



DEPARTMENT OF THE AIR FORCE
HEADQUARTERS UNITED STATES AIR FORCE
WASHINGTON DC

AFI48-123_AFGM2016-01
19 September 2016

MEMORANDUM FOR ALL MAJCOM SG

FROM: HQ USAF/SG
1780 Air Force Pentagon
Washington, DC 20330-1780

SUBJECT: Guidance Memorandum (GM) – AFI 48-123, *Medical Examinations and Standards*

By Order of the Secretary of the Air Force, this memorandum immediately implements changes to AFI 48-123.

This memorandum provides substantial changes to improve upon guidance regarding medical examinations and standards. It incorporates the previous GM and also adds direction for implementing and monitoring Remotely Piloted Aircraft (RPA) pilot standards. Further, this GM clarifies the definitions for the USAF Medical Serial Profile Annotation (PULHES) and incorporates recommendations for clarifying language for Duty Not Involving Flying (DNIF) procedures following a mishap. It also officially adopts the DoD equivalent to AF Form 1042, the DD Form 2992, *Medical Recommendation for Flying or Special Operational Duty*.

Compliance with this memorandum is mandatory. To the extent its directions are inconsistent with other Air Force publications, the information herein prevails, IAW AFI 33-360, *Publications and Forms Management*.

This memorandum becomes void after one year has elapsed from the date of this memorandum, or upon publication of an Interim Change or rewrite of the affected publication, whichever is earlier.

MARK A. EDIGER
Lieutenant General, USAF, MC, CFS
Surgeon General

Attachment:

Changes to AFI 48-123

(Add) Opening Paragraph. The authorities to waive wing/unit level requirements in this publication are identified with a Tier (“T-0, T-1, T-2, T-3”) number following the compliance statement. See AFI 33-360, *Publications and Forms Management*, for a description of the authorities associated with the Tier numbers. Submit requests for waivers through the chain of command to the appropriate Tier waiver approval authority, or alternately, to the Publication OPR for non-tiered compliance items.

1.1.2. (Add) The current Medical Standards Directory is located on the Knowledge Exchange under Flight Medicine in the [Medical Standards Directory folder](#).

1.1.2.1. (Add) The Medical Standards Directory and the Official Air Force Medicine Approved Medications must be used IAW AFI 48-123 and can be changed through the process noted in AFI 48-123 GM paragraph 1.1.2.2.

1.1.2.2. (Add) Medical standards and aircrew approved medications are changed through a process that includes review by the Aircrew Medical Standards Working Group (ASWG) which includes members from MAJCOMs, HAF/A3, and appropriate Subject Matter Experts for the specific standards. Then any recommended changes by the ASWG are reviewed by the Flight and Operational Medicine Corporate Board whose voting members include the MAJCOM/SGPs. All medical standards are approved IAW the AF/SG’s delegated authority. For retention and all special duty medical standards (including flying) the delegated authority is the AF/SG3/5P.

1.1.2.3. (Add) The Chief of Physical Standards Development is the OPR for any changes and can be contacted for any recommendations.

1.2.4.5. (Replace) Color Vision Testing: Pseudoisochromatic Plate (PIP) testing to determine color vision perception will be completed at accession, and the results will be recorded in member’s record (T-2). (SOD positions include but are not limited to GBC, SERE, PJ and Combat Control.) If an applicant wants to apply for flying or special duty, then they must pass the Cone Contrast Test (CCT) at an AF MTF or equivalent. (T-1) Exception: See section 3.1.3 for applicants for Initial Flying Class I and IFCII/FS and Remotely Piloted Aircraft (RPA) duties.

1.2.8. (Replace) **Disorders That Are Unsuiting.** Disorders that are unsuiting for, or interfere with, military service are managed administratively through the patient’s chain of command IAW AFI 36-3206, *Administrative Discharge Procedures for Commissioned Officers* and AFI 36-3208, *Administrative Separation of Airmen*. Unsuiting disorders are conditions that interfere with military service and must not be confused with disorders that render a member medically unfit for duty. These conditions are not entered into the Integrated Disability Evaluation System (DES), IAW DoDI 1332.18, *Disability Evaluation System (DES)* paragraph 3.i.

2.7.5.2. (Add) Retraining applications will be reviewed by the primary care provider at the request of the MSME. (T-1) The provider will then update the PULHES (see Table A3.1) for the applicant in an AF Form 422 IAW AFI 10-203, *Duty Limiting Conditions*. (T-2)

2.9.5. (Add) Retraining applications will be reviewed by the MSME to ensure members are qualified for entry into the AFSC(s) for which the member is applying IAW AFI 10-203. (T-1) MSME will ensure PULHES (see Table A3.1) is updated IAW AFI 10-203. (T-1)

5.3.3.1. (Replace) Certain conditions render an individual unsuited for duty, rather than unfit, and render the service member subject to administrative separation since these conditions interfere with military service. These conditions cannot be entered into the Integrated Disability Evaluation System (IDES). Consult AFI 36-3206, *Administrative Discharge Procedures for Commissioned Officers*, AFI 36-3208, *Administrative Separation of Airmen*, and DoDI 1332.18 for details and specific cases.

6.1.1.3.2. (Replace) Rated officers for continued flying duty (pilots, navigators/electronic warfare officers, 12SX Special Operations Combat Systems Officer and flight surgeons).

6.1.1.5. (Replace) Flying Class (FC) III qualifies individuals for aviation as indicated in the Air Force Officer Classification Directory (AFOCD) or the Air Force Enlisted Classification Directory (AFECD). For USAFA cadets participating in USAFA cadet airmanship program, see AFI 48-123 paragraph 6.24.6. A Categorical FCIII qualifies individuals for duty with certain restrictions. Granting categorical certifications and waivers does not guarantee operational utilization. Restrictions for FCIIIC and FCIIID will be documented in the remarks section of the AF Form 1042 or DD Form 2992. (T-1) See AFI 48-123 paragraph 6.4. and Table A2.1. for certification and waiver authority.

6.1.1.5.1. (Add) FCIIIC qualifies individuals for aviation duty as specified in the remarks section of AF Form 1042 or DD Form 2992. Example: Restricted to current and previously qualified systems. If using new systems requiring interpretation of different color symbology, an operational evaluation is required to verify capability to accurately recognize and respond to all display information.

6.1.1.5.2. (Add) FCIIID qualifies individuals for aviation duties that do not require stereopsis per the CFM, as documented in the AFOCD or AFECD.

6.1.1.7. (Add) RPA Pilot exam qualifies rated officers for RPA Pilot duties only. URT requires IFCII (see 6.1.1.3.1).

6.1.1.7.1. (Add) RPA pilots with AFSCs 11X or 12X who may return to manned aviation platforms should maintain FCII standards. For day-to-day operations, the pilots shall follow RPA Pilot medical, DNIF and waiver requirements. Special attention must be paid to 11X or 12X RPA pilots to identify medical conditions which may require a FCII waiver prior to their return to manned aviation platforms.

6.1.1.7.2. (Add) RPA pilots who have been granted a FCIIU categorical waiver shall follow the RPA Pilot standards with DNIF and waiver requirements. A new waiver is required to have the

FCIIU restriction removed if the pilot seeks to return to manned aviation (AFMSA retains waiver authority).

6.4.1.1. (Change) All initial and renewal categorical flying waivers; changes from one category to another; removal of a categorical restriction. Exceptions are for specific cases where AFMSA/SG3PF delegates to MAJCOM or in an official delegation letter from AFMSA/SG3PF (maintained on the KX). These cannot be further delegated to the base level.

6.4.1.9.1. (Add) AFMSA/SG3PF delegates to AETC/SGPS, AFRC/SG or ANG State Air Surgeon (IAW Table A2.1) the authority for initial FCIID certification for untrained personnel who do not require depth perception as stated in the AFOCD or AFECD. See AFI 48-123 GM paragraph 6.1.1.5.2.

6.4.1.9.2. (Add) AFMSA/SG3PF delegates to MAJCOM, AFRC/SG or ANG/SG (IAW Table A2.1) the waiver authority for FCIID waivers in trained personnel who do not require depth perception as stated in the AFOCD or AFECD. See AFI 48-123 GM paragraph 6.1.1.5.2.

6.4.3.1. (Replace) Command and USAFA surgeons may delegate waiver authority to another command surgeon or to a Residency Trained Aerospace Medicine specialist working on that MAJCOM staff (Aerospace Medicine Specialist (AFSC 48A), AFSC 48A3/48A4 or ARC 48R3/48R4). Exceptions will be approved by AFMSA/SG3P. Command surgeons may delegate base level (local) waiver authority to the installation Aerospace Medicine Specialist or most qualified Flight Surgeon, most likely the SGP, IAW paragraph 2.3.1. Waiver delegation will indicate authority based on residency trained Aerospace Medicine Specialist (Aerospace Medicine Specialist (AFSC 48A)) versus non Aerospace Medicine Specialist. **Note:** Authority to grant flying class III waivers to rated personnel who have been medically disqualified for flying class II is delegated to the member's MAJCOM/SG of assignment. See paragraph [6.4.1.11](#).

6.7.1.1. (Add) When an aviator or operator is in DNIF/C/J/A status, there may be other duties that can be performed. Clearance for simulator training, ground-based flight line duties (to include Supervisor of Flying) and/or other duties may be annotated on the AF Form 1042 or DD Form 2992.

6.7.5.1. (Add)"Involved in an aircraft mishap" is usually defined as all military crewmembers on the flight orders of the mishap aircraft, as well as all members of the mishap flight if the mishap aircraft was part of a formation. The AF Form 1042 or DD Form 2992 will temporarily DNIF aircrew for subsequent flight duties as appropriate.

6.21. (Replace) Medical Standards. For accessions and enlistments, the standards in Chapter 4 apply. Chapter 5 and the Medical Standards Directory apply to personnel already serving as AD or ARC (example, AD SSgt applying for IFCI duty must meet retention standards in Chapter 5, as well as IFCI standards in the Medical Standards Directory). For conditions listed in Chapter 5 and the Medical Standards Directory, ensure an I/RILO or MEB/FFD has been initiated if appropriate. The medical standards for SOD exams are based on AFSC, FC and special duties;

for medical standards reference the requirements in the AFOCD, AFECD, this section, 6H, 6I, 6J, and the MSD paying special attention to the notes at the top of each subheading.

6.22. (Replace) Ground Based Aircraft Controller Medical Standards. The standards in **Section 6H** and the Medical Standards Directory apply to all ground based aircraft controllers which includes air traffic controller, weapons controllers/directors, combat controllers, Tactical Air Control Party (1C4X1), Air Liaison Officer (13LX) and RPA sensor operators (1U0X1). Conditions in **Chapter 5** and the Medical Standards Directory or Worldwide Duty (WWD) standards also apply. For conditions listed in **Chapter 5** and the Medical Standards Directory, ensure an I/RILO or MEB has been initiated if appropriate.

6.24.3.3.6. (Add) Physiologic training participants without an AF Form 1042 (or DD Form 2992) and the above completed, will complete a medical history and examination based upon AFI 48-123 paragraph 6.24.2. OSF Duty.

6.24.6.1. (Replace) Flying Class III standards apply to Dean of Faculty (DF) parachute courses. RPA Pilot standards apply to all DF RPA programs. Flying Class II standards apply to all soaring/powered flight courses. The following exceptions apply:

6.24.7.1. (Replace) Pilots of fighter, rotary wing, fixed wing (non-fighter) and Remotely Piloted Aircraft transferring from sister service to an equivalent weapon system in the Air Force are considered trained assets, FCII or RPA Pilot standards apply as appropriate. Complete all requirements for pilot's age IAW PHA and ASIMS guidelines. This physical will be entered into PEPP for baseline comparison and into AIMWTS if flying waiver required.

6.24.7.2. (Add) Pilots of fighter, rotary wing, fixed wing (non-fighter) and Remotely Piloted Aircraft transferring to the AF from a different type of weapon system are not considered trained assets. Flying Class I standards apply for manned aviation platforms. These pilots would require initial FCI physical and successful completion of MFS. For those transferring into RPA, IFCII standards apply (see 6.1.1.3.). This physical will be entered into PEPP and into AIMWTS if flying waiver required.

6.24.8. (Add) Hyperbaric Duty.

6.24.8.1. (Add) The conditions listed in Chapter 5 and the Operational Support Flyer column of the Medical Standards Directory are disqualifying for personnel conducting hyperbaric duties within the chamber.

6.24.8.2. (Add) Personnel who perform hyperbaric duties are required to have a normal examination of tympanic membranes, lungs and chest, heart, abdomen, neurologic, weight, blood pressure and pulse documented in their health record for an initial examination. The exam's expiration date is the PHA expiration date. **Note:** AF Form 1042 or DoD equivalent is issued as satisfactory evidence of completion of the requirements outlined for training and duty. This examination does not need to be entered into PEPP.

6.24.9. (Add) **Small Unmanned Aircraft Systems Operators**. Must meet standards for continued military service (Retention) and Section U: SUAS Standards as listed in the Medical Standards Directory. (T-1)

(Replace entire Chapter 7)

CHAPTER 7

MEDICAL EXAMINATIONS FOR SEPARATION AND RETIREMENT

7.1. Policy. This is the AF policy implementing the DoD Separation History and Physical Examination (SHPE) IAW Directive-Type Memorandum (DTM) 14-006, “*Separation History and Physical Examination (SHPE)*”. Do not delay separation or retirement past scheduled date of separation or retirement to complete a medical examination unless medical hold is approved (see AFI 41-210, *TRICARE Operations and Patient Administration*, for further guidance on medical hold authority and related topics).

7.2. Purpose. To identify medical conditions requiring attention, to document current medical status, and potentially assist with the evaluation of disability claims.

7.3. Presumption of Fitness. Except for Service members previously determined unfit and continued in a permanent limited duty status, Service members who have been referred for a SHPE because of retirement or separation are presumed fit for retention. Service members will therefore only be referred to the Disability Evaluation System or Integrated Disability Evaluation System (IDES) if a condition that would prevent the member from performing further duty if he or she were not separating or retiring is detected at the time of the SHPE and the referral is in accordance with DoD Instruction 1332.18 (Appendix 1 to Enclosure 3).

7.4. Law Governing Disability Evaluation.

7.4.1. Title 10, United States Code, Chapter 58, outlines benefits and service for members being separated from the armed forces.

7.4.2. Title 38, United States Code, administered by the Department of Veterans Affairs governs disability compensation for ratable service-connected defects.

7.4.3. Title 10 United States Code Section 1145 directs conduct of separation examinations on specific individuals leaving the armed forces.

7.5. Mandatory SHPE

7.5.1. All members of the Military Services, to include Reserve Component (RC) service members, who are scheduled to be separated (deactivated) from active duty after serving for 180 days or more, will undergo a comprehensive SHPE prior to the scheduled date of separation (deactivation). (T-0, DTM 14-006) RC service members serving on active duty for a period of more than 30 days in support of a contingency operation, will also undergo a SHPE prior to the date of separation (demobilization) from AD service IAW with DTM 14-006. (T-0, DTM 14-006)

7.5.1.1. RC service members serving on active duty for less than 180 days or on active duty for training, other training duty, not annual training as defined in DoDI 1215.06 or other non-

mobilization orders are not required to undergo a SHPE, but will document their current health status and complete DD Form 2697, "Report of Health Assessment," before completing their scheduled tour of duty.

7.5.1.2. Except for service members previously determined unfit and continued in a permanent limited duty status, service members who have been referred for a SHPE because of retirement or separation are presumed fit for retention. Service members will therefore only be referred to the Disability Evaluation System or Integrated Disability Evaluation System (IDES) if a condition that would prevent the member from performing further duty if he or she were not separating or retiring is detected at the time of the SHPE and the referral is in accordance with DoD Instruction 1332.18 and SHPE Guide.

7.5.1.3. SHPE requirements under this AFI are in addition to any deployment health activities specified in DoD Instruction 6490.03, *Deployment Health*, and AFI 48-122, *Deployment Health*.

7.5.1.4. Active component or RC service members who intend to remain in the Selected Reserve upon separation from Active Duty and who elect to file a pre-separation disability claim with the VA must complete SHPE through the Military Health System or through the VA before separation. (T-3)

7.5.2. The SHPE examination will be completed by the DoD if the service member does not wish to file a disability claim with the Department of Veterans Affairs (VA) prior to the member's separation or retirement. The DoD will also complete the SHPE when VA is unable to complete the examination within the timelines required or there is not access to the VA within the local area. (T-0, DTM 14-006)

7.5.2.1. The PCM Team or Primary Care Clinic assigned will complete their empanelled members' SHPE requirements unless a MTF supplement is approved by AFI 48-123 OPR or waiver provided by AFMSA/SG3PF (see SHPE Guide). For Active Duty not enrolled to the MTF (i.e. TRICARE Overseas Prime Remote or TRICARE Prime Remote), the supporting MTF responsible for outprocessing the Service member will complete SHPE requirements.

7.5.2.2. If not completed by the VA, ARC service members should complete the mandated SHPE as directed by the MTF or as per SHPE Guide. Travel costs will be included as applicable. (See SHPE Guide.)

7.5.2.3. USAF facilities should instruct Navy and Army RC service members to complete their examinations through their mobilization/demobilization facilities or to other locations directed by their service.

7.5.3. Timing of SHPE. Refer to DTM 14-006 and subsequent DoDI for the timing of the SHPE. Please review to the SHPE Guide for guidance on how to execute the requirements.

7.5.4. DoD SHPE Components complete, per DTM 14-006, at a minimum:

7.5.4.1. DD Form 2807-1, *Report of Medical History*, completed by service member and signed by a licensed, privileged healthcare provider. (T-0, DTM 14-006)

7.5.4.1.1. The DD Form 2807-1 completed by the service member is available for the privileged provider performing the physical examination at the time of the encounter.

7.5.4.1.2. A face-to-face interview with a licensed, privileged healthcare provider to discuss care and services for medical concerns subsequent to their completion of the self-reported health assessment is conducted with the service members.

7.5.4.1.3. The privileged health care provider reviews the service member's complete medical history; current worldwide medical qualification status; the member's current health status; and need for referral for treatment or further evaluations for medical concerns.

7.5.4.1.4. All positive responses on the DD Form 2807-1 are addressed with comments by the privileged provider performing the SHPE.

7.5.4.2. DD Form 2808, *Report of Medical Examination*, as noted below, completed by a privileged provider. This includes a review of medical record and a record of significant medical conditions. (T-0, DTM 14-006)

7.5.4.2.1. Blocks, 1-44, 53, 54, 57, 58, 77 and 85.

7.5.4.2.2. Block 71 unless the threshold audiogram is contained in the Service Treatment Record (STR). See paragraph 7.5.4.3.

7.5.4.3. Threshold audiogram documented on DD Form 2808 threshold unless a recent audiogram (within 6 months of the SHPE) is documented in the STR. (T-0, DTM 14-006) Note: Unless the Service member is a member of the Hearing Conservation Program, an AF Form 1753, *Hearing Conservation Examination*, is NOT required.

7.5.4.4. Complete audiology evaluation if the threshold audiogram is abnormal. (T-0, DTM 14-006)

7.5.4.5. Optional Hepatitis C testing per CDC guidelines. (T-0, DTM 14-006)

7.5.4.6. Additional testing appropriate to the service member's health status, as determined by the examining licensed provider and in accordance with current DoD policy.

7.5.4.7. Verification that all occupational health examinations required by DoD policy (e.g., hearing conservation, radiation medical surveillance) have been completed before the SHPE is conducted.

7.5.4.8. Other Tests. Any periodic testing required by other issuances (e.g., HIV testing in accordance with DoD Instruction 6485.01 (Reference (j))) must be completed before referral for SHPE.

7.5.4.9. Any examination completed on DD Forms 2807-1 and 2808, threshold audiogram, laboratory testing, or other exams performed for any other reason that meets any of the requirements stated in paragraphs 7.5.4.1. and 7.5.4.2. within the time periods stated in paragraph 7.5.3. of this guidance memorandum is sufficient to meet this requirement, but only with the consent of the Service member and concurrence of the member's unit commander. If another examination documented on a DD Form 2807-1 and DD Form 2808 performed within the previous 12 months is used to meet this requirement, and more than 60 days have elapsed since the date of the qualifying examination, the Service member must complete a standard DD Form 2697. (T-0, DTM 14-006)

7.5.4.10. When the SHPE is completed by the DoD, the following documentation is required, at a minimum:

7.5.4.10.1. A medical encounter note must be included in the service treatment record when completed by DoD. (T-0, DTM 14-006) The note must include the DD Form 2807-1 in HAIMS, and either the DD Form 2808 in HAIMS or a medical record template may be used in lieu of completing a separate form if it includes all the essential elements of the DD Form 2808. (T-1)

7.5.4.10.2. The encounter note must include the accepted diagnosis code for a Separation History and Physical (V70.5_9) for the first diagnosis. (T-1)

7.5.4.10.3. The summary list of diagnoses from the DD Form 2808 should all be included in the Problem List or added in the electronic medical record with the SHPE encounter. (T-1)

7.5.4.10.4. Validate that service member meets medical requirements for retirement and/or separation. (T-1)

7.5.4.11. See DTM 14-006 for additional information.

7.5.5. DoD Responsibilities when SHPE performed at the VA.

7.5.5.1. Ensure the SHPE is complete and inserted into the STR per SHPE Guide. (T-1)

7.5.5.2. DoD Provider reviews the SHPE.

7.5.5.2.1. The encounter note must include the accepted diagnosis code for a Separation History and Physical (V70.5_9) as the first diagnosis. (T-1)

7.5.5.2.2. Add new clinical diagnoses into the STR and provide appropriate medical care IAW DoD Policy. (T-1)

7.5.5.2.3. Validate that service member meets medical requirements for retirement and/or separation. (T-1)

7.5.6. If a medical condition is noted during a SHPE which may delay retirement and/or separation, the reviewing provider will follow instructions IAW AFI 41-210. In addition, they will inform the MSME and/or DAWG of potential delay. (T-1) See paragraph 7.5.1.2. and SHPE Guide for additional details.

7.6. General Officers. Examinations for retirement must be conducted IAW this policy and AFI 36-3203, *Service Retirements*.

7.7. SHPE Metrics. SHPE required tracking will be completed IAW DTM 14-006 requirements.

Attachment 1. (Add) ***Adopted Forms*** DD Form 2992, *Medical Recommendation for Flying or Special Operational Duty*, <http://www.dtic.mil/whs/directives/forms/eforms/dd2992.pdf>

Attachment 1. (Add) ***Abbreviations and Acronyms***

MSME-Medical Standards Management Element

PULHES-Physical Profile Serial Chart

SHPE-Separation Health Physical Examination

STR-Service Treatment Record

Attachment 3 (Add)

Table A3.1. PULHES (Add)

	1	2	3	4
P: Physical Condition	Free of any identified organic defect or systemic disease.	Presence of stable, minimally significant organic defect(s) or systemic diseases(s). Capable of all basic work commensurate with grade and position. May be used to identify minor conditions that might limit some deployments to specific locations.	Significant defect(s) or disease(s) under good control. Capable of all basic work commensurate with grade and position.	Organic defect, systemic or infectious disease which requires, or is currently undergoing, an MEB or I-RILO as determined by the Deployment Availability Working Group (DAWG).
U: Upper Extremities	Bones, joints, and muscles normal. Able to do hand-to-hand fighting.	Slightly limited mobility of joints, mild muscular weakness or other musculoskeletal defects that do not prevent hand-to-hand fighting and are compatible with prolonged effort. Capable of all basic work commensurate with grade and position.	Defect(s) causing moderate interference with function, yet capable of strong effort for short periods. Capable of all basic work commensurate with grade and position.	Severely compromised strength, range of motion, or general efficiency of the hand, arm, shoulder girdle, or back (includes cervical and thoracic spine) which requires, or is currently undergoing, an MEB or I-RILO as determined by the DAWG.
L: Lower Extremities	Bones, muscles, and joints normal. Capable of performing long marches, continuous standing, running, climbing, and digging without limitation.	Slightly limited mobility of joints, mild muscular weakness, or other musculoskeletal defects that do not prevent moderate marching, climbing, running, digging, or prolonged effort. Capable of all basic work commensurate with grade and position.	Defect(s) causing moderate interference with function, yet capable of strong effort for short periods. Capable of all basic work commensurate with grade and position.	Severely compromised strength, range of motion, or efficiency of the feet, legs, pelvic girdle, lower back, or lumbar vertebrae which requires, or is currently undergoing, an MEB or I-RILO as determined by the DAWG.
H: Hearing (Ears). See Table A3.2.				
E: Vision (Eyes)	Minimum vision of 20/200 correctable to 20/20 in each eye.	Vision correctable to 20/40 in one eye and 20/70 in the other, or 20/30 in one eye and 20/200 in the other eye, or 20/20 in one eye and 20/400 in the other eye.	Vision that is worse than E-2 profile.	Visual defects worse than E-3 which requires, or is currently undergoing, an MEB or I-RILO as determined by the DAWG.
S: Psychiatric Stability	Diagnosis or treatment results in no impairment or potential impairment of duty function, risk to the mission or ability to maintain security clearance.	World Wide Qualified and diagnosis or treatment result in low risk of impairment or potential impairment that necessitates command consideration of changing or limiting duties.	World Wide Qualified and diagnosis or treatment result in medium risk due to potential impairment of duty function, risk to the mission or ability to maintain security clearance.	Diagnosis or treatment resulting in high to extremely high risk to the AF or patient due to potential impairment of duty function, risk to the mission or ability to maintain security clearance which requires, or is currently undergoing, an MEB or I-RILO as determined by the DAWG.

(Add) Table A3.2. Hearing Profile

Acceptable audiometric hearing level for Air Force							
Unaided hearing loss in either ear with no single value greater than:							
Frequency (Hz)	500	1000	2000	3000	4000	6000	Comments
H-1	25	25	25	35	45	45	Class I and IA, IFCII, IFCIII, AF Academy, GBC, and selected career fields as noted in the Officer and Enlisted Classification directories.
H-2	35	35	35	45	55	--	AF enlistment, commission, initial MOD, SERE, continued GBC, flyers require evaluation for continued flying (see Aircrew waiver guide for details on the evaluation).
H-3	Any loss that exceeds the values noted above, but does not qualify for H-4.						H-3 profile requires evaluation and MAJCOM waiver for continued flying, and Audiology evaluation for fitness for continued active duty.
H-4	Hearing loss sufficient to preclude safe and effective performance of duty, regardless of level of pure tone hearing loss, and despite use of hearing aids.						This degree of hearing loss is disqualifying for all military duty. These require evaluation for continued service via either ARC Fitness for Duty (FFD), Worldwide Duty (WWD) processing, or review by the DAWG IAW AFI 10-203 and 41-210 for Initial RILO.

**BY ORDER OF THE
SECRETARY OF THE AIR FORCE**

AIR FORCE INSTRUCTION 48-123

5 NOVEMBER 2013

Aerospace Medicine

**MEDICAL EXAMINATIONS AND
STANDARDS**



COMPLIANCE WITH THIS PUBLICATION IS MANDATORY

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This instruction implements Air Force Policy Directive (AFPD) 48-1, *Aerospace Medicine Enterprise*, AFI 36-3212, *Physical Evaluation for Retention, Retirement, and Separation* and Department of Defense (DoD) Directive, 1332.18, *Separation or Retirement for Physical Disability*, and DoD Instruction 6130.03, *Medical Standards for Appointment, Enlistment and Induction*. 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 and scholarship programs. In addition to Active Duty (AD) personnel, this publication applies to Air Reserve Component (ARC), the Air Force Reserve (AFR) and the Air National Guard (ANG), and Air Force Pre-Trained Individual Manpower (PIM).

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 AFI are outlined in Title 10, United States Code, Section 8013. Privacy Act System Notice F044 AFSG G, Aircrew Standards Case File, applies. This AFI may be supplemented at any level, but all supplements that directly implement this Instruction must be routed to AF/SG3P for coordination prior to certification and approval. Requests for waivers must be submitted through chain of command to the OPR listed above for consideration and approval. In accordance with AFI 33-360, *Publications and Forms Management*, requests for waivers must be submitted through the chain of command to the appropriate Tier waiver approval authority. Ensure that all records created as a result of processes prescribed in this publication are maintained IAW Air Force Manual (AFMAN) 33-363, *Management of Records*, and disposed of in accordance with the *Air Force Records Disposition Schedule (RDS)* located in the *Air Force Records Information Management System*

(AFRIMS). Refer recommended changes and questions about this publication to the Office of Primary Responsibility (OPR) using the AF Form 847, *Recommendation for Change of Publication*; route AF Forms 847s from the field through the appropriate functional chain of command. **Attachment 1** is a list of references and supporting information. This publication has been substantially revised and requires complete review.

SUMMARY OF CHANGES

This instruction has been substantially revised and must be completely reviewed. Major changes include the creation of a medical standards directory, clarification of applicable standards for retention and for Air Force civilian employees flying military aircraft, and the inclusion of instructions for identifying tier waiver authorities as approved by the Inspector General Advisory Board (IGAB).

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Chapter 1

GENERAL INFORMATION AND ADMINISTRATIVE PROCEDURES

Section 1A—Medical Standards

1.1. Medical Standards. Medical standards and medical examination requirements ensure accession and retention of members who are medically acceptable for military duty. Specific medical standards are listed within the medical standards directory table. Please see AFI 44-170, *Preventive Health Assessment* and Physical Examination Techniques for further information.

1.1.1. These standards apply to:

1.1.1.1. Applicants for enlistment, commission and training in the Air Force and Air Reserve Component (ARC), United States Air Force Academy (USAFA), Air Force Reserve Officer Training Corps (AFROTC) (scholarship and non-scholarship), and the Uniformed Services University of Health Sciences (USUHS).

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

1.1.1.3. Military members ordered by appropriate Air Force authority to participate in frequent and regular aerial flights or other Special Operational Duty (SOD) as described elsewhere in this instruction.

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

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

1.1.1.6. Members of the USAF PIM activated for mobilization exercises and/or actual contingency/wartime operations.

Section 1B—Medical Examinations

1.2. Medical Examinations. There are various types of medical examinations: Accession, Department of Defense Medical Examination Review Board (DODMERB), Initial Flying, Preventive Health Assessment (PHA), Flying, Retirement, and Separation. As long as all requirements are met, a medical examination may serve more than one purpose. Each is conducted and recorded according to the format and procedures prescribed in Aerospace Medicine Information Management System (ASIMS), AFJI 36-2018, *Medical Examination of Applicants for United States Service Academies, Reserve Officer Training corps (ROTC) Scholarship Programs, Including 2 and 3 Year College Scholarship Programs (CSP), and the Uniformed Services University of the Health Sciences (USUHS)*, and Physical Examination Techniques. **Note:** Enlisted flying criteria are guided by the AFSC Career Field Manager at AF/A3. All induction physical examinations accomplished overseas by a medical treatment facility must be submitted through Physical Examination Processing Program (PEPP) to Air Education and Training Command (AETC)/SGPS (T-1). AETC/SGPS is the certifying authority for all accession physicals not done at a Military Entrance Processing Stations (MEPS) facility and for individuals undergoing Basic Military Training School (BMTS). ARC/SG is the

certification and waiver authority for all initial enlistment, commissioning, Active Guard and Reserve (AGR) and Palace Chase packages. AFRC/SG delegates certification authority to the local medical unit for enlistment physicals that do not require a waiver.

1.2.1. A medical examination is required for the following:

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

1.2.1.2. Entry into Flying or other SOD training.

1.2.1.2.1. Documents forwarded to certification/waiver authority will be electronically submitted (i.e., PEPP) unless specifically authorized by certification/waiver authority for circumstances in which PEPP and Aeromedical Information Management Waiver Tracking System (AIMWTS) are not utilized or available. (T-1) **Note:** All induction physical examinations accomplished overseas by a medical treatment facility must be submitted through PEPP to AETC/SGPS. (T-1) AETC/SGPS is the certifying authority for all accession physicals not done at a MEPS facility. ARC/SG is the reviewing and certification authority for all ARC enlistment and commissioning exams.

1.2.1.3. Termination of service when specified by **Chapter 7** of this instruction.

1.2.1.4. As required by AFI 44-170.

1.2.1.5. As required for General Officer Boards.

1.2.1.6. Enlisted members applying for commissioning may use their most current PHA and completed AF Form 422, *Notification of Air Force Member's Qualification Status*, noting qualified for General Military Service (GMS), Commission and Retention without a deployment limitation, in lieu of accomplishing another physical for the specific purpose of commissioning.

1.2.2. Examiners: All personnel prior to entrance into the military service will have an examination completed by either DoDMERB contracted personnel or MEPS. For all other examinations, the following personnel can complete the required examination.

1.2.2.1. A credentialed physician employed by the armed services, regardless of AD status, to include TRICARE providers and United States Coast Guard (USCG) credentialed providers, as well as designated Air Force physician assistants, (Air Force Specialty Code (AFSC) 42G4X) or primary care nurse practitioners (AFSC 46NXC), under the supervision of, and subject to review by a physician, may accomplish non-flying medical examinations.

1.2.2.2. A credentialed military or USCG flight surgeon (FS) with current/active privileges in flight/aerospace medicine will perform medical examinations on Air Force flying and/or SOD personnel. (T-1)

1.2.2.2.1. When the exam is accomplished by a non-Air Force FS at a location where no AF FS is available, forward the documents (including PHA and clinical documentation, labs, AF Form 1042, *Medical Recommendation for Flying or Special Operational Duty*, or DoD equivalent, AF Form 469, *Duty Limiting Condition Report*, etc.) to the examinee's servicing military treatment facility (MTF) for review

and MAJCOM/SG for review and certification. This includes aircrew on joint/ North Atlantic Treaty Organization (NATO) tours, etc.

1.2.2.2.2. When the exam is accomplished by a non-AF FS at a joint base or AF MTF, the AF FS must ensure sister-service FS is trained in AF standards and associated paperwork. Training will be determined by the SGP and documented in the Provider Activity Folder. If trained, sister-service FS can sign AF Form 1042 or DoD equivalent without an AF FS review. Quality control will be assessed via FS peer review IAW AFI 44-119, *Medical Quality Operations*. If untrained, an AF FS must review all PHA and return to flying status (RTFS) documentation for AF aircrew. All aircrew and SOD members examined by a US military FS (to include USCG FS) and found qualified to perform flight or SOD will be returned to flying/SOD status upon completion of their examination.

1.2.2.2.3. Military flight surgeons must be credentialed and privileged in flight/aerospace medicine at the examining facility and can be of any branch of the military service or Coast Guard. All may make aeromedical dispositions (RTFS) if credentialed as noted.

1.2.2.2.4. Physicians who are Air Force civilian employees or contractors may perform medical examinations on AF flying and/or SOD personnel and be credentialed to make aeromedical dispositions only if they meet the qualification criteria listed in the Civilian Flight Medicine Physician Performance Work Statement located at https://kx.afms.mil/kxweb/dotmil/file/web/ctb_207539.pdf and approved by Air Force Medical Operations Agency (AFMOA)/SGPF.

1.2.2.3. NGB/SG may delegate review and certification authority to current, trained and designated State Air Surgeon (SAS) on certain initial Flying Class (FC) III and return to FCIII examinations, Commission/Enlistment physicals not requiring MAJCOM level waiver and on Active Guard Reserve (AGR) Title 32 physicals. **Note:** Consult current Tri-Service agreements and MAJCOM/SG prior to forwarding examinations.

1.2.2.3.1. State Air Surgeon that are current, certified, and trained as specifically identified by NGB/SG retain this authority. This authority will not be delegated further. At locations where SAS are not assigned, or are not trained, the certification/waiver authority reverts to NGB/SG.

1.2.3. **Locations.** Physical examinations are normally accomplished at the following locations:

1.2.3.1. Medical facilities of the uniformed services, including TRICARE facilities and Reserve Health Readiness Program (RHRP) () providers away from an MTF.

1.2.3.2. MEPS.

1.2.3.3. DODMERB contract sites.

1.2.3.4. Where no AF or DoD MTF exists, TRICARE Service agreement providers may accomplish examinations. This may include credentialed providers for military attaché and embassy members.

1.2.3.5. Air Force Medical Support Agency (AFMSA) AFMSA/SG3PF must authorize exceptions to the above. Exceptions to the above for Temporary Disability Retirement

List (TDRL) examinations require HQ Air Force Personnel Center (AFPC)/DPMADS approval.

1.2.3.6. Hospitalization of civilian applicants in military or government hospitals is authorized only when medical qualification for military service or flying training cannot be determined without hospital study and only after authorization by the Medical Group Commander. **Note:** Except as stated above, civilian applicants are not eligible for health care in DoD facilities unless they are an authorized beneficiary.

1.2.3.6.1. If additional testing is required to determine accession eligibility for non-beneficiaries and if the services are available, the Air Force may authorize testing to be accomplished at MTFs or other government agencies.

1.2.3.6.2. In the event a diagnosis or potential diagnosis of disease is noted during an examination, the examining provider will counsel the applicant and effect transfer of care to the member's private physician. (T-0) Treatment is not authorized for non-beneficiary applicants; however, every effort to secure positive transfer of care is mandatory in this instance. (T-0)

1.2.4. Required Baseline Tests and Sample Collections:

1.2.4.1. Blood type and Rh factor.

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

1.2.4.2.1. All service members initially identified with a G6PD deficiency require medical education in a face-to-face visit documented in the medical record.

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

1.2.4.3.1. All service members initially identified with confirmed positive result require medical education in a face-to-face visit documented in the medical record.

1.2.4.4. Human Immunodeficiency Virus (HIV) Antibody. Consult AFI 48-135, *Human Immunodeficiency Virus Program* for additional details.

1.2.4.5. Color Vision Testing: Pseudoisochromatic Plate (PIP) testing to determine color vision perception which will be completed at accession and results recorded in their record. If an applicant wants to apply for flying or special duty, then they must pass the Cone Contrast Test (CCT) at an AF MTF or equivalent. (T-1) **Exception:** See 3.1.3 for applicants for Initial Flying Class I and IFCII/FS and Remotely Piloted Aircraft (RPA) duties.

1.2.4.6. DNA Specimen Collection, for Genetic Deoxyribonucleic Acid Analysis sample storage.

1.2.4.7. Urine Drug Screen (UDS). See DoDI 1010.16, *Technical Procedures for the Military Personnel Drug Abuse Testing Program (MPDATP)*. **Note:** Overseas applicants excluding Alaska, Hawaii, and Puerto Rico can get their UDS screening within 72 hours after arriving at their first training base. Overseas MTFs must note on the DD Form 2808, *Report of Medical Examination* that the test was not done, and must be completed upon arrival at their first training location/base. (T-0) See US Code, Title 10, Subtitle A, Part II, Chap 49, section 978. and AFI 44-120, *Military Drug Demand Reduction Program*.

1.2.5. Testing Locations. The above tests must be accomplished at the MEPS with the exception of DNA and UDS. If tests are not completed at MEPS, accomplish at the following locations:

1.2.5.1. Air Force non-prior service recruits at Lackland AFB, Texas, during basic training.

1.2.5.2. Basic Officer Training (BOT) students at Maxwell AFB, Alabama, during OTS training.

1.2.5.3. Commissioned Officer Training (COT) students at their first permanent duty station.

1.2.5.4. USAFA cadets will be tested at USAFA.

1.2.5.5. All other entrants (e.g. AFROTC, prior service enlisted recruits and AF PIM Airmen) at their entry point or first permanent duty station.

1.2.5.6. Enlistment physicals for ANG/AFRC candidates must be accomplished at MEPS, and must be completed before submission to ANG/AFRC units. Certification and Waiver authority remains as described in [Attachment 2](#). **Note:** See US Code, Title 10, Subtitle A, Part II, Chap 49, section 978 and AFI 44-120.

1.2.6. Records Transmittal. Transmit reports of medical examination and supporting documents that contain sensitive medical data IAW AFI 41-210, *TRICARE Operations and Patient Administration Functions* and system of records notice FO 44 SG E, Medical Record System and HIPAA guidelines.

1.2.7. Disorders of substance abuse or dependence. Disorders of substance abuse or dependence receive duty restrictions IAW AFI 44-121, *Alcohol and Drug Abuse Prevention and Treatment (ADAPT) Program*.

1.2.8. Disorders That Are Unsuiting. Disorders that are unsuiting for or interfere with military service are managed administratively through the patient's chain of command IAW AFI 36-3206, *Administrative Discharge Procedures for Commissioned Officers* and AFI 36-3208, *Administrative Separation of Airmen*. Unsuiting disorders must not be confused with disorders that determine a member unfit for duty and potentially are entered into the disability evaluation system (DES) IAW DoDI 1332.38, *Physical Disability Evaluation*.

Section 1C—Medical Examination/Assessment/MISC--Accomplishment and Recordings

1.3. Medical History. If the patient's health record contains a completed SF 93, *Report of Medical History* or DD Form 2807-1, *Report of Medical History*, and the individual acknowledges that the information is current and correct; do not accomplish a new form.

1.3.1. Report of Medical History required updates. The report of medical history is to be updated when medical examinations are accomplished for the following purposes:

1.3.1.1. Entry into active military service.

1.3.1.2. Appointment or enlistment in the Air Force or Air Reserve Component.

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

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

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

1.3.1.6. Examination of an ARC member. For ANG flying and non-flying PHAs, accomplish a AF Web Health Assessment (WEB HA) in place of updated DD Form 2807-1.

1.3.1.7. Lost medical records. Accomplish a PHA with a detailed medical history.

1.3.2. Interval Medical History. Once a complete medical history has been recorded on a SF 93 or DD Form 2807-1, only significant items of medical history since the last medical examination are recorded. This is called the interval medical history. Reference each update to the medical history with the current date, followed by any significant items of medical history since last examination. ANG will use AF WEB HA for interval history.

1.3.2.1. Changes in Flight Status. Any significant medical condition requiring hospitalization, excusal, grounding for greater than 30 cumulative days for same or similar conditions, profile change or suspension from flying status is recorded as part of the interval medical history. The information concerning the interval medical history is obtained by questioning the examinee and by a thorough review of the examinee's health records.

1.3.2.2. Significant Medical History. Use SF 93/DD Form 2807-1, waiver requests, Medical Evaluation Board (MEB) diagnosis, or restricted duty for 30 days or more as a guide in determining items to include as significant medical history. Do not record "routine" items such as URIs, viral illnesses, etc., unless hospitalization was required or the illness is of a frequent or chronic nature.

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

1.3.2.4. No Interval Medical History Statement. If the examinee had no interval medical history, record the current date followed by the statement: "Examinee denies and review of outpatient medical record fails to reveal any significant interval medical or surgical history to report since last examination dated (enter the date of that examination in parentheses)." See physical examination techniques for denial statement used when accomplishing the DD Form 2807-1.

1.3.2.5. Additional Space. Use SF 507, *Clinical Record-Continuation Sheet* as an attachment to the Report of Medical History when additional space is required (See Physical Examinations Techniques).

1.4. Medical Examinations. The results of medical examinations are recorded on DD Form 2808 or approved substitutes in accordance with physical examination techniques.

1.5. Adaptability Rating. Adaptability Rating for Military Aviation (ARMA) and other military duties, such as for Marine Diving Duty (MDD), Ground Based Controller (GBC), RPA or Missile Operations Duty (MOD) etc., is the responsibility of the examining flight surgeon, as is the scope and extent of the interview. Initial (entry into training) unsatisfactory adaptability ratings are usually rendered for poor motivation for aerial or SOD adaptability, or evidence of a

potential safety of flight risk, etc. (see Medical Standards Directory and Physical Examination Techniques).

1.6. DD Form 2766, *Adult Preventive and Chronic Care Flowsheet*. DD Form 2766 is used to record results of tests such as blood type, G6PD, DNA, Flyer/SOD ground testing, flying/SOD waiver information, etc., and also may be used as a deployment document IAW AFI 10-403, *Deployment, Planning and Execution*.

Chapter 2

RESPONSIBILITIES

Section 2A—Responsibilities

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

2.1.1. AF/SG is the certification and waiver authority for Air Force-specific medical standards.

2.1.2. AF/SG may delegate waiver authority in writing to AF/SG3, AF/SG3P, AFMSA/SG3 or AFMSA/SG3PF. Other delegation of certification or waiver authority is only as designated in this instruction.

2.2. AFMSA/SG3PF.

2.2.1. AFMSA/SG3PF may delegate waiver authority to MAJCOM/SG level or lower IAW [Attachment 2](#). The delegation may be in this instruction or a separate delegation letter located on the Knowledge Exchange (KX).

2.3. MAJCOM/SG.

2.3.1. Delegates in writing the Aerospace Medicine Specialist/s waiver authority at the MAJCOM IAW [6.4.2.1](#)

2.3.2. MAJCOM/SG or delegated authority in [2.3.1](#)

2.3.2.1. Delegates in writing the local base Aerospace Medicine Specialist or Flight Surgeon who is authorized to act as waiver and certification for designated exams/conditions IAW [6.4.3](#)

2.3.2.2. Liaison between MTF, medical squadrons, or medical groups and AFMSA/AFMOA.

2.4. Medical Treatment Facility, Medical Squadron, or Medical Group Commander.

2.4.1. Ensures timely scheduling and appropriate completion of required examinations and consultations. Unless adequately explained delays are documented, examinations should be completed not more than 30 days after appointment with Flight Surgeon unless adequate explanation of delay is documented. (T-1)

2.4.2. Ensures medical documents are filed in the health record and a completed copy filed IAW AFI 41-210.

2.5. ANG SAS.

2.5.1. ANG SAS serves as local Aeromedical certification/waiver authority for selected initial and trained flying personnel when so designated by NGB/SG IAW [Attachment 2](#).

2.6. Chief of Aerospace Medicine (SGP).

2.6.1. Applies medical standards IAW AFI 48-101, *Aerospace Medicine Enterprise*, AFI 48-149, *Flight and Operational Medicine Program (FOMP)*, AFI 10-203, *Duty Limiting Conditions*, and AFI 44-170.

2.6.2. Reports to MTF/CC and/or MAJCOM/SGP any limitations to appointment access and completion of Initial Flying Class Examinations in a timely fashion. (T-1)

2.6.3. Coordinates with SGH, FHM, and Medical Standards Management Element (MSME) to ensure clear process exists for deployment medical waivers and that it is briefed to Professional Staff annually. (T-2)

2.6.4. Coordinates annual Professional Staff Briefing with SGH regarding provider responsibilities within this instruction. (T-2)

2.6.5. Serves as the local aeromedical certification and waiver authority when so designated by Attachment 2 and MAJCOM/SG or delegate written appointment. (T-1)

2.6.6. Serves as the installation subject matter expert on medical standards and physical qualifications. The SGP is the installation focal point in handling matters of medical standards application and resolving problems associated with conducting assessments, documentation and required follow-up of complicated or sensitive cases, and other matters that may call for resolution. (T-2)

2.7. Primary Care Elements (to include Flight Medicine).

2.7.1. During each encounter, review ASIMS status and determine qualification for retention, and deployment qualification IAW **Chapter 5**, Medical Standards Directory and **Chapter 11**. (T-2)

2.7.1.1. Ensure ASIMS is updated upon every encounter.

2.7.1.2. All providers must determine if the reason for the current encounter affects deployment, retention qualification, and whether the member needs to be placed on a Duty Limiting Condition (DLC) profile as described in AFI 10-203, *Duty Limiting Conditions*.

2.7.2. Completes PHA IAW AFI 44-170.

2.7.3. Refer to DoDI 5210.42-R, *Nuclear Weapon Personnel Reliability Program (PRP)*, to determine applicable PRP procedures.

2.7.4. Initiate and complete any Review in Lieu of (RILO)/MEB required for continued service for empanelled personnel. (T-0)

2.7.5. Non-flight medicine Primary Care Elements complete professional and paraprofessional clinical aspects of non-flying exams and/or assessments, to include those studies necessary to determine fitness for various clearances, special duty assignment profiling actions, overseas assignments, medical evaluation boards, retraining, transfer to ARC etc. Flight Medicine retains consultant oversight/management of the Occupational Medicine (OM) aspect of the exams/assessments unless there is a stand-alone OM clinic. (T-2)

2.7.5.1. Complete additional clinical consultations or follow-ups to finalize physicals, assessments and/or clearances to include all types of examinations no matter who performs initial examination.

2.7.6. Flight and Operational Medicine Responsibilities: Complete all professional, paraprofessional, and clinical components of flying and SOD exams. (T-1) In addition, completes occupational health exams and/or assessments unless separate OM Clinic is located at the MTF. (T-2) Clinical follow-ups for flying and SOD personnel are the responsibility of the Flight Medicine Primary Care Manager (PCM) team; this includes interim waiver evaluations as requested in AIMWTS. (T-1) Interim evaluations must be performed and tracked by the FM PCM team or health systems technician for the ANG. (T-2

2.7.6.1. Ensures each member of flight medicine subscribes to the Knowledge Junction of AFMSA/SG3PF Aerospace Medicine.

2.7.6.2. Ensure an effective grounding management program is maintained.

2.7.6.3. Initiate, track, and conduct follow up/interim evaluations or studies for all flying and SOD waivers, to include entry into AIMWTS and any RILO required for continued service.

2.7.6.4. Flight surgeons are responsible for all required aeromedical summaries.

2.7.6.5. Flight surgeons will act as OM consultants for all PCM teams. If the MTF/CC has appointed an OM physician that is not a FS, that physician will provide primary OM consultant services with support from flight surgeons.

2.7.6.6. Serves as the initial point of contact for scheduling of non-enrolled examinees, AFROTC, OTS applicants and ARC members requiring flying/SOD examination requirements. Identifies any required physical examination documentation and data entry, and assists with scheduling exams for all non-enrolled patients requiring flying/SOD physical examinations.

2.8. Public Health (Force Health Management (FHM) Element) or equivalent.

2.8.1. Is charged with the administrative oversight of ASIMS IAW AFI 48-101. Ensures each member of FHM is subscribed to the Knowledge Junction of AFMSA/SG3PF Aerospace Medicine. (T-2)

2.8.2. Keeps Primary Care Elements, medical facility executive leadership, unit health monitors, unit deployment managers, and unit/installation leadership informed of ASIMS (to include PHA, Individual Medical Readiness (IMR), Occupational Health Examinations, and Immunizations) requirements and current status for all AD and assigned civilian employees (as applicable). (T-1)

2.8.3. Performs all requirements IAW AFI 44-170.

2.8.4. Manages and performs all Occupational Hearing Conservation audiograms (except at bases where separate Occupational Medicine Services (OMS) are already established outside of PH) IAW Air Force Occupational Safety and Health (AFOSH) Standard 48-20. At bases with a separate OMS facility, PH manning for occupational audiograms will be part of OMS.

Note: For Air Force Reserves, the Reserve Medical Unit Wing Medical Support work center

is the equivalent element responsible for accomplishing deliverables outlined in paragraph 2.8 for AFRC members. (T-1)

2.9. MSME or equivalent.

2.9.1. Ensures initial flying/SOD physical exams are completed in a timely manner (should be less than 30 days for non-waiverable initial flying class/SOD exams; measured from date of examination to date sent to certification authority in PEPP). Completion rates and issues impacting completion are reported to SGP every month, or local MTF (RMU) leadership. (T-2)

2.9.2. Ensures training is completed for all PEPP and AIMWTS users for documentation of physical examination and waiver actions. (T-1)

2.9.3. Ensure mechanism for scheduling or schedules initial flying class/SOD examinations for all enrolled and non-enrolled personnel who require initial flying class/SOD examinations. (T-1)

2.9.4. Fulfills roles as outlined in AFI 48-149, AFI 10-203, AFI 44-170 and AFI 41-210.

2.10. Member's Commander. Ensures the member is available for and completes examination including required follow-up studies for final disposition. (T-2) Ensures medical and occupational restrictions are relayed to supervisors without revealing sensitive information. (T-2)

2.11. Member's Supervisor. Actively supports this AFI and coordinates with MTF personnel to ensure completion of required examinations and follow-up testing of their subordinates. (T-2) The supervisor is encouraged to implement recommended temporary medical and occupational restrictions until removed or restrictions expire. (T-2) **Note:** ANG coordinates with MDG Personnel and ensures member follows up with Civilian Primary Care Manager for care as needed. (T-2)

2.12. Member. Meets scheduled medical appointments as directed. (T-2) Member should inform unit supervisor of required follow-up evaluations and appointments. Reports and submits all medical/dental treatment obtained through civilian sources and any medical condition that might impact utilization and readiness of personnel to the assigned Primary Care Element team or ARC medical unit. (T-1) See [Chapter 10](#) for additional guidance regarding ARC members.

Chapter 3

TERM OF VALIDITY OF MEDICAL EXAMINATIONS

Section 3A—Term of Validity

3.1. Administrative Validity. Reports of medical examination are considered administratively valid as follows:

3.1.1. Enlistment. Physical examination is within 24 months of date of entry on active or ARC duty. **Note:** A physical examination for accession accomplished by MEPS is valid for two years regardless of certification date. The validity is based on the date of examination versus date of certification.

3.1.2. Commission:

3.1.2.1. The USAFA entrance physical may be utilized as the commissioning physical with the following additions: The cadet's medical condition must not have changed significantly since the entrance physical; all laboratory tests for DNA, HIV and drug/alcohol tests must have been accomplished during the cadet's tenure; a DD Form 2807-1 must be completed prior to commission; a focused medical examination must be performed if clinically indicated. Initial flying or SOD physicals must still be performed in their entirety. (T-1)

3.1.2.1.1. Air Force Academy. Physical examination is medically certified/waived within 24 months of date of entry into the Academy.

3.1.2.2. Civilian applicants. Physical examination is within 24 months of date of entry on to active or ARC duty. **Note:** A physical examination for accession accomplished by MEPS is valid for two years regardless of certification date. The validity is based on the date of examination versus date of certification.

3.1.2.3. Entry into Professional Officers Course (POC), AFROTC, USUHS, or HPSP scholarship. Physical examination is medically certified/waived within 24 months of date of entry into the program.

3.1.2.4. AFROTC, HPSP, Air Force Academy program graduates: commissioning physical examination is valid for 48 months from the date certified.

3.1.2.5. ARC members. Applicants accessed into the ARC from any service component must provide a current AF Form 422 or equivalent (within six months) to include PULHES, current DD Form 2697, *Report of Medical Assessment* and their last PHA.

3.1.2.5.1. Change in commission status for applicants for the Reserve program will be certified by ARC/SG, regardless of break in service.

3.1.2.6. AD service members who are applying for commission must have a current PHA. ARC members applying for commission must have a current PHA.

3.1.2.7. Certification for Reserves for AGR tours is the Reserve Medical Unit. Delegation of this certification authority is extended only to those Reserve Medical units responsible for providing physical exam support.

3.1.2.8. ARC/SG is waiver authority for all Regular AF members entering the ARC. Before Regular AF members will be considered for waiver for the ARC, all disqualifying defects must be appropriately evaluated for Fitness For Duty (FFD) IAW **Chapter 5**, Medical Standards Directory. Waiver by the AD authority does not guarantee waiver for AF Reserve duty.

3.1.2.9. The appropriate ARC/SG, or delegated authority, is the certification/waiver authority for AGR tour applicants not meeting standards in **Chapter 5**, Medical Standards Directory; or **Chapter 6, Section 6G**; MAJCOM level tours; and AGR tours with no supporting ARC medical unit.

3.1.3. **Flying Training.** Undergraduate Flying Training (UFT) includes all variants of Specialized Undergraduate Pilot Training (SUPT), Combat Systems Operator , Undergraduate Air Battle Manager Training (UABMT) and Undergraduate Remotely Piloted Aircraft Training (URT) training. Undergraduate Pilot Training (UPT) refers to applicants for pilot (manned). Examination (Flying Classes I and IA) must be current within 48 months prior to starting UPT/UNT. Examination (Flying Classes II) must be current within 48 months prior to starting URT. The 48 month period begins from date of certification/waiver of the physical examination (e.g. AETC/SGPS certifies examination on 1 Jan 2008. The 48 month period expires 1 Jan 2012.). Medical history (DD Form 2807-1) must be verified as current within 12 months prior to start of training. Service member must have a current PHA in addition to certified IFCI/IA. An initial certification examination does not exempt service applicants from accomplishing their required PHA while awaiting training. **Note:** If a member has an IFCI/IA examination and later applies for a flying or SOD duty that does not have to meet IFCI/IA standards, the IFCI/IA examination is valid for four years and no supplement is needed.

3.1.3.1. UPT applicants must meet Flying Class I standards to be eligible for entry into the Medical Flight Screening (MFS) program. URT pilot applicants must meet IFC II standards to be eligible for Medical Flight Screening-Neuropsychiatric (MFS-N) screening. Currently rated RPA applicants who previously completed MFS in conjunction with IFC I/IA and are in active flying assignments must meet IFC II standards but do not require repeat MFS-N screening.

3.1.3.2. All initial applications for UPT must pass MFS prior to beginning UPT.

3.1.3.3. All initial applications for URT must pass MFS-N prior to beginning URT. MFS for RPA pilot applicants will be limited to conditions requiring further evaluation (MFS-N is mandatory and may include enhanced MFS-N screening if appropriate).

3.1.3.4. Pilot and Navigator candidates must have a current, certified Flying Class I/IA examination, respectively, on record. AETC/SGPS will retain waiver authority for UPT/UNT students from successful completion of an IFC physical and MFS, until they graduate from UPT and are awarded a pilot AFSC. **Note:** While attending UPT/UNT training FCI/IA standards (as appropriate) apply. Upon UPT graduation FCII standards apply.

3.1.3.5. Flight surgeon and URT applicants must have a current, certified IFCII examination on record and be qualified for FCII duties while attending training and upon graduation.

3.1.3.6. The member's PHA should be current prior to beginning active UPT/URT. If a member was not on AD (e.g. AFROTC/OTS candidates) prior to arrival at UPT/URT or is otherwise not PHA current, then member will have PHA accomplished during in-processing at the UPT/URT base. PHA currency must be maintained throughout UPT/URT. See AFI 44-170 for additional details.

3.1.4. **Continued Flying.** Flying and Special Duty Operations personnel will follow existing guidance in AFI 44-170. Required examinations for these personnel are in sync with current PHA and IMR reporting business rules. The initial flying/SOD physical may also count as the commissioning physical as long as all requirements of the commissioning physical are met.

3.1.5. **Inactive Flyers.** Inactive flyers that do not receive aviation pay IAW AFI 11-402, *Aviation and Parachutist Service, Aeronautical Ratings and Aviation Badges* are not required to maintain Flying Class II standards as outlined in **Chapter 6**, and the Medical Standards Directory. Inactive Career Enlisted Aviators and Special Operator Duty (SOD) personnel that do not receive aviation pay IAW AFI 11-402 are not required to maintain their appropriate standards as outlined in **Chapter 6**, Medical Standards Directory. A flight surgeon may complete aeromedical waivers for inactive flyers or SOD if member intends to return to active status IAW **Chapter 6**, Medical Standards Directory. See **6.8.6** for additional details.

3.1.6. **Individuals selected to attend UPT and currently assigned to a non-rated position pending UPT report date.** If the start of UPT will be more than 48 months from the date of the certification of the original flying class I or IA physical examination, a new flying class I or IA exam will be required with certification by HQ AETC/SGPS. The requirements outlined in paragraph **3.1.3** and its sub-paragraphs apply.

3.1.7. Individuals selected to attend URT and currently assigned to a non-rated position pending URT report date. If the start of URT will be more than 48 months from the date of the certification of the original flying class II physical examination, a new flying class II exam will be required with certification by HQ AETC/SGPS. The requirements outlined in **paragraph 3.1.3** and its sub-paragraphs apply.

3.1.8. **Return-or entry (from ARC) to-AD Programs:**

3.1.8.1. Rated Recall Applicants: Participants in a Voluntary Rated Recall Program must meet IFCII/III standards and retention standards as appropriate to crew positions. Document the appropriate flying class physical in PEPP, and if a waiver is required, submit through AIMWTS. AETC/SG for AD is the enlistment/commissioning accession authority. See **Attachment 2, Table A2.1** for certification/waiver authority.

3.1.8.1.1. IFC physical is not required if the applicant separated from AD within 6 calendar months. Their last PHA must be valid through the date of re-entry or a new IFCII/III physical will be required.

3.1.8.2. Airmen entering AD following a break in service, must have an initial enlistment/commissioning/aviation (if appropriate) physical examination documented in PEPP if they have been off AD or incurred a break in service for more than 6 months. If they have been off AD for less than six months, a current/valid PHA is required. If aviation waiver is required, submit through AIMWTS. AETC/SG is the

enlistment/commissioning accession authority for AD. **Note:** See [5.2.2](#) and [Attachment 2, Table A2.1](#)

3.1.8.3. Airmen entering AD following ARC tours, must have an initial enlistment/commissioning/aviation (if appropriate) physical examination documented in PEPP if they have incurred a break in service for more than 6 months. If their break in service is less than six months, a copy of a current/valid PHA and a current AF Form 422 that reflects WWQ must be attached in PEPP. Examining facility will also complete the demographics tab in PEPP and the signature tab and forward to AETC/SG. If aviation waiver is required, submit through AIMWTS. AETC/SG is the enlistment/commissioning accession authority. **Note:** See [5.2.2](#) and [Attachment 2, Table A2.1](#)

3.1.9. **All other initial examinations.** All other initial examinations, including Flying Class III, Flying Class II (flight surgeon duties and RPA pilot), SOD, GBC, RPA Sensor Operator (1U0X1), and MOD are valid for 48 months from date of certification/waiver. If the certified physical examination will expire during formal technical training, the examination may be extended by the local SGP until completion of formal training. See AFI 44-170 for PHA examinations. (T-2)

3.1.10. **Non-rated applicants for flying duty (Class III),** who are currently medically qualified and performing flying duty, do not require additional review and certification or reexamination unless the individual is applying for Inflight Refueling Duty, Survival, Evasion, Resistance, and Escape (SERE) Specialist, Combat Control Duty, Pararescue Duty, Combat Rescue Officer (CRO), or the individual is on a medical waiver. The current examination and/or waiver is valid through its expiration date.

3.1.10.1. For those on a medical waiver a renewal must be submitted to HQ AETC/SGPS through AIMWTS with the most recent flying PHA with full medical history. (T-1) Based on review by HQ AETC/SGPS a full physical may be required.

3.1.11. **PHA's.** General Officers, Aircrew, SOD, ARC Personnel, AD personnel, and Operational Support Flyers. PHA is valid as specified in AFI 44-170. AF/SG or delegated authority as dictated by mission requirements may extend the PHA expiration (See AFI 44-170).

3.1.12. **PHA less than 12 months.** ARC members ordered to EAD with the regular AF do not need a physical examination since they need only meet standards in **Chapter 5**, Medical Standards Directory. Most recent PHA can be used for determining suitability to be mobilized.

3.1.13. **Interservice transfers.** Interservice transfers of officers to the United States Air Force and the United States Air Force Reserve must be IAW AFI 36-2004, *Interservice Transfer of Officers to the United Air Force (USAF) and to the United States Air Force Reserve (USAFR)*.

Chapter 4

APPOINTMENT, ENLISTMENT, AND INDUCTION

Section 4A—Medical Standards for Appointment, Enlistment, and Induction

4.1. References. DoDI 6130.03, *Medical Standards for Appointment, Enlistment or Induction in the Military Services*, <http://www.dtic.mil/whs/directives/corres/pdf/613003p.pdf>, establishes basic medical standards for enlistment, appointment, and induction into the Armed Forces of the United States according to the authority contained in Title 10, United States Code, Section 113. DoDI 6130.03. sets forth the medical conditions and physical defects that are causes for rejection for military service. These standards are not all inclusive and other diseases or defects can be cause for rejection based upon the medical judgment of the examining healthcare provider.

4.1.1. Personnel rejected for military service for any medical condition or physical defect listed in DoDI 6130.03 may be reviewed if the condition has resolved and a history of the condition is not disqualifying IAW this AFI.

4.1.2. DoDI 6130.03. directs utilization of the International Classification of Disease (ICD) in all records pertaining to a medical condition that results in a personnel action, such as separation or medical waiver. In addition, when a medical condition standard is waived or results in a separation, written clarification of the personnel action must be provided using standard medical terminology.

4.1.3. In accordance with DODI 1308.03, *DoD Physical Fitness and Body Fat Programs Procedures*, weight and height remain part of accession physical standards. See **Chapter 6**, and the Medical Standards Directory for additional requirements for flying applicants.

4.2. Applicability. These standards apply to:

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

4.2.2. Applicants for enlistment in the regular Air Force. Includes medical conditions or physical defects predating original enlistment, for the first six months of AD in the regular Air Force.

4.2.3. Applicants for enlistment in the Reserve or Air National Guard. For medical conditions or physical defects predating original enlistment (existing prior to service (EPTS)), these standards apply during the enlistee's initial period of AD for training until their return to their Reserve Component Units.

4.2.4. Applicants for reenlistment in Regular Air Force and ARC after a period of more than 6 months have elapsed since separation.

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

4.2.6. Retention of cadets at the United States Air Force Academy and students enrolled in the ROTC scholarship programs.

4.2.7. AFROTC graduates whose AD is delayed under applicable directives.

4.2.8. All individuals being inducted into the Armed Forces.

4.2.9. Individuals on TDRL who have been found fit upon reevaluation and wish to return to AD. The prior disabling defect or defects, and any other physical defects identified before placement on the TDRL that would not have prevented reenlistment, are exempt from this directive. **Note:** Individuals on TDRL are considered “retired” and thus have left AD, (most likely for a period of at least 6 months before their first re-examination as a TDRL designated member), and therefore, fall under accession standards prior to re-entering military service.

Chapter 5

CONTINUED MILITARY SERVICE (RETENTION STANDARDS)

Section 5A—Medical Evaluation

5.1. Medical Evaluation for Continued Military Service (Retention Standards). This chapter and the Medical Standards Directory include medical conditions and defects that are potentially disqualifying and/or preclude continued military service. These standards are not all inclusive and other diseases or defects can be cause for rejection based upon the medical judgment of the examining healthcare provider. Airmen with conditions listed in this chapter and the Medical Standards Directory require evaluation for continued military service (See paragraph 5.3). Other physical and mental conditions that render an individual unsuited for duty or otherwise interfere with military service do not constitute a physical disability. These conditions are not eligible for DES processing. See AFI 36-3208, para 5.11 and AFI 36-3212 for further instructions.

5.1.1. **For AD.** Potentially disqualifying medical conditions and defects are reviewed by the Deployment Availability Working Group (DAWG) IAW AFI 10-203 and AFI 41-210.

5.1.2. **For ARC.** Potentially disqualifying defects must first be determined if the condition is in the Line of Duty IAW AFI 36-2910, *Line of Duty (Misconduct) Determination*. If defects are found to be In Line of Duty, processing occurs through the AD process in paragraph 5.1.1 of this AFI. Potentially disqualifying defects that are not In Line of Duty require a fitness for duty evaluation and must be accomplished through the respective ARC/SG. All medical conditions and defects are reviewed by the Deployment Availability Working Group (DAWG), IAW AFI 10-203.

5.2. Applicability. The retention standards apply to:

5.2.1. Regular Air Force members on AD, unless excluded from DES by applicable directives (e.g. Punitive actions).

5.2.1.1. USAFA Cadets' retention standards for continued training at the Academy are the accession medical standards IAW DoDI 6130.03. If a USAFA Cadet has their accession medical standard waived, retention medical standards apply for that condition IAW 48-123 Chapter 5 and the Medical Standards Directory. If the Cadet does not meet accession standards and they are not waived, then Cadet is subject to DES processing in accordance with 10 U.S.C. § 1217 and AFI 36-3212.

5.2.2. All individuals who have separated or retired from AD with any of the regular Armed Services, but who are reenlisting in the regular Air Force or ARC when no more than 6 months have elapsed between separation and reenlistment. If more than 6 months have elapsed Chapter 4 applies.

5.2.3. ARC and retired regular members if mobilized or otherwise recalled to AD.

5.2.4. ARC members who are:

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

5.2.4.2. Ordered to EAD with the regular Air Force and who are eligible for fitness for duty evaluation under applicable directives.

5.2.4.3. Reenlisting in the regular Air Force when no more than 6 months have elapsed between release from EAD with any regular Armed Service and reenlistment or entry. If more than 6 months have elapsed **Chapter 4** applies.

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

5.2.4.5. AFRC members entering AGR tours. ANG members entering EAD statutory tours (Title 10) or AGR tours (Title 32).

5.2.5. **Air Reserve Components.** The appropriate ARC/SG IAW **Attachment 2** uses the standards in **Chapter 5**, Medical Standards Directory, and the list of allowable prescribed medications to determine:

5.2.5.1. The medical qualification for continued military duty in the ARC for members not on EAD and not eligible for disability processing.

5.2.5.2. The medical qualification of officers and enlisted members from any service component requesting entrance into USAFR and ANG.

5.2.5.2.1. The medical qualification of officers and enlisted members from any service component requesting entrance into the ANG provided no more than 6 months have elapsed between separation from the service component and entry into the ANG.

5.2.5.2.2. If more than 6 months (from date of separation) have elapsed, applicants must meet the standards of **Chapter 4**

Section 5B—Medical Standards for Continued Military Service (Retention Standards)

5.3. Standards. While this is not an all-inclusive list of disqualifying conditions, conditions and defects listed in **Chapter 5** and the Medical Standards Directory are potentially disqualifying and/or preclude continued military service. The standards and other diseases or defects not specifically listed can be cause for rejection based upon the medical judgment of the examining physician or reviewing authority. Retention standards also require members to be fit for mobility status IAW **Chapter 11**. For AD Airmen and ARC Airmen with duty-related (line-of-duty-yes conditions), refer members with disqualifying conditions to the DAWG. For I/RILO and MEB processing, see AFI 41-210 and **5.3.2** For ARC members with non-duty-related (line-of-duty-no) refer members with disqualifying conditions to the DAWG for Fitness for Duty evaluation, see **Chapter 10**. For Airmen returning to AD who do not meet retention standards but are eligible for an assignment limitation code, AETC/SG will coordinate with AFPC/DPANM through evaluation for Assignment Limitation Code C (ALC-C) for potential assignment restrictions. While elective surgery by itself is not necessarily disqualifying, intentional effects and unintended complications from elective surgery may render an individual unfit for WWD. For elective surgery information, refer to AFI 44-102, *Medical Care Management*. In addition, non-emergent elective surgeries within 6 months of separation or retirement must have additional prior approval by HQ AFPC/DPANM, as required IAW AFI 41-210.

5.3.1. General and Miscellaneous Conditions and Defects.

5.3.1.1. The individual is precluded from a reasonable fulfillment of the purpose of his or her employment in the military service.

5.3.1.2. The individual's health or well-being would be compromised if he or she were to remain in the military service. This includes, but is not limited to: dependence on medications or other treatments requiring frequent clinical monitoring, special handling or severe dietary restrictions.

5.3.1.3. The individual's retention in the military service would prejudice the best interests of the government. Questionable cases are referred to AFPC/DPANM or to the appropriate ARC/SG for those ARC members who are not on EAD and are not authorized disability processing.

5.3.1.4. The individual has an EPTS defect/condition which requires surgery, but the residuals of surgery may affect his/her retainability. In such cases, surgery may not be done until the expected results have been evaluated via I/RILO or MEB, and the member has been returned to duty.

5.3.1.5. Individuals requiring exemption from one or more components of the fitness test for greater than one year do not require I/RILO or MEB unless the underlying condition or limitation does not meet retention or deployment standards.

5.3.1.6. The individual's travel by military air transportation is precluded for medical reasons.

5.3.1.7. The individual has an assignment, TDY or deployment canceled due to a medical condition. Present case to the DAWG within 10 calendar days IAW AFI 41-210. The DAWG will evaluate if member meets retention medical standards or if deployment limiting condition will resolve within 365 days. If not, the DAWG must refer cases to AFPC/DPANM, AFRC/SGP or ANG/SGP. (T-1)

5.3.1.8. The individual continues to have a mobility limiting condition 1 year (cumulatively) after the defect became limiting and has not yet met an I/RILO/MEB or Fitness for Duty (FFD).

5.3.1.9. The individual has been hospitalized 90 calendar days and return to duty within 3 more months is not expected. I/RILO or FFD should be sent to AFPC/DPANM or appropriate ARC/SGP as determined by the DAWG.

5.3.1.10. The individual refuses required medical, surgical, or dental treatment or diagnostic procedures and the condition renders them not qualified for retention and/or mobility.

5.3.1.11. The individual requires determination of his or her competency for pay purposes.

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

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

5.3.1.14. A commander can refer a service member's case to the DAWG through the DAWG Chair or PEBLO, if a commander feels an individual's medical or mental health condition causes sufficient absence from duty that it interferes with mission accomplishment, poor duty performance and/or deployment concerns.

5.3.2. The following conditions require I/RILO or FFD initiation within 90 days of diagnosis: All members with organ failure requiring transplant or extensive medical treatment, brain injury with significant permanent physical or cognitive impairment, psychosis, bipolar or other mental health condition that will likely significantly impact member's ability to perform AFSC duties long-term, amputation of a limb, burns greater than 20% of body surface area (other than first degree) or resulting in loss of function or inability to wear personal protective equipment, blindness (bilateral, not just single eye), any terminal illness, seizure disorder, Acquired Immune Deficiency Syndrome (not just HIV positive), neoplastic diseases (a diagnosis of cancer or neoplastic disease may require additional time to establish a clear prognosis, will require lengthy treatment, or will be unable to perform his/her job for a protracted period of time), insulin dependent diabetes, and any other potentially career-ending condition. See AFI 41-210 for additional guidance.

5.3.3. General Conditions That Interfere With Military Service.

5.3.3.1. Certain conditions render an individual unsuited for duty, rather than unfit, and are subject to administrative separation since these conditions may interfere with military service. These conditions cannot be entered into the Integrated Disability Evaluation System (IDES). Consult AFI 36-3208 and DoDI 1332.38 for details and specific cases.

5.3.3.2. If a service member has a history of anaphylaxis and/or severe reactions requiring venom immunotherapy, although unsuited conditions, the service member will require an I/RILO or FFD for ALC-C consideration if retained and not administratively separated. (T-1)

Chapter 6

FLYING AND SPECIAL OPERATIONAL DUTY

Section 6A—Medical Examination for Flying and Special Operational Duty (SOD)

6.1. Flying and SOD Examinations.

6.1.1. Medical Classifications. All Air Force or ARC applicants requesting an Air Force flying or SOD physical examination must process through an Air Force MTF, ARC MDG, or MFS (as applicable) to have their physical examinations/waivers processed. (T-1) All of these physicals will be processed using PEPP and AIMWTS if a waiver is required. (T-1) Any exception to accomplishing these exams at facilities other than Air Force facilities must be coordinated with AETC/SGPS. ARC FCIII applicants may be processed through the ARC medical unit. **Note:** Additional instructions on how to complete initial sister service flying or special duty examinations see the Sister Service Examination page on the Knowledge Exchange.

6.1.1.1. Flying Class I qualifies for selection into MFS, and once MFS is passed, commencement of UPT.

6.1.1.2. Flying Class IA qualifies for selection and commencement of Undergraduate Navigator Training (UNT) and initial medical qualification for 12SX Special Operations Combat Systems Officer.

6.1.1.3. Flying Class II qualifies:

6.1.1.3.1. For selection into URT and flight surgeon training.

6.1.1.3.2. Rated officers for continued flying duty (pilots, RPA pilots, navigators/electronic warfare officers, 12SX Special Operations Combat Systems Officer and flight surgeons).

6.1.1.4. Categorical Flying Class II qualifies rated officers for duty in certain restricted aircraft categories. Granting categorical waivers does not guarantee operational utilization. Restrictions for FCIIA, FCIIIB, FCIIIC, and FCIIU will be documented in the remarks section of the AF Form 1042 or DoD equivalent. (T-1)

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

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

6.1.1.4.3. Flying Class IIC qualifies rated officers for aviation duty as specified in the remarks section of AF Form 1042 or DoD equivalent, as annotated on the DD Form 2808 or in AIMWTS. Example: Restricted to multi-place aircraft.

6.1.1.4.4. Flying Class IIU qualifies rated officers for duty as URT and RPA pilot duties only.

6.1.1.5. Flying Class III qualifies individuals for aviation as indicated in the Air Force Officer Classification Directory (AFOCD), and the Air Force Enlisted Classification

Directory (AFECD). USAFA cadets participating in USAFA cadet airmanship program, see [6.24.6](#)

6.1.1.6. SOD exams qualify individuals for duties in which aviation is not their primary function but they must meet standards as described in [Chapter 6](#) if indicated in the AFOCD or AFECD.

6.1.2. Medical examinations are required when:

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

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

6.1.2.3. Personnel, including personnel of the ARC, are directed to participate in frequent and regular aerial flight as defined by AFI 11-401, *Aviation Management*. This includes civilian government employees as documented on the Position Description whom the hiring agent has determined must meet appropriate military flying/SOD medical standards.

6.1.2.4. Flying personnel, including personnel of the ARC, are suspended from flying status for 12 months or more for medical reasons and are applying for return to flying duties. For AD and ANG personnel use a PHA with AMS. For AFRC personnel use a DD Form 2808, DD Form 2807-1, and AMS for any disqualifying condition. **Note:** A complete initial qualification examination is not required.

6.1.2.5. Flying personnel are ordered to appear before a Flying Evaluation Board. Refer to AFI 11-402. For AD and ANG personnel use a PHA with AMS. For AFRC personnel use a DD Form 2808, and DD Form 2807-1. **Note:** Air sickness may be managed IAW AETCI 48-102, *Medical Management of Undergraduate Flying Training Students*. If there is no underlying medical pathology and patient remains unresponsive to the measures IAW AETCI 48-102, this becomes an administrative function.

6.1.2.6. Aviation service requalification. If the duration of medical disqualification was less than one year, the local flight surgeon clears the member for flying duty. If the duration of medical disqualification extended for at least one year but less than five years, forward to the gaining MAJCOM/SG, or HQ AFMSA/SG3PF as applicable for review and certification. If the duration of medical disqualification extended five years or longer, HQ AFMSA/SG3PF must certify for flying duty. All waivers forwarded to AFMSA must first go through the gaining MAJCOM/SG. Refer to AFI 11-402 for further information concerning aviation service requalification. See [6.4](#) for further information.

6.1.3. Medical Evaluation Scope.

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

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

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

6.1.3.1.3. For the following initial exams the examining flight surgeon handles disqualifying defects in the following manner:

6.1.3.1.3.1. Complete all Flying Class I and IA UFT, Initial Flying Class II (flight surgeon and RPA pilots), Initial Flying Class III, GBC, or MOD examinations, regardless of the nature of disqualifying defect. (T-1) Send completed DD Form 2808, applicable portions of the DD Form 2807-1, and all associated documents to the appropriate certifying authority or requesting agency. (T-1) The examining flight surgeon completely identifies, describes and documents the disqualifying defects and enters demographics and disqualifying diagnosis into PEPP and AIMWTS, include a brief AMS with pertinent information, signs, dates and forwards to certification/waiver authority as defined in [Attachment 2](#). (T-2) These exams must not be disqualified at the base but must be completed as noted above and forwarded to the certification and waiver authority. (T-1) **Note:** At any point when the examining flight surgeon learns of a medical disqualification, including during medical record review or when obtaining a medical history, the flight surgeon must complete the minimum documentation as described above. (T-1)

6.1.3.1.3.2. Forward aeromedical disqualifications of untrained assets to AETC and of trained assets to the MAJCOM/SG for review and disposition. Local medical facilities do not have disqualification authority for medical cause.

6.1.3.1.3.3. Incomplete physical examinations or those where the individual no longer is pursuing a Flying/SOD physical, should have the reason for termination and/or the attempts by the MTF to ensure the individual completes the examination documented in PEPP. The MTF Aerospace Medicine Specialist may sign the certification tab to complete the PEPP entry after indicating the exam is incomplete and/or examination or individual no longer requires physical examination. Indicate on the certification that service member is qualified for retention and is not qualified for Flying/SOD secondary to incomplete examination or that individual no longer requires a physical examination

6.1.4. MAJCOM/SG will notify AFMSA/SG3PF of disqualified cases (rated pilots only). AFMSA/SG3PF will notify Federal Aviation Administration (FAA) of medical disqualification for rated pilots only.

Section 6B—Waiver Information

6.2. General Waiver Information. For applicants applying for initial flying (all classes) and SOD who are not currently already in the military, accessions and enlistments standards in [Chapter 4](#) and the Medical Standards Directory apply as well as appropriate flying/SOD standards for which they are applying. [Chapter 5](#) and the Medical Standards Directory apply to personnel serving as AD or ARC (e.g., AD SSgt applying for IFCI duty must meet retention standards and IFCI standards as reflected in the Medical Standards Directory, standards noted in [Chapter 5](#) and [Chapter 11](#) of this AFI.). The medical conditions listed in the Medical Standards Directory and [Chapter 11](#) are cause to reject an examinee for entry into any rated ,not-rated, or career enlisted aviator crew position training(all classes), or continued flying duty/SOD unless a waiver is granted. Additional information concerning aeromedical waivers can be found in the aircrew waiver guide. Acute medical problems, injuries, or their appropriate therapy are cause for withholding certification for entry into any rated ,not-rated, or career

enlisted aviator crew position training, or temporarily restricting the individual from flying until the problem is resolved, using AF Form 1042 or DoD equivalent. 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.

6.2.1. To be considered waiverable, any disqualifying condition must meet the following criteria:

- 6.2.1.1. Not pose a risk of sudden incapacitation. (T-1)
- 6.2.1.2. Pose minimal potential for subtle performance decrement, particularly with regard to the higher senses. (T-1)
- 6.2.1.3. Be resolved or stable, and expected to remain so under the stresses of the aviation environment. (T-1)
- 6.2.1.4. 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. (T-1)
- 6.2.1.5. Cannot require exotic tests, regular invasive procedures, or frequent absences to monitor for stability or progression. (T-1)
- 6.2.1.6. Must be compatible with the performance of sustained flying operations. (T-1)

6.3. Waiver of Medical Conditions. The individuals and organizations with authority to grant a waiver for medically disqualifying defects are listed in [6.4](#) and [Attachment 2](#). Controversial or questionable cases, and cases that fall outside of the parameters set by this instruction and the Medical Standards Directory, will be referred to AFMSA/SG3PF at the discretion of the MAJCOMs.

6.3.1. Term of Validity of Waivers.

- 6.3.1.1. The waiver authority establishes the term of validity of waivers.
- 6.3.1.2. An expiration date is placed on a waiver for any conditions that may progress or require periodic reevaluation.
- 6.3.1.3. Waivers are valid for the specified condition. Any significant exacerbation of the condition, or other changes in the patient's medical status, automatically invalidates the waiver, and they are placed in Duties Not Including Flying/Controlling (DNIF/DNIC) status until the medical evaluation is complete, and a new waiver is requested and approved.
- 6.3.1.4. If a condition resolves and member is qualified by appropriate standards, or the condition no longer requires a medical waiver, and the individual has no other conditions requiring medical waiver, retire the waiver using AIMWTS with concurrence of waiver granting authority. (T-2) The individual who retires the waiver must annotate reason and MAJCOM point of contact who concurred (by name including the office symbol) in the "Reason for Retirement" block, before signing in AIMWTS. (T-1)

6.4. Waiver Authority.

6.4.1. AFMSA/SG3PF retains waiver authority as follows:

6.4.1.1. All initial and renewal categorical flying waivers; changes from one category to another; removal of a categorical restriction. Exceptions are for specific cases where AFMSA/SG3PF delegates to MAJCOM or in an official delegation letter from AFMSA/SG3PF (maintained on the KX). These cannot be further delegated to the base level.

6.4.1.2. All initial waivers in cases previously certified as medically disqualified by AFMSA/SG3P or MAJCOM/SG (rated officer or career enlisted aviator).

6.4.1.3. All initial waivers for conditions that do not meet retention standards listed in **Chapter 5**, and the Medical Standards Directory unless specifically delegated by AFMSA/SG3PF, this AFI, or other official delegation letter to the MAJCOM/SG.

6.4.1.4. All initial waivers for conditions referred to the Aeromedical Consultation Service (ACS), except as noted in official delegation letter from AFMSA/SG3PF and **6.4.1.4.1**

6.4.1.4.1. MAJCOM/SG may grant initial and may renew waivers for all routine ACS clinical management group evaluations as defined by the ACS, 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 AFMSA/SG3PF.

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

6.4.1.5. All cases where the ACS recommends medical disqualification regardless of waiver authority (rated only).

6.4.1.6. All flying class and SOD personnel's initial waivers for maintenance medication, except those listed in "Official Air Force Aerospace Medicine Approved Medications". See section **6I** for MOD personnel.

6.4.1.7. All flying waivers and disqualifications on general officers, regardless of diagnosis. AFMSA/SG3PF will forward a copy of any general officer categorical waiver action to: AF/DPG 1040 Air Force Pentagon, Washington DC 20330-1040. **Note:** ARC does not have a requirement to forward categorical waivers to AF/DPO or AF/DPG.

6.4.1.8. Any controversial condition that in the opinion of the MAJCOM/SG warrants an AFMSA/SG3P decision.

6.4.1.9. AFMSA retains certification/waiver authority for all color vision and depth perception deficiencies for all flying/SOD classes unless otherwise delegated. **Note:** Enlisted flying criteria are guided by the AFSC Career Field Manager at AF/A3.

6.4.1.10. AFMSA/SG3P retains waiver authority for all flying classes/SOD for immunodeficiency syndromes (primary or acquired) and confirmed presence of HIV or antibody.

6.4.1.11. If AFMSA/SG3P disqualifies a service member, then second waiver requests for previously disqualified conditions are considered on a case-by-case basis only, and waiver authority for these individuals is AFMSA/SG3P.

6.4.1.12. All cases where an active flight surgeon or candidate for flight surgeon does not meet FC II standards and is unable to obtain a FC II waiver.

6.4.1.13. 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 AFMSA/SG3P.

6.4.1.14. For cases in which AFMSA/SG3PF is waiver authority, interim waiver or waiver extension authority by subordinate commands is specifically denied unless specifically delegated by AFMSA/SG3PF for a specific case or in a delegation letter.

6.4.2. MAJCOM retains waiver authority as follows:

6.4.2.1. MAJCOM certification and waiver authority for flying and SOD medical standards may only be accomplished by a specialist in aerospace medicine. MAJCOM/SGs who are not an Aerospace Medicine Specialist (AFSC 48A) will delegate their authority to an Aerospace Medicine Specialist on their staff. If the MAJCOM/SG is an Aerospace Medicine Specialist (AFSC 48A), authority may be delegated to qualified Aerospace Medicine Specialists (AFSC 48A) on their staff. When MAJCOM/SG desires to delegate MAJCOM Aeromedical Waiver authority to a Senior Flight Physician who is not an Aerospace Medicine Specialist, a waiver can be requested by MAJCOM/SG from AFMSA/SG3PF for a Senior Flight Surgeon to be delegated as a MAJCOM Aeromedical Waiver Authority.

6.4.2.2. MAJCOM/SG or delegated authority may grant initial and renewal waivers for all routine ACS clinical management group evaluations as defined by this AFI.

6.4.2.2.1. If delegated to the MAJCOM, categorical waivers (except IIC for pregnancy) for grade below Colonel need a copy of the waiver action sent to AFPC/DPAOT3, 550 C Street West Ste 31, Randolph AFB, TX 78150. Categorical waivers (except IIC for pregnancy) for Colonel (0-6) need a copy of the waiver action sent to: AF/DPO 1040 Air Force Pentagon, Washington DC 20330-1040. All FCIIC waiver actions delegated to MAJCOM/SG require memorandum cover letter by MAJCOM/SG be forwarded to AF/SGE, Attn: AFMSA/SG3PF, 1780 Air Force Pentagon, Washington DC 20330-1780 and USAF/A3OT, 1480 AF Pentagon Washington, DC 20032-1480, to include FCIIC waiver renewals. Ensure the categorical restrictions are contained in the memorandum. **Note:** ARC does not have a requirement to forward FCIIA, FCIIIB, FCIIIC, and FCIIU waivers to AF/DPO or AF/DPG.

6.4.2.3. Medical waiver authority has been delegated to the MAJCOM to which the member is assigned for duty unless specifically noted in [6.4.1](#) For example a member's MAJCOM is ACC, but they are assigned Permanent change of Station (PCS) to USAFE. The gaining MAJCOM (USAFE) becomes the certification and waiver authority in accordance with **Table A2.1**. If the member belongs to a tenant unit of one MAJCOM and the tenant unit is on the base of another MAJCOM, then the medical waiver belongs to the tenant unit's MAJCOM. For example a C-21 pilot stationed at Keesler AFB (AETC) is a member of the AMC tenant unit located at Keesler AFB; AMC is the waiver authority for delegated conditions.

6.4.2.4. Responsibility for medical waivers has been delegated as follows: Air Force District of Washington (AFDW) is delegated to AMC/SGP. Others: Air Force Element (AFELM), Defense Intelligence Agency (DIA), Air Force Operational Test and Evaluation Center (AFOTEC), if not otherwise specified in [Table A2.1](#) will be the medical facility's MAJCOM/SG that submits the aeromedical waiver examination package. Waiver authority for Air Force Inspection Agency (AFIA) is delegated to AFIA/SG when that position is filled by an Aerospace Medicine Specialist (AFSC 48A). Medical waiver authority for personnel assigned to USSOCOM is delegated to AFSOC/SG. Medical waiver authority for personnel assigned to NORTHCOM is delegated to AFSPC/SG.

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

6.4.3.1. Command and USAFA surgeons may delegate waiver authority to another command surgeon or to a Residency Trained Aerospace Medicine specialist working on that MAJCOM staff (Aerospace Medicine Specialist (AFSC 48A), AFSC 48A3/48A4 or ARC 48R3/48R4). Exceptions will be approved by AFMSA/SG3P. Command surgeons IAW 2.3.3. may delegate base level (local) waiver authority to the installation Aerospace Medicine Specialist or most qualified Flight Surgeon, most likely the SGP. Waiver delegation will indicate authority based on residency trained Aerospace Medicine Specialist (Aerospace Medicine Specialist (AFSC 48A)) versus non Aerospace Medicine Specialist. **Note:** Authority to grant flying class III waivers to rated personnel who have been medically disqualified for flying class II is delegated to the member's MAJCOM/SG of assignment. See [6.4.1.11](#)

6.4.3.1.1. Local Base Certification/Waiver Authority (AD only). Flight surgeons as specifically identified by the MAJCOM of the member, normally the Chief of Aerospace Medicine (AFSC 48X3/4), retain this authority. (T-1) This authority will not be delegated further. (T-1) At locations with flight surgeons who do not meet this criteria, the certification/waiver authority reverts to the MAJCOM of assignment. Non-flight surgeons are not authorized to sign, or certify medical examinations. (T-1) Flight surgeons granted this authority by their MAJCOM may not certify/waiver ARC aircrew members. (T-1) **Note:** Limited scope MTFs may delegate to a supporting MTF's Senior Aeromedical Specialist with MAJCOM approval and delegation. (T-2)

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

6.4.3.2.1. Delegation of this certification authority is extended only to those Reserve Medical units responsible for providing physical exam support.

6.4.3.3. AD non-aircrew members transitioning into ARC flying positions must have their medical examinations certified by the appropriate ARC Surgeon.

6.4.3.4. Certification and waiver authority for USAF flying personnel while assigned to the National Aeronautics and Space Administration (NASA) is NASA.

6.4.3.5. AFMC/SG has certification and waiver authority on USAF Test Pilot School applicants and all USAF Flight Test Engineers (62E3F) and Development Engineers (61S), except as noted in [6.4.1](#) May be further delegated at AFMC/SG discretion.

6.4.3.6. AETC/SGPS is the certification and waiver authority for all ARC members entering AD in the regular Air Force. Before ARC members will be considered for waiver for AD in the regular Air Force, all disqualifying defects must be noted, reviewed, evaluated and waived by the ARC waiver authority. Waiver by the ARC authority does not guarantee waiver for regular Air Force duty.

6.4.4. Centralized Flying Waiver Repository (AIMWTS).

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

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

6.4.4.3. Flying waivers that are no longer required due to personnel separation and/or retirement should be allowed to expire.

6.4.5. Waivers for Enlisted Occupations.

6.4.5.1. The medical service does not make recommendations for medical waivers for entry or retention in non-flying or SOD AFSCs for those who fall below qualification standards imposed by personnel directives. Any flying or special operational restrictions/limitations must comply with [6.4.1.9](#) 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.

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

6.4.6. Submission of Reports of Medical Examination to Certification or Waiver Authority.

6.4.6.1. Initial certification, waiver requests and disqualification recommendations for all flying, MOD and SOD examinations will be submitted using PEPP and/or AIMWTS. Submissions to the reviewing/certification authority using PEPP and/or AIMWTS must be accomplished simultaneously (e.g. do not submit AIMWTS without submitting physical in PEPP if you accomplished one). Supporting documents must be uploaded as attachments into these applications and forwarded to the reviewing/certification authority. Do not accomplish DD Form 2808, or PHA solely for the purpose of a waiver submission unless flight surgeon deems necessary, or directed by higher authority. **Note:** PHA, SF 600, *Medical Record – Chronological Record of Medical Care*, or DD Form 2808 must be accomplished according to the frequency in AFI 44-170 and is irrespective of waiver action. (T-1)

6.4.6.2. All waiver requests referred to AFMSA/SG3P must be submitted through the MAJCOM/SG. (T-1) MAJCOM/SG must provide a recommendation on the case to AFMSA/SG3P through AIMWTS in the forwarding remarks. If a waiver requires an ACS evaluation or review, the MAJCOM/SG must request the ACS evaluation/review. The MAJCOM/SG will not forward to AFMSA/SG3P until the ACS evaluation/review results are completed and documented in AIMWTS. **Note:** In the case of unapproved medications, MAJCOM/SG will send to AFMSA/SG3P who will review and determine appropriate action.

6.4.6.3. All waiver requests must include as a minimum: (T-1)

6.4.6.3.1. Aeromedical Summary with other supporting documents pertinent to the case included as attachments within AIMWTS additional guidance can be found in the Aircrew Waiver guide. (T-1)

6.4.6.3.2. If available, include the results of DPANM adjudication, indicating the member has been returned to duty following I/RILO or MEB/ Physical Evaluation Board (PEB). (T-1)

6.4.6.3.3. All waiver cases submitted must include any pertinent medical documentation from the member's civilian health care provider. Examining flight surgeon will review this information and reference it in the aeromedical summary. (T-1)

6.4.7. Routing of Dispositions:

6.4.7.1. The certifying authority certifies the AMS in AIMWTS. Flight medicine ensures a printed or electronic copy of the certified AMS document is placed into the electronic or paper health record IAW current guidance in AFI 41-210.

6.4.7.1.1. Trained Assets: Flight Medicine prepares, files, and forwards the AF Form 1042 or DoD equivalent with appropriate remarks indicating a waiver or disqualification as appropriate.

6.4.7.1.2. Initial flying waivers: Flight Medicine provides member or their designated authorized representative a copy of their initial medical examination to include with their training request.

6.4.7.2. MAJCOM/SG notifies AFMSA/SG3PF of disqualifications on rated pilots. See [6.1.4](#) for further information.

6.4.7.3. If certified disqualified (trained asset): A flight surgeon will advise the member they are medically disqualified from their flying or SOD, and provide the member with the AF Form 422, for use in retraining actions with the Military Personnel Flight. (T-2) Document the notification of disqualification in the health record. The member's unit must also be notified of the member's disqualification from flying or SOD. (T-1) The AF Form 422, AF Form 1042 if required by Host Aviation Resource Management (HARM) or DoD equivalent may be used, with appropriate comments in the remarks section of the AF Form 1042 or DoD equivalent of the member's permanent disqualification from flying and SOD.

6.4.7.4. Repatriated Prisoners of War (RPW). MSME sends a copy of each medical examination (DD Form 2808, DD Form 2807-1, or DD Form 2697) to USAFSAM/FEC, 2947 Fifth Street Wright-Patterson AFB, OH 45433-7913, and to the Office of Special Studies, Naval Operational Medicine Institute (NOMI), Code 25, NAS Pensacola, FL 32508-5600. **Note:** Include "RPW" on Report of Medical History form, as an additional purpose for examination.

Section 6C—Medical Recommendation For Flying Or Special Operational Duty or DoD equivalent

6.5. Applicability. Applies to each Air Force MTF or ARC medical squadron/Group providing support for flying or SOD personnel. Use AF Form 1042 or DoD equivalent to convey updates

and changes to medical qualification for flying or SOD. Flying or SOD 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 **6G**, **6H**, **6I**, and **6J**.

6.6. Authority to determine aeromedical dispositions. Non-flight surgeon medical providers may ground flying or SOD personnel via the AF Form 1042 or DoD equivalent. For all encounters with a non-FS, a DoD FS; must document review and aeromedical disposition of all non-flight surgeon medical providers' entries in the member's medical record. (T-1) A grounding AF Form 1042 or DoD equivalent initiated by a non-flight surgeon medical provider must be reviewed, countersigned and dated by the DoD FS, however, effective date will be the date issued. (T-1) Only a flight surgeon can return flying/SOD to flying/SOD or continue them on flying/SOD during/after a medical encounter IAW AFI 11-202V3, *General Flight Rules*. (T-1) **Exception:** HQ AF/SG delegates to the Medical Treatment Facility (MTF) Commander the authority to grant AFSOC Physician Assistants (PAs) working independently in support of Special Operations Command missions, aeromedical disposition privileges when deployed and without reasonable access to a FS preceptor, IAW AFI 48-149. (T-1)

6.6.1. Personnel on flying or SOD status who receive dental treatment will be managed IAW AFI 47-101, *Managing Air Force Dental Services*. Dental personnel will use AF Form 1418, *Recommendation for Flying or Special Operation Duty – Dental*, to notify the flight surgeon of recommended flying or special duty restrictions exceeding 8 hours. The reviewing flight surgeon should then initiate a DNIF via AF Form 1042 or DoD equivalent. (T-1) See AFI 47-101, Paragraph 6.16. for further details.

6.6.2. Aeromedical Disposition of ARC Personnel On Air Sovereignty Alert (ASA), Total Force Initiative (TFI) units or Federal RPA missions. ARC aviation personnel performing ASA, TFI, or operating large RPA systems in support of a Federal mission are eligible for AD grounding management (DNIF and RTFS) and care for acute medical conditions that if not addressed would negatively impact completion of that mission. **Note:** Routine medical care is not authorized and remains the responsibility of the Airman via his/her regular health care provider.

6.6.2.1. If a flight surgeon is not co-located with the flying operation, these aircrew may be seen by a non-flight surgeon health care provider (military or civilian). The aircrew must inform the provider that written or verbal communication of the details of the visit (including history, physical, and treatment provided) must be submitted to the appointed military flight surgeon immediately following the visit. (T-1) The flight surgeon may render an aeromedical disposition determination remotely if he/she has sufficient information, and after communicating both with the provider and the aircrew member. The flight surgeon must be confident that there has been sufficient resolution of symptoms and treatment side effects. (T-1) All relevant medical and medication standards still apply. Aeromedical disposition decision must be communicated immediately to the aircrew's unit. (T-1) The AF Form 1042 or DoD equivalent must be sent electronically to the aircrew's unit the morning of the next duty day. (T-1)

6.6.2.2. Aircrew and special duty personnel in locations not co-located with an AD base may be returned to flying status to perform alert, combat or National Air Defense duties when their unit flight surgeon is not available. These personnel may be returned to

flying/SOD status after being examined by a military or civilian physician via reach-back consultation with a military flight surgeon as designated by AFMSA/SGPF.

6.6.2.3. ANG or AFRC flight surgeons who maintain active credentials and privileges in Flight Medicine may use their Flight Medicine credentials to make aeromedical dispositions while employed in a civilian Flight Medicine physician role.

6.7. Prepare a new AF Form 1042 or DoD equivalent when an individual is:

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

6.7.2. Determined by a flight surgeon to be fit for RTFS or RTC/A (Return to Controlling/Alert) for SOD.

6.7.3. Medically certified for flying by appropriate review authority following disqualification.

6.7.4. Medically certified for continued flying/SOD following medical examinations.

6.7.5. To temporarily “ground” or clear aircrew following involvement in any class of aircraft mishap.

6.7.6. To permanently medically disqualify a member for flying or SOD.

6.7.6.1. Only after MAJCOM or higher authority certifies examination in AIMWTS, permanent disqualification authority is the same for waiver actions as noted in [Attachment 2](#). Also, refer to **6.1.3.1.3.2. Note:** An AF Form 1042 or DoD equivalent 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 or DoD equivalent is not received by the expiration date.

6.8. Form Completion:

6.8.1. AF Form 1042 or DoD equivalent must contain the date the individual is actually found certified. (T-1)

6.8.2. Date of the flight surgeon signature will serve as the date the action was accomplished. (T-1) For DNIF action signed by another provider the flight surgeon only needs to countersign the provider signature as the date the form was initiated needs to be the action date.

6.8.3. If the examination cannot be completed prior to expiration due to reasons beyond the member’s control, and the patient has a flying medical waiver that will expire, the examining flight surgeon may request a waiver extension from the appropriate MAJCOM/SG. If granted, a new AF Form 1042 or DoD equivalent must be accomplished to reflect the extension and sent to the member’s HARM Office as specified in this chapter. (T-1) **Note:** Only extensions in AIMWTS are authorized. If an extension to an existing waiver is warranted, waiver extension must be recorded in AIMWTS and a new waiver renewal initiated at base level. (T-1)

6.8.4. Flyers and SOD personnel unavailable for PHA secondary to deployment will follow guidance in AFI 44-170.

6.8.5. The remarks section of the AF Form 1042 or DoD equivalent can be used for local special purpose determinations, i.e., “May perform Supervisor of Flying duties,” with the determination based upon the flight surgeon’s assessment of the member’s mental alertness and physical capabilities. The remarks section of the 1042 may also be used by FS to comment on Special Tactics/Combat Rescue operator dispositions regarding jump, dive, control status/clearance as determined by the credentialed FS (ie...may control/dive, continue DNIF). The Remarks section of any AF Form 1042 or DoD equivalent leaving the MTF will not have member’s diagnosis or other protected health care information written or otherwise affixed in accordance with HIPAA rules. (T-0) Commanders must be advised to contact the flight surgeons office if more details about a member’s condition are required.

6.8.6. Inactive Flyers. Do not complete DNIF or RTFS on an AF Form 1042 or DoD equivalent for individuals in inactive aviation service categories. The exceptions are for individuals who are collecting flight pay or plan to go back to active flying. Completion of the AF Form 1042 or DoD equivalent for these exceptions notifies ARMS that member completed their PHA, potential permanent disqualifying condition is recognized, or an aeromedical waiver may be required.

6.9. AF Form 1042 or DoD equivalent Distribution:

6.9.1. Original to patient’s health record. For transient personnel, send the original and 2 copies to the individual’s home MTF flight medicine clinic for distribution.

6.9.2. Grounding management communications with operational units and HARM offices must be treated as Protected Health Information (PHI). (T-0) Release of this information to operational units, commanders and HARM offices is allowed under DoD 6025.18-R, *DoD Health Information Privacy Regulation*. This release of PHI must be documented as an accountable disclosure IAW AFI 41-210, Section 6D.

6.9.2.1. The ASIMS database is currently installed with a HIPAA-compliant documentation log for any releases of PHI sent via email notification from within ASIMS. All such actions automatically generate an electronic log entry to document each release of PHI. This function includes e-mail notification to operational flying/SOD units and HARM offices regarding AF Form 1042 or DoD equivalent grounding management actions.

6.9.2.2. In addition to email notifications, a signed copy of the AF Form 1042 or DoD equivalent must still be provided to the HARM office for inclusion in the member’s flight Record. This action constitutes its own release of PHI and must also be documented. To prevent unnecessary additional workload, the email notification template in the Grounding Management module of ASIMS states: “A signed copy of this grounding management action is also being forwarded to the HARM office for inclusion in the member’s Flight Record Folder.”

6.9.2.3. One copy to the local HARM Office (within 1 duty day) for flying/SOD personnel, or to the unit commander or supervisor for other personnel using the HIPAA compliant documentation log within the e-mail notification of the grounding management module.

6.9.2.4. One copy to the member's unit. **Note:** Flight medicine clinics maintain current and accurate unit and HARM office Point of Contact information in the email notification database as HIPAA requires the capability to identify all recipients of PHI.

6.9.2.5. One copy to the member.

6.9.2.6. Flying PHA performed by a non-AF flight surgeon requires review and certification by parent MAJCOM/SG if no AF flight surgeon is available at that location.

6.10. Disposition of Expired AF Form 1042 or DoD equivalent:

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

6.10.2. Remove previous PHA clearances when superseded by a new PHA clearance AF Form 1042 or DoD equivalent.

6.10.3. Do not remove AF Form 1042 or DoD equivalent recording a member's RTFS following a period of DNIF, medical clearance post mishap or return to flight status from the outpatient medical record. These must remain a permanent part of a member's medical record. (T-1)

6.11. 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 included within ASIMS.

6.12. General Officer Notification. The flight medicine PCM will notify their MAJCOM/SG or designee by telephone during duty hours when a general officer or wing commander is grounded. Reports will include: date of DNIF, 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. (T-2) Also, notify the MAJCOM/SG or designee when the GO or Wg/CC is RTFS. (T-2) **Note:** ANG does not require notification of the grounding of general officers or Wing Commanders.

6.13. Death Notification. The flight medicine PCM will notify their MAJCOM/SG or designee by telephone during duty hours when an aircrew or SOD member dies. (T-2) 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. (T-2)

Section 6D—Aeromedical Consultation Service (ACS)

6.14. General. The ACS conducts specialized aeromedical evaluations.

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

6.14.2. AD Air Force and ARC personnel on flying/SOD status, or as requested by the MAJCOM/SG or AFMSA/SG3P. Persons medically disqualified when approved by the MAJCOM/SG or AFMSA/SG3P.

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

6.14.4. 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).

6.14.5. At the discretion of the MAJCOM/SG or AFMSA/SG3P, initial ACS evaluations of inactive flyers only if reassignment to active flying is pending.

6.14.6. Army and Navy personnel with approval of U.S. Army Aeromedical Center (USAAMC) Fort Rucker, AL, or NOMI, Pensacola, FL.

6.14.7. Coast Guard personnel with approval of CG Health, Safety, and Work-Life Service Center (HSWL-SC) Operational Medicine (OM), Norfolk, VA.

6.14.8. Military personnel of foreign countries when approved by the State Department and AFMSA/SG3P.

6.14.9. Applicants for flying duty with approval by HQ AETC/SG or AFMSA/SG3P.

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

6.15. Referral Procedures.

6.15.1. Initial Evaluations: The referring flight surgeon prepares an aeromedical summary using AIMWTS. Once ACS evaluation is approved by either MAJCOM/SG or AFMSA/SG3PF, the ACS evaluation/review will be requested using AIMWTS. MAJCOMs will request the ACS evaluation and receive the results prior to submitting to AFMSA/SG3PF if AFMSA/SG3PF is the waiver authority. **Exception:** AFMSA will request the ACS evaluation if the waiver request is for an unapproved medication. **Note:** See waiver guide for information required for waiver submission. The appropriate mailing address is: U.S. Air Force School of Aerospace Medicine, 2510 5th Street, Bldg 840, Wright-Patterson AFB, OH 45433-7913.

6.15.2. 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 AFMSA/SG3P, using AIMWTS.

6.16. Scheduling Procedures.

6.16.1. 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 referral request. The ACS will only reschedule appointments due to mission essential reasons. Any requested documentation must be forwarded in sufficient time to reach the ACS 10 days prior to appointment. (T-2)

6.16.2. Members scheduled for ACS evaluations will be briefed by the referring local flight surgeon regarding ACS requirements and reporting instructions. (T-2) This responsibility may be delegated to MSME.

6.16.3. 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).

6.16.4. The orders state that the TDY is for aeromedical evaluation and that 10 days, in addition to travel time, is authorized.

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

6.17. Consultation Procedures.

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

6.17.2. The preliminary ACS report and recommendation patient status worksheet 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.

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

6.17.4. The final ACS report and recommendation 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.

Section 6E—Medical Flight Screening

6.18. Medical Flight Screening.

6.18.1. MFS is managed by the ACS and conducted at the ACS and the USAFA.

6.18.2. MFS uses additional advanced medical screening techniques (list of screening tests approved by AFMSA/SG3P 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/URT applicants must complete and successfully pass MFS/MFS-N or receive a waiver prior to starting UPT/URT Pilot training.

6.18.3. Detailed information regarding MFS can be found on the KX).

Section 6F—USAF Aircrew Corrective Lenses

6.19. General USAF Aircrew Contact Lens Policy. Aircrew are authorized to use contact lenses (CLs) for vision correction provided they are in compliance with the requirements detailed in the USAF Aircrew Soft Contact Lens (ACSCL) Program. For complete program details on routine contact lens use, specialized contact lens use, and authorized contact lens solutions, refer to the AF Aircrew Contact Lens Program on the KX.

6.19.1. **ACSCL Applicability.** Adherence to this policy is required by:

6.19.1.1. Flying Class I/IA electing to wear contact lenses, on or off duty. (T-1)

6.19.1.2. Flying Classes II and III while performing aircrew duties. (T-1) **Note:** Flying Classes II and III electing to wear contact lenses off duty are not required to follow the ACSCL policy, but are highly encouraged to do so.

6.19.2. **Aeromedical Requirements for ACSCL Wear.** The member shall have no 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 not achievable with spectacles require an aeromedical waiver.

6.19.2.1. Visual acuities of 20/20 or better in each eye with current spectacles for both near and distant vision, immediately after removing SCL.

6.19.2.2. Visual acuities of 20/20 or better 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.

6.19.2.3. Refractive astigmatism (at spectacle plane) of no greater than 2.00 diopters. Aircrew exceeding 2.00 diopters of astigmatism may be authorized to use SCLs but will require an aeromedical waiver.

6.20. Authorized Spectacle Frames for USAF Aircrew (USAF Aviation Spectacle Frame Program and AFI 11-202 V3). USAF military, civil service or USAF contracted aircrew personnel who wear spectacle based prescription eyewear (clear and/or sun protection) and/or spectacle based non-prescription sun protection are required to wear USAF approved eyewear while performing in flight duties. The USAF Aircrew Spectacle Frame Program defines and authorizes USAF aircrew eyewear. Authorized eyewear are identified under the Aircrew Flight Frame (AFF) series as the AFF-OP, AFF-DR (AFD), and AFF-JS (AFJ). No other spectacle frames are authorized for use in USAF aircraft by USAF aircrew or USAF contracted aircrew.

6.20.1. Prescription Eyewear

6.20.1.1. Local base optometry office is responsible for coordinating (prescribing, ordering, fitting, as required) spectacle-based vision correction for USAF aircrew. (T-1)

6.20.1.2. The DoD Optical Fabrication Enterprise will fabricate prescription clear and/or neutral density gray (N-15) sun protection as prescribed in an authorized AFF spectacle frame. (T-2) No other sun protection tint or spectacle frame is authorized for use in USAF aircraft by USAF military, civil service or contracted aircrew. The eye clinic will order the required spectacles through the DoD Optical Fabrication Enterprise in the same manner as other military eyewear orders through the Spectacle Request Transmission System (SRTS). (T-2) The eye clinic will fit and issue aviation spectacles to USAF military, civil service and contracted aircrew. (T-2) Eye clinics may also order AFF replacement parts (nose pads, temple screws, temples, etc) using MTF unit funds through the Electronic Catalog. (T-2)

6.20.1.3. USAF aircrew requiring prescription eyewear are authorized four sets of AFF spectacles per year, or as required. Two of these sets are fabricated with clear prescription lenses. The remaining two are fabricated as neutral density (gray) 15% transmission (N-15) sunglasses. Contractor aircrew requiring prescription eyewear are authorized two sets of AFF spectacles per year, one set with clear prescription lenses and one set with neutral density gray (N-15) sunglasses. USAF military, civil service or USAF contracted aircrew who use night vision goggles are also authorized an additional frame with polycarbonate lenses. These frames can be in any combination of the styles listed above.

6.20.2. Non-Prescription Eyewear:

6.20.2.1. Non-prescription AFF sun protection is obtained through local Individual Equipment Issue or equivalent supply office using member's unit funds.

6.20.2.2. Authorized non-prescription sun protection consists of an AFF series spectacle frame combined with neutral density gray (N-15) lenses. No other sun protection tint or spectacle frame is authorized for use in USAF aircraft by USAF aircrew or USAF contracted aircrew.

6.20.2.3. Aircrew not requiring prescription sun protective eyewear or who wear contact lenses for in-flight duties are authorized two sets of non-prescription sun protection eyewear (two pairs of spectacles) for flight duties.

6.20.2.4. Aircrew with defective color vision and a valid waiver may wear issued neutral density gray tinted sunglasses and laser eye protection when operationally authorized. However, aircrew with defective color vision are not authorized to wear the yellow high Contrast visor.

6.20.3. Ballistic Eye Protection: The Air Force Ballistic Protective Eyewear (BPE) Program manages the Air Force Protective Eyewear List (AFPEL) and provides implementation guidance. The Air Force adopted the Army's Authorized Protective Eyewear List (APEL). Products on the APEL have been evaluated by the Army Program Executive Office and found to meet or exceed military ballistic standards. AFPEL items are intended for ground use. Ballistic protection for authorized aircrew is found on the Flight Protective Eyewear List (FPEL). The AFF series frames are not equivalent to BPE. Flight ballistic protective eyewear (non-prescription spectacle/goggles) are obtained through local Aircrew Flight Equipment or equivalent supply office through the member's unit. Prescription inserts for FPEL items are ordered by the local optometry clinic through the SRTS ordering program. Current APEL and FPEL available at USAF Optometry Knowledge Junction / BPE: <https://www.kx.ams.mil/optometry> and USAF Flight Medicine Knowledge Junction / BPE: <https://www.kx.ams.mil/flightmedicine>. Aircrew BPE must be approved by the USAF Spectacle Frame Program (POC: USAFSAM/FECO). No other BPE is authorized for use by USAF aircrew.

6.20.4. Aircrew Laser Eye Protection (ALEP): Prescription Requirements. The flight medicine and ophthalmology/optometry clinics will ensure aircrew ALEP prescription accessory devices, when available, meet individual corrective vision specifications and are properly fitted per AFI 11-301v4, *Aircrew Laser Eye Protection (ALEP)*. (T-2)

6.20.4.1. Prescription laser eye protection accessory devices are ordered through SRTS. For non-prescription aircrew laser eye protection refer to AFI 11-301v4 and **KX**.

6.20.5. Refractive Surgery: Corneal refractive surgery is authorized for eligible military personnel who request this surgery as part of the USAF Refractive Surgery Program. Complete details can be found on the KX. (T-2)

Section 6G—Medical Standards for Flying Duty

6.21. Medical Standards. For accessions and enlistments the standards in **Chapter 4** apply. **Chapter 5** and the Medical Standards Directory apply to personnel already serving as AD or ARC (example, AD SSgt applying for IFCI duty must meet retention standards in **Chapter 5**, as

well as IFCI standards in the Medical Standards Directory). For conditions listed in **Chapter 5** and the Medical Standards Directory, ensure an I/RILO or MEB has been initiated if appropriate.

6.21.1. All medical treatment obtained from any source must be cleared by a flight surgeon prior to reporting for flight duty and documented in the medical record. (T-1) When a crewmember receives care by a non-flight surgeon provider, the clinical encounter must be reviewed by a flight surgeon for appropriate aeromedical disposition prior to the member resuming flying duties. (T-1) Aircrew members must maintain a medical clearance from the flight surgeon to perform in-flight duties. (T-1)

6.21.2. All dental treatment obtained from any source other than trained military Dental Clinic personnel must be cleared by a flight surgeon prior to reporting for flight duty. (T-1) 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 has been reviewed by a flight surgeon. (T-1)

6.21.3. Use of any medication is prohibited, except as described in the "Official Air Force Aerospace Medicine Approved Medications" updated periodically by AFMSA (approved by AF/SG3P). (T-1) Use of any Over the Counter (OTC) Medications, except as described in the "Official Air Force Aerospace Medicine Approved Medications" and "Over the Counter (OTC) Medications," updated periodically by AFMSA (approved by AF/SG3P) is prohibited. (T-1) Dietary, herbal, and nutritional supplements can only be used with the approval of a flight surgeon. (T-1)

Section 6H—Ground Based Aircraft Controller

6.22. Ground Based Aircraft Controller Medical Standards. The standards in **Section 6H** and the Medical Standards Directory apply to all ground based aircraft controllers which includes air traffic controller, weapons controllers/directors, combat controllers and Command & Control Battle Management Ops (1C5X1), Tactical Air Control Party (1C4X1), Air Liaison Officer (13LX) and RPA sensor operators (1U0X1). Conditions in **Chapter 5** and the Medical Standards Directory or Worldwide Duty (WWD) standards also apply. For conditions listed in **Chapter 5** and the Medical Standards Directory, ensure an I/RILO or MEB has been initiated if appropriate.

6.22.1. In addition to the standards in **Section 6H** and the Medical Standards Directory for ground based control, Combat Controllers must also meet the standards for parachute duty (FCIII and relevant sister service school standards) and Medical Standards Directory standards. See Physical Exam Techniques and **6.24.1**

6.22.2. In addition to the standards in **Section 6H** and the Medical Standards Directory for ground based control, Air Battle Managers (13BX) and Air Weapons Controllers/Directors, required to perform frequent and regular aerial flights must also meet Flying Class III standards in **Section 6G** of this AFI.

6.22.3. The medical conditions listed in **Chapter 5**, Medical Standards Directory, and relevant **Section 6J** categories 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. Acute conditions which impair safe and effective performance of duty are cause for temporary removal from controlling duties using AF Form 1042 or DoD equivalent IAW [Section 6C](#). **Note:** These standards do not apply to Small unmanned aircraft systems operators (SUAS-Os).

Section 6I—Missile Operations Duty (MOD) Standards

6.23. The medical conditions listed in Chapter 5, Medical Standards Directory, and [Section 6I](#) are cause to reject MOD personnel for initial accession in and continued missile operations (AFSC 13SXC) career field unless a waiver is granted. The certification authority for initial MOD examinations and waivers is AFGSC/SGP. For conditions listed in **Chapter 5**, ensure an I/RILO or MEB has been initiated if appropriate prior to the waiver request.

6.23.1. Acute medical problems, injuries, or their appropriate therapy can be cause for withholding certification for initial training or temporarily restrict the individual from MOD 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. Acute conditions which impair safe and effective performance of duty are cause for temporary removal from MOD using AF Form 1042 or DoD equivalent IAW [Section 6C](#).

6.23.2. Medication (See Approved MOD List on AFMSA Knowledge Junction).

6.23.2.1. Personnel may not perform Combat Mission Ready (CMR) or Basic Mission Capable (BMC) duties (AFGSCI 13-5301v3, *Rapid Execution and Combat Targeting (REACT) Crew Operations* paragraph 6.1.) while using any medication whose known common adverse effect or intended action(s) affect alertness, judgment, cognition, special sensory function, mood or coordination. (T-2) CMR and/or BMC personnel prescribed medication with these known common adverse effect or intended action(s) must be placed in DNIC or DNIA status while under their effects. (T-2) If chronic or long-term use of such medications is required, a medical waiver must be requested. Approval authority is the AFGSC/SGP. (T-2)

6.23.2.2. MOD personnel in non-CMR/BMC 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 before removal of the DNIA/DNIC action.

6.23.2.3. FDA-approved OTC medications and commercially available (in the United States) substances, to include herbal and nutritional supplements, may generally be used by MOD personnel without flight surgeon approval, provided the product is used in accordance with manufacturers' directions for its intended use and not in violation of Air Force policy.

6.23.2.3.1. MOD personnel are required to consult with the flight surgeon whenever: the member is within 12 hours of reporting for MOD and will be using the product for the very first time; or member experiences adverse reactions which may affect the member's ability to perform MOD.

Section 6J—Miscellaneous Categories

6.24. Requirements.

6.24.1. **Attendance at Sister Service Schools.** All personnel who require upgrade training or specialty training at sister services schools must meet any additional Sister Service medical requirements (which may be more restrictive). AETC/SGPS will initially certify these types of examinations to meet Air Force AFSC requirements, with the exception of static line (Airborne) not requiring a waiver which may be certified by the local aerospace medicine specialist as designated by the MAJCOM. Certification by AF does not guarantee Sister Service acceptance. Applicants must provide a copy of the AF exam to the medical staff of the sister service school with their application. (T-2)

6.24.1.1. Refer to US Army Regulation (AR) AR 40-501, *Standards of Medical Fitness* for most current requirements for attendance at Army schools. **Note:** See AF Physical Examination Techniques which contains AF and Sister Service requirements.

6.24.1.2. See *Manual of the Medical Department NAVMED P-117*, Article 15-102 for attendance at Navy schools. **Note:** See AF Physical Examination Techniques which contains AF and Sister Service requirements.

6.24.2. Operational Support Flying (OSF) Duty.

6.24.2.1. The conditions listed in **Chapter 5**, the Medical Standards Directory and this section are disqualifying for OSF personnel. Operational support applies to personnel fully qualified in non-aircrew specialties and required to temporarily perform duties of the specialty in-flight. OSF are required to occasionally fly. Since the member's primary full-time duties do not require him or her to be on board an aircraft, performance of in-flight duties is a special duty for the particular career field. Examples of operational support flyers are CCATT members.

6.24.2.2. Personnel who perform aviation duties as an OSF are required to have a normal examination of tympanic membranes, lungs and chest, heart, abdomen, neurologic, hemoglobin, weight, blood pressure and pulse documented in their health record for an initial examination. The exam's expiration date is the PHA expiration date. **Note:** AF Form 1042 or DoD equivalent is issued as satisfactory evidence of completion of the requirements outlined for training and duty. This examination does not need to be entered into PEPP.

6.24.3. Physiologic Training Participation

6.24.3.1. Individuals must have the appropriate medical clearance to be eligible for physiological training (i.e. hypobaric chamber, reduced oxygen breathing device [ROBD] and/or centrifuge training). See AFI 11-403, *Aerospace Physiological Training Program* and/or AFI 11-404, *Centrifuge Training for High-G Aircrew* for additional information. See "Medical Standards Directory" for details on specific conditions which typically exclude trainees from physiological training (https://kx.afms.mil/kxweb/dotmil/kjPage.do?cid=ctb_155907&functionalArea=AerospaceMedicine).

6.24.3.2. Individuals with medical contraindications for hypobaric chamber training (e.g. history of neurological decompression sickness) must be directed toward normobaric

hypoxia training (e.g. ROBD) to meet AFI 11-202V1, *Aircrew Training*. If appropriate, AF Form 1042 should include statement “Hypobaric chamber training contraindicated; must meet AFI 11-202V1, requirements via normobaric hypoxia training”. (T-1)

6.24.3.3. Documentation requirements. All clearances must have a specific expiration date ensuring the trainee is medically cleared through the duration of training.

6.24.3.3.1. US Military or Government Service Civilians. Copy of current AF Form 1042, , DA (Army) Form 4186, *Medical Recommendation for Flying Duty*, or Naval Medical Form 6410/2, *Clearance Notice (Aeromedical)*, indicating that a flying class I, II, or III physical has been completed.

6.24.3.3.2. Foreign Military. North Atlantic Treaty Organization (NATO) and other foreign military personnel may use the local base clearance or annual physical 1042 prepared by home station flight surgeons based on the standards of medical fitness for flying duties issued by the parent country IAW **Chapter 9** of this instruction. The supporting USAF flight surgeon(s) may provide medical clearances for “physiological training only” for foreign military personnel.

6.24.3.3.3. Service Academy/ROTC Cadets or Midshipmen. Same as **para 6.24.3.3.3.1** or evidence of medical clearance for hypobaric chamber training within previous 12 months prior to this training. The flight surgeon’s office supporting the AOP Training Unit scheduled to provide this training must provide adequate oversight to ensure all cadets are medically qualified, to include clearing any current medical issues.

6.24.3.3.3.1. AF, Army, or Navy ROTC cadets will present evidence of satisfactory completion of DD Form 2808, or DD Form 2351, *DODMERB Report of Medical Examination*, accomplished within 48 months of the scheduled physiological training. **Note:** Before scheduling cadets for training, the ROTC detachment must send copies of the DD Form 2808, and 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 or DoD equivalent, is not required for this group of trainees, but any current medical problems must be cleared by the local flight surgeon

6.24.3.3.4. Government Contractors, Non-DoD Government Civilians and Non-Government Civilians (to include DVs). Copy of current Federal Aviation Administration (FAA) Medical Certificate flying class I, II or III. The local flight surgeon should assist the AOP Training Unit CC in evaluating the medical suitability of any individual who does not appear to have the physical health commensurate with high-risk physiological training.

6.24.3.3.5. Civilians undergoing physiological training are required to present a current FAA medical certificate, or the forms listed in paragraph **6.24.3.3.3.1** or a valid AF Form 1042 or DoD equivalent.

6.24.3.4. Aerospace & Operational Physiology (AOP) personnel (AFSC 43AX and/or 4M0X1) are required to meet FCIII.

6.24.4. Duty Requiring Use of Night Vision Goggles (NVG).

6.24.4.1. Aircrew members and SOD personnel who wear NVGs in the performance of their duties are required to achieve at least 20/50 visual acuity with the NVGs in the pre-flight test lane. Aircrew who fail visual acuity standards for their flying class, complain of visual problems either with or without NVGs, or fail to achieve 20/50 visual acuity in the NVG pre-flight test lane must be referred for a clinical eye examination. The flight surgeon/PA must refer to AL-SR-1992-0002, *Night Vision Manual for Flight Surgeons*, for additional guidance.

6.24.4.1.1. Personnel required to inspect, maintain or certify NVGs for use by Aircrew must possess visual acuity of at least 20/20 corrected or uncorrected in each eye. Prior to being assigned these duties, technicians will be referred for a routine clinical eye examination. Results will be documented in their medical records and re-certified annually as long as their duties include NVG inspection, maintenance, or certification. Technicians with visual acuity less than 20/20 will be issued spectacles IAW 6.24.4.2 to correct their vision. Technicians who cannot attain visual acuity of 20/20 corrected or uncorrected in each eye will be restricted from performing NVG inspection, maintenance or certification. (T-2)

6.24.4.2. Each aircrew or SOD member who requires corrective lenses in order to meet the visual acuity standards for flying, and who are required to wear NVGs in the performance of flying duties, are encouraged to 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:

6.24.4.2.1. If the individual has not had a refraction done within the past year, obtain a current refraction.

6.24.4.2.2. Order aviator spectacles using the current prescription through the local optometry clinic, or send the prescription using a DD Form 771, *Eyewear Prescription*, to the USAFSAM Aircrew Program Manager. Include verification of NVG duties statement when ordering the spectacles. See KX for further details.

6.24.4.2.3. Dispense the glasses to the individual with instructions to wear them only when using NVG and to protect the lenses from marring or scratching.

6.24.5. Incentive and Orientation Flights.

6.24.5.1. Incentive and Orientation Flights in Ejection Seat Aircraft.

6.24.5.1.1. 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. (T-1) A flight surgeon will accomplish a medical records review and a physical examination (scope of examination to be determined locally). (T-1) In lieu of medical record review, civilians must provide a statement of health from their physician to include a summary of medical problems and medications. All individuals (military and civilian) identified for incentive rides or orientation flights must be able to safely eject without unduly endangering life or limb. (T-1)

Communicate medical clearance and recommendations and/or restrictions to the flying unit on AF Form 1042 or DoD equivalent. This clearance will be valid for no longer than 14 days. **Note:** ARC clearances will be valid for no longer than 40 days. The following guidelines apply:

6.24.5.1.2. Signed parental consent is required if candidate is not on AD and under the age of 18.

6.24.5.1.3. Body weight, buttock-to-knee and sitting height measurements must be within minimums and maximums as specified in **Table 6.1** and **associated references**:

Table 6.1. Anthropometric Standards For Incentive and Orientation Flights.

Airframe	Weight		Buttock-to-Knee Maximum	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-4	136 lbs	211 lbs	27.0 inches	34.0 inches	39.0 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 Northrop Ejection Seat	140 lbs	211 lbs	27.0 inches	33.8 inches	40.0 inches
U-2	132 lbs	201 lbs	26.0 inches	33.8 inches	40.0 inches

6.24.5.1.4. Individuals selected for incentive or orientation flights who do not meet anthropometric standards will be referred to the flying unit or wing commander (O-6 or above) for final authority disposition. (T-1) ACES-II ejection attempts above 340 KEAS (Knots Equivalent Air Speed) 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 must 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. (T-1)

6.24.5.2. Incentive and Orientation Flights in Non-Ejection Seat Aircraft.

6.24.5.2.1. 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 DLC? (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 if deemed necessary and medical recommendation for incentive and orientation flying. (T-1)

6.24.5.2.2. Candidates must be able to safely egress the aircraft in an emergency without endangering life or limb.

6.24.5.2.3. All civilians selected for incentive or orientation flights will complete a locally generated health statement. These health statements must address any history of or current medical problems, medications individual is currently taking, and any physical limitations. All health statements on civilians will be referred by the flying unit to the flight surgeon for review, referral for appropriate medical examination to their health care provider if deemed necessary, and medical recommendation for incentive and orientation flying. (T-1)

6.24.5.2.4. Passengers scheduled to fly onboard Air Force aircraft will not routinely be referred to the flight surgeon office.

6.24.5.2.5. Communicate medical clearance, recommendations and/or restrictions to the flying unit on AF Form 1042 or DoD equivalent. Medical clearances for incentive and orientation flights are valid for no longer than 14 days with the exception of AMP 101 and AMP 202 candidates. See the AMP 101 website for further information. **Note:** ARC clearances will be valid for no longer than 40 days.

6.24.6. Instructors and students participating in USAFA Airmanship programs. The medical standards for these duties are the same as [Section 6G/6J](#) (except as noted below):

6.24.6.1. Flying Class III standards apply to Dean of Faculty (DF) parachute courses. FCII standards apply to all DF RPA programs. Flying Class II standards apply to all soaring/powered flight courses. The following exceptions apply:

6.24.6.1.1. Refractive error, no standards.

6.24.6.1.2. Applicants for programs in [6.24.6.1](#) 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.

6.24.6.1.3. Color Vision, no Standard.

6.24.6.1.4. Depth perception:

6.24.6.1.4.1. No standard for DF flight, parachute, RPA, and student soaring programs provided the soaring instructor pilot has normal depth perception.

6.24.6.1.4.2. Participants with abnormal depth perception are disqualified from solo flight.

6.24.6.2. For USAFA flying and parachute programs, FAA 3rd class 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. A

USAFA Form 1042, will be generated prior to performing flying operations in USAFA owned aircraft.

6.24.6.3. Clearance to perform DF flight, student parachute, cadet jumpmaster, student soaring, cadet soaring instructor pilot, RPA, and powered flight programs are performed prior to flight and is contingent upon the cadet meeting the following requirements:

6.24.6.3.1. Compliance with [6.24.6.1](#) accomplished by review of all available medical documentation and appropriate physical examination to ensure standards are met.

6.24.6.3.2. 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.

6.24.6.3.3. 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.

6.24.6.3.4. Cadets receive physiology training prior to flight or at least prior to solo flight.

6.24.6.3.5. Cadet/Flight Medicine Clinic flight surgeons issue a medical clearance for DF flight, soaring, Flying Team, RPA and parachute programs. The USAFA clearance will contain risk communication statements that reinforce the issues in [6.24.6.3.3](#) 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. (T-2)

6.24.6.3.6. Grounding management of all cadet participants will convey temporary disqualification and clearances following illness or injury to the local HARM. (T-2) For grounding management purposes, civilians will comply with all FAA regulations and guidance.

6.24.6.3.7. The USAFA airmanship program medical clearance expires upon graduation. While attending 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.

6.24.6.3.8. USAFA flying clearance (for DF, parachute, soar, RPA, or flight programs) does not imply meeting any other Air Force Initial Flying Class or special duty requirements such as I/IA/II/III, MOD, or GBC standards.

6.24.6.3.8.1. HQ AETC/SG certified Flying Class I physical examination must be completed prior to entering SUPT after graduation from USAFA.

6.24.7. Interservice Transfers.

6.24.7.1. Pilots of fighter, rotary wing, fixed wing (non-fighter) aircraft transferring from sister service to an equivalent weapon system in the Air Force are considered trained assets. Air Force FCII standards apply. Complete all requirements for pilot's age IAW

PHA and ASIMS guidelines. This FCII physical will be entered into PEPP for baseline comparison and into AIMWTS if flying waiver required. Pilots of fighter, rotary wing, and fixed wing (non-fighter) transferring to AF from a different type of weapon system are not considered trained assets. Flying Class I standards apply. These pilots would require initial FCI physical and successful completion of MFS. This FCI physical will be entered into PEPP and into AIMWTS if flying waiver required.

Chapter 7

MEDICAL EXAMINATIONS FOR SEPARATION AND RETIREMENT

7.1. Policy. Do not delay separation or retirement past scheduled date of separation or retirement to complete a medical examination unless medical hold is approved (see AFI 41-210 for further guidance on medical hold authority and related topics).

7.2. Purpose. To identify medical conditions requiring attention and to document current medical status to determine continued fitness for duty.

7.3. Presumption of Fitness. If performance of duty in the 12 months before scheduled retirement is satisfactory, the member is presumed to be physically fit for continued AD or retirement. (See AFI 41-210 for presumption of fitness prior to retirement). Reservists who have not been participating (in a no-pay/no-points status) solely due to administrative restrictions on participation IAW AFI 36-2254 Vol 1, *Reserve Personnel Participation* or due to noncompliance with requirements are not considered to overcome the presumption of fitness.

7.4. Law Governing Disability Evaluation.

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

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

7.4.3. Title 10, United States Code Sec 1145 directs conduct of separation examinations on specific individuals leaving the USAF.

7.5. Mandatory Examinations.

7.5.1. All AD personnel will complete, as a minimum, a DD Form 2697 (see paragraph 1.5) for separation or retirement. This will be reviewed and signed by a credentialed provider using local protocol. This will be initiated not earlier than 180 days of scheduled separation, retirement or beginning of terminal leave, and not later than 30 days prior to these events. If the service member requires a medical examination per 7.5.2, the DD Form 2697 can be completed at that visit. (T-0)

7.5.1.1. The DD Form 2697 is only required for AFRC and ANG members leaving an AD tour of 31 days or more and is not required for retirement purposes if the PHA is current.

7.5.2. A medical examination by a credentialed provider as outlined in 7.5.3 is mandatory when:

7.5.2.1. Member has not had a PHA within one year.

7.5.2.2. If transferring to ARC, an AF Form 422, will be used to document the member's retention qualification. Members who are current on their PHA (within the 12 months preceding the actual date of retirement or separation) will complete a DD Form 2697 within 180 days of transfer, from which the need for further evaluation will be

determined. Potentially disqualifying conditions must be appropriately addressed prior to any Palace Chase/Front action. (T-1)

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

7.5.2.4. Separation is involuntary, or is voluntary in lieu of trial by court martial, or retirement in lieu of involuntary administrative separation. **Exception:** Member is separated or retired in absentia.

7.5.2.4.1. If the member has had an initial enlistment/commissioning examination within the preceding 12 months, DD Form 2697 will be the only requirement.

7.5.2.5. Members having had a PHA within one year of AFPC approved retirement date (no DD Form 2808). The DD Form 2697 will be accomplished not earlier than 180 days prior to projected separation or retirement and not later than 30 days prior to projected separation or retirement. (T-0) Exceptions to meet mission requirements or short-notice separation/retirement will be handled on a case-by-case basis and must include coordination with the local VA transition officials if the member is expected to file a disability claim with the VA. (T-2)

7.5.2.6. The member is tentatively approved by HQ AFPC for early separation from AD and assignment into an ARC under PALACE CHASE or PALACE FRONT, and the member's most recent medical examination (PHA) was completed more than 12 months ago at the time of application. **Note:** Members with a disqualifying medical condition who desire to transfer to the ARC must undergo evaluation for Assignment Limitation Code or an MEB while on AD. (T-1)

7.5.2.7. The member's medical record has been lost. Accomplish PHA, DD Form 2807-1 along with the DD Form 2697. Provider examination must address significant medical history and determine if qualification for continued service is questionable. (T-1)

7.5.2.8. The member is a RPW (Mil-PDS assignment limitation code 5, or 7). The evaluation will include an I/RILO unless waived by HQ AFPC/DPANM. Forward a copy of the examination to the addresses in [6.4.7.4](#) (T-1)

7.5.2.9. Members of the reserve component separated from AD to which they were called or ordered in support of a contingency and for whom the period of AD exceeded 30 days. This includes ARC members called/ordered to initial AD for training, AD, or federal service during times of contingency, conflict, or war.

7.5.2.10. Members separated from AD who pursuant to voluntary agreement of the member to remain on AD for less than one year, unless [7.5.2.4.1](#) applies.

7.5.2.11. Members involuntarily retained on AD in support of a contingency unless they have a current (within 12 months preceding the actual date of separation) PHA.

7.5.2.12. Members who are being recommended for administrative separation IAW AFI 36-3208 under a characterization other than honorable and who have been deployed overseas in support of a contingency operation within 24 months prior to initiation of discharge and were diagnosed by a physician, clinical psychologist, or psychiatrist as experiencing Post Traumatic Stress Disorder (PTSD) or Traumatic Brain Injury (TBI), or

reasonably alleges the influence of PTSD or TBI, based on deployed service to a contingency operation during the previous 24 months.

7.5.2.13. Review of DD Form 2697 determines a medical evaluation is required.

7.5.3. Medical examination. Members who require a separation examination IAW [7.5.2](#) will complete, as a minimum, a medical assessment as described below. (T-1) This assessment will be accomplished not earlier than 180 days of scheduled separation, retirement or beginning of terminal leave, and not later than 30 days prior to these events. (See paragraph [7.5.1](#)) (T-0)

7.5.3.1. The assessment must include:

7.5.3.1.1. A completed DD Form 2697 (see paragraph [1.5](#)). (T-1)

7.5.3.1.2. Clear documentation of any significant medical history and/or new signs or symptoms of medical problems since the member's last medical assessment/medical examination. (T-1) See the last two sentences in Section II, DD Form 2697 for additional guidance.

7.5.3.1.3. An examination by a privileged health care provider. When appropriate/required, examinations will be done and results documented in section II, item 20 of DD Form 2697. (T-1) The examination and studies will be those determined by the provider to be necessary to determine the examinee's continued qualification for worldwide service, evaluate significant items of medical history, or evaluate new signs and/or symptoms of injury or illness.

7.5.3.1.4. All personnel 35 years of age and older who are separating or retiring from the Air Force will complete screening for Hepatitis C per USPSTF recommendations. (T-1)

7.5.3.2. File the completed DD Form 2697 in the medical record. If the medical record is not available, forward sealed DD Form 2697 to the Separation and Retirements Section of the member's servicing MPF. File all consultation reports with the DD Form 2697.

7.5.3.3. Forward copies of medical examinations/medical assessments accomplished on ANG full-time AGR Title 32, EAD Title 10 members to HQ Air Reserve Personnel Center (ARPC). ARPC/DSFRA for retention as required by Title 10, United States Code, Chapter 8502.

7.5.3.4. Forward a copy of DD Form 2697 (ensure HIPAA compliance with signed authorization from the member) to the In-Service recruiter for all members entering an ARC through the PALACE CHASE/FRONT Programs.

7.5.4. HIV testing for separation or retirement is required only when deemed appropriate by the primary care manager (see AFI 48-135).

7.5.5. Termination Occupational Examinations. If a termination occupational examination is required, the separation or retirement examination/assessment can be accomplished during this examination.

7.6. General Officers. Examinations for retirement must be conducted IAW AFI 36-3203, *Service Retirements*, Chapter 5.5.

Chapter 8

MEDICAL CLEARANCE FOR JOINT OPERATIONS OR EXCHANGE TOURS

8.1. Applicability. Air Force personnel must meet Air Force standards while in joint assignments, or inter-Service exchange tours. The host nation is the nation where TDY flying duties take place, or the nation with primary aeromedical responsibility. The parent nation is the nation of whose armed services the individual is a member.

8.1.1. 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.

8.1.2. 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 AFMSA/SG3P.

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

8.1.4. 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.

8.2. Joint Training.

8.2.1. 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.

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

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

8.2.4. If individuals develop medical problems while in training, the training must not be continued unless both host and parent services concur.

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

Chapter 9

NATO AND OTHER FOREIGN MILITARY PERSONNEL

9.1. Implementation. This chapter implements STANAG 3526, Interchangeability of NATO Aircrew Medical Categories.

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

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

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

9.2.2. 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. (T-1)

9.2.2.1. 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.

9.2.3. In the case of progression of a pre-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 (see [9.2.5](#)).

9.2.4. 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.

9.2.5. Groundings exceeding 30 days and permanent medical disqualification must be discussed with AFMSA/SG3P and the appropriate parent nation liaison. (T-1)

9.3. Medical Qualification of NATO Aircrew Members:

9.3.1. NATO Aircrew will have the same medical benefits and requirements as USAF aircrew (See AFI 41-210). **Note:** Members must have documentation in the medical record that a DNA sample has been obtained and on record. (T-1)

9.3.2. Waivers for flying/SOD duty positions granted by another nation may not necessarily be continued upon return to the USAF.

9.4. Medical Qualification for Security Cooperation Education and Training Program (SCETP) Flying (Non-NATO Students):

9.4.1. Flying student candidates will complete a medical and dental examination using DD Form 2807-1 and DD Form 2808, within three months prior to departure from parent country IAW AFI 16-105, *Joint Security Cooperation Education and Training*.

9.4.2. All medical qualification documentation will be forwarded through SCETP to the training MTF SGP, where case will be reviewed and any missing items will be added and forwarded to AETC NLT 30 days before training or Defense Language Institute (DLI) start date. AETC/SGP will determine if the flying student candidate possesses adequate physical examination documentation and is qualified under **Chapter 6, Section 6G** and the Medical Standards Directory. AETC/SGP will certify student as qualified with or without waiver on the DD 2808 (attach documents to PEPP, (AIMWTS is not required on these students)) prior to issuing Invitational Travel Order (ITO) IAW JSCET.

9.4.3. ny student who fails to meet medical standards will be managed on an individual basis by HQ AETC/SG and HQ AETC/IA, who will in turn, coordinate with AF/SG (AFMSA/SG3P), SAF/IA as appropriate.

9.5. 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 10

EXAMINATION AND CERTIFICATION OF ARC MEMBERS NOT ON EAD

10.1. Purpose. Establishes procedures for accomplishing, reviewing, certifying, and administratively processing medical examinations for ARC members not on EAD who are assigned to the Ready Reserve and Standby Reserve. IAW AFI 36-2254 Vol I, any USAFR member profiled with a duty limiting condition code 37 may not perform military duty for pay or points, unless issued a participation waiver by the AFRC/SGP or delegated authority.

10.2. Applicability.

10.2.1. ARC Unit and individual members of the ANG and Air Force Reserve, IMA.

10.2.2. ARC Members of the Ready Reserve:

10.2.2.1. Air National Guard. Administered by ANG/SGP.

10.2.2.2. Air Force Reserve Unit/IMA/Participating Individual Ready Reserve (PIRR) Members. Administered by HQ AFRC/SGP, Aerospace Medicine Division)

10.2.3. Nonparticipating Members of the Ready, Standby, and Retired Reserve. These members are ordered to EAD only in time of war or national emergency declared by the Congress.

10.3. Medical Standards Policy. Each ARC individual must be medically qualified for deployment and continued military service according to **Chapter 5**, the Medical Standards Directory and **Chapter 11**.

10.4. Responsibilities.

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

10.4.2. ARC Member. Each ARC member is responsible for promptly (within 72 hrs) reporting an illness, injury, disease, operative procedure or hospitalization not previously reported to his or her commander or supervisor, and supporting medical facility personnel IAW AFI 36-2910. Any concealment or claim of disability made with the intent to defraud the government results in possible legal action and possible discharge from the ARC.

10.4.3. ARC Physicians. Responsible for determining ARC member's medical qualifications for continued WWD IAW this instruction and appropriate ARC supplemental guidance.

10.4.4. Air Force medical service personnel record any illness, injury or disease incurred or aggravated by ARC members during any training period on appropriate medical forms to include initiation of a line of duty determination, since the illness, injury, or disease may be used as the basis for government claims leading to potential benefits and entitlements IAW AFI 36-2910.

10.5. General Responsibilities/ARC Medical Units.

10.5.1. Establish health and dental records for each ARC member.

10.5.2. Forward original IMA medical examinations to the AD MTF where the individual's medical records are maintained. If a disqualifying condition is identified, an appropriate AF Form 469 must be generated and forwarded to the Physical Evaluation Board Liaison Officer (PEBLO) at the AD MTF. (T-1) Initial RILO/MEB packages shall undergo standard processing through the MTF and Informal Physical Evaluation Board (IPEB). (T-1) HQ AFRC/SGP retains authority to assign Assignment Limitation Code C (ALC-C) codes for IMAs returned to duty IAW AFI 41-210.

10.5.3. Medical examinations accomplished on unit assigned and IMA members of the AFR are subject to review by AFRC/SGP to verify their medical qualification for continued military duty. AFRC/SGP is the final authority in determining medical qualifications for all reserve personnel.

10.5.4. All ANG medical examinations are maintained by the servicing medical unit and are subject to review by NGB/SGP to verify qualification for participation. NGB/SGPA is the final authority in determining ANG member qualification for WWD.

10.5.5. For ARC members with questionable medical conditions or found medically disqualified send complete medical case files as noted. For Air Force Reservists, send requested medical documents to AFRC/SGP at afrc.sgp@us.af.mil or through the Electronic Case Tracking (ECT) system for review of questionable or disqualifying medical conditions. For Air National Guard members, send medical case files to: NGB/SGPA, 3500 Fetchet Avenue, Andrews AFB, MD 20762-5157; for Air Force Reserve members (unit assigned and IMA), send to: HQ AFRC/SGPA, 135 Page Road, Robins AFB, GA 31098-1601.

10.6. Inactive/Retired Reserve. Applicants currently assigned to the inactive or Retired Reserve or retired from active military service for less than 5 years may request entry to active reserve status.

10.6.1. The appropriate ARC/SG must review and certify all applicants identified with **Chapter 5** and Medical Standards Directory disqualifying medical conditions; history of MEB evaluation, fitness for duty evaluation, or ALC-C status; applying for a different aircrew AFSC from their previous aircrew assignment, require a medical waiver for flying, or retired from a sister service.

10.6.2. The Chief, Aerospace Medicine of the gaining/supporting AFRC medical unit or AD MTF and ANG SAS may certify, but not waiver for entry into active reserve status, all applicants not identified in paragraph **10.6.1** above using **Chapter 5** and the Medical Standards Directory.

10.6.2.1. Individuals diagnosed with Attention Deficit Hyperactivity Disorder (ADHD) must be carefully evaluated for suitability for continued service. If treatment with medication is required, a WWD evaluation and waiver request to ANG/SG is required.

10.6.3. The following documentation is required for all applicants:

10.6.3.1. Current DD Form 2807-1.

10.6.3.2. Current Reserve Web HA with supporting documentation for positive responses (AFRC only).

10.6.3.3. PHA with associated paperwork less than 12 months old (non aircrew assignments).

10.6.3.4. Flying PHA with associated paperwork less than 12 months old (aircrew assignment same as previous aircrew AFSC).

10.6.4. Applicants applying for a new aircrew position, rather than the one previously held will require an initial flying exam. Applicants whose Reserve Component Health Risk Assessment (RCHRA) or PHA is greater than 12 months old will require a current enlistment or flying exam as appropriate.

10.7. Reenlistment. Ensure members who want to reenlist in the ANG have a current PHA. Ensure members, who want to reenlist in AFRC, complete a current RCHRA unless a PHA or RCHRA less than 12 months is on file.

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

10.9. General Officers. ANG medical units will maintain the annual PHA accomplished on general officers and ANG wing commanders in the medical records. Reserve medical units will forward to HQ AFRC/SGPS, a copy of all physical examinations accomplished on reserve wing commanders.

10.10. AGR Tours. The AGR program requires individual applicants to contact the appropriate ARC medical unit, or AD MTF, to request the appropriate medical evaluation. The following guidance along with AFI 36-2132V2, *Active Guard/Reserve (AGR) Program*, and ANGI 36-101, *Air National Guard Active Guard Reserve (AGR) Program*, will be used to manage these requests.

10.10.1. General. Members selected for initial AGR positions must meet the medical standards as outlined in this AFI prior to assignment. Applicants who have started an AGR tour and are found to have medical condition(s) which makes their medical qualifications for continued military duty questionable will be processed through the Air Force DES IAW AFI 36-3212.

10.10.2. Physical Exam Requirements.

10.10.2.1. Applicants with a concurrent AGR assignment must have a current PHA on file.

10.10.2.2. Applicants with no service affiliation (i.e. Individual Ready Reserve (IRR), AD, reserve, guard, etc.) require an accession physical exam, which would be valid for 24 months prior to AGR assignment. See medical standards in **Chapter 4** and **Chapter 6**, Medical Standards, **Section 6G** (aircrew applicants only).

10.10.2.3. Active military (AD, ARC) applicants for non-aircrew assignments may use PHA with associated documentation less than 12 months old. Members must also be current in all IMR requirements. AF Form 422, must be dated within 60 days prior to tour start date. Medical standards in **Chapter 5** and Medical Standards Directory apply. Prior service (IRR, etc.) applicants for non-aircrew assignments within 180 days of separation may use the same standards as AD. Applicants whose date of separation is

greater than 180 days will require an accession examination and medical standards in [Chapter 4](#) apply.

10.10.2.4. For aircrew assignments into the applicant's current aircrew AFSC, flying PHA with associated paperwork less than 12 months old may be used.

10.10.2.4.1. Applicants for new aircrew assignments require an initial flying examination.

10.10.3. Certification/Waiver Authority.

10.10.3.1. AFRC/SGP is the certification and waiver authority for all AFRC AGR applicants. For ANG, the SAS, having completed specialized training, is authorized certification authority for Title 32 AGR applicants. Medical Standards in Chapter 5, Medical Standards Directory and Chapter 6, Section 6G apply.

10.10.3.1.1. The Chief, Aerospace Medicine/SAS for the ANG will certify the appropriate medical document with a certification stamp. Delegation of this certification authority is extended only to those Reserve Medical Units responsible for providing physical exam support.

10.10.3.2. The appropriate ARC/SG is the reviewing, certification and waiver authority (see [Attachment 2](#)) for those applicants with disqualifying medical conditions in **Chapters 4, 5**, Medical Standards Directory and **Chapter 6, Section 6G**, except initial entry into IFCI/IA/II, unless otherwise directed by other guidance within this instruction. Also, the appropriate ARC/SG is the certification authority for all MAJCOM or higher-level AGR positions (ANG Title 10 EAD) and those positions with no gaining ARC medical units.

10.11. Involuntary EAD. ARC members involuntarily ordered to AD will not delay such action because of an expired PHA. See AFI 44-170 for details.

10.11.1. An ARC member ordered to EAD due to mobilization is medically processed IAW the mobilization order. The ARC member's medical status must be established within 30 days of mobilization.

10.11.2. Within 30 days of mobilization, the health records of the ARC member will be reviewed for disqualifying defects according to [Chapter 5](#) and Medical Standards Directory and to determine if the member's PHA is current. Members found medically disqualified or questionably qualified for WWD are evaluated IAW AFI 41-210, unless otherwise directed by the mobilization order.

10.12. Annual Training (AT) or AD for Training or Inactive Duty for Training (IDT). Commanders ensure members reporting for duty are medically qualified. Members with medical conditions, which render questionable their medical qualifications for continued WWD, are evaluated for fitness for duty.

10.13. Inactive Duty for Training.

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

10.13.2. If a member reports for duty and does not consider him or herself medically qualified for continued military service based on a diagnosis from the PCM, the ARC

commander or AD supervisor will schedule the member for a medical evaluation during the IDT period. (T-1) If the member is not qualified for WWD, a medical evaluation is sent to AFRC/SGP, or NGB/SGPA as appropriate. (T-2) The member is excused from training pending a review of the case. **Note:** ARC members will be given a DLC (AF Form 469) and follow the guidance found in AFI 10-203.

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

10.14. Medical Examination.

10.14.1. General Information:

10.14.1.1. Medical personnel perform medical examinations according to **Chapter 1** and physical examination techniques.

10.14.1.2. All personnel undergo an annual dental examination according to the PHA grid at the time of the PHA. Bitewing radiographs are accomplished at the discretion of the examining dental officer for diagnostic assistance.

10.14.1.3. The PHA is an annual requirement for members of the ARC, IAW AFI 44-170, Preventive Health Assessment.

10.14.1.4. ANG MPF and commander are notified by the ANG Medical Group when a member cannot continue the United Training Activity (UTA) because of a medical condition. AF Form 469 is used for notification, as appropriate.

10.14.2. Dental Class III.

10.14.2.1. AFRC members placed in dental class III are not qualified for military duty other than at home station until returned to Dental Class 1 or 2. Manage AFRC members IAW paragraph **10.16** of this instruction unless the dental officer has determined the member may continue reserve participation in restricted status. ANG members placed in Dental Readiness Class III are not IMR ready and are non-deployable. Members are placed on an AF Form 469 code 31 for mobility restrictions. Members in Dental Readiness Class III lasting for more than one year will be processed administratively IAW AFI 36-3209, *Separation and Retirement Procedures for Air National Guard and Air Force Reserve Members* unless the member has a dental defect defined in **Section 5B** of this instruction. Members with a dental defect defined in **Section 5B** of this instruction and the Medical Standards Directory will be processed for Initial RILO/MEB/WWD. More Guidance in AFI 47-101.

10.14.2.2. The examining military dental officer has the authority to allow AFRC in dental class III to continue Reserve participation at home duty station only while undergoing corrective dental treatment. The dental officer will determine the length of time (not to exceed 1 year) given to a member to complete dental treatment or improve to at least dental class II.

10.14.2.2.1. Aircrew members in dental class III will be placed on DNIF status unless the examining dental officer determines the AFRC member may continue reserve participation and the flight surgeon determines flying safety will not be compromised. (T-1) Aircrew in this status will be limited to local sorties only. (T-1)

10.15. Scheduling PHA. Schedule a PHA in accordance with current ARC directives ASIMS/PHA Guide.

10.16. Medical Evaluations to Determine Fitness for Duty.

10.16.1. Reasons to accomplish medical evaluations in determination of medical and dental qualification for military duty:

10.16.1.1. Disqualifying or questionable medical conditions discovered during the annual assessment.

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

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

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

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

10.16.4. Accompanying Documents. The following documents are included in the reports forwarded to the appropriate component surgeon (see [paragraph 10.5](#)) for review. Note: For AFRC, submit documents through the ECT system.

10.16.4.1. For unit assigned or IMA reserve members:

10.16.4.1.1. Civilian medical and dental documentation.

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

10.16.4.1.3. AF Form 469 properly formatted.

10.16.4.1.4. SF 502, Medical Record - Narrative Summary (Clinical Resume), must provide a clear picture of the member's current medical health as well as the circumstances leading to it. (T-1)

10.16.4.1.5. Medical Evaluation (ME) for Military Duty Fact Sheet.

10.16.4.1.6. PEB Election.

10.16.4.1.7. PEB Fact Sheet.

10.16.4.1.8. AF Form 422.

10.16.4.1.9. Unit Commander Memorandum.

10.16.4.1.10. Member Utilization Questionnaire.

10.16.4.2. For ANG members:

10.16.4.2.1. Unit commander's endorsement.

10.16.4.2.2. SF 502, Narrative Summary must include:

10.16.4.2.2.1. Date and circumstance of occurrence.

10.16.4.2.2.2. Response to treatment.

10.16.4.2.2.3. Current clinical status.

10.16.4.2.2.4. Proposed treatment.

10.16.4.2.2.5. Current medications.

10.16.4.2.2.6. The extent to which the condition interferes with performance of military duty (see [Chapter 11](#)).

10.16.4.2.2.7. Prognosis.

10.16.4.2.3. Civilian medical documentation. Medical documentation from the member's civilian health care provider will be included in all waiver cases submitted on ARC members. (T-1) The provider will review this information and reference it in the SF 502, *Narrative Summary*. (T-1)

10.16.4.2.4. A written statement from the member's immediate commanding officer describing the impact of the member's medical condition on normal duties, ability to deploy or mobilize, and availability of a non-deployable (ALC-C) position.

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

10.17. Failure to Complete Medical Requirements. ARC members who fail to complete medical/dental requirements are referred to their commanders in writing IAW AFMAN AFI 36-2254 Vol I and are processed IAW AFI 36-3209.

10.17.1. Refusal. A member of the ARC with a known medical or dental condition who refuses to comply with a request for medical information or evaluation is considered medically unfit for continued military duty and is referred to their immediate commander for processing IAW AFI 36-3209. Reservists or Guardsmen who fail to provide documents or appear for scheduled appointments are considered to be non-compliant and will be referred to their Commander in writing for administrative separation IAW AFI 36-3209.

Chapter 11

MOBILITY STANDARDS AND DEPLOYMENT CRITERIA

11.1. General Considerations. For the purposes of this instruction mobility status is an ongoing condition where the member is free from any chronic medical conditions or limitations other than temporary limitations (under 1 year) that would preclude an Air Force deployment or TDY for six months in field conditions. A fitness for deployment determination is an assessment of current medical condition. A deployment (as defined in this instruction) is defined as any temporary duty where Contingency, Exercise, and Deployment TDY orders were issued, and the TDY location is outside of the United States. ANG deployment is greater than 30 days regardless of location. Conditions, which may seriously compromise the near-term well being if an individual were to deploy, are disqualifying for mobility status or deployment duty. Medical evaluators must consider climate, altitude, rations, housing, duty assignment, and medical services available in theater when deciding whether an individual with a specific medical condition is deployable. In general, a member must be able to perform duty in austere environment with no special food, billeting, medical or equipment support for up to 179 days. See DoDI 6490.07, *Deployment-Limiting Medical Conditions for Service Members and DoD Civilian Employees* for medical standards not consistent with deployment. Also review CoCOM reporting instructions for individuals tasked to deploy. **Note:** For DoD civilian employees, DoDD1400.31, *DoD Civilian Work Force Contingency and Emergency Planning and Execution*, and DoDI 1400.32, *DoD Civilian Work Force Contingency and Emergency Planning Guidelines and Procedures*, See DoDI 6490.07, *Deployment-Limiting Medical Conditions for Service Members and DoD Civilian Employees* and AFI 36-507, *Mobilization of the Civilian Workforce* apply. Civilian Contractors shall follow DoDI 3020.41, *Operational Contract Support (OCS)*. (T-0)

11.1.1. Individuals returned to duty as “fit” by PEB may not meet deployment standards. Such individuals, if they are retained, will have assignment limitation codes limiting or restricting them from deployment duties or be placed on Limited Assignment Status (LAS). They may be assigned or deployed with appropriate coordination per AFI 41-210.

11.1.2. The deployment standards in DoDI 6490.07 are the minimum necessary to maintain mobility status (see Kx for additional USAF Guidance). (T-1) Any individual who cannot maintain mobility status for a chronic or recurrent medical condition must meet an initial RILO or MEB evaluated IAW 41-210. **Note:** Pregnancy does not require an MEB and is handled as a code 81 mobility restriction annotated on an AF Form 469. Any mobility (or TDY) restrictions following completion of pregnancy are detailed in AFI 36-2110, *Assignments*.

11.1.3. Any individual having a deployment or assignment cancelled due to medical reasons must be referred to the DAWG within 10 calendar days for appropriate action IAW AFI 10-203.

11.1.4. ARC members must have deployment criteria addressed in the Narrative Summary submitted in the WWD Medical Evaluation package for the purpose of enabling the ARC/SG to make a valid deployability determination.

11.2. Non-mobility status personnel (ALC-C1, 2, 3 or LAS or ANG members with a condition waived for WWD) who have existing medical conditions may deploy if all of the following conditions are met and approved by the gaining COCOM.

11.2.1. The condition is not of such a nature that an unexpected worsening or physical trauma is likely to have a grave medical outcome or negative impact on mission execution.

11.2.2. The condition is stable and reasonably anticipated by the pre-deployment medical evaluator not to worsen during the deployment under care in theater, in light of physical, physiological, psychological, and nutritional effects of the duties and location.

11.2.3. Any required ongoing health care or medications must be available in-theater within the military health system. All special requirements (e.g. special handling, and storage) must receive prior approval by gaining COCOM.

11.2.4. There is no need, or anticipation of a need, for duty limitations that preclude performance of duty or accommodation imposed by the medical condition (the nature of the accommodation must be considered).

11.2.5. There is no need for routine evacuation out of theater for continuing diagnostics or other evaluations. (All such evaluations must be accomplished prior to deployment).

11.2.6. Coordination with deployed commanders (or delegated waiver authority) may be required based on current conditions, host nation requirements or changing mission requirements.

THOMAS W. TRAVIS, Lt Gen., USAF, MC, CFS
Surgeon General

Attachment 1

GLOSSARY OF REFERENCES AND SUPPORTING INFORMATION

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Title 10, United States Code, Chapter 61

Title 10, United States Code, Section 113

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Medical Standards Directory

Official Air Force Aerospace Medicine Approved Medications Quick Reference List
https://kx.afms.mil/kxweb/dotmil/file/web/ctb_128486.pdf

Physical Examination Standards
https://kx.afms.mil/kxweb/dotmil/kjPage.do?cid=ctb_155907&functionalArea=AerospaceMedicine

Adopted Forms

DD Form 771, *Eyewear Prescription*

DD Form 2351, *DoD Medical Examination Review Board (DODMERB) Report of Medical Examination*

DD Form 2492, *Report of Medical History*

DD Form 2697, *Report of Medical Assessment*

DD Form 2766, *Adult Preventive and Chronic Care Flowsheet*

DD Form 2807-1, *Report of Medical History*

DD Form 2808, *Report of Medical Examination*

SF 507, *Clinical Record-Continuation Sheet*

SF 600, *Medical Record – Chronological Record of Medical Care*

AF Form 469, *Duty Limiting Condition Report*

AF Form 422, *Notification of Air Force Member's Qualification Status*

AF Form 1041, *Medical Recommendation for Flying or Special Operational Duty Log*

AF Form 1042, *Medical Recommendations for Flying or Special Operational Duty*

AF Form 1418, *Recommendation for Flying or Special Operation Duty – Dental*

AF IMT 847, *Recommendation for Change of Publication*

Abbreviations and Acronyms ACS—

Aeromedical Consultation Service

ACSCL—Aircrew Soft Contact Lens

AD—Active Duty

ADHD—Attention Deficit Hyperactivity Disorder

AFECD—Air Force Enlisted Classification Directory

AETC—Air Education and Training Command AFI—

Air Force Instruction

AFMOA—Air Force Medical Operations Agency

AFMSA—Air Force Medical Support Agency

AFOCD—Air Force Officer Classification Directory

AFPC—Air Force Personnel Center

AFR—Air Force Reserve

AFRC—Air Force Reserve Command

AFRIMS—Air Force Records Information Management System

AFROTC—Air Force Reserve Officer's Training Corps AFSC—

Air Force Specialty Code

AF/SG—Headquarters United States Air Force Surgeon General

AGR—Active Guard Reserve

AIMWTS—Aeromedical Information Management Waiver Tracking System

ALC—C – Assignment Limitation Code C

AMP—Aerospace Medicine Primary

AMS—Aeromedical Summary ANG—

Air National Guard

ARC—Air Reserve Component (AFR and ANG)

ARC SURGEON—AFRC/SGP for unit assigned and IMA members of the Air Force Reserve; ANG/SGP for guardsmen

ARMA—Adaptability Rating for Military Aviation

ARPC—Air Reserve Personnel Center

ASA—Air Sovereignty Alert **ASC**—
Aviation Service Code

ASIMS—Aerospace Medicine Information Management System

BMC—Basic Mission Capable

BMTS—Basic Military Training School

CCT—Cone Contrast Test **CL**—
Contact Lenses

CMR—Combat Mission Ready

CRO—Combat Rescue Officer **DAWG**—
Deployment Availability Working Group **DF**—Dean
of Faculty

DLC—Duty Limiting Condition **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 **DoDI**—

Department of Defense Instruction

DODMERB—Department of Defense Medical Examination Review Board

DSM—Diagnostic and Statistical Manual

EAD—Extended Active Duty **ECT**—

Electronic Case Tracking **EPTS**—Existing

Prior to Service **FAA**—Federal Aviation

Administration **FC**—Flying Class

FDA—Food and Drug Administration

FFD—Fitness for Duty

FHME—Force Health Management Element

FS—Flight Surgeon

GBC—Ground Based Controller **G6PD**—
Glucose-6-phosphate dehydrogenase **HARM**—
Host Aviation Resource Management
HIPAA—Health Insurance Portability and Accountability Act
HIV—Human Immunodeficiency Virus **HPSP**—
Health Professions Scholarship Program **IDES**—
Integrated Disability Evaluation System **IDT**—
Inactive Duty for Training
IFC—Initial Flying Class **IGAB**—
Inspector General Advisory Board **IMA**—
Individual Mobilization Augmentee
IMR—Individual Medical Readiness
IRR—Individual Ready Reserve
JSCET—Joint Security Cooperation Education and Training
KEAS—Knots Equivalent Air Speed
KX—Knowledge Exchange **LEP**—
Laser Eye Protection **MAJCOM**—
Major Command **MDD**—Marine
Diving Duty **MEB**—Medical
Evaluation Board
MEPS—Military Entrance Processing Station
MFS—Medical Flight Screening **MPF**—
Military Personnel Flight **MOD**—Missile
Operations Duty **MRI**—Magnetic Resonance
Imaging **MTF**—Medical Treatment Facility
NATO—North Atlantic Treaty Organization
NOMI—Naval Operational Medicine Institute
NVG—Night Vision Goggle **OM**—
Occupational Medicine
OTC—Over the Counter
PCM—Primary Care Manager

PEB—Physical Evaluation Board

PEPP—Physical Examination and Processing Program

PHA—Preventive Health Assessment

PHI—Protected Health Information

PIM—Pre-trained Individual Manpower

PIP—Pseudoisochromatic Plates

PSR—Patient Status Report **RDS**—

Records Disposition Schedule

RHRP—Reserve Health Readiness Program

RILO—Review in Lieu of **ROTC**—

Reserve Officer Training Corps **RPA**—

Remotely Piloted Aircraft **RPW**—

Repatriated Prisoner of War **RTFS**—Return
to Flying Status

SAS—State Air Surgeon

SCETP—Security Cooperation Education and Training Program

SCL—Soft Contact Lenses

SERE—Survival, Evasion, Resistance, and Escape

SOD—Special Operational Duty **SRTS**—

Spectacle Request Transmission System

SUAS—O – Small Unmanned Aircraft Systems Operators

TDRL—Temporary Disability Retirement List **TDY**—

Temporary Duty

TFI—Total Force Initiative **UDS**—

Urine Drug Screen **UFT**—

Undergraduate Flying Training

UNT—Undergraduate Navigator Training **UPT**—

Undergraduate Pilot Training **URT**—Undergraduate

Remotely Piloted Aircraft Training **USAFA**—United
States Air Force Academy

USAFR—United States Air Force Reserve. Includes unit assigned reservists and Individual
Mobilization Augmentees

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

USUHS—Uniformed Services University of Health Sciences

WEB HA—Web Health Assessment

WWD—Worldwide Duty

Attachment 2

CERTIFICATION AND WAIVER AUTHORITY

Table A2.1. Certification and Waiver Authority.

Attachment 2		
Table A2.1. Certification & Waiver Authority		
Category	Certification Authority	Waiver Authority
Flying Class I, IA Includes AD, Reserves, ANG	AETC/SGPS	AETC/SGPS
Initial FCII		
On or entering AD	AETC/SGPS	AETC/SGPS
Reserves	AFRC/SG (AMP)	AETC/SGPS
ANG	ANG/SG (AMP)	AETC/SGPS
Test Pilot School Flying Class II	AFMC/SGPA	AFMC/SGPA
Continued Flying Class II		MAJCOM/SG
Flying Class III		
Initial (AD) Required by AFSC	AETC/SGPS	AETC/SGPS
Initial (Reserves)	AFRC/SG	AFRC/SG
Initial (ANG)	State Air Surgeon (ANG)	ANG/SG
Continued Flying (All)	Local Base Certification/Waiver Authority	MAJCOM/SG
Flight Test Engineers and Developmental Engineers	AFMC/SGPA	AFMC/SGPA
Special Operational Duty		
Initial AD	AETC/SGPS	AETC/SGPS
Initial Reserves	Appropriate ARC SG	AFRC/SG
Initial ANG	State Air surgeon (ANG)	State Air Surgeon (ANG)
Continued Special Operational Duty	Local Base Certification/Waiver Authority	MAJCOM/SG
Operational Support Duty		
AD	Local Base Certification/Waiver Authority	Local Base Certification/Waiver Authority Local
Reserves	Local Base Certification/Waiver Authority	Local Base Certification/Waiver Authority
ANG	State Air Surgeon (ANG)	State Air Surgeon (ANG)

Missile Operations Duty		
AD	AFGSC/SG	AFGSC/SG
Reserves	AFGSC/SG	AFGSC/SG
ANG	State Air Surgeon ANG	AFGSC/SG
USAFA Cadet Incentive Flight, cadet parachute, cadet jumpmaster, cadet soaring, and cadet soaring instructor pilot duties, and powered flight programs	USAFA/SGP	USAFA/SGP
Initial Commission		
Entering AD	MEPS	AETC/SG
Extended AD (Res/ANG to AD)	AETC/SGPS	AETC/SGPS
Entering Reserves	MEPS for non-prior service AFRC/SG for prior service	AFRC/SG
Entering ANG	MEPS for non-prior service AFRC/SG for prior service	ANG/SG
USAFA	USAFA/SG	USAFA/SG
Change In Commission Status without Break in Service		
AD	Local Base Certification/Waiver Authority	AFPC/DPANM
Reserve Program	AFRC/SG	AFRC/SG
ANG	State Air Surgeon (ANG)	ANG/SG
Officer Program Applicants		
USAFA	DODMERB	USAFA/SG/SGP
ROTC	DODMERB	AETC/SGPS
USUHS	DODMERB	Assistant Secretary of Defense Health Affairs (ASD HA)
HPSP	MEPS	AETC/SGPS
Special Officer Procurement	AETC/SGPS	AETC/SGPS
AF Initial Enlistment		
AD	MEPS	AETC/SGPS
Reserves	MEPS IRR (AFRC/SG)	AFRC/SG
ANG	MEPS	ANG/SG
Continued Military Service/WWD following MEB		
AD (MEB)	AFPC/DPANM	
Reserves		AFRC/SG

ANG		ANG/SG
Return to AD following break in service	MEPS	AETC/SGPS
Recall to AD ARC		AFPC/DPANM
PALACE CHASE or FRONT Reserves ANG	AFRC/SG ANG Medical Group	AFRC/SG ANG/SG
AGR Tours		
Base Level AGR tour (ANG Title 32)		
Reserves	AFRC/SG	ARC SG
ANG	State Air Surgeon (ANG)	ANG/SG
MAJCOM Level AGR Tour (ANG Title 10)		
Reserves	AFRC/SG	AFRC/SG
ANG	ANG/SG	ANG/SG
Static Line, Free Fall, HALO, Jump Master (Required for AFSC)		
Initial AFSC Entry	Local Base Certification/Waiver Authority	AETC/SGPS
Trained Asset: Upgrade and Additional Duty Training	Local Base Certification/Waiver Authority	MAJCOM/SG
Static Line, Free Fall, HALO, Jump Master (Not required for AFSC)		
AD	Local Base Certification/Waiver Authority	MAJCOM/SG
Reserves	AFRC/SG	AFRC/SGPS
ANG	State Air Surgeon (ANG)	ANG/SG
Ground Based Controllers (ATC, TAC-P, ALO, 1U0XX, etc)		
Initial AD	Local Base Certification/Waiver Authority	AETC/SGPS
Trained AD		MAJCOM/SG
Reserves Initial/Trained	AFRC/SG	AFRC/SG
ANG Initial/Trained	State Air Surgeon (ANG)	State Air Surgeon (ANG)

Note: *AFMSA/SG3PF continues to be the waiver authority for conditions as listed in 6.4.1.*

For all other certification or waiver authority, see table [A2.1](#).