



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

MEMORANDUM FOR ALMAJCOM/SG

NOV 17 2016

FROM: AFMSA/SG3P

SUBJECT: Implementation of AFI 10-203 Supplemental Guidance

In accordance with Air Force Instruction 10-203 *Duty Limiting Conditions*, the attached Supplemental Guidance is provided. This guidance does not supersede the AFI 10-203, but does offer clarification and assistance in methodology for meeting AFI requirements.

This edition of the Supplemental Guidance supercedes the previous edition dated June 2014. This Supplemental Guidance will be available through the AF Knowledge Exchange on the AFI 10-203 *Duty Limiting Conditions* subpage. AFMSA/SG3PF is the waiver authority for requirements in this Supplement, unless they are otherwise tiered (higher or lower) in the parent AFI.

Changes include clarification and deconfliction with updates in other DoDIs and AFIs. No significant policy changes are directed or implied by this Supplemental Guidance. Office symbols, organizations and references are updated. Guidance is provided for profiles identified as "permanent" by other AFI changes. Responsibilities for NARSUM completion in complex cases is clarified. Additional guidance for completion of Strength Aptitude Testing is provided. DAWG responsibility for trigger events as a result of known conditions is clarified. This Supplemental Guidance removes an implied limitation on mental health team providers signing AF Form 469s, this will be further clarified in the next update of AFI 10-203. Dental conditions that require a DLC are also discussed. The changes to DoD pregnancy policy are summarized. Additional guidance for evidence-based profiles is included.

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Attachment
AFI 10-203 Supplemental Guidance

1. PROVIDER GUIDANCE (INCLUDES ALL MILITARY CREDENTIALLED PROVIDERS WHO HAVE MILITARY PATIENTS)

1.1. Consultant timeliness metric: For airmen with mobility restricting conditions, examinations (including laboratory/radiology studies and specialty evaluations) should be completed within 30 days after initiation of the AF Form 469 for that condition, unless the reasons are adequately explained and documented in the medical record. (For ARC Airmen with Line of Duty (LOD) or other condition limiting their ability to perform their duties, the 30-day limit applies. For ARC Airmen with non-duty related conditions, examinations shall be completed within 90 days.)

1.2. Provider completion of AF Form 469:

1.2.1. All providers, including military consultants, will ensure patient encounters are appropriately documented in the medical record. This will include duty limitations, anticipated recovery time and further evaluation/treatment plans. Providers will also ensure duty limitation data is entered into ASIMS (or equivalent program) and an AF Form 469 is initiated for transmission to the unit. Examples of documentation in the Assessment and Plan portion of the medical note for a patient with the diagnoses are noted below.

- Ankle sprain mild: “WWQ, Duty restriction: limited walking/standing for one day, Fitness restriction - no run/walk/sit-ups for 30 days”.
- Pulmonary embolus: “Not WWQ, refer to DAWG. Duty restriction: walking/standing as tolerated, Fitness restriction – no run/walk/push-ups/sit-ups for 90 days.”
- Asthma controlled: “Code C-1 (next RILO DEC 2016). No fitness restrictions. Duty limitations: SM to carry relief medications and identify triggers to supervisor.”

1.2.2. Providers will evaluate and update the airman’s AF Form 469 at every face-to-face clinical encounter. Additionally, all special purpose medical examinations and Preventive Health Assessments (PHA) must include a review of existing limitations. For ongoing conditions, a simple annotation in the medical record encounter note (e.g. “WWQ, no change to DLC” or “Code C, DLC remains appropriate”) will suffice if there are no changes. See examples in 1.2.1. for new conditions identified. This includes any profiles identified as “permanent” in accordance with AFI 36-2905, which require an annual review and renewal, or may be removed if no longer appropriate.

1.2.3. Ensures airmen under their care with mobility restrictions originally anticipated to expire within 30 days are converted to an Assignment Availability Code (AAC) 31 if the restrictions need to be extended beyond 30 days.

1.2.4. On initiation of an AF Form 469, providers must ensure airmen understand the DLC process. A local process may be developed to ensure that service members understand the meaning of the limitation(s) and any requirements they may have.

1.2.5. If an airman has a medical condition that does not meet retention standards or may result in mobility restrictions (trigger event), the provider (including specialty providers) is to refer the

case to the DAWG for consideration of an initial RILO at the next scheduled DAWG, ideally using the “Refer to DAWG” feature in ASIMS.

1.3. Provider responsibility for assignment, retraining or deployment:

1.3.1. When completing these reviews, the provider will consider the requirements of the assignment, new AFSC or deployment, as well as the medical care available at the proposed location(s). If the provider is uncertain of available medical care at the proposed location(s), consult the SGH for guidance. The MSME, profile officers and, if necessary, the airman’s commander may be consulted if there are concerns about medical risk related to the airman’s condition and/or the assignment, training, or deployment.

1.3.2. In cases where the medical condition of an airman appears to resolve or develop in close association with a new assignment, training opportunity, or deployment tasking; commanders will contact the SGP or SGH if there are concerns about the fidelity of past and/or present duty or mobility restrictions. In such cases, the SGP and/or SGH will coordinate with the PCM and MSME, in consultation with the commander, to ensure that the airman’s restrictions are accurately reflected. In all cases, MTF personnel shall consider unit commanders and first sergeants to be teammates in the accomplishment of appropriate restrictions.

2. PROFILE OFFICERS

2.1. Profile Officer:

2.1.1. Receives formal training on their duties and the appropriate AFIs.

2.1.2. Ensures unit interest (mission) and the patient’s interests (sustainment or restoration of health) are considered to maximize the benefit to both.

2.1.3. Reviews 469s and 422s in accordance with AFI 10-203 to ensure they meet the intent of the AFI.

2.1.4. Maintains familiarity with the most current medical standards for retention, special duty and deployment as outlined in AFI 48-123, Medical Standards Directory and DoDI 6490.07.

2.2. Non-concur by Commander: When an airman’s commander does not concur (or chooses not to sign) with a mobility restriction on an AF Form 469, the SGP should review the medical case and discuss concerns with the commander. If they are unable to resolve the non-concur, then the case is to be presented to the next level commander in the chain. If both commanders non-concur and it results in an airman being placed at risk for medical complications due to deployment, the MTF/SGP will advise MAJCOM/SGP of the case.

3. MSME GUIDANCE

3.1. Manages the profiling/duty limitation system following the guidance below:

3.1.1. Provides oversight regarding AF Forms 422 and 469 processing status on each airman, and acts to ensure process effectiveness and compliance with established timelines.

3.1.2. Tracks and reports compliance with AF Forms 422 and 469 processing timelines to the DAWG. Notifies SGH, SGP or Senior Profile Officer (SPO) regarding timeline compliance issues as soon as possible after issues are identified.

3.1.3. Actively engages Profile Officers (PO) when SGP/SPO is unavailable or timelines are not being met.

3.1.4. Upon request, provides updates regarding AF Forms 422 and 469 processing status to airmen, Commanders, Unit Fitness Program Manager (UFP), PCM, or PO. Note: UFPs must be appointed in writing as a commander's designee IAW AFI 41-210 in order to receive PHI.

3.1.5. Ensures airmen with mobility restrictions originally anticipated to expire within 30 days will be converted to an AAC 31 if the restrictions need to be extended beyond 30 days.

3.1.6. MSME is responsible for timely execution and follow-up once the provider has initiated the AF Form 469. Questions on applicability of standards, restrictions, and provider non-compliance, may be addressed with either the provider, the PO or the SGP/SPO.

3.2. Ensures that DAWG decisions secondary to trigger events (see AFI 10-203, 4.1.3.3 for trigger events) are appropriately documented in ASIMS "Refer to DAWG" section per ASIMS Guidance. Additional information for PCM team can also be noted in the notes section at the request of the SGP.

3.3. Oversees the administrative quality control reviews on AF Forms 422 and 469.

3.3.1. Performs administrative quality control review on AF Forms 422 and 469 after Initial RILO, MEB or Physical Evaluation Board (PEB) processing as applicable. Particular attention will be paid to airmen who have been given an Assignment Limitation Code C (ALC-C) by AFPC/DP2NP or ARC/SGP.

3.3.2. Tracks, at the discretion of the SGP, PCM team trends on completion of 469 and 422s. Briefs these at the DAWG each month. For example, tracks by team the first 10 errors for each provider, reviews for trends, provides team training with approval of the SGP, and records these results/actions at the DAWG.

3.3.3. SGH directed Diagnostic and Medication Surveillance

3.3.3.1. At a minimum of ten times per year, MSME will present findings to the DAWG of selected diagnostic or medication utilization queries as directed by the SGH to ensure airmen with certain medical conditions do not remain unidentified in the mobility reporting system. The steps for completing this review are described below.

3.3.3.2. The SGH will develop a list of the ten most frequent diagnoses at the MTF that require Initial RILO, including ICD 10 codes, as well as medications associated with treating these conditions. For each review a different diagnosis and/or medication from the list will be selected.

3.3.3.3. A Composite Health Care System (CHCS), AHLTA, or DoD Electronic Healthcare Record (EHR) query will be compared to existing AAC 31, 37 and 81 lists to provide increased visibility on conditions which may impact deployment availability. Personnel identified using this surveillance will be referred to their PCM for initiation of DLC action if indicated.

3.3.3.4. MSME will ensure the reviews are performed and will present findings (i.e. cases that may need DLC action or Initial RILO) to the DAWG.

3.3.3.5. Findings will be presented to the professional staff by the SGH at least annually for education purposes. This paragraph does not apply to ARC units.

3.3.3.6. Example diagnosis and medication surveillance list:

- 1) Obstructive Sleep Apnea, sleep study referrals
- 2) Diabetes, metformin, insulin, Januvia
- 3) Asthma, Advair, Flovent
- 4) Seizure, epilepsy, lithium, Seroquel, Abilify, Provigil, NuVigil
- 5) Low Back Pain and narcotics for greater than 3 months
- 6) Crohn's disease, celiac disease, ulcerative colitis
- 7) Warfarin, methotrexate, Humira, Enbrel, Remicade
- 8) Review AD high utilizer list
- 9) Epipen
- 10) Locally determined list of personnel with chronic benzodiazepine and/or narcotic use.

3.4. Retraining Personnel: MSME will review retraining applications to ensure airmen are qualified for entry into AFSC(s) specified for potential retraining. Review of each AFSC's physical requirements is found in the Air Force Enlisted Classification Directory (AFECD) and the Air Force Officer Classification Directory (AFOCD) located on the Air Force Personnel Center (AFPC) website under "Careers". The AF Form 422 will indicate each of the selected AFSCs the airman is and is not qualified to enter. When flying or special operational duty AFSCs are selected that require specific qualification examinations, AFI 48-123 will be reviewed for disqualification criteria and the certification examination process will be initiated in accordance with AFI 48-123. During the AFSC disqualification process, airmen are considered for return to a prior AFSC for which they may remain qualified prior to considering other possible AFSCs for retraining. MSME will then forward the edited AF Form 422 for appropriate signature by the provider, MSME technician and PO. The signed/completed AF Form 422 will be transmitted to the unit Commander who will initiate AFSC disqualification.

3.4.1. Strength Aptitude Test (SAT) is used to determine if members applying for retraining or special duty meet minimum strength requirements. This is usually performed at MEPS for initial applicants.

3.4.1.1. The AFECD establishes a SAT standard for the AFSC. Waiver authority is the AFSC's Career Field Manager (CFM).

3.4.1.2. When AFPC requests a SAT evaluation in writing, MSME reviews the accession MEPS physical and current medical records and completes the appropriate endorsement.

3.4.1.3. If the profile "X" factor equals or exceeds the SAT standard for the retraining AFSC, do not retest unless a medical condition is discovered changing the SAT. If a medical condition is discovered, refer the individual to a health care provider for evaluation prior to SAT testing. See AFECD/AFOCD for detailed requirements.

3.4.1.4. If the profile "X" factor is blank, contains a numeric character 1, 2 or 3, or is an alpha character less than the SAT standard, the SAT results are unsatisfactory.

3.4.1.5. A provider's review of medical records must indicate no potential medical reason that member cannot perform safe successful lifting attempt.

3.4.1.6. Refer member to the Fitness Center (gym) for administration of the SAT for those seeking retraining. If SAT testing equipment is not available at the Fitness Center (or nearby DoD facility or MEPS station), request assistance from the MTF Physical Therapy team for evaluation of SAT with available resources. If no MTF Physical Therapy team is available, SGH/SGP/MSME/PO (as appropriate) may supervise the retraining applicant perform the SAT at the Fitness Center with the most similar equipment available. Contact AFPC for additional options. AFRSI 36-2001 has additional details on performance of SAT.

3.5. Assignment Action Reviews: MSME will review assignment actions to ensure Airmen are qualified for PCS to gaining base in accordance with applicable Personnel Processing Codes (PPC). The PPC provides processing instructions for the airman and Military Personnel System to ensure the airman is qualified and prepared to proceed on assignment. PPCs are generally included in the airman's notification of PCS, but are also located on the AFPC website. The AF Form 422 will contain a statement as indicated by PPC listing.

4. DAWG GUIDANCE FOR REVIEWING TRIGGER EVENTS

4.1. If a trigger event is identified and patient is referred to the DAWG, then place a brief statement within the assessment of the medical encounter describing the trigger event and referral. Not all trigger events require a full DAWG evaluation. For example, if a service member has already met an MEB and was returned to duty, and they are denied deployment *due to that condition*, a brief review and brief documentation by the DAWG chair is sufficient.

4.2. Providers should refer cases to the DAWG if the continuous or cumulative time for the restriction or recovery from the condition exceeds 365 days, or is reasonably anticipated to exceed 365 days. Providers, in consultation with the SGP and/or SGH as appropriate, are encouraged to refer cases to the DAWG for Initial RILO consideration *at the earliest time possible* it can be reasonably anticipated that the airman will not be recovered to mobility status within 365 days.

4.3. Once an airman has been identified by the DAWG as requiring an Initial RILO (or FFD/WWD evaluation for ARC Airmen with non-duty related conditions), the provider will work with the Physical Evaluation Board Liaison Officer (PEBLO) (or ARC equivalent) to ensure all Initial RILO (or FFD/WWD) requirements are met in accordance with AFI 41-210 in a timely fashion.

4.4. The SGH will ensure local protocol exists on assignment of physicians for the narrative summary; this could include medical subspecialists. For example, if a member has a medical condition falling within one medical specialty, the NARSUM may be completed either by the PCM or by a medical specialist in that specialty within the MTF. The decision is made by the SGH or SGP. If a member has two or more medical conditions which require MEB that fall into two or more medical specialties, the NARSUM should be done by the PCM, who is expected to synthesize the information from both specialists into one NARSUM. Current specialist notes can be included with the NARSUM in the Initial RILO package. However, if a member has more than one condition which requires an Initial RILO, including at least one medical condition and at least one mental health condition, then that member will require two NARSUMs - one by the PCM or medical specialist using the medical NARSUM template, and one by a mental health provider using the Mental Health NARSUM template. Both NARSUMs should be submitted at the same time. The local protocol may be approved at ECOMS or Executive Staff whichever is deemed most appropriate by the SGH or SGP.

4.5. The DAWG will review each case using the criteria listed below:

4.5.1. Is timing appropriate for Initial RILO Referral? Verify the member's hospitalization or treatment progress appears to have medically stabilized (and the course of further recovery is relatively predictable). There is no minimum medical evaluation time period and no need to wait for complete or near-complete recovery. There should be no delay in referral of a member's case as long as the course of recovery is relatively predictable, and a reasonable determination can be made that the limiting condition is not likely to resolve or improve within 12 months to an extent which renders the service member capable of fully performing the duties of their office, grade, rank or rating, to include the ability to deploy to field conditions.

4.5.1.1. In cases where there is no definitive diagnosis, but the preponderance of clinical evidence suggests a probable underlying cause in which the treatment progress, or progression of the condition, appears to be reasonably predictable, Initial RILO processing may proceed without a definitive diagnosis.

4.5.1.2. Neoplastic Diseases. A diagnosis of cancer or neoplastic disease may require additional time (beyond 90 days) to establish a clear prognosis. However, if it is clear the service member will require lengthy treatment, or will be unable to perform their job for a protracted period of time, referral of I-RILO to AFPC/DP2NP should expeditiously occur regardless of prognosis.

4.5.1.3. Solid Organ Transplants. When it is determined that a patient requires a solid organ transplant, an Initial RILO shall be submitted within 90 days of the initial organ transplant determination date.

4.5.2. Is the case appropriate for Initial RILO referral? Only unfitting conditions are eligible for referral. Unsuiting conditions must be distinguished from unfitting conditions because they are handled using administrative action. Many unsuiting conditions are listed in AFI 36-3208, *Administrative Separation of Airmen*, section 5.11 “Conditions That Interfere with Military Service” (although not an all-inclusive list). These conditions are prohibited from medical disability processing (MEB or DES). Exception: History of anaphylaxis or severe reactions requiring venom immunotherapy requires an Initial RILO for ALC-C consideration.

4.5.3. Is the member unable to reasonably perform the duties of their office, grade, rank, or rating due to a physical or mental condition which is not likely to resolve or improve such that they can perform these duties within 12 months?

4.5.4. Is this a chronic condition which imposes unreasonable requirements on the military to either maintain or protect the member?

4.5.5. Is this a chronic condition which may preclude or limit the member’s ability to safely and effectively deploy to field conditions?

4.5.6. Has an Initial RILO package been directed by AFPC/DP2NP?

4.5.7. Is this a condition with 12 months of cumulative AAC 31 status for the same or related issue(s)?

4.5.8. Is the member refusing required professional, medical or dental care which would be necessary to achieve fitness for continued military service?

4.6. Upon review of a case referred due to a trigger event, if it is determined that above criteria are affirmed, then the Initial RILO package should be completed. If additional review of the Initial RILO package is required, this will be accomplished at the next scheduled DAWG meeting. However, the Initial RILO case may be referred to AFPC/DP2NP without another DAWG review if the SGP and SGH concur that the RILO package meets enough of the requirements. All decisions should be tracked in the ASIMS “Refer to DAWG” Tool.

5. DAWG GUIDANCE FOR FITNESS EXEMPTIONS

5.1. Abdominal Circumference (AC) component exemption. Recommending abdominal circumference measurement exemptions should be rare. AC exemptions for mass effect should be based on the size and location of the mass, i.e. a 2 cm renal cyst should not prompt an exemption, but ascites should be considered for possible exemption. Diagnoses such as depression, diabetes and chronic knee pain are insufficient reason for an AC exemption. Smoking cessation and the use of certain medications (corticosteroids and some psychoactive medications) has been associated with weight gain. AC increase in these scenarios is not universal and may be countered by appropriate diet. AC exemption should not be recommended in most of these situations. For additional guidance in specific cases, contact MAJCOM/SGP.

5.2. Cases referred secondary to prolonged or recurrent fitness exemptions or cancelled deployment, TDY, or PCS. These cases are reviewed with the 8 criteria listed above in 4.5. These cases do not automatically require an initial RILO. However, they may require a brief DAWG review using the guidance above. Consider using the “Refer to DAWG” Tool to send response to commander or document DAWG review on an AF Form 422 when referred for prolonged or recurrent fitness exemptions to inform the Commander. For example, “Member has been reviewed by the MDG/DAWG with PULHES as indicated. No requirement for IRILO or MEB at this time.”

6. SGH GUIDANCE

6.1. Process for profiling deployment limiting conditions without duty limitations (often mental or behavioral health related conditions or diagnoses). The SGH, with assistance from the SGP, should have a local policy on how to support appropriately profiling these conditions and also how to also ensure the privacy of the patients.

6.1.1. Identify and teach the providers on how to profile for these conditions.

6.1.2. In accordance with DoDI 6490.08, command notification by healthcare providers is not always required for referrals to mental health care or substance abuse/misuse education, unless disclosure is authorized as listed in Enclosure 2 of that DoDI. Evaluations that determine a service member is at risk for harm to self, or harm to others, require a direct notification to command. The AF Form 469 is insufficient without direct contact to appropriate line leadership (i.e. in person or via direct phone call). Special personnel such as those on PRAP or aviation duties may require notification to command, even for diagnoses that are not an immediate risk to self or others. Acute medical conditions that interfere with duty, or represent harm to the mission may require notification to the command. These notifications should include appropriate duty limitations noted on an AF Form 469 and may be signed by appropriate mental health providers. Diagnoses and treatments are never identified, only duty/fitness restrictions, the same as any other 469. Initiation or change of psychiatric medications requires 90 days DLC in accordance with DoDI 6490.07.

6.1.3. Identify a standard statement for all these conditions. Consider, “service member is undergoing medical evaluation and/or treatment for a condition that precludes deployment at this time. A deployment waiver may be considered if tasked to deploy prior to expiration date. Contact (SGP/MSME/PCM) if tasked for deployment.” Do not include the statement “A deployment waiver may be considered if tasked to deploy prior to expiration date” if the provider would not recommend a waiver, or the condition requires a Code 37.

6.2. Duty Limiting Conditions and peer reviews

6.2.1. Provider Peer Review: May be used to monitor the quality of the Duty Limiting Condition (DLC) determinations, Fitness Assessment Exemptions (FAE) and application of medical standards. The SGP’s role is to monitor and SGH’s role is to ensure this is accomplished with data reported in the appropriate forum (ex. DAWG).

6.2.2. DLC Quality Reviews. The DAWG will determine the method for performing the DLC Quality Reviews. These will often be accomplished via the Provider Peer Review process. They will include the following at a minimum:

6.2.2.1. Are functional limitations appropriate for the diagnosis and written appropriately?

6.2.2.2. Is the estimated duration of medical recommendations (duty, mobility and/or fitness) appropriate?

6.2.2.3. Was mobility qualification appropriately addressed?

6.2.2.4. Was potential medical disqualification (e.g. diagnosis rendering an airman unfit for duty) with concomitant need for Initial RILO referral to the DAWG, appropriately identified?

6.2.2.5. Were FAE appropriate?

7. PROVIDER AND PRIMARY CARE TEAM TRAINING

7.1. Responsibility is shared by the MTF SGP and SGH to maintain a program for when a new provider arrives at the MTF as well as (at a minimum) annual training. This training should include: appropriate application of medical standards, completion of profiles and duty limitations, Fitness Restrictions (FR), Fitness Assessment Exemptions (FAE) and Initial RILO and Medical Evaluation Board (MEB) processes.

7.2. The SGP will ensure that all Primary Care Management (PCM) providers understand the purpose of the DAWG and the processes utilized by the DAWG to meet its mission.

7.3. Training should include members of the PCM team and can be completed by any member of the DAWG as directed by the SGP.

8. DENTAL READINESS

8.1. For ADAF, an AF Form 469 must be completed if a service member is anticipated to be in DRC 3 for more than 30 days. An AF Form 469 may be completed for Airmen in DRC 3 under other circumstances to facilitate patient care or to meet local mission requirements. For ARC, when it is determined that a member is in DRC3, an AF Form 469 will be completed immediately. See AFI 47-101, *Managing Air Force Dental Services*, for more information and ARC management requirements.

9. PREGNANCY

9.1. The AF standard pregnancy profile template should be used for all pregnant airmen, with modifications as required for the specific individual. This template is only for use while the member is pregnant. The AF has updated relevant AFIs as below.

9.1.1. AFI 36-2905 incorporates the change to fitness assessment restrictions following pregnancies that last 20 weeks or more. Airmen are exempt from mandatory fitness assessments for 12 months postpartum. Airmen may, at their discretion, choose to test earlier. The postpartum 469 should only state “Member is excused from Fitness Assessment until [DATE]”. It should also include “This does not preclude participation in unit or individual fitness programs,” or appropriate restrictions, if approved by PCM.

9.1.2. AFI 36-2110 incorporates the deployment restriction policies. In summary, “After the birth of a child to an airman, deferment from PCS, TDY and deployment is authorized for 12 months following the date of birth, unless waived by the member.” AFPC updates deployment restrictions upon notification of AAC 81 and this is not required to be written on the 469. This does not preclude all PCS or TDYs, see AFI 36-2110 for details.

9.1.3. For postpartum 469s, do not use Code 81, as they are no longer pregnant. The 469 is for fitness restrictions only. Use the ICD10 code of Z02.79, “issuance of medical certificate” for this 469, unless there are other restrictions due to other medical conditions.

10. EVIDENCE-BASED PROFILES

10.1. Evidence-based profile templates for many specific medical conditions are provided with guidance from the AF Occupational Medicine team using the most current medical literature. These are available for use by PCM, PO/SPO or DAWG (or any interested MTF provider) through the AF Knowledge Exchange under the AFI 10-203 *Duty Limiting Conditions* subpage in the “Documents” tab. These may be encouraged by the SGH/SGP, with appropriate modifications as needed.