition which would interfere with the performance of flying duties.

A4.26.3.11. Osteochondritis dessicans of the knee, or ankle, if there are X-ray changes.

A4.26.3.12. Osteochondritis of the tibial tuberosity (Osgood-Schlatter disease), if symptomatic, or with obvious prominence of the part, and X-ray evidence of separated bone fragments.

A4.26.3.13. Limitation of motion.

A4.26.3.14. Toes-stiffness which interferes with walking, marching, running, or jumping.

A4.27. Spine and Other Musculoskeletal.

A4.27.1. Flying Classes I and IA, II and III.

A4.27.1.1. History of disease or injury of the spine or sacroiliac joints, either with or without objective signs, which has prevented the examinee from successfully following a physically active lifestyle.

A4.27.1.2. Arthritis of the spine, all types.

A4.27.1.3. Granulomatous disease of the spine, active or healed.

A4.27.1.4. Lumbar scoliosis of more than 20 degrees or thoracic scoliosis of more than 25 degrees as measured by the Cobb method.

A4.27.1.5. Abnormal curvature of the spine of any degree in which there is a noticeable deformity when the examinee is dressed, in which pain or interference with function is present, or which is progressive.

A4.27.1.6. Symptomatic spondylolisthesis or spondylolysis.

A4.27.1.7. History of frank herniated nucleus pulposus, or history of surgery or chemonucleolysis for that condition.

A4.27.1.8. Fractures or dislocations of the vertebrae. History of fractures of the transverse processes is not disqualifying if asymptomatic. See Aircrew Waiver Guide for waiverable spinal fractures.

A4.27.1.9. Spina bifida, when more than one vertebra is involved, if there is dimpling of the overlying skin, or a history of surgical repair for spina bifida.

A4.27.1.10. Juvenile epiphysitis with any degree of residual change indicated by x-ray or kyphosis.

A4.27.1.11. Weak or painful back requiring external support.

A4.27.1.12. Recurrent disabling low back pain due to any cause.

A4.27.1.13. Any surgical fusion.

A4.28. Skin.

A4.28.1. Flying Classes II and III.

A4.28.1.1. Any chronic skin disorder, which is severe enough to cause recurrent grounding from flying duties, or is aggravated by, or interferes with, the wearing of military equipment.

A4.28.1.2. Extensive, deep, or adherent scars, which interfere with muscular movements, with the wearing of military equipment, or show a tendency to breakdown.

A4.28.1.3. Atopic dermatitis with active or residual lesions controlled with chronic topical steroids.

A4.28.1.4. Dermatitis herpetiformis.

A4.28.1.5. Eczema, chronic and resistant to treatment.

A4.28.1.6. Fungal infections of the skin, systemic or superficial, that interfere with duty performance or the wear of life support equipment.

A4.28.1.7. Furunculosis, which is extensive, recurrent or chronic.

A4.28.1.8. Hyperhidrosis, if chronic or severe.

A4.28.1.9. Leukemia cutis; mycosis fungoides; Hodgkin's disease.

A4.28.1.10. Lichen planus.

A4.28.1.11. Neurofibromatosis.

A4.28.1.12. Photodermatosis, unless due to medication.

A4.28.1.13. Psoriasis.

A4.28.1.14. Scleroderma.

A4.28.1.15. Xanthoma, if symptomatic, or accompanied by hypercholesterolemia or hyperlipoproteinemia.

A4.28.1.16. Chronic urticaria.

A4.28.2. Flying Classes I and IA. In addition to **A4.28.1.**, verified history after age 8 of atopic dermatitis, eczema, and/or psoriasis.

A4.29. Endocrine and Metabolic.

A4.29.1. Flying Classes II and III.

A4.29.1.1. Adiposogenital dystrophy (Frohlich's syndrome).

A4.29.1.2. Adrenal dysfunction of any degree, including pheochromocytoma.

A4.29.1.3. Cretinism.

A4.29.1.4. Diabetes insipidus.

A4.29.1.5. Diabetes mellitus. (See Note at AFI 48-123V2, Attachment 2.17.5 for diagnostic criteria).

A4.29.1.6. Gigantism or acromegaly.

A4.29.1.7. Thyroid disorders.

A4.29.1.7.1. Goiter, if associated with pressure symptoms, or if enlargement is of such degree as to interfere with wearing of a military uniform or military equipment.

A4.29.1.7.2. Hyperthyroidism or thyrotoxicosis.

A4.29.1.7.3. Thyroiditis, acute and subacute.

A4.29.1.7.4. Hypothyroidism.

A4.29.1.8. Gout.

A4.29.1.9. Hyperinsulinism, confirmed, symptomatic.

A4.29.1.10. Parathyroid dysfunction.

A4.29.1.11. Hypopituitarism.

A4.29.1.12. Myxedema, spontaneous or postoperative, with clinical manifestations.

A4.29.1.13. Nutritional deficiency diseases (including beriberi, pellagra, and scurvy) which are more than mild and not readily amenable to therapy, or in which permanent pathological changes have been established.

A4.29.1.14. Other endocrine or metabolic disorders which obviously preclude satisfactory performance of military service, or which require frequent or prolonged treatment.

A4.29.1.15. Hypercholesterolemia controlled by medication other than resin binders.

A4.29.1.16. Osteopenia.

A4.29.1.17. Hypoglycemia from any endogenous source.

A4.29.2. Flying Classes I and IA. In addition to **A.4.29.1.**

A4.29.2.1. Diabetes mellitus (for diagnostic criteria see Note in AFI 48-123V2, Attachment 2.17.5). Persistent glucosuria from any cause, including fasting renal glucosuria is disqualifying. Glucosuria post-prandially, or during glucose loading challenge, is not disqualifying in the absence of any renal disease, or history of recurrent genitourinary infections. However, this finding requires evaluation.

A4.29.2.2. Any confirmed (repeated) serum fasting LDL cholesterol in excess of 190 mg/dl (one or less cardiac risk factor) or 160 mg/dl (two or more cardiac risk factors) is disqualifying. Aviator may remain on flying status for up to 1 year (from the date the LDL cholesterol was first identified to meet the above criteria) while undergoing non-pharmacological intervention to achieve acceptable values.

A4.30. Height and Weight.

~~A4.30.1. Flying Class II/III.~~

~~A4.30.1.1. Height.~~

~~A4.30.1.1.1. Height less than 64 inches or more than 77 inches. Waivers may be considered when appropriate based on crew position. Note: RPA/Sensor operators, Weapons Controllers/ Directors, Combat Control, Pararescue and Air Battle Managers have no standard.~~

~~A4.30.1.1.2. Minimum functional reach for aeromedical evacuation duties is 76 inches, regardless of height.~~

~~A4.30.1.2. Weight.~~

~~A4.30.1.2.1. For initial qualification a weight in relation to body mass index applies (refer to AFI 48-123V2, Attachment 4). Additional standard applies for duties in ejection seat aircraft; in no case may weight be less than 103# or greater than 240# for T-38 and 245# for all other ejection seat aircraft. (Includes body and personal equipment weight.)~~

~~A4.30.1.2.2. For trained personnel in ejection seat aircraft. Weight may not be less than 103# or greater than 240# for T-38 and 245# for all other ejection seat aircraft. (Includes body weight and personal equipment.)~~

AMENDMENT TO AFI 48-123, Volume 3, Flying and Special Operations Duty, Paragraph A4.30.

A4.30.1.2.1 For initial qualification a weight in relation to body mass index applies (refer to AFI 48-123V2, Attachment 4). Additional standard applies for duties in ejection seat aircraft; in no case may weight be less than 103 lbs or greater than 240 lbs for T-38 and 245 lbs for all other ejection seat aircraft. *Weights are unclothed (nude) body weight.*

A4.30.1.2.2 For trained personnel in ejection seat aircraft. Weight may not be less than 103 lbs or greater than 240 lbs for T-38 and 245 lbs for all other ejection seat aircraft. *Weights are unclothed (nude) body weight.*

A4.30.2.2.1 For initial qualification a maximum and minimum weight in relation to body mass index (BMI) applies (refer to AFI 48-123V2, Attachment 4). Additional standard applies for duties in ejection seat aircraft; in no case may weight be less than 103 lbs or greater than 240 lbs for T-38 and 245 lbs for all other ejection seat aircraft. *Weights are unclothed (nude) body weight.*

A4.30.3.2.1 For initial qualification a maximum and minimum weight in relation to BMI applies (refer to AFI 48-123V2, Attachment 4). Additional standard applies for duties in ejection seat aircraft; in no case may weight be less than 103 lbs or greater than 240 lbs for T-38 and 245 lbs for all other ejection seat aircraft. *Weights are unclothed (nude) body weight.*

~~A4.30.2. Flying Class I.~~

~~A4.30.2.1. Height.~~

~~A4.30.2.1.1. Height less than 64 inches, or more than 77 inches.~~

~~A4.30.2.1.2. Sitting height greater than 40 inches or less than 34 inches. (See AFPAM 48-133 for method of measurement.)~~

~~A4.30.2.1.2.1. Buttock to knee measurement no greater than 27 inches. (See AFPAM 48-133 for method of measurement.)~~

~~A4.30.2.2. Weight.~~

~~A4.30.2.2.1. For initial qualification a maximum and minimum weight in relation to body mass index (BMI) applies (refer to AFI 48-123V2, Attachment 4). Additional standard applies for duties in ejection seat aircraft; in no case may weight be less than 103# or greater than 240# for T-38 and 245# for all other ejection seat aircraft. (Includes body weight and personal equipment.)~~

~~A4.30.3. Flying Classes IA and Initial II (Flight Surgeon).~~

~~A4.30.3.1. Height.~~

~~A4.30.3.1.1. Height less than 64 inches or more than 77. Waivers may be considered by weapons system.~~

~~A4.30.3.1.2. Sitting height greater than 40 inches or less than 33 inches. (See AFPAM 48-133 for method of measurement.)~~

~~A4.30.3.2. Weight.~~

~~A4.30.3.2.1. For initial qualification a maximum and minimum weight in relation to BMI applies (refer to AFI 48-123V2, Attachment 4). Additional standard applies for duties in ejection seat aircraft; in no case may weight be less than 103# or greater than 240# for T-38 and 245# for all other ejection seat aircraft. (Includes body weight and personal equipment.)~~

NOTES:

1. For UPT students, fighter-track UNT students and trained ejection seat aircrew identified outside of the weight for ejection seat standard, notify Squadron/CC via AF Form 1042 action.
2. IAW AF/XO message R 252140Z APR 01 "Aircrew Weight and Ejection Seats," dated 1 May 2002 any aircrew member assigned to ejection seat aircraft who has failed to attain/maintain weight within the ejection seat standard will be placed DNIF and referred to the Squadron/CC for cross-flow to non-ejection seat aircraft.

A4.31. Systemic and Miscellaneous Causes for Rejection.

A4.31.1. Flying Classes II and III.

A4.31.1.1. Any episode of decompression sickness (DCS) or arterial gas embolism (AGE), which produces residual symptoms after completion of all indicated treatment, or persists for greater than 2 weeks. See Aircrew Waiver Guide.

A4.31.1.1.1. All episodes of DCS/AGE require a minimum of 72 hours DNIF after completion of treatment.

A4.31.1.1.2. Consult base SGP and USAFSAM Hyperbaric Medicine on all cases of acute DCS/AGE.

A4.31.1.1.2.1. Bends-only DCS that resolve completely within two weeks may be RTFS by local flight surgeon after consultation with base SGP and USAFSAM Hyperbarics and MAJCOM/SGPA.

A4.31.1.1.2.2. DCS/AGE with neurological involvement may be RTFS only after complete resolution is confirmed by neurologist or USAFSAM hyperbaricist exam, and after consultation with USAFSAM Hyperbarics and MAJCOM/SGPA.

A4.31.1.1.2.3. DCS/AGE cases with persistent residual symptoms require complete evaluation and MAJCOM waiver.

NOTE: Previous episodes of DCS/AGE do not modify or change requirements noted.

A4.31.1.2. Malignancies. History, or presence of, malignant tumor, cyst or cancer of any sort. Basal cell and squamous cell carcinomas and carcinoma-in-situ of the cervix which have been adequately excised (as evidenced by pathology report, or basal cell carcinoma which have been treated by electrodessication and curettage by a dermatologist credentialed to perform this procedure), are exempted from tumor board action, but are reported to tumor registry, and are not disqualifying. Childhood malignancy considered cured may be considered for waiver on a case-by-case basis.

A4.31.1.3. Benign tumors which interfere with function or the wear of equipment, and tumors which are likely to enlarge or be subjected to trauma during military service or show malignant potential.

A4.31.1.4. Following bleomycin chemotherapy, AFMOA/SGPA may consider granting a FCIIC waiver with the following restrictions:

A4.31.1.4.1. **"** No assignment to aircraft requiring routine use of oxygen equipment. Waiver from altitude chamber exposure. Ground training without supplemental oxygen is acceptable." These restrictions must be annotated in the remarks section of the AF Form 1042.

A4.31.1.5. Bone marrow donation. DNIF the person until their hematocrit and hemoglobin return to their own pre-donation level and all symptoms referable to the donation have been resolved.

A4.31.1.6. Airsickness in flying personnel is not cause for medical disqualification unless there is medical evidence of organic or psychiatric pathology. Flying personnel should be entered into the Airsickness Management Program, described in AFI 48-123V4, paragraph 1.2.19. to be given an opportunity to overcome in flight airsickness. If airsickness is of such chronicity, or severity, as to interfere with the performance of flying duties by a rated officer, their potential for further use in rated duties are addressed by a Flying Evaluation Board. Copies of these cases are sent through medical channels to MAJCOM/SG for review before convening a board. Continued airsickness by nonrated personnel, after completing the Airsickness Management Program while enrolled in flying courses, is medically disqualifying, if it is of such severity or chronicity as to interfere with the performance of flying duties. Final determination of medical qualification in these cases are made by the MAJCOM/SG.

A4.31.1.7. Any allergic condition which requires desensitization therapy. Waivers are considered if symptoms are controlled by desensitization or in combination with approved medication see "Official Air Force Approved Aircrew - Quick Reference List", updated quarterly by AFMOA (approved by AF/SGOP).

NOTE: Aircrew will not deploy on immunotherapy. When immunotherapy is contemplated, this restriction should be considered by the treating flight surgeon.

A4.31.1.8. Eosinophilic granuloma.

A4.31.1.9. Gaucher's disease.

A4.31.1.10. Schuller-Christian disease.

A4.31.1.11. Letterer-Siwe's disease.

A4.31.1.12. Chronic metallic poisoning.

A4.31.1.13. Residual of cold injury, such as deep-seated ache, paresthesia, hyperhidrosis, easily traumatized skin, cyanosis, ankylosis, amputation of any digit, or cold urticaria.

A4.31.1.14. Heat pyrexia (heat stroke or heat exhaustion) if a reliable history indicates an abnormally lowered heat tolerance threshold.

A4.31.1.15. History of malignant hyperthermia.

A4.31.1.16. Syphilis, congenital or acquired. A history of primary or secondary syphilis is not disqualifying provided:

A4.31.1.16.1. The examinee has no symptoms of disease.

A4.31.1.16.2. There are no signs of active disease, and no residual thereof.

A4.31.1.16.3. Serologic Venereal Disease Research Laboratory (VDRL) testing rules out reinfection.

A4.31.1.16.4. There is a verified history of adequate treatment.

A4.31.1.16.5. There is no evidence or history of CNS involvement.

A4.31.1.17. Parasitic infestation, all types until adequately treated.

A4.31.1.18. History of food-induced anaphylaxis.

A4.31.1.19. Other congenital or acquired abnormalities, defects or diseases which preclude satisfactory performance of flying duty.

A4.31.1.20. Miscellaneous conditions such as porphyria, hemochromatosis (275.0), and amyloidosis.

A4.31.1.21. Inflammatory idiopathic diseases of connective tissue.

A4.31.1.22. Lupus erythematosus (acute, subacute, or chronic).

A4.31.1.23. Active tuberculosis in any form or location, or substantiated history of active tuberculosis within the previous 2 years.

A4.31.1.24. Sarcoidosis (135.0).

A4.31.2. Flying Classes I and IA. In addition to **A4.31.1. to A4.31.1.24.**

A4.31.2.1. Motion sickness experienced in aircraft, automobiles, or watercraft after the age of 12 with any significant frequency. Any history of motion sickness is completely explored.

A4.32. Medication. Use of any medication, except as described in the "Official Air Force Approved Aircrew - Quick Reference List", updated quarterly by AFMOA (approved by AF/SGOP).

Attachment 5

MEDICAL STANDARDS FOR MISCELLANEOUS CATEGORIES

A5.1. Attendance at Service Schools. Applicants for all types of training courses must be free of any abnormal physical or mental condition, which is likely to interfere with successful completion of the course. Certain technical training courses and AF specialty classifications impose additional requirements.

A5.2. Parachute Duty. The medical standards for applicants for parachute duty training and subsequent parachute duty are the same as those for Flying Class III, and those requirements listed in **A5.3.**. Static line jumpers are handled per **A5.2.1.**

A5.2.1. Static Line Parachute Duty. If static line jumping is only a periodic additional duty, and the individual is not required to be the jumpmaster, then no additional standards need be met above those required for their primary AFSC and those of the Army parachute duty, i.e. they must meet the standards for Army parachute duty as listed in AR 40-501 and have documentation on their SF 88 or DD Form 2808 for the physical requirements listed at **A5.4.2.1.1.** to **A5.4.2.1.11.**, and normal extremity and spine examinations (a history of spinal fusion is disqualifying for any jump duty and is non-waiverable). If these individuals are not required to meet Flying Class III standards for their primary AFSC, then they will not need to meet FC III standards for static line parachute duty. However, all must meet at a minimum the FC III visual acuity requirements as documented in **Table A4.1.** Due to their additional duties, these personnel are considered "special operational duty personnel," and must have this examination performed by a flight surgeon, and recorded on AF Form 1042. Local SGP is certification authority. HQ AETC/SGPS retains sole waiver authority.

A5.2.2. Free Fall, HALO, and Jump Master Duties. Must meet static line parachute duty requirements as listed above IAW AR 40-501. In addition, the following visual standards must be met:

A5.2.2.1. For personnel scheduled to attend sister service schools, uncorrected visual acuity no worse than 20/200 uncorrected in one eye and 20/70 uncorrected in the better eye, correctable to 20/20 OU or, those personnel whose uncorrected visual acuity is 20/100 OU, corrected to 20/20 OU.

NOTE: These requirements are more stringent than those for initial Air Force FCIII, but required for sister service schools; applicant must meet the sister service standards.

A5.3. Marine Diving Duty (Pararescue and Combat Control Duty). The medical standards are those for Flying Class III plus those here and those listed in **A5.4.** Failure to meet standards is cause to reject an examinee for initial Marine Diving duty and for continued duty unless a waiver is granted. Acute medical problems, injuries, or their appropriate therapy may be cause for withholding certification for initial training or temporarily restricting from duty until the problem is resolved.

A5.3.1. The following conditions are disqualifying:

A5.3.1.1. Any disease or condition that causes chronic or recurrent disability, sudden incapacitation, or has the potential of being exacerbated by the hyperbaric environment.

A5.3.1.2. History of injury or procedure involving entrance into thoracic, pericardial, or abdominal cavities in the previous 6 months, or the cranial cavity at any time.

A5.3.1.3. Ear, Nose, and Throat.

A5.3.1.3.1. Any history of inner ear pathology.

A5.3.1.3.2. Any history of inner or middle ear surgery except PE tubes before age 10.

A5.3.1.3.3. Inability to equalize middle ear pressure.

A5.3.1.4. Eyes.

A5.3.1.4.1. Night vision impairments.

A5.3.1.4.2. Vision worse than 20/70, each eye, near and distant, without correction.

A5.3.1.4.3. Vision that does not correct to 20/20, each eye, near and distant.

A5.3.1.5. Pulmonary.

NOTE: Inspiratory and expiratory Chest X-ray is accomplished within 1 year of entering training.

A5.3.1.5.1. Congenital and acquired defects which may restrict pulmonary function, cause air-trapping, or affect the ventilation-perfusion balance.

A5.3.1.5.2. Chronic obstructive or restrictive pulmonary disease of any type.

A5.3.1.5.3. Pneumothorax (512).

A5.3.1.6. Gastrointestinal. History of irritable bowel syndrome (564.1).

A5.3.1.7. Skin and Cellular Tissues. Acute or chronic diseases that are exacerbated by the hyperbaric or marine environment.

A5.3.1.8. Dental.

NOTE: Dentist signs the SF 88/DD Form 2808 for initial Pararescue or Combat Control duty.

A5.3.1.8.1. All divers or hyperbaric chamber operators/personnel (see **A5.5.** and **A5.10.** for ASC 9C) will be Dental Class I or II before assuming diving duty. Divers who are Dental Class III for acute conditions will be temporarily disqualified from diving duty until the acute condition is corrected. Divers who are Dental Class III because of a chronic condition (e.g. periodontal disease) receive ongoing dental care for the condition if they are to be considered qualified for diving duty. Divers are restricted from diving duty for 48 hours following operative dental procedures.

A5.3.1.8.2. Acute infectious diseases of the soft tissues of the oral cavity, until treatment is completed.

A5.3.1.8.3. Any defect of the oral cavity or associated structures which interfere with effective use of SCUBA.

A5.3.1.8.4. Dental corrections are corrected and documented in item #44 of the SF 88/DD 2808 prior to entry into initial Pararescue or Combat Control training.

A5.3.1.9. Blood and Blood-Forming Tissues. Any significant anemia or hemolytic disease.

A5.3.1.10. Neurologic. Unexplained or recurrent syncope.

A5.3.1.11. Psychiatric.

A5.3.1.11.1. Personality disorders, neurosis, immaturity, instability, asocial traits, or psychosis.

A5.3.1.11.2. Stammering or stuttering.

A5.3.1.11.3. Alcoholism except those who have successfully completed a recognized rehabilitation and aftercare program (see **A4.25.1.5.1.** for demonstrated recovery definition and post treatment aftercare program requirements). Any relapse is cause for disqualification.

A5.3.1.11.4. History of claustrophobia.

A5.3.1.12. Musculoskeletal. Intervertebral disc disease with neurological deficit.

A5.3.1.13. Height and Weight. Weight in excess of that specified in AFI 48-123V2, Attachment 4.

A5.3.1.14. Systemic/Miscellaneous. Any episode of DCS/AGE which produces residual symptoms after completion of all indicated treatment, or persists longer than two weeks. See attachment AFI 48-123V4, paragraph 1.2.19. for further guidance.

A5.4. Medical Certification and Waiver Requirements for Combat Control (1C2X1) and Pararescue (1T2X1) Duty.

A5.4.1. Initial Flying Class III examinations for 1C2X1 duty applicants must meet the requirements in paragraph **A5.3.** In order to meet Army and Navy requirements, the following additional tests must be documented on the SF 88 or DD Form 2808. (Note: HQ AETC/SGPS retains sole certification and waiver authority.)

A5.4.1.1. Item No 32 - Digital rectal and prostate examination, stool for occult blood (792.1).

A5.4.1.2. Item No 41 - Neurological evaluation by the flight surgeon; each specific item must be addressed (i.e., serial 7's-normal; deltoid 5/5).

A5.4.1.2.1. Cranial nerves.

A5.4.1.2.2. Serial 7s.

A5.4.1.2.3. Heel-toe.

A5.4.1.2.4. Gait.

A5.4.1.2.5. Muscle strength.

A5.4.1.2.5.1. Deltoid.

A5.4.1.2.5.2. Bicep.

A5.4.1.2.5.3. Tricep.

A5.4.1.2.5.4. Grip.

A5.4.1.2.6. Toe raises.

A5.4.1.2.7. Heel raises.

A5.4.1.2.8. Knee flex.

A5.4.1.2.9. DTRs.

A5.4.1.2.9.1. Bicep.

A5.4.1.2.9.2. Tricep.

A5.4.1.2.9.3. Patellar.

A5.4.1.2.9.4. Achilles.

A5.4.1.2.10. Heel-shin slide.

A5.4.1.3. Item No 18 - must read "Type II/Class 1 qualified." Include bite-wing x-rays with package.

A5.4.1.4. Item No 19B - Chest x-ray (inspiratory and expiratory).

A5.4.1.5. Item No 19C – Rapid Plasma Reagin (RPR).

A5.4.1.6. Item No 19E - ECG tracing must be reviewed/signed by a physician.

A5.4.1.7. Item No 19F - Must include complete CBC results.

A5.4.1.8. Item No 41 - Reading aloud test (RAT), adaptability rating-diving duty (AR-Diving Duty), ARMA.

A5.4.1.9. Item No. 42 - Must state: "applicant possesses no fear of heights, depths, dark, or confined places. Applicant possesses the ability to hold breath for 60 seconds subsequent to deep breathing."

A5.4.1.10. Item No. 46 – Must state: "(is) qualified for initial Flying Class III/Airborne/Combat Control/Pararescue/Marine Diving Duty."

A5.4.1.11. Item No. 48-51. - Must contain all signatures.

A5.4.2. Trained personnel attending the U.S. Army military free fall, free fall jump master, special forces combat diver, dive supervisor, dive medical technician, or the survival, evasion, resistance and escape course will also need to have their most current physical certified by HQ AETC/SGPS prior to attending training. The same special requirements must be met. (Any personnel attending any Army special school will need to meet these requirements also.)

A5.5. Physiological Training and Physiological Training Personnel/Hyperbaric Chamber Training/Duty/Operational Support Flying Duty (ASC 9C).

A5.5.1. The conditions listed in AFI 48-123V2, Attachment 2 and this section are disqualifying for physiological training, hyperbaric duty, and operational support flying personnel.

A5.5.2. Clearance to complete physiologic training:

A5.5.2.1. Military personnel on flying status must have a current Flying Class I, IA, II, or III physical on record (or PHA if applicable).

A5.5.2.2. Military personnel requiring passenger training, or who perform aviation duties in ASC 9C, and physiological training personnel are required to have a normal examination of tympanic membranes, lungs and chest, heart, abdomen, neurologic, hemoglobin, weight, blood pressure and pulse documented in the health record. Examination is required annually in accordance AFI 48-123V1, Attachment 2.

NOTE: AF Form 1042 is issued as satisfactory evidence of completion of the requirements outlined for training and duty.

A5.5.2.3. AF, Army, or Navy ROTC cadets will present evidence of satisfactory completion of SF 88/DD Form 2808, or DD Form 2351, *DOD Medical Examination Review Board (DOD-MERB) Report of Medical Examination,* accomplished within 36 months of the scheduled physiological training.

NOTE: Before scheduling cadets for training, the ROTC detachment must send copies of the SF 88/DD Form 2808, and SF 93/DD Form 2807-1, or DD Form 2351, with DD Form 2492, *Report of Medical History* to the Aerospace Physiology Unit. The Aerospace Physiology Unit will have the local flight surgeon's office review these forms and stamp these documents "Qualified to Participate in Altitude Chamber Training" for all cadets physically qualified. AF Form 1042, is not required for this group of trainees, but any current medical problems must be cleared by the local flight surgeon.

A5.5.3. Civilians undergoing physiological training are required to present a current FAA medical certificate, or the forms listed in paragraph **A5.5.2.3.**, or a valid AF Form 1042.

A5.5.4. The following conditions are disqualifying for physiological training, hyperbaric duty or operational support flying:

A5.5.4.1. Any disease or condition that causes chronic or recurrent disability, sudden incapacitation or has the potential of being exacerbated by the hyperbaric/hypobaric environment.

A5.5.4.2. History of injury or procedure involving entrance in to thoracic, pericardial or abdominal cavities in the previous 6 months, or the cranial cavity at any time.

A5.5.4.3. Ear, Nose and Throat.

A5.5.4.3.1. Any history of inner ear pathology.

A5.5.4.3.2. Any history of inner or middle ear surgery except PE tubes before age 10.

A5.5.4.3.3. Inability to equalize middle ear pressure.

A5.5.4.3.4. Current or chronic obstructive ear, nose, throat, sinus.

A5.5.4.4. Pulmonary.

A5.5.4.4.1. Abnormal inspiratory or expiratory chest x-ray.

A5.5.4.4.2. Chronic obstructive or restrictive pulmonary disease of any type.

A5.5.4.4.3. History of spontaneous pneumothorax.

A5.5.4.5. Dental-Class III.

A5.5.4.6. Anemia, significant chronic or nonreversible.

A5.5.4.7. Gastrointestinal - tendency to excessive flatulence.

A5.5.4.8. Neurological - unexplained or recurrent syncope.

A5.5.4.9. Neurosis, or psychosis.

A5.5.4.10. History of claustrophobia.

A5.5.4.11. Loss of 200 cc or more blood is disqualifying for at least 72 hours following the loss.

A5.5.4.12. Sickle cell disease or heterozygous sickling disorders other than sickle cell trait.

A5.5.4.13. Sickle cell trait if there is a history of symptoms associated with sickling disorder. Symptomology attributable to intravascular sickling during decompression in an altitude chamber is also disqualifying.

A5.5.4.14. History of migraine, organic heart disease, or symptomatic hiatal hernia.

A5.5.4.15. Inguinal hernia.

A5.5.4.16. Pregnancy.

A5.5.4.17. Use of medications which may impair mission performance.

A5.5.4.18. Any disease, which in the judgment of the flight surgeon, is likely to limit the performance of duty or place the individual at increased health risk.

A5.5.4.19. Individuals cleared for flying after bleomyocin chemotherapy are not to have altitude chamber exposure. Ground training without supplemental oxygen is acceptable. These restrictions must be annotated in the remarks section of AF Form 1042. For further details concerning this unique condition, see AFI 11-403, *Aerospace Physiological Training Program*.

A5.6. Survival Training Instructor Duty-Selection and Retention. The Survival Training Instructor course is physically demanding and requires the ability to withstand daily running up to 5 miles, 50 push-ups, mountain climbing, heat and cold exposure, hiking and backpacking with a weight up to 70 pounds. A medical examination recorded on SF 88/DD Form 2808 and SF 93/DD Form 2807-1 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.

A5.6.1. Selection. The causes for rejection are:

A5.6.1.1. Any condition listed in AFI 48-123V2, Attachment 2.

A5.6.1.2. Profile less than P-1, U-1, L-1, H-2, E-2, S-1, except the uncorrected distant vision is not worse than 20/400 each eye corrected to 20/20.

A5.6.1.3. Speech impediment which interferes with clear enunciation. At a minimum, a Reading Aloud Test (RAT) is required.

A5.6.1.4. History of recurrent or chronic back pain.

A5.6.1.5. Scoliosis over 25 degrees measured by the Cobb method. Any other abnormal curvature of the spine of any degree in which there is a noticeable deformity, or in which there is pain, or interference with function, or which is progressive.

A5.6.1.6. Spondylolysis or spondylolisthesis, if symptomatic.

A5.6.1.7. History of recurrent knee pain or chondromalacia of the patella. A history of knee surgery requires an orthopedic evaluation and a demonstrated ability of at least 1 year of strenuous physical activity not requiring a brace.

A5.6.1.8. History of recurrent shin splints.

A5.6.1.9. History of recurrent ankle sprains.

A5.6.1.10. History of recurrent foot pain.

A5.6.1.11. History of stress fractures.

A5.6.1.12. History of any vertebral fractures, except that history of a healed, asymptomatic fracture of the transverse process is not disqualifying.

A5.6.1.13. History of surgery involving a major joint requires an orthopedic evaluation.

A5.6.1.14. History of frostbite or heat exhaustion.

A5.6.1.15. History of asthma, reactive airway disease or exercise induced breathing difficulties.

A5.6.1.16. Allergy to stinging insects, pollen, trees, grasses, or dust unless desensitized and controlled on maintenance dosage.

A5.6.1.17. Deficient night or color vision (368.5).

A5.6.1.18. Food aversions, insect or snake phobias.

A5.6.1.19. History of personality or behavior disorders.

A5.6.1.20. History of alcohol or drug abuse.

A5.6.1.21. History of suicidal gesture or attempt.

A5.6.1.22. Intolerance to close or confined spaces.

A5.6.1.23. Mental health condition that indicates the applicant is unable to accept constructive criticism or unable to function in a high stress environment.

A5.6.2. Retention. A trained and experienced survival instructor is considered using these standards as a guide, but continued duty is dependent upon the member's demonstrated ability and performance.

A5.6.3. Certification and Waiver Authority. HQ AETC/SGPS is the medical certification and waiver authority for selection and retention of survival instructors and trainees.

A5.7. Military Training Instructor (MTI) Duty. MTIs have the primary responsibility for conducting basic military training. They instruct, supervise, counsel, and inspect indoors and outdoors under all kinds of environmental situations.

A5.7.1. MTI applicants will require:

A5.7.1.1. Health records review by Public Health for retention standards, ability to participate in fitness training, and specifics in paragraph **A5.7.2.**

A5.7.1.2. Physician interview and examination. Additionally, an interview and recommendation by a military psychiatrist, or psychologist, specifically for MTI duty is mandatory. The results of the interview and examination are recorded in the applicant's outpatient health record on SF 600, Chronological Record of Medical Care.

A5.7.1.3. Current physical profile assessment recorded on AF Form 422, with the statement indicating the applicant was interviewed and examined by a physician and psychiatrist or psychologist.

A5.7.2. Specific causes for rejection are:

A5.7.2.1. Physical profile less than 121221.

A5.7.2.2. Speech impediment which interferes with clear enunciation. At a minimum, a Reading Aloud Test (RAT) is required.

A5.7.2.3. History of injury to, or defects of, the spinal column, major bones, or joints which have caused recurring symptoms.

A5.7.2.4. History of symptomatic defects of the foot including pes planus, bunions, hallux valgus, hammer toes, plantar warts, recurring ingrown toenails, and pes cavus.

A5.7.2.5. History or current evidence, of a psychiatric condition.

A5.7.2.6. Personality disorder which precludes the applicant from accepting criticism, supervising large groups of students, or functioning effectively in a high stress situation.

A5.7.2.7. Asthma, recurrent bronchospasm, reactive airway disease or emphysema.

A5.7.2.8. A fitness score less than 75% IAW AFI 10-248.

A5.7.2.9. Any other medical or psychiatric condition which, in the opinion of the examiner, contraindicates duty in a physically and psychologically demanding environment.

A5.7.2.10. Annually, a mental health provider interviews MTIs and reviews their health records to insure their medical fitness for continuation as an MTI. An AF Form 422 serves as the annual medical certification for continued duty.

A5.7.2.11. HQ AETC/SG is the medical certification and waiver authority in the MTI selection and retention process.

A5.8. Duty Requiring Use of Night Vision Goggles (NVG).

A5.8.1. Aircrew members and special operational duty personnel who wear NVGs in the performance of their duties are required to meet no additional vision standards over and above those already required for their duty AFSC (exceptions are discussed in this paragraph). The corrected visual acuity standards for each flying class normally yield a visual acuity of at least 20/50 while wearing NVG. The flight surgeon should screen the health records of personnel required to wear NVGs initially, and periodically thereafter, to confirm that the member has passed the most recent annual vision screening. Aircrew who fail this screening, complain of visual problems with or without NVGs, or fail to achieve 20/50 visual acuity in the NVG pre-flight test lane should be referred for a routine clinical eye examination. The flight surgeon should refer to AL-SR-1992-0002, *Night Vision Manual for Flight Surgeon*s, for additional guidance.

A5.8.2. Each aircrew or special operational duty member who requires corrective lenses in order to meet the visual acuity standards for flying, and who is required to wear NVGs in the performance of flying duties, should wear soft contact lenses (SCL) with appropriate correction. Members who cannot, or do not wish to, wear SCLs are to wear industrial safety lenses (polycarbonate or 3.0 mm thick CR-39 plastic) when using NVG. Two pairs of aircrew spectacles with safety lenses ground to the appropriate correction can be obtained in the following manner:

A5.8.2.1. If the individual has not had a refraction done within the past year, obtain a current refraction.

A5.8.2.2. Send the current prescription written on a DD Form 771, *Eyewear Prescription*, with verification of NVG duties written in the "Special Lenses or Frame" block to: Optical Fabrication Research Unit, USAFSAM/FECO, 2507 Kennedy Circle, Brooks City-Base TX 78235-5116.

A5.8.2.3. Dispense the glasses to the individual with instructions to wear them only when using NVG and to protect the lenses from marring or scratching.

A5.9. Remote or Isolated Duty.

A5.9.1. Verification of Medical Acceptability. All personnel alerted for overseas assignment or assignment to a geographically separated unit (GSU) are sent to their PCM team for verification of medical acceptability for assignment. This verification consists of the following:

A5.9.1.1. A thorough health record review by Public Health will determine if the individual has any significant medical problems which might be exacerbated by pending assignment, or would be difficult to manage medically at the projected gaining base. Any questionable conditions will be validated by the PCE. Public Health will coordinate with the gaining MAJCOM/SG and HQ AFPC to obtain proper disposition.

A5.9.1.2. Completion of AF Form 422 showing that the individual is qualified for Worldwide, Remote or Isolated duty (See AFI 48-123V2, 4.5.4.7).

A5.9.1.3. Annotate the SF 600 that the review and appropriate actions have been accomplished.

A5.9.2. If the individual is going to a base that does not have a USAF medical treatment facility, complete a Preventive Health Assessment (PHA), or periodic medical examination as required, if the exam is due during the tour. Flying and Special Operational Duty Personnel assigned to remote sites, where required interval medical examinations are not available, are authorized no more than a 6 month deferral period to allow mission completion. This deferred period is effective only while assigned to the remote site. Members must ensure currency once assigned to medical facilities capable of performing examinations. Also, complete an audiometric examination if the individual is on the hearing conservation program.

NOTE: Personnel qualified for worldwide duty in accordance with AFI 48-123V2, Attachment 2 may not be acceptable for remote or isolated duty assignments. Individuals in need of specialized and recurrent medical or dental care are not acceptable. Personnel with known conditions that could produce catastrophic or life threatening illness should not be assigned to remote or isolated duty. Assume the independent duty medical technicians are the only level of medical care immediately available to the individual.

A5.9.3. If qualification for worldwide duty is questionable, Public Health prepares an AF Form 422 according to this instruction, and the form is reviewed by the MTF/CC or designated senior profile officer before sending it to the MPF.

A5.10. Incentive and Orientation Flights.

A5.10.1. Incentive and Orientation Flights in Ejection Seat Aircraft.

A5.10.1.1. All incentive and orientation flight candidates scheduled to fly in an ejection seat aircraft will be referred to the flight medicine clinic for a medical clearance prior to the flight. A flight surgeon will accomplish a medical records review and a physical examination (scope of examination to be determined locally). In lieu of medical record review, civilians should provide a statement of health from their physician to include a summary of medical problems and medica-

tions. All individuals (military and civilian) identified for incentive rides or orientation flights must be able to safely eject without unduly endangering life or limb. Communicate medical clearance and recommendations and/or restrictions to the flying unit on AF Form 1042. This clearance will be valid for no longer than 14 days. The following guidelines apply:

A5.10.1.2. Signed parental consent is required if candidate is not on active duty and under the age of 18.

~~A5.10.1.3. Body weight, buttock-to-knee and sitting height measurements must be within minimums and maximums as specified in table below:~~

~~Anthropometric Standards for Incentive and Orientation Flights~~

~~Airframe~~	~~Weight~~		~~Buttock-to-Knee~~	~~Sitting Height~~
	~~Minimum~~	~~Maximum~~	~~Maximum~~	~~Maximum~~
~~B-1~~	~~140 lbs~~	~~211 lbs~~	~~28.0 inches~~	~~44.4 inches~~
~~B-2~~	~~140 lbs~~	~~211 lbs~~	~~30.6 inches~~	~~55.3 inches~~
~~B-52~~	~~132 lbs~~	~~201 lbs~~	~~28.4 inches~~	~~53.0 inches~~
~~F-15~~	~~140 lbs~~	~~211 lbs~~	~~27.2 inches~~	~~44.1 inches~~
~~F-16~~	~~140 lbs~~	~~211 lbs~~	~~27.1 inches~~	~~39.7 inches~~
~~T-6A~~	~~103 lbs~~	~~245 lbs~~	~~29.7 inches~~	~~41.5 inches~~
~~T-37~~	~~132 lbs~~	~~201 lbs~~	~~27.3 inches~~	~~40.9 inches~~
~~T-38~~	~~140 lbs~~	~~211 lbs~~	~~30.8 inches~~	~~40.0 inches~~
~~U-2~~	~~132 lbs~~	~~201 lbs~~	~~27.0 inches~~	~~40.0 inches~~

~~***NOTE:*** Above listed minimum and maximum body weights do not necessarily apply to Air Force pilot minimum and maximum ejection seat weights.~~

A5.10.1.4. Individuals selected for incentive or orientation flights who do not meet anthropometric standards will be referred to the flying unit or wing commander (06 or above) for final authority disposition. ACES-II ejection attempts above 340 KEAS can result in increased injury risk due to limb flail and drogue chute opening shock for body weights below 140 pounds. ACES-II ejection attempts above 400 KEAS with body weights in excess of 211 pounds increase the risk of injury. Commanders may consider weight waivers and/or impose airspeed restrictions in the incentive or orientation flight profiles. Commanders waiving weight specifications should ensure the individual selected for incentive or orientation flight is briefed on the increase of injury risk prior to flight. Buttock-to-knee waivers to exceed maximum length are not authorized. The examining flight surgeon and MAJCOM/SG do not have waiver authority for indoctrination and incentive flights.

A5.10.2. Incentive and Orientation Flights in Non-Ejection Seat Aircraft.

AMENDMENT TO AFI 48-123, Volume 3, Flying and Special Operations Duty, Subparagraph A5.10.1.3

Anthropometric Standards for Incentive and Orientation Flights

Airframe	Weight		Buttock-to-Knee	Sitting Height	
	Minimum	Maximum		Minimum	Maximum
B-1	140 lbs	211 lbs	27.0 inches	34.0 inches	40.0 inches
B-2	140 lbs	211 lbs	27.0 inches	34.0 inches	40.0 inches
B-52	132 lbs	201 lbs	27.0 inches	33.8 inches	40.0 inches
F-15	140 lbs	211 lbs	26.2 inches	34.0 inches	40.0 inches
F-16	140 lbs	211 lbs	26.1 inches	34.0 inches	39.7 inches
T-6A	103 lbs	245 lbs	26.9 inches	31.0 inches	40.0 inches
T-37	132 lbs	201 lbs	26.3 inches	33.8 inches	40.0 inches
T-38	140 lbs	211 lbs	27.0 inches	33.8 inches	40.0 inches
U-2	132 lbs	211 lbs	26.0 inches	33.8 inches	40.0 inches

A5.10.1.3 Body weight, buttock-to-knee and sitting height measurements must be within minimums and maximums as specified in table below:

Note: Above listed minimum and maximum body weights do not necessarily apply to Air Force pilot minimum and maximum ejection seat weights.

A5.10.2.1. Incentive and orientation flight candidates scheduled to fly in non-ejection seat aircraft will sign a locally generated health statement which asks the candidate: (1) Do you have any medical problems? (2) Are you on a medical profile? (3) Do you take any medications? (4) Do you feel you need to see a flight surgeon? Those individuals making any positive responses (YES) on the health statement will be referred by the flying unit to the flight surgeon for review, appropriate medical examination, and medical recommendation for incentive and orientation flying. Candidates must be able to safely egress the aircraft in an emergency without endangering life of limb. All civilians selected for incentive or orientation flights will be referred to the flight medicine clinic. (Passengers scheduled to fly onboard Air Force aircraft will not routinely be referred to the flight surgeon office.) Communicate medical clearance, recommendations and/or restrictions to the flying unit on AF Form 1042. Medical clearances for incentive and orientation flights are valid for no longer than 14 days.

A5.11. Firefighters. DoDI 6055.6 provides instruction for fitness standards for firefighters. HQ AFCESA/CEFX, in conjunction with HQ AF/SGOP, develops National Fire Protection Association Technical Implementation Guides (TIGs) for assistance in implementing fitness policy. The TIGs are available on the AFCESA's web site. Military firefighters with any Category A conditions and Category B conditions (see National Fire Protection Association 1582, *Standard on Comprehensive Occupational Medical Program for Fire Departments)* where there is a clear fitness-for-duty issue, or they no longer meet standards for continued military duty IAW AFI 48-123V2, Attachment 2, should be evaluated with adherence to Medical Evaluation Board procedures.

A5.12. Instructors and students participating in United States Air Force Academy (USAFA) Airmanship programs. The medical standards for these duties are the same as **Attachment 4** (except as noted below):

A5.12.1. Flying Class III standards apply to Dean of Faculty (DF) flight and parachute courses. Flying Class II standards apply to all soaring courses/programs with the following exceptions:

A5.12.1.1. Refractive error, no standards.

A5.12.1.2. Near and Distant Visual Acuity corrected to 20/20, bilaterally.

A5.12.1.2.1. Applicants for programs in **A5.12.1.** may be cleared by a flight surgeon to fly if uncorrected visual acuity is not less than 20/25 in one eye and 20/20 in the other; while the applicant awaits delivery of corrective spectacles.

A5.12.1.3. Color Vision, no Standard.

A5.12.1.4. Depth perception:

A5.12.1.4.1. No standard for DF flight, parachute, and student soaring programs provided the soaring instructor pilot has normal depth perception.

A5.12.1.4.2. Participants with abnormal depth perception are disqualified from solo flight.

A5.12.2. For USAFA flying and parachute programs, FAA medical certificates are an acceptable standard of medical examination for civilian flight and parachute jump instructors, and USAFA Flying Team cadets. These participants will have their medical qualification reviewed by the USAFA/SGP, (or their appointed delegate) annually. An AF Form 1042, *Medical Recommendation for Flying*

or Special Operational Duty will be generated prior to performing flying operations in USAFA owned aircraft.

A5.12.3. Clearances to perform DF flight, student parachute, cadet jumpmaster, student soaring, and cadet soaring instructor pilot programs are performed prior to flight and is contingent upon the cadet meeting the following requirements:

A5.12.3.1. Compliance with **A5.12.1.** Accomplished by review of all available medical documentation and appropriate physical examination to ensure standards are met. This will be coordinated with Force Health Management.

A5.12.3.2. Cadet Optometry Clinic performs a targeted optometry exam, if necessary, to determine at a minimum; refractive error, color vision, depth perception, and presence of any other potentially disqualifying ocular pathology.

A5.12.3.3. Cadets receive risk communication in freshman year regarding airsickness, self medication, crew rest, not flying with a cold, alcohol and flying, and personal responsibility for seeing, or notifying, a flight surgeon for medical problems.

A5.12.3.4. Cadets receive physiology training prior to flight or at least prior to solo flight.

A5.12.3.5. Cadet/Flight Medicine Clinic flight surgeons issue a medical clearance for DF flight, soaring, Flying Team and parachute programs using AF Form 1042. The AF Form 1042 will contain risk communication statements that reinforce the issues in **A5.12.3.3.** Participants initial these risk communication statements on the clearance document acknowledging their understanding. Cadets performing pilot-in-command or jump instructor/jumpmasters duties must have their medical clearance reviewed annually.

A5.12.3.6. Grounding management of all cadet participants will be accomplished using AF Form 1042, USAFA Form 1042, USAFA Form 18, or the electronic equivalent, to convey temporary disqualification and clearances following illness or injury to the local HARMS. For grounding management purposes, civilians will comply with all FAA regulations and guidance.

A5.12.3.7. The USAFA airmanship program medical clearance expires upon graduation. While matriculating at USAFA, the ability to continue performing USAFA Airmanship Program flying duties is continually evaluated and potentially altered based on routine medical encounters and the required commissioning/Flying Class I physical examination performed prior to graduation.

A5.12.3.8. USAFA flying clearance (for DF, parachute, soar, or flight programs) does not imply meeting Initial Flying Class I/IA/II/III, RPA, SMOD, Ground Based Controller standards. HQ AETC/SG is the approval and waiver authority for Initial Flying Class I, IA, II, or III physical examinations.

A5.12.3.9. USAFA flying clearance (for DF, parachute, soar, or flight programs) does not imply meeting Initial Flying Class I/IA/II/III, RPA, SMOD, Ground Based Controller standards. HQ AETC/SG is the approval and waiver authority for Initial Flying Class I, IA, II, or III physical examinations.

A5.12.3.9.1. HQ AETC/SG certified Flying Class I physical examination must be completed prior to entering SUPT after graduation from USAFA.

A5.12.4. The USAFA/SGP is the approval and waiver authority for USAFA Airmanship Programs and courses covered under this attachment.

Attachment 6

ACCOMMODATIVE POWER

(Maximum for Age)

Age	Diopters
17	8.8
18	8.6
19	8.4
20	8.1
21	7.9
22	7.7
23	7.5
24	7.2
25	6.9
26	6.7
27	6.5
28	6.2
29	6.0
30	5.7
31	5.4

Age	Diopters
32	5.1
33	4.9
34	4.6
35	4.3
36	4.0
37	3.7
38	3.4
39	3.1
40	2.8
41	2.4
42	2.0
43	1.5
44	1.0
45	0.6

Attachment 7

USAF AIRCREW CORRECTIVE LENSES

A7.1. Contact Lens Policy. Aircrew may use SCL for visual correction without medical waiver provided they meet the requirements detailed in this attachment and have enrolled in the USAF Aircrew SCL Program. Only USAF approved SCL and related solutions may be used under this program (see **A7.1.4.**). Medical conditions requiring use of contact lenses to obtain 20/20 vision in either eye, requires medical waiver (see **A7.1.10.**).

A7.1.1. Eligibility. Adherence to this policy is required by:

A7.1.1.1. Flying Class I (UFT) electing to wear SCL, on or off duty (see **A7.1.3.**).

A7.1.1.2. Flying Class II electing to wear SCL, on or off duty.

A7.1.1.3. Flying Class III electing to wear SCL while performing flying duties.

NOTES:

Flying Class III electing to wear SCL, but not while performing flying duties, are NOT required to follow the USAF Aircrew SCL policy, but are highly encouraged to do so. Ground based controllers wearing contacts who are receiving flight pay and performing their duties while on aircraft should be complying with the SCL program. If they are not performing controlling duties, they do not need to comply.

USAF contracted DoD civilian aviators and flight instructors electing to wear SCL, on or off duty, may use any FDA approved SCL, but must provide documentation of efficacy of fit to the local Flight Surgeon's Office (FSO). This must include documentation of at least 20/20 vision in each eye with current spectacles immediately after removing SCL, and in each eye while wearing SCL for both near and distant vision. Bifocal spectacles used in combination with SCL to correct near vision to 20/20 are permitted as detailed in **A7.1.4.**

A7.1.2. Program Administration/Funding.

A7.1.2.1. Administration of the SCL program is the responsibility of the local FSO.

A7.1.2.2. Active Duty Flying Class II will receive fitting, prescription, and follow-up at local MTF.

A7.1.2.3. Air Reserve Component (ARC) Class II may receive fitting, prescription, and follow-up at local ARC Medical Squadron (MDS) if an eye specialist is assigned. If this capability does not exist at MDS, fitting, prescription, and follow-up will be provided by a civilian eye care professional.

A7.1.2.4. Active Duty Flying Class III who wear SCL while performing flying duties will receive fitting, prescription, and follow-up at local MTF if the MAJCOM/SG agrees that capability exists within the MTF, and flying squadron commander determines operational justification exists.

A7.1.2.5. ARC Flying Class III may receive fitting, prescription, and follow-up at local MDS if an eye specialist is assigned, and flying squadron commander determines operational justification exists.

A7.1.2.6. Flying squadron commander will purchase SCL and supplies with unit funds for Class II and/or III, if operational justification to fly with SCL exists.

A7.1.2.7. Funding is not authorized for Flying Class I.

A7.1.3. UFT Entry into USAF Aircrew SCL Program. Flying Class I/IA applicants must satisfy the following conditions prior to enrollment into the SCL program, in addition to those detailed in this attachment.

A7.1.3.1. Only UFT applicants who have been wearing USAF approved SCL for at least six months prior to UFT, without difficulty, will be authorized to enter the USAF Aircrew SCL Program, and be allowed to wear SCL during UPT. The UFT applicant is responsible to provide civilian SCL documentation to the local FSO. The UFT applicant must be examined and processed by the local FSO and Optometry Clinic to determine adequacy of fit and visual function. Refitting SCL will NOT normally be accomplished during UFT unless operational or medically indicated.

A7.1.3.2. UFT students authorized to enter the USAF Aircrew SCL Program must buy their own SCL and solutions.

A7.1.3.3. All UFT applicants are to cease wearing SCL for 30 days prior to their Initial Flying Class I/IA physical examination. UPT applicants must also cease wearing SCL for 30 days prior to the Medical Flight Screening physical examination**.** This is to overcome any temporary alteration in the cornea that may be caused by SCL wear.

A7.1.4. Special Considerations. All aircrew should note that:

A7.1.4.1. Bifocal, multifocal or varifocal SCL are **NOT** permitted.

A7.1.4.2. Monovision SCL correction (one eye corrected to near vision) is **NOT** permitted while performing flight duties.

A7.1.4.3. Hard Contact Lenses or Rigid Gas Permeable lenses and Combination (hard/soft) lenses are **NOT** permitted without medical waiver for any aircrew, military or civilian, on flying status, on or off duty, including any aircrew who participate as a crewmember in military flights while on an “inactive” status.

A7.1.4.4. The wearing of spectacles in combination with SCL for distance correction is **NOT** permitted. The use of flat-top or double-D bifocal spectacles in combination with SCL for near correction is permitted, provided the distance portion is plano. Bifocal power may be adjusted for cockpit use (cockpit demands may differ from clinical test range). Progressive Addition (no line) bifocals are **NOT** permitted.

A7.1.4.5. Aircrew wearing or requiring contact lenses for medical reasons must obtain a medical waiver after evaluation at the ACS.

A7.1.4.6. Only those SCL and related solutions on the Air Force approved list are permitted. This list is issued by USAFSAM/FECO and is reviewed each year and updates are posted on the AFMOA/SGPA website in the knowledge exchange.

A7.1.4.7. Wearing SCL labeled with generic terminology only are **NOT** permitted. The SCL must be clearly labeled with one of the names on the approved list.

A7.1.5. Aircrew Responsibilities.

A7.1.5.1. Aircrew requesting initial SCL are to visit local FSO for briefing and assessment.

A7.1.5.2. Aircrew wearing SCL are to report use and any complications to local FSO.

A7.1.5.3. Aircrew will receive and be familiar with mandatory instructions for SCL use.

A7.1.5.4. Aircrew are responsible for maintaining the currency of SCL prescriptions.

A7.1.5.5. Aircrew are responsible to follow General Flight Rules (see AFI 11-202, Vol 3) which states that aircrew "who wear corrective spectacles or contact lenses must carry a spare set of clear prescription spectacles on their person while performing aircrew duties."

A7.1.5.6. Aircrew are responsible to ensure that their primary and backup spectacles are current and adequate.

A7.1.5.7. Aircrew must maintain at least one set of replacement SCL that are unused and current. Aircrew on mobility must satisfy requirements listed in **A7.1.9.**.

A7.1.5.8. Aircrew buying their own SCL and supplies are responsible to ensure these materials comply with the current Air Force approved list.

A7.1.6. Flight Surgeon Responsibilities.

A7.1.6.1. Administrate the USAF Aircrew SCL Program. Document and manage SCL use by all approved aircrew members as defined by this attachment.

A7.1.6.2. Brief USAF aircrew and ensure they are familiar with the contents of "USAF Aircrew Soft Contact Lens (SCL) Program."

A7.1.6.3. Report all SCL related operational incidents, medical complications, and DNIF days to USAFSAM/FECO in the format "USAF Aircrew Soft Contact Lens (SCL) Incident Report."

A7.1.7. Eye Clinic Responsibilities.

A7.1.7.1. Examine, fit and prescribe SCL for all active duty Flying Class II, other Active Duty aircrew identified by flying squadron commander, and ARC aircrew authorized to wear SCL in flight and who have access to a unit eye clinic.

A7.1.7.2. Report to local FSO all SCL related incidents and complications.

A7.1.7.3. Obtain from USAFSAM/FECO the current list of Air Force Approved SCL and related solutions published each year.

A7.1.7.4. Train aircrew in the emergency removal of SCL.

A7.1.8. Medical Requirements for USAF Aircrew SCL Wear. No history of ocular, periocular or medical condition that would require or contraindicate SCL wear. Conditions requiring use of contact lenses to obtain 20/20 vision in either eye, require medical waiver (see **A7.1.10.**).

A7.1.8.1. Visual acuities of 20/20 in each eye with current spectacles for both near and distant vision, immediately after removing SCL.

A7.1.8.2. Visual acuities of 20/20 in each eye while wearing SCL for both near and distant vision. Bifocal spectacles used in combination with SCL to correct near vision to 20/20 are permitted as detailed in **A7.1.4.**

A7.1.8.3. Refractive astigmatism (at spectacle plane) of no greater than 2.00 diopters.

A7.1.9. Mobility Requirements.

A7.1.9.1. Aircrew on mobility are required to maintain in mobility bag:

A7.1.9.1.1. Two replacement SCL for each eye in factory sealed containers if wearing non-disposable SCL.

A7.1.9.1.2. Three month supply of replacement SCL in factory sealed containers if wearing disposable or frequent replacement SCL.

A7.1.9.1.3. One pair of clear and one pair of sunglass spectacles, each with current prescription lenses.

A7.1.9.1.4. Sufficient, current SCL solutions for initial deployment (one month supply).

A7.1.9.2. Squadron Life Support retains responsibility to maintain USAF approved SCL solutions for deployment.

A7.1.10. Medical Waivers. Aircrew required to wear contact lenses outside the scope of the USAF Aircrew SCL Program must obtain a medical waiver after evaluation by the Aeromedical Consultation Service (USAFSAM/FECO), Brooks City-Base TX. Medical waivers may be given for treatment of medical conditions requiring specialized soft or rigid contact lenses and treatment of refractive errors outside of authorized range.

A7.2. Spectacles Frames Approved for Flying (Civilian frames no longer authorized).

A7.2.1. The new Improved Aircrew Spectacle (IAS) frame has been fielded and has replaced the HGU-4/P. (The IAS is also referred to as the Air Force Flight (AFF) frame by the DoD Optical Fabrication Enterprise). The current HGU-4/P can be worn until it is replaced by a new prescription in the individual crewmember. **No other frames are authorized to be worn for flying by USAF aircrew or contract personnel flying USAF aircraft.**

A7.2.2. Lens Materials Approved for Flying.

A7.2.2.1. Required.

A7.2.2.1.1. Lenses may be fabricated from Crown glass, CR-39, polycarbonate, or hi-index plastic. All lenses must meet or exceed the Z-80 ANSI standards for dress eyewear.

A7.2.2.1.2. Thickness: glass and CR 39 lenses (2.2 mm minimum), polycarbonate (1.5 mm minimum). Aircrew using NVGs: all lenses must be 3.0 mm minimum (ANSI Z-87).

A7.2.2.1.3. Clear or neutral gray sunglass tint (sunglass transmission not less than 15%).

A7.2.2.1.4. Scratch resistant coatings for polycarbonate lenses.

A7.2.2.2. Recommended.

A7.2.2.2.1. Anti-reflection coating.

A7.2.2.2.2. Scratch resistant coatings for CR-39, polycarbonate, and hi-index plastic.

A7.2.2.3. Not Allowed.

A7.2.2.3.1. Polarized lenses.

A7.2.2.3.2. Photochromic lenses.

A7.2.2.3.3. Progressive addition (no line) bifocal lenses.

A7.2.2.3.4. Glass lenses other than chemically hardened, shatter resistant Crown glass.

A7.3. Sunglasses Approved for Flying.

A7.3.1. The only sunglass lenses authorized for USAF aircrew must be made of neutral density materials no darker than 15% transmission. They must be fitted into the new IAS (AFF), or the old HGU-4/P until the individual aircrew member requires a replacement, or new prescription for the old approved frame. At that time, the IAS (AFF) frame should be ordered.

A7.3.1.1. Not allowed:

A7.3.1.1.1. Commercially procured sunglasses.

A7.3.1.1.2. Polarized lenses or photochromic lenses.

A7.3.1.1.3. Any tinted or colored lenses, other than neutral density grey.